Final Transcript

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

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SPEAKERS

Anastasia Dodson
Kim McCoy Wade
Ellen Goodwin
Chris Gizzi
Patty Berg
Ellen Schmeding
Jeff Thom
Carrie Graham
Peter Mendoza
Julia Figueira-McDonough
Karen Fies
Kristina Bas-Hamilton
Susan DeMorris
Catherine Blakemore
Marty Omoto
Karen Keesler
Donna Benton
Nina Weiler-Harwell
Brandi Wolf
Claire Ramsey
Jedd Hampton
Sarah Steenhausen
Ana Acton
Christina Mills

PRESENTATION

Moderator — Ladies and gentlemen, thank you for standing by, and welcome to the Master Plan for Aging LTSS Subcommittee Meeting. At this time, all participants are in a listen-only mode. Later there will be time for public comments. [Operator instructions]. As a reminder, this conference is being recorded.

I will now turn the conference over to our host, Ms. Anastasia Dodson. Please go ahead.

Anastasia — Thank you. I'm going to start with some housekeeping for folks who are in the room and on the phone. Then, I'll hand it off to Kim McCoy Wade.

So, welcome, everyone, to this meeting for the Master Plan for Aging. For the folks here in the room, there are ceiling microphones and speakers, so you do not need an individual microphone at your table in order to be heard by the folks on the phone. So, just please project, and then the folks on the phone will be able to hear you through the microphones in the ceiling. Again, if you're having sidebar conversations, they can also hear through the microphones, so just a reminder about that.

There are restrooms outside, and also there will be a public comment period at the end of the meeting. We will have public comments from folks in the room and over the phone. There are many people listening on the phone through an operator-assisted line, and there will be a process at the end of the meeting for folks to comment over the phone.

With that, I will turn it over to Kim McCoy Wade.

Kim — Good afternoon. Welcome. Let's start with introductions at the Master Plan for Aging Long-Term Services and Supports Subcommittee Meeting number two. To my left, project manager, Ellen Goodwin.

Chris — Hi. Chris Gizzi [ph] with Milliman.

Anastasia — Anastasia Dodson, Department of Aging today, Department of Healthcare Services tomorrow.

Patty — Patty Berg former State Assemblywoman.

Ellen	Hi. I'm Ellen Schmeding. I'm with Saint Paul Senior Services, and I'm also here on behalf of the California Commission on Aging.
Jeff	Jeff Thom, California Council for the Blind.
Carrie	Carrie Graham. I'm from UC San Francisco, but I'm acting as an external consultant to the Master Plan.
Peter	Peter Mendoza [ph]. I'm [indiscernible] LTSS.
Julia	Julia Figueira-McDonough. I'm a leadership and government fellow for the coming year, and I'm a liaison for the Secretary of Labor.
W	I'm just here.
Kim	Just a member of the public?
W	Captioner.
Kim	Captioner. Thank you.
Karen F.	Hi. Karen Fies, Sonoma County Human Services Department, Area Agency on Aging.
Kristina	Hi. Kristina Bas-Hamilton with UDW/AFSCME.
Susan	Susan DeMorris representing the Alzheimer's Association.
Catherine	Catherine Blakemore, Disability Rights California.
Marty	Marty Omoto, CDCAN, California Disabilities Senior Community Action Network.
Karen K.	Karen Keesler, pleased to be having my 60th birthday with all of you today. I'm with the California Association of Public Authority.
W	You're dedicated, Karen.
Donna	Donna Benton, University of Southern California and California Association of Caregiver Resource Centers.

Nina — Nina Weiler-Harwell with AARP California.

Brandi — I'm Brandi Wolf with SEIU Local 2015.

Claire — Claire Ramsey with Justice in Aging.

Jedd — I'm Jedd Hampton with Leading Age California.

Kim — Wonderful, and do we have subcommittee members on the phone? Sarah?

Sarah — Can you hear me? This is Sarah Steenhausen from the SCAN Foundation.

Kim — Yes. Sarah, I believe is calling from the CAADS, the Adult Day Services state conference. So, thank you for walking off the stage and into our subcommittee meeting.

Sarah — Absolutely.

Kim — Let's go ahead and jump in. We are really trying to do two different things today. I'm going to start the meeting by spending some time continuing to organize our work. This is our second meeting, so we are still forming how we're going to work, so we have a lot of documents and organizing principles to go through.

Then, we will do what we like to do is spend most of our time doing a deep dive on a focus topic, and we're so thrilled today that we'll be talking about the potential of a long-term care benefit with an expert panel. I want to thank Anastasia particularly for her work in building this great, robust program, and she will be facilitating as well because I have to head to agency. So, that will be the bulk of it, and of course, public comments both in the room and on the phone.

You'll see we want to be very clear at the end we're going to end by summarizing any recommendations that came out and the action steps. We'll capture those in the last few minutes as well.

What we wanted to do is, again, as we talked about last time even as we dove into our first topic of Information and Referrals, we really need to lay some foundation work here. So, first of all, a reminder of the diversity and illustriousness of our subcommittee members and thank you to those of you who are lending your time, and you are traveling when you can,

and we know it's a very intense calendar of conversations and discussions to meet our goals. So, thank you to all of you.

As you remember from the executive order, we're trying to do two things here. We are both advising the full stakeholder committee and the administration on the deliverables around the master plan executive order which are in October. That's parallel to every other part of the stakeholder committee moving towards the master plan with a state plan, a local blueprint, a data dashboard, and a resource kit.

But, uniquely, this subcommittee has a special opportunity and honor of writings its own report on Long-Term Services and Supports, which is expected to go through the full committee and to the governor by March, which every month is sooner now.

That's the high level of what we're doing from the executive order, and we can return to the charter in a second. Before we go to the charter and the calendar and the reports and all that, we really wanted to go where Catherine and Claire and many of you have been asking us to go to which is spend some time on the framework.

On the slide, you can see the high level, which every time we meet, every time we have a conversation continue to revise, and we went ahead and attached to the meeting, and it's on the agency webpage, kind of the whole piece, the vision, the values, and the goals with objectives and our very first recommendation beginning to appear below it on the Information and Referral system coming out of the last meeting.

We want to take a second on this because this has been evolving, and this will go to the full committee, but because you all are meeting before the full committee and because it's been so important to grounding the LTSS work, we want to take a second and talk about it.

We have really heard a lot of feedback from everybody about inclusivity of the language both making sure we're not doing it about people who are older, but about all of us who are aging and being intergenerational, and also fully including people with disabilities. So, you'll see the language continues to evolve and emerge, so you see now a vision statement that we are really trying to build a California for all across the lifespan is our current attempt at this.

The mission continues to remain to deliver a master plan by October, and then the values have been expanded upon. What does it mean by choices? What does it mean by equity, dignity, inclusion, innovation, and partnership all to reflect?

For this subcommittee, we have continued to try to deepen the goal statement around services, supports, and caregiving. Again, trying to go to that next level, what does that mean? If that's your big picture goal that we all can live where we choose as we age and have the help we and our families need to do so, but let's get specific.

So, trying to set an objective that could then become measurable on the dashboard about where Californians are living and the help they're receiving, and below they have recommendations that help us achieve that objective. So, the objective might be about outcomes, and the recommendations might be about inputs where we're providing referrals, we're providing slots, we're providing services, and the outcome is more people living where they want to live, and there's others on there.

So, we just wanted to ground the work in this, and we are very open for discussion or feedback. This will be a living document. This will end up informing the final plan 11 months from now, but we want to keep working at it. As we have more conversations and more revelations to keep going and knit it to the recommendations from the data indicators that are starting to come from the Policy committees and the Research committee.

Let me pause. Questions, comments, on—? Yes, Patty.

Patty Hi, Kim. Of course, I support the goals. I hear the goals. I love them. The objectives make no sense to me, and firstly I just want to say this again. There has been no recognition of the 37 rural counties in the state yet, and as far as I know, the Research committee has not yet, that I'm aware of, looked at any rural [cough], let alone services.

I mean, let alone services, so if this is a master plan for aging, which is not on aging, which is why it's much more future-focused and includes all three populations, not just aging, we have to deal with rural California. That's nowhere here. Rural is not even on the program other than workforce which is a whole other issue [background noise]. Anyway, these objectives don't make sense.

W Which objectives? Can we clarify? What are you looking at? I'm sorry.

Kim Do you have the document, the handout?

Patty No.

Kim So, if you have access to the webpage, there's about, I want to say, six or seven attachments that came with this agenda. There was the framework document, the charter document—

Patty Got it. Sorry about that.

Kim That's okay. Sorry to be so document-heavy this meeting, so I would say if you're talking about objective 1.1, which is the one most aimed at LTSS, we're absolutely aiming to have that be interactive between Policy and Research. What is the objective that can be measured, and Catherine and Claire have suggested language, so let's work that back and forth so it does have meaning and does have an indicator that can go with it.

In terms of the rural, at this point, it is nodded to in geography in terms of equity, and there is rural representation on this board including yourself and City Councilperson Jan Arbuckle, and we're having a rural roundtable December 19th in Grass Valley to begin that conversation, but again, really welcome concrete suggestions of where to put it, where to name it, where to have it. It's absolutely intended the data dashboard would have data by all communities.

Patty Who wrote the objectives, Kim, because—who created these objectives?

Kim Oh, it's been a group process to try to move it forward.

Patty Not people on this committee.

Kim I honestly couldn't remember who wrote that sentence in this moment, Patty.

Patty I'm not asking who wrote the sentence. I'm just—I mean, I've done a lot of work with goals and objectives, and the objectives are measurable. They relate. This is a state plan, it's not just a plan for a piece. It's a state plan, so when you look at these goals, which are very broad-based and ideal, you have to look at then [cough] that we got there. How are we going to know?

Kim — Right. How are we going to make those objectives measureable? That's right. That is the question.

Patty — Raise that to whoever. [Background noise] the objectives don't feel—

Kim — Yes, the objectives need more work. Right.

M — I would say keep going.

Kim — Okay. So, we will keep rewriting the objectives based on the discussions of every meeting and feedback. So, what we have started to do is break that big, lofty goal and big objective about choices where you live into manageable topics, although I think everybody will agree that each of these topics is quite big as well. Again, we did Information and Referrals last time.

Today, we have, if you look at the calendar document there's a column for LTSS subcommittee, and again reiterating that this is a subcommittee focused on goal one, so we're not immediately talking about programs. We are talking about our vision and our goals.

We have a calendar that currently has the following flow. Information assistance and long-term care benefits. Then, we'd like to do three in December if possible. IHSS, and I'm so thrilled to hear that that that planning committee met again today and has an update in just a moment.

A second one we were scoping as all other home and community-based services, but we're working with DHCS right now to see if that should be tweaked to be a little more CalAIM focused or stay there, so more to come very, very quickly on that one.

Then, of course, group living settings, the range of group living settings.

The two meetings that have been suggested for January for focus topics, the January Workforce Family Caregivers and Assisted Technology, How is the Care Provided, and then the suggestion of pull back from all this program focus and look at the system. How is care coordinated? How is it integrated? How is it financed? Those are two envisioned for January before we turn to pulling it all together, reviewing a draft report, finalizing the report in March.

Brandi, do you want to give a little update on the planning for the next meeting?

Brandi — Yes. This is my little planner. Feel free to jump in. So, the next meeting is on IHSS. We are looking at a four-hour timeframe for the meeting in the afternoon of the 2nd.

How we sort of talked about it is breaking it up into having a short opening at the beginning, doing some overarching principles and goals for debate and discussion amongst this group on IHSS that will sort of serve as our North Star as we are putting forward the recommendation for the report in March. Then, breaking up the discussion pieces into a set of topic areas.

So, we have workforce standards, consumer needs, emergency preparedness, and I know that there's a separate meeting that's sort of focusing on that, but we're looking at emergency preparedness and emergency response in terms of registry services in IHSS. Administration simplicity, places in the program that can be streamlined or simplified to potentially have some cost savings and program simplicity.

Then, a potential fifth bucket around financing of the program just sort of depending on the substance of the conversation today, if we need to continue to have that as part of the discussion specific to IHSS on the 2nd.

So, looking at having short sort of presentations in each of those buckets, very short. Patty, I heard you when you sais you don't want to get 101s, and I think we're generally feeling that same way, and then each topic will have an open discussion in trying to get to a set of recommendations in those topics, so more to come on the details. We'll be fleshing that out and sending out some notes to this group as the agenda is forming, but that's sort of the direction we're looking at for the 2nd.

Kim — Kristina.

Kristina — I apologize so profoundly if I messed up somehow, but I am on a plane from Florida back home on December 2nd, so I don't know how on earth that date got in that I didn't notice that, but I did just notice that today. Is there any chance we can flip the 2nd for the 5th?

W — I cannot be here on the 5th.

Kristina Oh, cripes. Okay.

Kim We will send an email in the next day or two confirming the plan for currently the proposed 2nd, the time. We'll get that feedback.

Kristina I'm sorry. There's just been so many meetings. I don't know how this escaped my—I don't even know.

[Overlapping voices].

W Yes, I did do that.

[Overlapping voices].

Marty Either way, safe flight, though.

Kristina Thanks, Marty.

Marty Marty Omoto, CDCAN. One suggestion, more logistics, if we use this room again, it's probably a good idea to have mics even though you can pick things up because it's kind of hard to hear people who don't have really loud voices, and I have a loud voice.

So, I thank the planning committee on the IHSS for December 2nd. Just one question though. On current issues that are before us in terms of priorities regarding IHSS financing, so what looms over for many people within IHSS and the families is the potential of a 7% across the board reduction. So, how does that fit in? It should because if we just keep talking about future and ignore something that is actually a given budget action that will take effect December 31, 2021 unless there's action by the administration or legislature to reverse that, that will happen.

So, I just think that we also need to talk about the reality of certain budget actions and priorities that the legislature and the administration has taken in regard to IHSS, and the other programs as well and services without—I mean, I understand we don't want to dive too deep in those things, but if we don't do that, we're going to lack the kind of credibility that the master plan is going to need, not only from those who receive services or provide it, but from the broader community.

The credibility of this report and whatever we recommend is as crucial as any recommendation we come up with, which is to Patty's point, too. So, thanks.

W [Speaker off mic].

Kim I see a lot of the planning group's heads nodding, and I take that to mean short, medium, and long-term recommendations are contemplated as part of the discussion, part of the report, part of the—and I also want to acknowledge our CDSS colleagues in the room, director Kim Johnson and completing the Kim triumvirate, IHSS leader Kim Rutledge. Any other Kims who want to identify?

W [Speaker off mic].

Kim Yes, sure. So, we will continue to build out that calendar with those of you who are helping us on everything from the dates to the room and the AV to the format so that we capture that. So, thank you to the IHSS planning. We'll be working with the others and continuing to update the calendar as soon as we have but thank you for holding those dates that we have on the calendar.

Patty, yes.

Patty Your favorite person.

Kim Always.

Patty I really totally understand IHSS is the big elephant in the room. I understand that, but my understanding was on a Master Plan for Aging, the population that we're focused on or to be focused on is the middle class, not the low-income, but the middle class.

So, we're taking four hours out essentially to talk about—which I understand—the big elephant in the room, IHSS, but I don't see how that fits with the master plan that we've been charged with. So, I just raise that. I'm still trying to clarification.

Kim Brandi.

Brandi Just to that point, the executive order calls for a specific set of topics that have to be examined in the master plan, and particularly in the report

that's due in March around IHSS specifically, so funding stability in the program, economic and workforce implications for retention, and meeting the demand of the workforce. So, there is a specific callout on IHSS, which I think is why there's a meeting dedicated to it is that there is an actual directive on IHSS in the executive order.

Kim — Yes, the executive order specifically calls out four topics in LTSS, and we are roughly dedicating a meeting to at least each of them, so the growth of state long-term care programs including IHSS. We have these December meetings we've lined up, the financing conversation today with the middle-class benefits and also again at the end, workforce in January, and stabilizing, again, that last meeting. So, we're trying to cross walk without being too constrained. We're trying to make sure we cover it all.

Nina, and then Karen.

Nina — Good afternoon. Nina, AARP. So, I guess I need a point of clarification because it's my understanding the middle class benefit conversation, caregiving will definitely focus on the needs of middle class individuals that can't save for long-term care or can't purchase long-term care insurance and need additional assistance, but it was also my understanding we're really looking at the whole framework of LTSS services including IHSS, and of course, there are many people who kind of bounce between qualifying, not qualifying.

There's also a population of younger folks with development disabilities that can qualify regardless of income because that was offered to my family. So, I just want a point of clarification that when we talk about CalAIM, for example, we're really talking about different ranges of income.

Kim — Thank you.

Karen K. — My question is back to more I guess kind of housekeeping, timeline, etc. So, I understand what you had said, Kim, at the last meeting about the draft report to the legislature needing to be done in January, and I understand the deadline of December 13th to submit recommendations from organizations. What I don't understand is the task of this subcommittee to draft or input into the master plan's report that you'll be having a draft on in January.

If there's specific recommendations that we'll be acting on that come out of the December 13th, how all of that separates from the meeting dates, but has committee input.

Kim — Sure. That's a great question and a good segue into what we want to talk about next which is the recommendation template. So, there are two ways right now that we're capturing the recommendations. One is this series of meetings, and what we want to do today is practice. We captured a recommendation from Information and Referral putting it on the template, reviewing it, and so there's a set of those that will come from those meetings.

We also wanted to open the doors wider to people who aren't on the subcommittee, who can't come to the meetings to offer a chance for recommendations. So, that's that public call. Send in those recommendations.

I think we're going to see what we get on December 13th, and then try to again, catalog, organize, and share those with the group as well so that you have the benefit of that as well, but we wanted to have both of those places doors open to get recommendations, bring to the subcommittee, to bring to the full committee for the report.

Karen K. — Am I the only one—

Kim — No, it's confusing. Go ahead.

Karen K. — So, just like on the December 13th, if you could unpack that a bit. That is the deadline for outside—

Kim — It's not really a deadline. It's an initial date where if people know they have recommendations, it's helpful to us to have them for two reasons. One, the volume to start cataloging and organizing, and second to help inform content. Remember, it's more than just LTSS, so we're looking at housing, transportation, parks to help inform the content of other topics and who could be a speaker, what program. So, we're trying to kind of do a wide net, if you will, at that.

In addition, the subcommittees are meeting and making recommendations here, so there will be those two streams that will have to come together.

Karen K. So, the recommendations can be done in three ways. One is by individual organizations including organizations represented on the subcommittee submitting per the template on the 13th. The second would be the recommendations that evolve out of each subcommittee's topic and meeting. Then, the third would be the master plan committee synthesizing, if you will, or the administration evaluating recommendations needed to meet your overall task. Is that right?

Kim I think that's a fair restatement.

Karen K. Then, in terms of the report, I think there are some of us trying to figure out what—because putting together recommendations that are meaningful is a lot of work, and then is there an additional goal or task for the subcommittees to be assisting in drafting the report in part or in whole?

Kim Great. We would love that if people do have the ability to write and draft and do as much as possible. If that's a helpful thing for us to do is do outlines and assign paragraphs, we can do that.

Carrie Graham is our consultant dedicated to this subcommittee. I'm sure she would love all the help. So, we're trying to walk that line of it is from the subcommittee to the full committee so authorship resides with the stakeholders, and it's a lot of work. So, we wanted to provide that staffing and technical assistance to help make that happen.

We are open to, as these recommendations get created by the subcommittee, as the recommendations get cataloged from the public, who starts writing?

Karen K. It's a little bit more clear. Thank you.

Kim Open to continuing to refine. Here comes the mic to Ana.

Ana Hi. Thank you so much. Ana Acton with FREED. I thought it might—I know at our first meeting Catherine had brought up the idea of really doing some work around what our values are as a group and based on some of the things I hear today, I feel like that might be really beneficial for us to get on the same page on what our values and goals are as a subcommittee.

I'm just going to throw that out there again because I feel like it might be good to know. Are we all talking about keeping people in the most

integrated setting and aging in place and living in the community and people of all income levels and people of any type of disability. I just think it might be helpful to have that conversation.

Kim — Dr. Benton.

Donna — Hi. I'm wondering could we maybe start with the values that were put out by the larger advisory committee because I think we do have those values to discuss. I don't know, I saw it on one of several of the things that we got, but maybe we could start with that as a base for values and see if that's inclusive enough to cover our subcommittee.

W — That's great. I think that's what we talked about last time.

Kim — So, we should go back to that for a few minutes? Okay.

Donna — Maybe folks disagree, but—

Kim — No, I think one of the things that's a strength and a challenge of this process is not everyone on the subcommittee is on the full committee, so half of this room had the conversation with the full committee, and half of this room didn't. So, let's take a second to get everybody moving in the same direction because we did, just a week ago, have a robust values conversation, but not with everybody here, to your point, Ana.

I think there is a slide with it, but if you have the document—

Donna — I have it.

Kim — You have the document. Yes, and actually both in the spirit of collaboration and also not talking so much, would folks who are on the full committee like to take a crack at walking through some of them and sharing some of the discussion? There's six volunteers.

W — Can Dr. Benton just read them out?

Kim — Sure. You're on.

Donna — I was volun-told?

Kim — Yes.

[Overlapping voices].

Donna — Okay, values. So, the first one it says choice, which is around access, quality, and autonomy. So, this is like we, as Californians, blah, blah, blah.

Equity, not the same as equality, but equity which eliminates health and social disparities due to age, disability, geography to your point, Patty, income, race, ethnicity, immigration status, language, religion, faith, sex, gender identify, sexual orientation, and family status.

Third, dignity and disruption of age bias, ableism, and discrimination.

Fourth, inclusion and accessibility for all older adults and people with disabilities.

Innovation and evidence-informed practice. That was a debate around evidence-informed versus evidence-based.

Partnership among local, state, federal government, philanthropy, and private sectors.

So, that was our general values statement which I think is supposed to kind of filter down to everything we do as we're looking at our goals and objectives.

Nina — Again, Nina AARP. So, one thing I'm not seeing here is a mention of the family as central to this conversation. So, whether it's under mission, person, and family-centered, that would really be preferential just because caregivers are often left out of the conversation, so making sure that they are included.

Kim — Yes, it's tricky because we also got feedback about a lot of people are living alone and families of choice and heteronormativity and making sure families is an inclusive work, interestingly. So, we tried in the preface to the goals, I'm not sure what you'd call that, as more and more diverse Californians live longer lives, California has the following goals for all older adults, people with disabilities, families, and communities.

Could it be somewhere else? Could it be stronger? Absolutely, but that was an attempt.

Nina — Just a quick follow-up. So, when I say family, I can mean family—

Kim — Of course, yes.

Nina — I'm being really clear. I'm not thinking heteronormative.

Kim — We need a way to say that somehow. All families.

W — To expand on that, I don't know if it might be helpful to have a definition section. I think we had mentioned earlier that I think it might very well be implicit in here that caregivers are contemplated, but I think it should be explicit and to extend beyond the family to paid caregivers, IHSS and beyond. That isn't here anywhere.

One potential way to phrase it, it doesn't really—I don't think it's important where it is personally because I think the values, again, could be read as inclusive of family, and paid caregivers, but for example, in the goals section maybe where we say California has the following goals for all older adults, people with disabilities, their caregivers, families, and communities, perhaps. Then, that way it becomes part of the definition of we. Then, perhaps we don't have to repeat it.

Kim — Excellent. The full stakeholder committee is getting a follow-up email today with all the action items in which a couple of people were asked to volunteer to help us continue to work on this. I'm coming to Jeff next, and then I also think, to several points, the interplay between the Research committee and Policy committee to tighten up the objective is definitely a needed next step.

Jeff.

Jeff — This is definitely wordsmithing and picky, but after disabilities if you have their caregivers, that sounds like every person with a disability has a caregiver. I'd rather take the word their out.

Kim — Very good.

Ellen — This is Ellen Schmeding. I just really appreciate the inclusiveness of the statement. I think one of our target groups are younger people, family members in the community. We have to put some energy behind having everyone support the master plan of all ages because we're all aging, and I think the younger generations have to be able to understand their need to

save and plan for the future. So, there's really a sense of urgency for all of our Californians, not just older adults or persons with disabilities. Thank you.

Kim — Okay. We will revisit each time as our thinking continues to engage and we edit, and it's not wordsmithing at all, Jeff. It's really important to get that right, so thank you.

A couple other foundational documents, I don't know if—the charter, we took a crack at simplifying dramatically to really focus on the scope and the executive order. Again, if there are burning comments, we're happy to have them now, but we're also happy to take them and put this to bed as well. So, this is just to make sure we're all on the same page, and it's supposed to travel with the framework. This is the values and the goals, and this is the scope and the process.

The other thing that was requested which we were happy to share was our list, and please let us know if we have omissions or prior plans on aging. Many of you have been a part of many that have looked at some of these same issues around Information and Referrals, universal assessments, integrated care, so those are there for you, and I commend them to you so that we do not reinvent the wheel.

W — I just have a quick question. Was there any sort of analysis done of all the reports to find out the commonalities, the recommendations that were made that are uniform?

Kim — Yes, we do have a little bit of an internal worksheet that we could share. There are—I don't know if I could do it off the top of my head. There are five or six common themes in all of them.

W — Okay, that was my guess.

Kim — Anastasia, could you do it off the top of your head, the five—

Anastasia — Not off the top of my head.

W — I do think that would be helpful to share with the group because my guess is there's been a groundswell of support for these items for years.

Kim — Yes. Okay, so the last item we wanted to do before we do turn to our topic is, as a good meeting practice, review the recommendation that was

made the end of last meeting. So, we have two things for you to look at. One is the template itself. You're the first ones to use it. You're the pilots. Then, one is the substantive recommendation that we were attempting to capture. So, if you could look at that document, the recommendation template.

Again, it would track back to a goal and objective. It would have a short statement of the recommendation, information and assistance system. Description, we tried to capture many of the points that were made, and then get to who is this targeted for, what is the evidence, what are the measureable indicators to track progress, potential cost, where did this source come from, to Karen's point, did it come from an organization letter or a subcommittee, and then, there's a question about prioritization. Are we going to look at short, medium, long? Are we going to look at some kind of periodization or tiering that we see in other reports?

I've also had the suggestion come in that we clarify who the recommendation is to. What state department or local actor or private sector, but sort of add that field of who would be the actor, if you will.

This is the idea of a template that, of course, is really an Excel spreadsheet where we're logging all of these, but would want to each meeting, spoiler alert, next meeting we'd have the recommendation coming out of today from this discussion about the long-term care benefit. Then, we'd have the IHSS. Then, we'd have the other home and community-based services, etc. By the end of this meeting sprint, we'd have a nice stack of these.

Yes, Patty

Patty Just a question again. Is it Shireen?

Kim Shireen from San Francisco?

Patty From San Francisco. Okay, the ADRCs are not statewide. I don't want a statewide I&A. They don't work. What we need is something at the local level. So, are you talking about—I'm just thinking in terms of budget. Are we talking about something like what Shireen has in San Francisco in 58 counties of the State of California? Is that what we're talking about? Because not a statewide system. I won't support a statewide system like a 911 number. It doesn't work.

Kim — The recommendation that was attempted to capture was an ADRC being in every part of the state, which I think the word for that statewide, so help me with that. When ADRCs are covering all of the state, and building off that local foundation, having a common name, number, webpage to push people to it so that you're not reinventing every single community. So, we were trying to capture both, and that's the important description bullet of being specific about what that means to have that service available in every part of the state through networked local services.

Patty — But, that could be—I mean, she created the model. That would be a model that could be replicated, correct, so that it could cover all 58 counties, but you have to have local people doing the job. Then, we're talking some big dollars potentially. It's not I&A how AAAs run I&A currently, totally isn't. It's a whole different, 21st Century I&A service with trained, professional people.

W — Can I get clarity? Are we voting on this as a template or a recommendation? A template right?

Kim — Where does the group want to start? I'd like to talk about both, but wherever people want to go first we can do.

Ellen — That was going to be my question. Do you want feedback on it now, or are you looking for feedback on it in writing? How would you like to receive—

Kim — Let's do a minute on the template. How's the template look? What's missing, what's needed? Karen.

Karen F. — Karen Fies, Sonoma County. I think that for me what would be helpful would be to have a little bit of language about background or history or if there's something in legislative or law to have some reference to it. Just some reference to what's happened, what the current state is or what's happened in the past.

Kim — Very good. Thank you. Other template improvements, comments, questions? Dr. Benton.

Donna — Just a point of clarification. Where is says potential cost, you don't mean that we actually have to say a number value. I man, like what are we asking when we say potential cost on the template?

Kim — I think that's something for the full committee and the subcommittee to kind of wrestle with. I've seen different workgroup processes do scale, do low, medium, high. I don't think anyone's expecting—we don't have the capacity and the time to do rigorous cost analysis, but I think that's a question. Do you want to have something in there about scale of cost?

Donna — Next, indicators. Is that the same terminology or another term for evaluation?

Kim — We were thinking metrics, data, and the evidence was more sort of the evaluation, but open.

Donna — Okay.

Nina — The reason Dr. Benton is mentioning—the issue is I had a question about evaluation and making sure there's a continuing evaluation assessment and improvement process so that we're making sure the services are anything meeting people where they need them.

W — I guess because you're saying it's possible that's what evidence or indicators are, maybe we should use the term evaluation. It seems like maybe people may understand that one a little better. I don't know.

Kim — I think we also want to make room for how many calls received, just some volume as well as quality, meaningful, true person-centered outcomes, so I'm trying to do the biggest, but I like that you're calling out more than just widgets so how do we capture both/and. That's a really good point.

W — Thank you.

W — Is this a template that's supposed to be for the subcommittee members and for the public?

Kim — Well, we were not going to put it on the public if it's not helpful to them, but we thought it would be helpful for the subcommittee to track where we are with each of these and keep going deeper, but if people want us to, we can push the public into that, but we're trying to be open to feedback coming in in all kinds of ways.

W — I think that's a great goal. I'm stumbling over these terms evidence and indicators big time because I think that one step away from the

subcommittee and for me still in the middle of the subcommittee, those terms are not intuitive.

Kim — Understood.

W — I think about things like problem statement. How does your recommendation address the problem? What data do you have that indicates the problem is real? The more that we can simplify terms because I definitely think there could be consumers and even my own members that will want to see some of these source documents, and those terms just aren't intuitive at all.

Kim — Very helpful. Okay.

Susan — This is Susan with the Alzheimer's Association. So, in terms of process, what I gather is each subcommittee will have these templates produced on an ongoing basis. In terms of our work, to Ellen's point, I would like us to get comments, but then I'd like an opportunity at the end where we see them all laid out in front of us because I would expect there will be some duplication and crossover at the end. So, as far as process today, do we just keep this as a working draft and keep rolling forward, or do you want us to perfect it as a workgroup today?

Kim — It's helpful if things are way wrong, way off if this reads like we mean a brand-new state-only funded service, let's fix that right away. This is what Carrie is doing is capturing, documenting, revising, revising as we go so that there's this set. So, perfection is not the goal today.

Susan — Good.

Kim — We could take the template back, add some plain language, add the background. That's very helpful. Be clear about that. Then—sorry, Ana. Go ahead.

Ana — So, we're just giving feedback on the form at the moment?

Kim — In a second I'm going to pivot. Do what you like, and I'll pivot.

Ana — Let me just start by Sarah Steenhausen is trying to get on and says she can't hear or something like that, so I just wanted to raise that issue.

Kim — Okay. Thank you, Ana.

Ana — So, I think that the conversation about quality indicators and evaluation is really important. We've been having this conversation on the state ADRC Advisory Committee, and one of the pieces we've kind of been pivoting towards is the HIEs in the Health Information Exchanges. We've been looking at other models in other parts of the state of how they collect outcomes based on these kind of initiatives. We've looked at Oregon, and we've looked at some of the 211s in San Diego and how they do their risk assessment with callers.

One of the pieces is the Health Information Exchange. Other states have used CMS data to determine outcomes. So, you might look at admission rates in the hospitals or pieces like that, and that might be accomplishable through the HIE which is not everywhere, but that's something we could look at as a recommendation with the I&A and with other pieces we're going to be talking about.

The last piece on this form is the strategies pieces. What are the strategies? With the SCAN Foundation that we've done and recommendations to the master plan, we kind of broke things down into policies, services, and projects or tools or kind of different strategies. Is this legislation? Is this policy? Is this something else, service coordination and how we provide services so that we can kind of narrow down the strategies? Maybe we add that to the tool as potential strategies that could accomplish our recommendation.

Then, on the form itself, there is a piece, I think it's the last bullet which talks—and, to Patty's point about local control, that's where all the beautiful stuff happens when you coordinate services is through that relationship development and the local level understanding the resources and the people in the community.

The last bullet talks about partnership and collaboration, and I would add into there that it's collaboration across nonprofit, for-profit, and government entities because that's how we're going to meet people regardless of income is through that cross-partnership.

Kim — Karen Fies.

Karen F. — One last thing on the template for me is that it would be nice as these are coming out there would be lots of versions, so managed version control,

some sort of date and/or version and/or something on there so that we could manage that would be great.

Then, on the recommendation itself on the first bullet, building a well-funded, statewide ADRC it may be it's a statewide system of ADRCs that can be regional or local, so depending on whether or not you're a large county or a small county or you would need a regional ADRC.

Kim Okay. Ellen.

Ellen Are we moving to the content?

Kim Yes, please.

Ellen I just want to provide tremendous support for the concept of a statewide I&A system. You know, in San Diego, we spent quite few years trying to build a system that was a No Wrong Door philosophy, and we were able to integrate IHSS, Adult Protective Services, the Older Americans Act programs, and it was a full-time job for many people to get the word out in the community. So, it's one thing to form it. It's another thing to get people to use it.

So, I think a key component of it will always be outreach and education of the community so that they begin to see this as a real source of good information.

The other thing that's so valuable is the partnership that is envisioned with ADRC between the independent living center and the AAA, and I think that is a unique component that really says a lot about how these systems can work. Thank you.

Kim That's great. Any other—yes, Patty.

Patty I would just alert because it's one thing to be a county AAA that has the access to things like, yes we administer in-home supportive services, adult services, blah, blah, blah, but we still have eight nonprofit AAAs in the state, and their access to those things are like nil. So, we just have to, when we're talking about a statewide system, I'm just saying.

Sarah Hello?

Kim Oh, Sarah, did you get through?

Sarah — Oh, good. You can hear me.

Kim — Jeff, you'll be next.

Sarah — I have two comments, one about the template itself. Thank you for taking a stab at this. It will be very helpful to have a common way to submit recommendations. I think that it would be helpful, I think as Karen was saying if you can lay it out by starting with the problem statement, moving to the recommendation, and how the recommendation addresses the problem, but then also having a section or bullet on best practices or local examples. It could be other states or local levels.

Then, what funding mechanisms are available right now for that, and then anticipated cost as you had said. So, that was just the way I'd heard it, and I thought that would be an effective way to outline it.

Then, in terms of the ADRC, I'm concerned a little bit about—I love the concept, but do we want to consider at some point thinking about language and how to frame this as a tool that will resonate with people? Do we know that the term ADRC is something that people hear and will know what it helps with?

It's just more of a question about how it's framed and if it is something that is truly accessible to consumers who aren't well versed in this system. Is that a word that will resonate with them? The same goes for I&A. Is that a word that resonates with people?

It could be that you develop standards for these types of models across the state but that each local level has their own unique approach and that you can have one call-in number, but it doesn't have to be the exact same model at every local level, so you can allow for flexibility.

Kim — Great.

Jeff — This is Jeff Thom with the California Council for the Blind. I think it is very difficult to assess what exactly will work best, and I applaud the work of the folks who looked at the different health exchanges, but I kind of think that a combination of having these regional entities, and what they ought to be called I'm not going to even suggest, but maybe ADRCs for now.

Having a statewide number and a statewide website that can easily be linked to regional entities may be the best way to do it so that people don't have to look up different numbers whether they live in Plumas or LA or whatever and different websites, or whatever, but by the same token, they have to easily be either linked or fed over to their local or regional entity to get what they need.

Kim — Great. Any other—I do want to move us to our next topic. This is the challenge of this process, but I want to make sure—Ana, do you want the last word? As a member of actually operating an ADRC and on the ADRC committee, it seems fair, and one of the co-presenters at this meeting, you and Susan should get the last word.

Ana — Thank you. On quality and assurance and evaluation, I forgot to mention, we want to say person-centered, so with these pieces, we want to make sure that we have a way for the consumers, individuals of services to provide feedback on the effectiveness of any program.

So, I think evaluation should be through follow up, it should be through doing surveys, the actual participants if they got their needs met. So, I think we always want to remember HIE is a great potential method, but we also have to keep the person first.

Kim — Any other—Sue, did you want to—oh, okay. I do want to circle back to Karen. So, this is the question about now who does what. So, obviously we'll work on the template as the holders of this process, but the building out of all of those fields could very well be with the people who helped, not to name Susan and Ana and especially not Karen since she was fighting fires when this happened, but that work could be done by the stakeholders who helped shape that. It's also a lot.

We're happy to do what we can, too, but that's kind of the question of who fills in the template now with all that really important citation, evidence. We're open to work on that in a collaborative way, but someone needs to take that piece.

W — For the people on the phone, I am nodding meaningfully.

Carrie — So am I.

Kim — So is Carrie, yes. Okay. Alright, so we will continue to refine the template, continue to refine that process. I'm also seeing that documents

that are not on the slides and not handed out are challenging for folks. I'm noting that, so we will also try to do a better job of if we're going to talk about documents projected as well so people have it in multiple formats.

I have lots of next steps from this that we'll sum up at the end, but I think what I'd like to do is, having spent that time kind of organizing our work, turn to our next topic. Are we ready? Alright, Anastasia, I'm going to hand you the hot mic.

Anastasia Thank you, and I'm just going to do a very brief introduction to the topic, but then turn it over to our presenters. As you all may know, there was funding in the current-year budget to have an actuarial study on long-term services and supports financing including Medicaid but also including services and supports funding for people above the Medicaid income limit.

So, there's been work done on this in the State of Washington recently that Milliman has done, and also other states are looking at it from different angles. So, the federal government has also looked at this. We're going to hear a little bit about all of this, and then we want to try to get through the presentation in a way that we hear the presenters and then allow plenty of time for discussion amongst all of you, and then also public comments period, too.

So, we do have this room until 5:00, so we're not constrained by the 4:15 time, but I think we should try to—if people had planned to be here only until 4:15, we'll aim for that.

So, with that, the Milliman study is going to have kind of draft. We're still figuring out what exactly will be in that draft. It's not going to have numbers for the March report. The report that the Milliman folks are conducting, it has a due date of it needs to be submitted to the legislature by the end of June of 2020.

So, the Milliman team has agreed to have some intermediate information. Probably not numbers, again, but we will try to do get as much as we can by February or so from the Milliman folks, and then put that into the LTSS report. Then, again, look to later in the end of the spring for a final report from them.

So, with that, thank you, Jedd Hampton from Leading Age, Christina Mills from the California Foundation for Independent Living, and Christopher Gizzi from Milliman. So, I'll pass the mic down to Jedd.

Jedd

First of all, I'd like to thank acting director, Kim McCoy Wade and Anastasia Dodson for the invitation to speak here today. I just want to kind of get out there I'm self-quarantined here. I have a bit of a cold, so I will do my best to project as loudly as I can and ensure that everybody can understand and hear clearly what I'm saying.

Again, my name is Jedd Hampton. I'm the director of Public Policy at Leading Age California. For those of you in the room who don't know about Leading Age California, we are a trade association here in Sacramento. We have approximately 650 mostly not-for-profit members, providers of senior affordable housing, care and services for older adults, and we serve the needs of approximately 200,000 seniors across the state.

We wanted to, again thank Kim McCoy Wade and Anastasia Dodson for inviting us here today, and really discuss how we can rethink financing Long-Term Services and Supports. Our association here at the state level and also our national affiliates have long been involved in looking at new and innovative ways to finance long-term services and supports. We've really seen this general disparity that's come for many, many years really for the individuals particularly in the middle class as to how we incentivize them or dis-incentivize them to pay for long-term services and supports.

The way we really look at is you have a group of individuals who are able to access and help finance their long-term services and supports needs via Medicaid or Medi-Cal here in California which we generally peg that as a 30% here specifically in California. Then, you have another 10% or so that are wealthy enough to really finance their own long-term services and supports needs should they have them, which really leaves 60%, in general, a 60% gap of individuals who have to figure out how to pay for these long-term services and supports. Again, if it's a long-term need, what systems and mechanisms do we have in place to help these individuals pay for that sort of care?

Again, we've been thinking about this for quite a long time, both nationally and here at the state level, so I just want to kind of go through where we're at, how we got here, some of the work that's been done at the national level, and then some of the work that we've done as a grass roots stakeholder group here in California, and how we can pave the pathway forward.

So, just in general, I know for informational and contextual purposes, I'm pretty sure everybody in this room knows who needs long-term services and supports and why they need them, but I want to give a very brief refresher just to set the table as we move into this discussion moving forward.

Who needs long-term services and supports? Obviously, we look at among persons age 65 and older. An estimated 70% will use long-term services and supports at some point in their lifetime. That's not including those individuals with disabilities who are under the age of 65, so it's a significant part of our population.

So, 85% of those LTSS needs will last less than three years, but I think the big caveat is that persons age 85 and older are really the fastest-growing segment of the US population, and they're the same cohort of individuals that are much more likely to have a need for long-term services and supports.

Specifically, as we look at California, 20% of California's population will be 65 or older by 2030, and 15% of seniors over the age of 65 will incur long-term services and supports expenses over $250,000. So, it's a pretty significant portion.

I think we've all heard a lot of statistics thrown around about what long-term services and supports actually costs, but when you look at things like a nursing home, when you're in a nursing home, in California it's guaranteed to be over $100,000 a year. So, if an individual has a long-term need, you have to think how that individual is going to be paying for that care.

So, what do we need to rethink how we finance long-term services and supports? Again, I think most folks are already well aware that the financing component is a major issue moving forward. Again, we highlighted, particularly for the middle class, it's a particularly acute problem. When you have a system that we have currently where you have a lower-income population utilizing Medicaid and a high-income population having the ability to use their own wealth to pay for services, what you're doing to that 60% or so of individuals is really incentivizing them to spend down all of their assets to afford that care.

Again, if you have a cognitive disability or Alzheimer's or something along those lines that has statistically been shown to have a significant

financial impact on families, you can spend down relatively quickly, and so there's always a kind of an anecdote that I use.

My boss, Jeannee Parker Martin, who is on the stakeholder advisory group shared a story with me once about a friend of hers who you would never have imagined would have needed to spend down their care, They were an upper-middle-income individual from San Francisco, owned their home, and one of the individuals—it was a couple—one of the individuals had a long-term services and supports need, and the costs were so astronomical that they spent down, I don't remember exactly the timeframe, but it was quickly enough to where they were able to access Medi-Cal relatively soon after the diagnosis.

So, when you're thinking of this acute need for how we finance this care, we often tend to think middle class, maybe even on the lower end of the middle-class spectrum. It's individuals who may not have done a great job saving for retirement or don't have a lot of other assets. That's not necessarily always true, especially when you have a long-term need, especially in the cognitive, dementia, Alzheimer's space. Those costs add up very, very quickly.

So, we'll address a little bit of how that has affected long-term care insurance rates soon, but that's just to set the table. It's not just middle-income or even lower-middle-income individuals that we're talking about. We're even looking at upper-middle-income individuals that have this issue to where if they have a need it's relatively easy to spend down and access Medicaid, and obviously there are implications for Medicaid when that occurs.

So, we obviously have a changing demographic. I think everyone's pretty well aware of the demographic changes and shifts that are going on both in California and in our country. Currently, California has approximately 8 million person who are either older adults or persons with mobility, sensory, intellectual, developmental, and/or mental health, or have a mental health disability, so it's a significant portion of our population. Again, if we're looking at this in the context of aging and disability, that number will only continue to grow exponentially.

Again, the population will grow significantly as the baby boomers retire, and as that age cohort grows, that's going to put the additional financial pressure on our existing systems as to how we finance this meaning the individuals that are the top 1% will still be able to afford their care, and

then you'll have a larger portion of the middle class utilizing Medicaid which will only grow our Medicaid budget, so it's really kind of a death spiral, so to speak, in terms of how we're financing this care moving forward with the changing demographics.

Also, it's worth noting that things like medical advancements and other things have resulted in longer life expectancies. So, when we're looking at these systems like Medicaid, and when we're looking at things like long-term care insurance, we're looking at them through the lens where individuals did not live as long as they do now, and the individuals who are living longer are living longer with more complex, typically comorbid conditions, so they're more complex patients, and they're getting older and older.

So, those changing demographics are our serious considerations that we have to look at when we're looking at how we finance care moving forward and how we're looking at our own system of financing of care currently.

Another component that adds to why we need to rethink how we finance long-term care is growing financial insecurity. Again, I think this is probably not a new topic to most of the individuals in the room, but just for some context facts and figures from the California State Treasurer's Office.

They note that approximately 7.5 million Californians today have no workplace pension or retirement savings program. That's a critical component when you're looking at the planning piece because as we all know, when we talk about how we finance long-term services and supports, the discussion of how we plan for it when we're younger is always the central narrative to that discussion, so it's important to note that if you don't have a workplace pension or retirement savings program, it makes it a heck of a lot more difficult to save up enough to retire and fund that care moving forward.

Also, a large majority of workers without access to a workplace retirement plan are people of color with Latinos making up the largest share of 46%. So, when we're looking at diversity and cultural equity and how we're making California healthier for all, I think that's a component that we do need to look at when we're looking at financial insecurity. Nearly half, 47% of California workers, both public and private are projected to retire with incomes below 200% of the federal poverty level, so $22,000 a year.

So, we have not only individuals that are not saving enough to traditionally retire and potentially finance care should they need it, we are likely to see individuals who are either retiring or forced to retire with a very minimal amount of savings moving forward. So, that's another thing that we need to look at.

Weaved into that conversation, as I know Nina brought up earlier, is the idea of caregivers, and obviously caregivers, particularly women who leave the workforce early to become unpaid caregivers for their spouses or their family members, not only are—when you're leaving the workforce early, you're also sort of kneecapping your own ability to save for your own retirement, which again creates another cycle where you're leaving the workforce early, and now likely going to need some sort of state support moving forward for yourself because you were not able to save enough for yourself moving forward.

So, that's another consideration that we look at when we're looking at how we need to rethink financing long-term care.

Just a couple more things. Even for those with retirement savings, there are two components that I want to note that tax penalties for withdrawing savings before the age of 59 are still in place and withdraws at any age are still taxed as ordinary income even if used for long-term services and supports.

So, if you have a long-term services and supports need, and you need to leave the workforce, and you have saved or worked towards saving towards a retirement, you can't access those funds until you're age 59, and then once you do, those funds or taxes are ordinary income. So, there's a dis-incentive to save theoretically because you can't even access those funds, and once you do you're getting hit with a significant tax bill as you're withdrawing the funds to potentially pay for your care.

So, again, when we're looking at this, we're looking at this [indiscernible] as systems and what our current existing systems are for financing long-term care and how they're all kind of interwoven together and where the incentives are and where the dis-incentives are. I think we would argue right now there's probably some general consensus.

The way we finance care, long-term services and supports as a whole right now is a pretty broken system that dis-incentivizes people in a variety of

different ways in addition to not providing adequate financing or adequate coverage or adequate access.

The third piece as to why we need to rethink long-term care revolves around the long-term care insurance market. Again, interwoven to this narrative often is well, why you don't purchase long-term care insurance when you're young. Long-term care insurance will help you in several different ways.

Again, I think it's probably no surprise to most of the individuals in this room that the long-term care insurance system and market in general is a pretty broken system. When you talk to individuals who have a long-term care insurance plan or even the long-term care insurers themselves, they'll say there are a multitude of problems within the system including across-the-board premium hikes on both perspective and respective business meaning—and for those of you have CalPERS, you're probably acutely aware of this discussion, but back in the 90s when most of these long-term care insurance products were created, the actuarials were bad on them, to put it mildly.

So, when claims started coming in, the long-term care insurers recognized fairly quickly that the actuarials were bad, that they were going to have to have massive premium increases and broaden the risk pool in order to pay for this. It was a double-edged sword where you have the broad premium increases that made current holders of policies upset, rightfully so, and then also again, with dis-incentivizing individuals to purchase a long-term care insurance plan because you're seeing what might have happened to your mother or father or your grandparents where their premiums were going up significantly. It's like I don't want any part of that.

So, it makes—it's funny. I get asked often enough about long-term care insurance and is there any way to really revive the market, make it a robust market, and develop it in the future to develop something that would be adequate enough to pay for long-term services and supports. I think personally, for me, I don't see that that's a really viable pathway. For one, 90% of the long-term care insurance plans have gotten out of the business, so when nine out of ten have said we don't want to touch this product anymore, even those products we developed, I think that's a good first sign.

Secondly, with a long-term care insurance product, it's built on the assumption that an individual in their 30s is going to purchase this

product, kind of like you would car insurance, meaning you pay the premiums for 30 to 40 years before you would need to cash in on any sort of claim.

Really, I think the whole premise of that product is it's difficult to see that thriving, and obviously I'm personally, myself, in my mid-30s. I have been studying this issue for almost ten years, and I don't have a long-term care insurance product, and I'm not going to spend money on a long-term care insurance product because I have a mortgage, I have two kids, and I have other elements, school loans, all those things that are much higher of a priority than worrying about something that may or may not come 30 to 40 years from now.

So, really when you're looking at the long-term care insurance market, you have to keep those things in mind when we're looking at is there any sort of pathway forward or any sort of viability to covering a large portion of the population who would have complex needs moving forward.

So, that's a bit of a soapbox piece. My apologies, but I just wanted to frame the discussion for you when we talk about long-term care insurance because that's obviously something that's brought up consistently.

Anastasia We can give you five minutes.

Jedd Perfect. So, again underwriting policies, reduction of customer demand, really the long-term care insurance market is really just not a viable option moving forward.

We talked about the current financing structure and how it incentivizes those middle-class Californians to spend down their assets and enroll in Medi-Cal to receive and have affordable long-term services and supports benefits. Again, that's the trend that we imagine will continue to go moving forward.

So, what's happened at the federal level? Obviously, during the discussion around healthcare and the Patient Protection and Affordable Care Act 2010, Congress enacted the Community Living Assistance Services and Supports Act, or the CLASS Act, as a part of the Affordable Care Act. It's a little-known piece that would that would have voluntary enrolled eligible individuals 18 and older and provided them with a benefit for those individuals who paid premiums for five years and had a

minimum earning requirement for at least three of those five years and provided some sort of benefit to access long-term services and supports.

It was really kind of the first real step in many years that the federal government had looked at in terms of addressing this issue for individuals that have long-term services and supports needs, so it was really encouraging, but in 2011, the Department of Health and Human Services concluded that the CLASS Act would not be actuarially sound if enacted, and it was thus stripped out of the Affordable Care Act.

Again, that actuarial study or that actuarial component is really important primarily because it looked at this program as a voluntary benefit, meaning individuals had the chance to opt into the program versus more of a mandatory style if you look at Social Security or Medicare where it's mandatory. You have to pay that tax, and you receive the benefit afterwards.

So, that's really why CLASS fell apart, but in 2014, Leading Age along with AARP and the SCAN Foundation jointly funded research by the Urban Institute and Milliman to analyze different policy options to help finance LTSS, and they studied a variety of different things looking at coverage, performance indicators, voluntary or mandatory coverage, participation, a whole host of elements, and I have some links here that you should be able to access on your PowerPoint if you wanted to read the study and the corresponding articles that address that.

So, as all this is going on in California, a group of 20 or so organizations back in 2017 still said hey, this is a big deal. If the federal government isn't going to do anything about it, then California should. So, these 20 organizations formed a group call California Aging Disability Alliance, and we formed, again, to address the lack of actions at the federal level.

The California Aging Disability Alliance, or CADA as we call ourselves, is really unique because it's a group of organizations that include long-term services and supports providers, consumers, long-term care advocates, unions. It's a very broad, diverse organizations that don't typically always play in the same sandbox together, but we have for this issue and have made quite a bit of progress moving forward including initiating and succeeding in securing $3 million to incorporate LTSS screening questions into the California Health Interview Survey which is really the largest population-based state health survey in the United States.

We also worked to initiate and succeeded in securing $1 million to fund an actuarial feasibility study here in California, which I'm sure will be discussed very shortly. Then, also sponsored Senate Bill 512 by Dr. Richard Pan which would have created a framework for California to build an in-state backed long-term services and supports benefit. So, our organization, CADA, still meets regularly, still trying to crack this very difficult nut.

What else is needed? I have other resources up here with what else we needed in terms of a central resource for long-term services and supports, education and awareness, but in the interest of time and seceding my time to my esteemed colleague, Christina, I will pass the mic, and I'm sure we'll discuss more later. Thank you.

Christina Thank you, Jedd. I'm getting over my cold, so glad to have the microphone. So, Anastasia asked me to—first, let me just say I'm Christina Mills from the California Foundation for Independent Living Centers. Happy to be joining with you today, and sorry that I missed your first meeting. I was in Spain talking bout personal assistant services which I'm excited to share, a little briefly, notes about.

Anastasia asked me to present on eligibility gaps for people with disabilities, and I really wanted to rename it manholes and clips for people with disabilities. That's really the reality for our community.

So, for those of you who aren't familiar with the different models of disability, I would very much encourage you to check out, Google disability models, but literally put in disability justice models, and it will give you the framework of pretty much what I see as an evolution and timeline of what benefits have looked liked in the United States from early century to mid-century to current. What you'll be able to immediately see is that the system has not kept up with the needs. That is probably the biggest problem with our fractured system.

Also, in California specifically, we're lacking data. Instead of looking at people with disabilities based on our functional needs, we're tracked by programs and services instead. This is perpetuating the need that people with disabilities are not seen as human capital, and that was the biggest difference in Spain.

So, I was there for a personal assistant conference, and I was the keynote speaker on how government personal assistants specifically work in

California, so I was referring to the IHSS system, what it was like for me when I was younger to go through it, and then what it was like when my daughter was on it. The most immediate thing that stuck out to me was that the eligibility in Spain is based on your functional need, not a diagnosis, or your income level.

When I asked if people with disabilities and older adults considered a burden on the system because they need a level of personal assistance or caregiving, whatever you call it, they looked at me like they didn't understand what I was saying. They said we take care of our people, and the chances of people needing caregiving or personal assistance at some point in their life for something, why wouldn't you pay for it?

That's what people need to be able to stay in their home or with their families. What a concept, right? I mean, I was floored.

So, moving on from that, in terms of the manholes and the clips, part of that is because—let me just say, I wasn't asked to talk about recommendations, so that's a whole different topic for another day, but I think part of the issue is that the Social Security benefits programs that were set up for us have dis-incentivized people with disabilities to go to work or to return to work.

What that looks like for me, I'm just going to use myself as an example. When I turned 22, I had been on SSI. SSI was a part of the Social Security reauthorization in 1972. First, it was in the 50s. Social Security and Social Security Disability came out. Then, supplemental security came out in the early 70s.

When I was put on that system to begin with, it automatically came with Medi-Cal, and there's this assumption in California and even across the country that people with disabilities, especially preexisting conditions, we automatically have Medi-Cal if we work or if we don't work. That is a myth. That is a stereotype, and I think we all in this room know that.

What it sets you up to do is never want to be able to leave the system because there's no incentives hardly to want to leave the system. So, while I was going to school and had big dreams and hopes of what I wanted to do, I was also on supplemental security income and receiving Medi-Cal which was very important to me. I break bones, and when I need to go to the doctor, I need to go to the doctor for a number of different things.

So, when I made the decision to leave the system and go to work, it was deciding to leave my healthcare and what that would look like. It just so happened that I ended up fracturing about six months after leaving and did not have Medi-Cal, and that was a bill that I ended up having to pay out of pocket for because my employer's insurance hadn't started yet.

So, talk about a dis-incentive. Well, then, as I went back to Medi-Cal to see if there was anything I could get, people said you could have gone into the Medi-Cal 1619(b) program, but nobody had told me that when I told them that I was going to work and deciding to switch over to my employer's insurance. So, outreach and marketing for these very, very small incentive programs that exist is almost nonexistent in our state and across the country.

Over 70% of you put on disabilities supplemental security income before the age of 18 ever transition off the program, 70%. Medicaid is seen as the only long-term services and supports system that is the option for people with disabilities because like Jedd pointed out so many reasons why he might not purchase a long-term services and supports benefit, I don't even have that choice. I have a preexisting condition; that's off the table from the start.

Unless you are among the 1% and able to pay for your durable medical equipment and personal assistant services or caregiving needs, there is little reason to leave Social Security. In the independent living world, we call it personal assistant services. It's not always necessarily caregiving. Like, an example, I pay out of pocket for domestic services. I wouldn't consider that necessarily caregiving.

California is one in about six states that has a Working Disabled Program that allows you to qualify for Medi-Cal while working, but even at the 250% above the federal poverty level, there's little motivation to go to work.

It also, when you enroll in the program, there are several hoops to go through, and ways that you find yourself constantly having to re-document or talk to someone different at healthcare services that implement the program in what was missing. Maybe it was a paystub or your premium went up or your premium went down. There's just a lot of complication when you're on the program.

There's also the 1619(b) program that I talked about that allows individuals that are on Social Security to keep their Medi-Cal for up to five years no questions asked and allows you to go right back on Social Security if there's a need within those five years.

There's also the Student Exclusion Program that allows full-time students to try working while they're full-time in school until the age of 22 without any penalties as long as they can show that the funds are spent on their disability needs. I don't know about you, but a lot of 22-year-olds have a lot of other expenses side from just their disability expenses, but it doesn't even matter because not enough youth even know that that program exists.

Aging with a disability is frightening, especially if you choose to work. We can't buy into plans because of our preexisting conditions, and it's either live on a fixed income and remain on Medi-Cal to get the little long-term services and supports that you qualify for or pay out of pocket and risk losing everything.

Home modifications, assistive technology, housing, siloed systems, transportation, service coordination, mental health and healthcare together, and preventative services are things that need to be built into a system that is able to support people without siloes.

I bring those specifically up because last week, CFILC started a community forum series out in the areas of the state that are least served, and we started with the Inland Empire, so we were in Riverside in the morning and San Bernardino in the afternoon. When we talked to older adults and people with distribution and ask them what the gaps are in services, that is specifically what came out: housing, siloed systems, transportation, lack of service coordination, mental health and healthcare being separated, and no preventative services.

Above all, what everyone agreed on, too, was that there is a sense of continuous ableism around our country and around California and stereotypes that people with disabilities are not worth anything, that we don't contribute, and that we aren't a capital that you need to worry about.

With that, that's why we've gotten into this conversation and why we've been a part of the California CADA because we believe that there is a real opportunity to change the system and incentivize people with disabilities to want to go to work and to be eligible for LTSS beyond Medicaid.

Chris I think we're all announcing if we have a cold or not. It sounds like I will have one next week at some point.

Jedd I tried to keep it clean.

Chris Well, thank you for having me. I'm Chris Gizzi with Milliman. For those of you who don't know, Milliman is made up of consultants and actuaries which might be a bad word now after Jedd's intro.

Really what I was going to talk about just briefly today and wanted to leave a lot of time open for discussion is to talk a little bit about this feasibility study that Anastasia had mentioned. I know Jedd covered some of these statistics, and as a numbers person, I think I might have less numbers than both Christina and Jedd which could be a first in one of my presentations.

When I think about this, I boil it all down, and not to oversimplify it, I really think about four main themes of why this is all important and why financing solutions are needed. Jedd had put up the statistic, many people will need long-term care at some point in their lifetime, so if there's a 65-year-old today, the chance that they're going to need long-term care, and pretty high level of long-term care, need help with two of six activities of living, or severe cognitive impairment, one in two people, at some point in their lifetime will need long-term care. Everybody thinks this is a small event that's never going to happen to me. That's just not true.

As we've talked about quite a bit, care is expensive, so average nursing home care, $100,000 is not very difficult to get up to, so on top of that, when people need care, as Jedd was mentioning, people can need care for many years, so the costs quickly add up.

We've talked about the Medicaid program quite a bit, and certainly as costs and the demographics change, there can be a strain financially on the Medicaid program, and we've talked a lot about families as well. When we look at the pie chart up here, when we look at who pays for long-term care today, Medicaid programs are by far the dominant payor, but right behind that are people paying it out of pocket.

So, long-term care insurance, the penetration in that market has been a lot lower than probably that market would have hoped, so when we look at the two dominant payors today, it's really individuals out of pocket and the Medicaid program.

Various statistics, if you Google you'll find that there's probably 10,000 people a day turning age 65, so you have those people turning age 65, one in two of those people are going to need care. They're going to need care for multiple years probably $50,000, $60,000, $100,000 a year. You can see how that all adds up pretty quickly.

We touched on federal activity a little bit. I guess I would expand. There's some other discussions to part of some of the proposals, and just follow the elections. People perhaps considering attaching a universal long-term care as part of the Medicare for all. There's long-term care testing lumped into some of that. There's been some discussions around can long-term care be attached to Medicare Advantage or original Medicare offerings. So, there's a lot of things going on at the federal level.

What I wanted to touch on a little bit is to talk about some of the state activity as well. You guys definitely should be commended. You're on the leading edge of state activity and looking at different financing solutions and reforms.

So, I did have an opportunity to work and participate in the feasibility study for Washington. For those of you who aren't aware, they passed back in the spring the first ever public social long-term care program. Starting January 1, 2022, there's going to be a new 0.58% payroll tax on wages, and that's going to finance a new public long-term care benefit for individuals in the State of Washington.

Some other states have looked at things. Hawaii, I was just reading up a little bit on this because I wasn't sure where they were involved. They initially set aside a pilot program of some money to look at setting aside $70 a day up to five days a week to help with individuals who are working but also caregivers, so they had some benefits set up to help those individuals. It was a pilot program. My understanding is that just got renewed. There's some extra funding for that. I think they cut the $70 a day down to $210 per week, but that's still happening, and it's being tested in Hawaii.

Maine looked at a universal long-term care benefit. That was initially shot down in a ballot initiative. I think that was late last year, but they're still looking at different options there on the homecare side.

Kind of concurrent with California, we're actually involved with these two projects as well. Both Illinois and Michigan are kind of on a similar path right now where they are in the early stages of doing feasibility studies to explore different long-term care financing options.

Finally, Minnesota perhaps taking a little bit different angle. They are exploring more trying to attach long-term care to Medicare Advantage and Medicare Supplement policies. They're also looking at there was a Society of Actuaries pilot program that looked at this life stage product which basically combines long-term care together with life insurance. So, they're looking at some private solutions as well.

I'm sure I've missed out on some states. Sorry, a question.

Kristina — Really quickly, the states that you have listed, are those just the ones that Milliman is working on, or all of them as totality?

Chris — That is the totality of the ones we are aware of.

Kristina — The ones you are aware—so, even if they're going with another actuarial firm. Got it.

Claire — Could I ask one question, too?

Anastasia — Sorry, could you just say your name for the folks on the phone?

Kristina — I'm so sorry. Kristina Bas-Hamilton.

Claire — Claire Ramsey from Justice in Aging. I was just curious on the Washington. What is the tax actually funding? You said—is it 0.58%?

Chris — Well, hold on. I'll keep you in suspense in a couple of slides. We'll get there.

Claire — Thank you.

Chris — Alright. So, I'm not going to get into all of the fun details of actuaries when we do these studies and the outcomes we like to get into and the numbers but taking a step back and looking at some of the key objectives that will come out of this long-term care or LTSS feasibility study, one is simply what's the level of revenue or tax needed to support the benefit.

I know that seems like a very simple exercise, but obviously, it's complex and a lot of moving pieces, and depending how the program features and parameters interact, just coming up with the level of perhaps premiums or revenues or taxes that are needed is certainly a critical piece of doing a study like this.

The other thing is the time horizon. W hen we think about long-term care, you had mentioned people in their 30s, are they planning for long-term care, or are people in their 60s planning for long-term care, so a lot of these programs that we're looking at are really looking at financing 50, 60, 70 years perhaps into the future, so it's a really long-time horizon.

Not only do we need to figure out overall what level of revenue we need, we need to make sure we have enough revenue each year to make sure we're paying the benefits and expenses incurred by the program.

Probably the most interesting I would think to the people in this room is the next bullet which is the financial tradeoffs. In a perfect world we'd like to have a whole lot of benefits for maybe no cost, but in reality, we know that's not always the case. So, one of the things this study hopefully will highlight is the financial tradeoffs.

So, if you perhaps loosen a feature here, what is that in terms of cost? Or, perhaps you enhance a benefit, what is the tradeoff in cost? Maybe you can make a small tweak here, an you get a large—you know, a small tweak in premium, but it resulted in you had a large increase in benefits. So, trying to find, almost if you wanted to think about gaming the system so to speak, where do you get the most bang for your buck in understanding those tradeoffs?

As actuaries, anytime we have uncertainty, and we're making projections many years into the future, we want to look at the sensitivity to different assumptions. We know things like mortality rates have changed in our lifetime, the rate of how people use long-term care, so making sure that we don't just put one guess out there in the program, and the assumptions don't realize perhaps like the private market would have expected, look at different conditions to make sure that the program will be financially sound under different scenarios.

Finally, certainly one of the things that we're going to study as well as whether is the impact or ramifications for existing state programs, and certainly the Medicaid program will be studied, things like the CalPERS

program. People have policies there. Certainly, looking at the interactions to what the impacts are to existing programs.

For my final slide, then, is to really kind of talk through what a public option could look like just as a sample. As part of this feasibility study, we're actually kind of in the process of gathering feedback from various stakeholders right now and purposely staying very open-ended.

So, it could mean maybe it's a public program, maybe it's a private program, maybe it's a hybrid program somewhere in between, but to give everybody some context of what potentially something could look like, we thought we'd just focus on the public program today and talk through some of the key program features you might find in a public program.

For reference to the question I think Claire had over there, I put down the parameters from the State of Washington as an example for each one of these features. We won't go through all these in great detail. I'll kind of maybe breeze through them quickly, and then leave that open for discussion. I know we wanted to get to the public comments as well.

One of the biggest decisions when you think about setting up a program is whether it's mandatory or voluntary. So, Jedd had mentioned the CLASS Act which was going to be a voluntary design. People can choose to sign up if they want versus mandatory, you have no choice. You're in the program no matter what.

As an example, Washington went with a design where it is mandatory. Everybody is in with one small exception; they are going to let people opt out if you currently have a private long-term care insurance policy.

Eligibility age, so individuals under 18 who are disabled from a long-term care perspective are not eligible for any benefits, so really when we think about, for example, the developmentally disabled population, they are kind of carved out from the Washington design. That doesn't mean that's the right or wrong solution, but that's what Washington picked.

So, when you think about eligibility or participation age, that's one of the key features. Perhaps there could be no age limit. Maybe it's 18, maybe this focuses on just the 65-plus population, so there's potential parameters there to test.

Benefit eligibility. So, this is akin to when you think about what's the hurdle for when benefits are paid. So, do I need help with a certain number of activities of daily living, instrumental activities of daily living, or perhaps cognitive impairment? Perhaps considerations there would be you could develop a trigger that aligns with the private market. What Washington ultimately landed on was a definition that's consistent with their current state Medicaid definition.

In terms of benefits, really the next two lines go together, so it's starting in 2025, you can get up to $100 a day to help offset your long-term care costs. That $100 has an inflation index attached to it so it will go up 3% annually, and over your lifetime then, you can use up to $36,500 also with a 3% index. So, if you use that $100 every day, you would use it up roughly over a one-year period is what that works out to.

The benefit structure that they chose was a reimbursement structure which basically means you have to incur some cost, and then you get reimbursed for those costs. Potentially some other considerations there would be more of like a cash design. Let's say once I've demonstrated I need help with a certain number of activities of daily living, you could just get cash every day, and you perhaps wouldn't even have to incur services, so it's a little bit richer design, perhaps gives the individual a little bit more flexibility on how they use benefits.

One thing that Washington did add to their structure was to give some flexibility around using portions or ramping up some of the benefit for home modification and things like family caregiver training as well.

The next item, vesting requirements. So, we talked about paying 0.58% payroll tax into the system. So, to get credit for vesting into the program, you need to have earned a credit for three of the last six years or ten years over your entire lifetime. To be able to get that credit, you have to work roughly the equivalent of 500 hours in a year to get that credit.

One of the interesting things—I'm moving onto the next item. We talked about the federal perhaps program or on a federal level taking the initiative to "solve" the long-term care financing problem. One of the unique issues if you do it at the state level is portability. What happens if I—well, it's easier for me coming from Wisconsin, say I've lived in Wisconsin my whole life and decided I want to move up to California and enjoy this beautiful weather instead of three inches of snow when I left yesterday. How does that look? Does the benefit portal leave with you?

What Washington landed on was a divesting period. So, if an individual had moved out of the state having been gone for more than five years, they no longer received any benefits under the program.

We talked about program revenue. It's all financed by a tax or an assessment on wages, so there are no additional premiums, only as a tax on wages. Then, although we did some testing, they did not have any low-income subsidies, so that 0.58% applied to wages regardless of income level.

So, I'm sure there are probably a lot of questions and comments on that. That is the end of my prepared remarks, so maybe I'll turn it over to Anastasia first, and you can guide the room.

Anastasia — Yes, great. Thank you to all three of the speakers. Okay, great. So, in this discussion part for the full subcommittee here, what we want to try to do, we're not going to, I don't think, come up with something similar to this Washington chart for California. That's really beyond the time that we have today and the preparation that we did for today, but what I think should start out doing is look at what the questions are, and maybe not—I'm going to change this slide.

We don't want to just put our blinders and just think about Washington. We want to think broader than that. So, let's start with some questions for the panelists, and then we'll kind of migrate the discussion more to think about okay, what recommendations might you all have for what would be in the February report keeping in mind that there will be more details later on after the February report is submitted?

Does that sound good with folks? Okay, great. So, we'll start with questions here in the room. Ellen, yes.

Ellen — You known, I've been following this story for a long time, as most people here have, and I understood there was bipartisan support for the prior work that was done at the federal level that would have included a public option, a private option, a catastrophic option. Is that all off the table, or is any of that thinking still circulating as part of your study?

Chris — Let me make sure I'm understanding the question. So, you said at the federal level?

Ellen At the federal level, there was a lot of work done, new actuarial work that was done that looked at a tiered approach so that that people who were Medicaid recipients would be in one category, middle class people in a separate category. There were many different ways of looking at it, and apparently it was enjoying broad support, bipartisan support, but I just haven't heard anything recently. I think it was looking at serving different populations with a different benefit as part of the overall plan.

Chris I guess I'm not familiar with—

[Overlapping voices].

Jedd The actuarial work that came out in 2016 was pretty nuanced. It was pretty in-depth, and they did a variety of different modeling components to that. I would say most recently, what's gotten the most traction was a piece of legislation introduced by Frank Pallone out of New Jersey, what folks are calling the Pallone Bill, and it's looking at creating—well, it's looking at a couple different things, but it's looking at creating an LTSS benefit. It's also looking at a potential Medicaid buy-in. There were different components to the bill that they were floating around.

It had been introduced in 2018, the beginning of 2018 and kind of floated around. Conceptually speaking it's gotten—I mean, that's kind of the challenge with this. Conceptually speaking, there's broad bipartisan support to resolve this issue. I think once you start drilling down into the details, when you start looking at program eligibility and benefits and what a payroll tax level looks like is when I think the rubber is probably going to start meeting the road.

At the federal level, I would say the most recent effort was probably the Pallone Bill, and it never got quite to the point of drilling down on the details of what that looks like. It was just more or less establishing a public benefit, long-term services and supports benefit.

My understanding is that relevant stakeholders are still working with Mr. Pallone's office to flesh that out and develop it more, but my understanding is that it was only introduce. I think it was referred to the Ways and Means Committee. It never received a hearing, so that's kind of my understanding for the most recent federal update.

Anastasia — It looks like one of our colleagues from Milliman may have something to add on that. Am I reading you right, Al? Yes, okay, great. Go ahead. You can speak without a mic?

Al — I can speak without a mic?

Anastasia — Yes, just project.

Al — Al Smith. I'm with Milliman and work with Chris. On a federal level, I agree. The Pallone thing, that was introduced. They put a lot of benefits in there, and it's all going to come down to financing, how it actually pays for what they have introduced there.

The other thing I wanted to mention, as far as the bipartisan support, there is a lot of interest. The Bipartisan Policy Center has put out a lot of information on different benefit design structures whether that's front end or back end.

The other thing I wanted to mention that is going on is that the US Treasury Department has taken strong interest in this issue, and they have convened a task force, I guess is the name of it, and they are coming out with a pretty big, somewhat detailed report in the first quarter of 2020 because they've been looking at a lot of either regulatory issues or what are all the financing issues, so they've been trying to talk to multiple different stakeholders and come out with their recommendation and support, so that's another thing to add just from a federal level.

Anastasia — Thank you. Okay, Carrie, I think you probably have something to add, and then we're going to go back to the queue which is Donna, Claire, and then Catherine. Yes, if you could do your nametags sideways, that will help us keep track. Oh, good. We have lots of people. So, Carrie, you had something to add.

Carrie — I just want to quickly say on a federal level, I worked on the Ways and Means Committee all last year on their House subcommittee. There is a hearing this Thursday at 10:00 a.m. East Coast time on Caring for Aging Americans where LTSS issues will very likely be coming up.

Anastasia — What subcommittee or committee?

Carrie — It's a full committee hearing for the Ways and Means Committee in the US House or Representatives, 10:00 a.m. East Coast time in DC.

W What did they call it, Carrie? Caring for what?

Carrie Caring for Aging Americans, or something like that.

[Speakers off mic].

Anastasia Okay, so we have Donna next, and then Claire, Susan, Catherine, Marty.

Donna Thank you so much. This is really very informative and kind of started us thinking. One this is, are you modeling anything? Is it always just going to be a tax benefit, or are you doing any modeling where there's also a benefit for employers paying in to some degree?

Chris I think all of those are on the table. So, it could be a tax that's shared by employee or employer. It could be premiums. It could be tax on something else. I think it's all open-ended right now in terms of where the revenue might come from.

Donna Okay, and then the other thing, just kind of broadly, in general, I know when we look at the LTSS and the eligibility is based on the person who is suffering from the disability, but I don't know if we also want to look at the family impact and if there's a way for families to also apply because they may need it, but sometimes the person who has the issue, particularly with the dementia, they may think they don't need it, but the family might actually need this kind of benefit. So, just kind of putting that concept out there of is there a way to assess a family's need also. Thank you. That's family in the broad sense.

Anastasia Claire is next.

Claire Claire Ramsey from Justice in Aging. I have two questions. What are we thinking the most challenging elements of this will be for California as opposed to I get that it's a challenge to balance what somebody individually might be willing to pay into a payroll tax based on the benefit they will get out? I understand that there's sort of a selling it to the public side of it, but what for California are the biggest challenges? Is that something that we can articulate now?

Anastasia Do you want to try to—

Chris I don't think I can speak on behalf of California.

Jedd — I think politically speaking, I think a payroll tax of any kind is always a pretty significant lift. A 0.58% payroll tax doesn't sound like a lot, but getting that passed is still a significant hurdle, so looking at through like the political end, the tax is going to be a huge lift for folks because you're going to need obviously widespread tax-based support paying into this, and you're always going to have the perceived free rider problem which always is an issue.

So, I think that's a big challenge. I know, Christina, you were going to mention something about—

Christina — Yes. I was just going to add that certainly the elephant in the room is also keeping people with preexisting conditions eligible for the benefit, what that will look like. Will it be an age requirement whether they've paid into the system? I think we need to look at flexibility and making sure that we're not the only community in the middle class that's left to have to spend down.

Chris — I'll just add one other comment in terms of from a practical perspective as we do the feasibility study. One of the things we are trying to do is a little bit of survey work to figure out and get opinions on what potentially is politically feasible. So, if that means a 5% tax, let's not waste our time trying to develop a benefit because there's no way that's ever going to pass. So, whatever that number is, we can almost reimburse, engineer, and develop a benefit package that perhaps meets the general consensus of what might be politically feasible.

Claire — So, it sounds like it's not going to be really on the state to figure out what their burden would be. It's going to be really about figuring out what's politically is palatable and what's enough of a benefit. Okay. That's really helpful.

I think the other question I had was just about how much we're thinking about what the relationship between the Medicaid programs and a public option is and how we're navigating that. Has that thought been given yet?

Chris — We'll be spending a lot of time working—

[Overlapping voices].

Anastasia — I'll just add, not just Medicaid, but Medicaid includes IHSS.

Claire Oh, yes, I mean that.

Anastasia So, we're covering all.

Chris That's absolutely part of the work.

Anastasia Susan is next, and then Catherine.

Susan Thank you, all. Susan with the Alzheimer's Association. The annual cost of care for an individual with Alzheimer's is $250,000—I'm sorry, the lifetime cost, not the annual cost, shared by Medicare, Medicaid, and private costs.

I'm curious about the vesting requirement. So, in the case of Alzheimer's about one in ten people at age 65 and about one in three or one in two by age 85, so how will that work with having been out of the workforce for possibly two, three, four decades or a retiree who never worked of that generation? A lot of women were not in the workforce who are now in their 70s and 80s.

Does that get grandfathered into the actuarial study, or do you pick a date certain where you flip a switch and only people in the workforce then? Would we be writing off three generations of people that could need the help? How does that work, or could it work?

Chris I think it's open for discussion. I would echo Anastasia's sentiment to not get boxed in just on what Washington has done as that being the solution, but where Washington has landed is basically this is not a benefit for people who need help now. This is really going to be probably 10 to 15 years down the road where you're going to start to see a lot more benefits being paid out of this program.

So, individuals who are 60, 65-plus now, or individuals like you said who are never going to be able to incur any working credit in their lifetime, this program will not have any benefits for them. So, right or wrong, that's where they've landed.

Anastasia That's the Washington one.

Chris That's for Washington. So, again, I think where we're coming into this, I would encourage everybody to have a very open mind, open slate. That doesn't mean that's the right solution for California.

Patty Pass that one on to Maria Shriver.

Anastasia We're going through that corner of the room, and then back to Patty.

Catherine Perfect. I will be the next part of the corner of this room. Catherine Blakemore, Disability Rights California. The thing I want to echo what several people here have said is the interface between the private benefit and the public benefit because what happens now is obviously people spend down to become Medicaid eligible or are forced to do that depending on where they are in their life. Just looking at Washington, which I understand is not the model, but it wouldn't really help solve for that problem particularly for a long period of time.

I guess the other thing I'm interested in when thinking about this is is there a way to expand CalABLE so people could put money in that could then be used by that person to pay for long-term services. So, certainly at the point that you need long-term care, arguably your family were able, your family could put money in, but this is sort of a proactive strategy where people you essentially open up the eligibility criteria to say I don't have a disability now, but the likelihood when I'm 90 is I might need long-term services so can I put in money that then has the same benefits of being tax free.

So, just a different way to think of a piece of the solution which probably can kind of come on line sooner than some of this other financing.

Marty I'm the actual corner of this little group here. Marty Omoto, CDCAN. First, appreciate the three presentations. I think they complemented each other nicely, especially, Christina, you gave the impact—well, the manhole thing I was trying to figure—

[Overlapping voices].

Marty I think there's a gender-neutral term for that, but—

[Overlapping voices].

Marty Trap, right? But, I do think the human impact of all these things is always needed, and the other element is we can't look at our community and people with disabilities as they were 30, 40 years ago, and your relative—I remember when you first kind of emerged at CFILC in your 20s, and now you're a lot older.

[Overlapping voices].

Marty Not as old as me, but I remember, and the expectations—I know where did that come from? I also want to, on the other states that you listed out is that we always have to remember that it's important for us to question what those other states provide to people with disabilities and people with mental health needs and people with intellectual disabilities.

We always find that they provide less, or they don't provide overtime for IHSS, or their services are limited through a Medicaid waiver only. So, it's always important for us to question what else they do or don't do. What do they do in terms of reasonable accommodations or public accommodations access? So, the total community because that's what we're looking at is the whole person, and so how a state treats the whole person is important when looking at a pilot.

The other thing is, and this kind of goes back, Christina, the issues you raised looking at the study which I really applaud CADA for pushing that [cough] through the legislature, and a lot of us supported that, and it was needed. The feasibility study is vital, but it is scary, too, because we know there's good people at the Department of Finance here in California, but we also know how they look at things, and they look at things in terms of the impact and, Patty, you know this from your time working in the legislature, they look at things on the impact of the state general fund and the savings, and how you contain, and they use words like sustainability and things like that.

Those are words that maybe you would understand and appreciate and don't think of it in the way that we do. In our community, when we hear those terms sustainability, cost-containment, cost-neutral, all those terms might sound like innocent—those are words that we have to always—they're like words of danger to our community.

So, when things are financial tradeoffs of different program features and benefits, that sounds pretty bland, but that could mean the difference between my sister when she was alive getting services that she desperately

needed in the home, Christina getting services that you may need or the people that you know, so that human impact, and I know that's somewhere out there in this study, but is it?

I mean, I think in trying to change the conversation about how the state and policymakers look at things in terms of funding and what's feasible is also including other elements that are normally not in studies like this. That's what is scary because many years ago DRC and other groups fought against an effort by the State of California, what was it ten years ago, on the Fundamental Index Score. They were looking at ways to reduce services by using an index score that was not meant as an eligibility tool actually.

So, I just don't know—I mean, there probably is no answer to this because this is a feasibility study, but I just want to make sure that the rest of us somehow we include in this or make sure the legislature knows and the administration knows that financial tradeoffs of different program features and benefits—other terms like that, if this is really person-centered, we have to put a person behind every one of those terms. I don't know how we always do that in every instance, but we're going to have to do that.

Anastasia I think we're going to Kristina and then Patty. I know Karen is part of the corner, but Patty had her card up next. So, Kristina then Patty.

Nina Then, Nina.

Anastasia Okay, Nina, absolutely.

Kristina Thank you. Kristina Bas-Hamilton, UDW. I have three questions or comments. Chris, is it a given that the study, the options you will look at will range from the most generous to some version of the less generous, meaning that is it a given that you will have to start from a base of what it would cost to give a maximum benefit with no age restriction, no vesting period?

You know what I'm saying because we will need that to sell this, even if we don't choose that benefit because it ultimately is expensive and we can't afford it. That at least shows we looked at it and came up with a number. So, is that like every actuarial study has to include this and this, and that's a part of it?

Chris — I think it's open for discussion. I think we'll probably work together with Anastasia and her team to figure out what makes sense. We're obviously under a tight timeframe, so can we model every single option and variation? Probably not, but if that ends up being a priority and that would help frame the discussion a little bit better, to me, I think that makes sense.

Kristian — So, when will that discussion happen, the modeling?

Anastasia — Kristina, what I hear you saying is a recommendation that the study include a wide range, and then basically over the next couple of months, it will be an iterative discussion with Milliman and the state as far as how many different options, permutations, and maybe there's a way that they can cost out or project out some with little subsets, and then put them in five buckets, or maybe it's ten buckets—

Kristina — So, we at CADA have had ad nauseam discussion about this. We just look at it as different scenarios. So, A to Z, and in the middle you land what if it's 40 years old, what if it's 60 years old.

I guess what I'm suggesting is it absolutely needs to have the most generous included because politically, I can tell you from the actual practice of attempting to get legislation passed, that will be the question legislators ask, and if we tell them we clipped it off because we just assumed it would be too expensive, and stakeholders who perhaps get excluded or not, to say well we never even looked at that to begin with, you just lose a lot of support right there.

Anastasia — We will look—yes, we will look at most generous, least generous. That's for sure.

Kristina — It has to be no age restriction. It has to be looking at from 0 to 100.

Anastasia — I think the question about children—right, so we can consider different categories, different options. Yes.

Kristina — Again, we have to not look at this as a purely theoretical practice. We will have to then sell this, so we're selling it not only to the legislature, but to the public, and we can predict the questions that these folks are going to ask, and if I'm a parent of a child with disability, my first question will be is my child eligible for this.

Then, the second question is, we understand from talking with the Commonwealth Fund that they are doing something similar but looking at revenue sources, and I have heard that they've been in touch with you, Anastasia. Is this something that they should be working with Milliman on and doing it simultaneously, or do they start once we have a number to work from? How will that work?

Anastasia We're coordinating with them. Part of what we want to do first, we welcome all the help we can get with this, so yes. We spoke to the Commonwealth Fund and their researchers already. We're going to speak with them again in another month, but basically for this week, this is the week that Milliman is in town and meeting with state agencies in a public stakeholder meeting so that they're gathering information. Then, next week, we will okay, now that we've had these meetings and had this public input, we'll go back and talk with the Commonwealth people, talk with the Milliman people, and continue iterating on a plan.

Part of what I'm hoping that we can talk about today, too, is thinking about what would be important or wish list items for the March report. Again, the final report from the Milliman team will not be done in time for the March report, but maybe there's some things that you all want to really to get in and see if it's possible. Again, we can look at the Commonwealth Fund folks as well for that.

Kristina So, have you entered into an agreement with them yet, or that's all still being discussed?

Anastasia With the Commonwealth?

Kristina Commonwealth, yes.

Anastasia We don't need a formal agreement with them. They're just offering their information.

Kristina So, it's not necessarily working together. It's them saying we have this thing we're going to give you.

Anastasia Yes.

Kristina Ah, got it. Is that thing yet created, or they're working on it?

Anastasia They shared a draft with us, but it's not ready for primetime.

Kristina Got it. We only saw them six months ago, so I'm like wow, they move quickly. Okay, that's great. A draft of a thing.

Anastasia Literally like every day we're getting more information, ideas trying to pull it all together and have it make sense.

Kristina That's great because I don't want to keep going on this payroll tax thing, like I mean, we within CADA always kind of go back to it, but we shouldn't limit ourselves to that in terms of a course of revenue. I just want us to be really careful that we're not just narrowing our choices just by virtue of how we're talking.

Then, the third thing that I wanted to say was, Christina, my fellow Christina's comments, I think that the subcommittee should look to questions around the Working Disabled Program and the 1619(b), although is that a federal program?

[Speakers off mic].

Kristina So, then the state in the Working Disabled Program I think it would be something important to include within the work of the subcommittee. Could we create recommendations, for example, expanding it, better marketing it? Is 250% of federal poverty even a good number? Maybe it should be 450% because we want to incentivize folks with disabilities to have work and not create this pigeonhole situation.

Then, complementary to that, could we then even look at what the tax revenue benefit would be to the state? So, maybe it costs more on the Medi-Cal side because you're expanding access to this population, but then the taxes that they're paying by virtue of having work maybe offsets that. So, I want to recommend that we, as a group, actually contemplate that and look at that as a recommendation. Thank you.

Anastasia Okay, Patty's next.

Patty I guess I'd start out by saying back when I developed the first Master Plan on Aging for the State of California, I brought in the States of Washington, Oregon, and Florida. That's only because Minnesota hadn't gotten as far as they've gotten now.

Washington is one of the best states in the nation in terms of putting money into senior programs, way better than California. Washington, which is where I was born and raised, but Washington also makes sense. The biggest challenge we're going to have in California is the legislature, I can tell you that.

They do like precedence, so I really like what Washington is doing. I trust Washington. I can't say that about a whole lot of states, but I can say that about this one.

The legislative body, aging programs is not even on their radar. You just have to know that. God knows I did everything I could to try and made it so, but it isn't, but they do like precedence, and Washington State has been extremely generous, and they've been a real model in the nation as it relates to responding to this population. So, I would just say that. Okay.

Anastasia Thank you, Patty. Okay, Nina and then Ana and then Karen.

[Overlapping voices].

W I became less enthusiastic about my point. Others have made it.

[Overlapping voices].

Anastasia Okay, great. So, Nina is next.

Nina [Indiscernible] always have a lot to say, but I think I just check in some of the things I heard. One is definitely explore the interaction between any future LTSS program and Medi-Cal and other programs. Also want to echo what Kristina noted about exploring as wide a range of options as possible.

So, as part of CADA we actually did share some of our own ideas, and it was very broad about what we would like to see tested and tested against each other because I know we're going to get there. By the way, I do want to say, Anastasia, thank you for having talked to us on this issue and taking it seriously.

I did have a question—oh, and one other thing. Washington is usually one or two on the LTSS scorecard. They're great.

Patty Yes, they are.

Nina — Minnesota is up there, too. Okay, now that I've gotten away from the dittos, I do remember some of the federal studies that Ellen referred to. It also looked at the breakpoint for what people were willing to pay for. I thought that Washington examined that as well, so how much—that's how you go to the 0.58% payroll tax increase because people wouldn't—you can correct me if I'm wrong—because it was assessed from stakeholder conversations that more than that would be a challenge.

In California, not only do we still have the two-thirds if we went with some kind of tax increase, and that will be determined. Of course, you have the two-thirds challenge in the legislature, but you also are going to get lawsuits, so [cough] suit.

So, even if you believe that would be overcome, it's still like that extra hurdle that has to be considered. So, Christopher, I just wanted to ask if Washington had looked at what folks there were willing to pay in addition to paying for the benefit.

Chris — I'm not aware, at least as part of the work in our involvement, any studies where they looked at what consumers are willing to pay, but kind of the consensus that came out of our meetings with the stakeholders out there is that the 0.50% payroll tax is what's going to be politically feasible and everything then works from that as a pivot point going forward.

Anastasia — Okay, Ana.

Ana — Thank you. Many of you have covered the points, the Kristina team by the way, I just want to ditto that. Great teamwork. I just want to bring it back to person-centered. So, someone such as myself was injured in a car accident at the age of 14. We didn't have a Working Disabled Medi-Cal Program at that time, so I just want to ditto the idea of expanding programs like that because when I wanted to go back to work being that less than 1% that got off of benefits to go to work, I realized I had to make quite a bit of money to go back to work. That's not necessarily in everyone's cards per se, so thank goodness now we have the Working Disabled Program, but it's really expensive to be me, like it's really expensive.

I hit my deductible within the first two months of the year for my private insurance through my group plan, and I have hundreds of dollars every month of out-of-pocket what I would consider LTSS expenses for

wheelchairs and insulin supplies and all those things, so we have to be able to figure out how to do better. There's going to be people who are not going to be able to vest and work to be eligible, but we still would be better off having them in the workplace and working rather than just on disability benefits.

Anastasia — Julia.

Julia — Julia Figueira-McDonough. So, I just wanted to, as a point of clarification, understand for the prior plans on aging that were included in the materials that you sent out, do all of those predate the federal study that was done on this long-term care subsidy or benefit?

Anastasia — I think some of the—well, I'm not sure if the reports are reflecting the federal studies.

Julia — I guess I could rephrase the question. I'm just wondering whether any, and maybe any of you guys or, CADA, maybe you could answer this question. Do any of those prior reports contemplate a similar benefit, and if so, what was the specific problem with implementing that—

Patty — We have not worked that out. [Speaker off mic]. We didn't structure anything.

Julia — Okay, so I guess that's sort of a complementary point. I know someone talked about having a summary of the prior plans or proposals, and someone mentioned the five unifying principles. I think it would be—I don't know if this is what you meant, but I think it'd be really helpful to know concretely what was proposed and what actually happened. I don't know if that's too big of a job for anybody to do.

I haven't had a chance to look at all of them, but I feel like if there's anything that—obviously we need to reinvent the wheel if the first time it was invented it didn't roll, like it didn't work, but it would be helpful to know what was proposed concretely and what the roadblocks were so that we don't go in the same exact direction and face the same exact roadblocks.

It just seems like that's repeating work that may have already been done, and I think Patty maybe of everyone around the table would know that best, but I think that would be really, really helpful information as we move forward.

Anastasia So, we have, as Kim mentioned before she left, we have an internal kind of working draft of a matrix that shows this is the report, and this such-and-such was included, and then so we can spruce that up and share it out. As far as why certain things were and were not adopted, I don't think from the administration that we would necessarily surmise that. It's a lot of factors about that—

Patty SCAN might be a very good resource for that.

Anastasia Yes, the SCAN Foundation.

Patty SCAN would be the best resource.

Julia Okay, thank you.

Anastasia Okay, Peter, we've added you to the list, but—well, Claire, you've gone once, so we'll put you—so, Jeff and then Peter, and we're going to go back to Donna, Claire, and Ellen.

Jeff Thank you. So, I want to associate myself with a lot of the person-centered comments, but I want to come at it from a different direction. There's a commonality, I think, between the Alzheimer population and the population with sensory impairments, and that is that the vast majority of both of these populations acquire their disabilities once they have aged. These disabilities, whether it's vision or hearing or dementia, are age-related in terms of their onset.

So, what that commonality leads to is that fact that in most of the cases, for all these groups, the people you are dealing with are going to have come from the middle class and aren't going to be eligible for Medicaid until they have spent down.

There are, in the sensory impairment cases, a lot of services that aren't even covered by Medicaid, so in essence, you have a double whammy. You can't go on Medicaid even if you want to, and even if you do you can't get the services that you need. For example, if you want to get services such as learning how to travel or purchasing assistive technology or daily living skills services, the funding is virtually nonexistent. There's a few million dollars to cover the state. In an urban area, you may be lucky enough to get it. In rural areas like Patty's, it's virtually nonexistent for most folks in those areas.

So, if the universal benefit that we recommend doesn't have a money-follows-the-person type of component, a lot of the services that are going to be most important to folks with sensory impairments that they will still never get.

Anastasia — Thank you. Great point. Peter is next.

Peter — I wanted to mention one thing that when we talk about spending down to be eligible for Medi-Cal, spending down resources, but there's a tremendous reluctance from people that we talk to every day who need services and supports, LTSS, whether it's in-home care or even memory care. They have resources, and they're scared to spend them down to be eligible for Medicaid, so we have to messenger that better so people understand the value and when it's appropriate.

Also, for many of us, we learned how to navigate the system because of all the mistakes we made, so we can teach other people. We need to better about messaging about the programs that are available like the Working Disabled Program, like for example, what are the pitfalls I had when I first starting using the program.

I'm not on it now, but when I first started using the program, nobody told me that I had to sign up for Medi-Cal every year. So, when I was in the hospital, my family received notification that my Medi-Cal stopped because I didn't sign up, but I was in the hospital.

I called the Medi-Cal office to ask for an RA to have them complete the form for me because I was in the hospital. They declined. So, what I wound up doing is I dictated a letter which my family sent to the head of the county Health and Human Services, and it took—I resolved the situation, but we really have to start figuring out how to resolve those pitfalls.

Many people don't work because they don't know how to navigate the system, or the family tells them they shouldn't work because of their disability, or they get an overpayment from SSA, and then they're scared to work again.

So, we really do have to message better. We also need to remember when we develop programs or when we develop this—I'm sorry, I'm getting tired, and I'm drawing a blank on a word I'm trying to think of, but these

are rights issues. So, when we write the recommendation, we need to use rights-focused terminology. I noticed in a couple of the recommendations it says help. I think it should say support.

Also, this conversation is exactly what we need a No Wrong Door system, and a good information and referral because a lot of these questions could be answered by community members through an 800-number, a number folks can call to get all the answers from experts who know how the system works. Thank you.

Anastasia Thank you. Okay, so now we're going to Claire, Donna, Ellen, and Nina. No, Nina—

Nina I can speak again.

Anastasia If I can ask since we're getting close to the end for this discussion time where we're going to move into public comments soon, what type of recommendations do you have in mind for what you might want to see in the report? I mean, we can always for Chris and his team, they may or may not be able to give it to us by February, but if there's anything in particular.

Again, we're not going to have strict dollar amounts on options A, B, C, and D, but anything that you think would be helpful to get by February, and then anything just as far as the report, the LTSS report, that would want to be in there. Again, there will be further opportunities to add onto that, but if you have any initial thoughts on that.

Claire Okay, my point is—sorry, I'm not really—

[Overlapping voices].

Claire But, I'll be really quick. It's just sort of spring boarding off what Kristina and Christina and several other people have said around Medi-Cal eligibility. I just want to point out we keep talking about people getting to a desperate situation and have to spend down, and that is certainly true, but that is a resource question, and some people have resources that can be spent down.

A huge problem is people have just too much income, and they can never be eligible for free Medi-Cal because their income is too high, so I think one of the other things we have to think about is how share of cost and

income work in all this because that's really a whole different stream, and if had a more sensible share of cost system, I don't think people object honestly to paying into some of their services. They just can't pay in what they can't afford. You cannot ask someone to pay in half of their income and still have a place to live and food to eat.

So, I do think that we have to be sensible. The other thing I was just going to say is we have an extremely low asset limit, so when people are talking about 250% working disabled, 250% is about $2,500 a month. You still have to only have $2,000 in assets. That's nothing. So, I think that's another thing. It's like how do we have a sensible Medi-Cal system that empowers people, and then a middle-class benefit that works well for people, so I do think we have to think about those.

Anastasia Great. It looks like Donna is next.

Donna Hi, Donna Benton. I want to echo the share of cost. I think that that should be in our modeling. The other thing is I think we need to also, I will get to what you've asked, is that we also should have maybe in the report if there's a way to have case scenarios so that it really can be seen by people that you kind of turn it into a real person kind of thing. That might make the report richer, but also something that people can really envision. So, while I like the chart, that might help.

The other part is making—when we talk about spending down, I know what I hear from families is I don't want to spend down because if that happens (A) in some families there's never a way to get any generational wealth built up for families. Part two is Medicaid beds, Medicaid places just don't have the quality. They're seen as second-class places, and the private paid people seem to get better services.

So, if we're going to try to get people to use safety nets, they can't be seen as a second-class thing. They're not equal, they're not equitable. They're just not there like if you have Medicaid, oh you get to go to the four-bedroom room. If you're private pay, you get the two-people room. So, that's part of—that's just quality stuff.

Anastasia Thank you. Those are excellent points. Ellen and then Susan.

Ellen Great. Thank you. Just as Jeff was mentioning having flexibility in the plan for a variety of different service needs, I also say we need flexibility in where you can spend it. So, if you choose to be in your home, that's

one aspect of where the benefit can pay, but if you'd like to be in a memory care or assisted living board and care, the benefit is also transferrable.

Patty — That's a very good point.

Anastasia — Great. Susan, yes.

Susan — I heard Christopher say this, and I just wanted to make sure that whatever definition is used that it accounts for IADLs and cognitive impairment. When I saw on the Washington model that they used the Medicaid definition, I know there's the Medicaid eligibility in terms of income, but for different Medicaid programs, there are different eligibilities, and sometimes people with Alzheimer's if you only have Alzheimer's sometimes you're not eligible for some Medi-Cal programs if you don't have a physical need. So, I just want to make sure that we account for that.

W — Or dementia.

Susan — Alzheimer's, dementia, cognitive impairment.

Anastasia — Great. So, it looks like Nina has a final comment.

Nina — I just have one more really quick comment about Washington. They used three ADLs as their Medicaid standard. Their ADLs are broader than ours, so they actually include IADLs. So, again, that really brings us back to one, don't look at Washington as a template. It's a template, but [indiscernible] could do better, but also that their definitions of ADLs are different than ours.

Anastasia — Great. Okay, so I think we're going to go to public comment in the room and on the phone, and then before we leave, I'm going to come back and share my notes as to any next steps and recommendations that we have so far, and then of course, we can always revisit those.

So, we'll start with public comments in the room, and—okay, good, we have a microphone. Oh, Gary.

Gary — Hi. I'm Gary Paz Warren [ph], and I've been involved in the CADA work, heavily involved, so I have some experience with this subject. The first one would be a comment, and that is if you are thinking of messaging

this topic that you be very cautious about using the term public option which has a very clear and different meaning across the country right now with regard to healthcare and healthcare reform.

I think it could become very confusing. It's a similar term, so we need to find a way to either make it clear that it's a public option for long-term care or something, but I was very concerned about it when you started using it along.

The second comment I would have is that the Urban Institute has done some work in which they looked a great deal at the idea of creating a program where the mandatory payment for participation began at age 40 as an appropriate age after the debt of college or family formation are covered that maybe it's around 40 when people begin to think about what their long-term care responsibilities are or worry about their parents' costs.

So, I guess I would make sure that we consider some option or options for making it mandatory at some future age beyond age 18 when somebody typically starts to work.

The third comment that I would make is given where we are today and the bulge of baby boomers that we're in, and we've already started experiencing—I am one. There are going to be a lot of people that would not be covered by what we recommend, a lot of them, and I think we need to think about that and the consequence for what that means for gaining popular support and whether there's a way to have a different kind of way to pay for it so that, for me, there's no such thing as paying for ten years before I would eligible for benefit because I don't have ten more years to work.

The final question or comment that I would make is no one has mentioned the phrase that is critical. Undocumented, and California is full of undocumented people. We need to look at ways to make IHSS available to undocumented people, and I think that we ought to look at ways to make this available and consider the consequences for what it means as we go forward.

Anastasia Thank you so much, Gary. I'm just going to ask the operator if you could queue up anybody on the phone who wants to make a public comment. We're going to stay in the room for another couple minutes.

Moderator — Sure. Thank you. [Operator instructions]. Our first question comes from Connie Arnold. Please go ahead.

Anastasia — Sorry, operator, can you hold on with that question? We're going to take one more question in the room, and then we'll go to the phone.

Moderator — Sure.

Anastasia — Thank you.

Peter H. — Thanks. Peter Hansel with CalPACE representing the 15 programs of all-inclusive care for the elderly. We are also members of CADA. I want to really support the comments and the direction offered to make sure our work in this area is inclusive of a broad range of options. I think that's totally on point at both the benefit level, how it can be used, and I think the points about looking at the interactions with Medi-Cal are really, really critical. Some very good comments about shared cost issues, and so forth.

Putting on my PACE hat, I just want to make reference to the framework or the template for recommendations. I don't see any mention of PACE in the home and community-based options that would be integrated in an information and referral system, and I'd like to make sure that we get that on the table. PACE is really on the continuum of home and community-based options as a fully-integrated option. So, thank you.

Patty — I told you I planned on saying it loud and clear myself [speaker off mic].

Anastasia — Okay, operator. Go ahead with Connie Arnold.

Moderator — Alright. Ms. Arnold, your line is open.

Connie — Hi. This is Connie Arnold. I'm a disability rights advocate for 30 years or more, and the World Institute on Disability has done a number of publications in the past regarding the issues related to working and poverty issues for persons with disabilities, and I would really highly suggest you look at some of the work that Brian McDonald had done years ago on that issue.

Also, I would contend that although the Master Plan on Aging LTSS committee says that it has a representative to represent people in receipt of LTSS that the community members on disability benefits and on programs like IHSS have been left out and don't have a voice even though the

executive order had said that it was going to be nothing about us without us.

So, if you don't have any beneficiaries that are solely on things like IHSS or an IHO waiver, then you don't have participation from our group, even if you're holding DSS listening sessions to our group. We don't have the same level of voice that the people do that are on the committee.

I would also contend that Californians in the middle class don't want to be taxed to death, so people are leaving California. Of course, on top of PG&E and the shutoff, that's increasing movement where people and businesses are looking maybe to relocate. There should be concern about that about increasing taxes when Californians are already overtaxed. So, that's another comment.

Then, when it comes to seniors and the middle class, there are people that just may not need IHSS as much as they may need—a 90-year-old may need a housekeeper or somebody to do some cooking for them. So, you have to look at things a little differently about what a person might need.

I know somebody who had Merry Maids, and they fired their Merry Maids and hired the neighbor's housekeeper because he had had eight back surgeries, and he couldn't make his bed. So, there are different levels of services that are needed, but he was highly functioning otherwise. So, you need to differentiate needs.

You also have an issue of seniors that are being taken advantage of by the cost of care and the demands by caregivers who seem to be setting the rates. It's also difficult for people on IHSS to find caregivers that are competent and capable of doing the care and have a good work ethic.

So, those are other issues to be looking at besides just the issues about sustainability and services for seniors. So, I would highly look into some of those other areas as well. Thank you very much.

Anastasia Thank you so much, Connie. Operator, is there anyone else in the queue?

Moderator There is, and now we go to the line of Ann Baugh [ph]. Please go ahead.

Ann Hi. I am a caregiving spouse who's currently in the middle class and hope to stay here for a while. I was really dismayed that I didn't hear any mention of any kind of catastrophic coverage. Hearing about this

Washington State plan is a crumb to me. I might be able to save $36,500, but there's no way I could save $650,000 which I believe was given as the average lifetime cost of Alzheimer's disease.

I honestly feel like the $36,500 to me makes more sense as a deductible than as the lifetime coverage amount. I hope you'll look at catastrophic coverage. That's all.

Anastasia — Thank you so much, Ann. That's a very good point, and yes, we're looking at a wide range. Operator, who's next in the queue?

Moderator — Our next question comes from Zach Karnazes. Please go ahead.

Zach — HI. My name is Zach Karnazes. I'm a San Francisco IHSS recipient. I want to thank Gary for his comments in support of our highly-vulnerable immigrant population, and I also want to thank Connie Arnold for her comment, especially about inclusivity which has been a huge problem for me as an IHSS recipient, especially with the San Francisco Public Authority, which is just appallingly bad at advocating and helping us as clients.

Executive director, Kelly Dearman, has blocked me multiple times from trying to get the services that I need, from trying to get transparency about public meetings, from trying to get disability accommodations to attend public meetings, from trying to do outreach for letting people know when public meetings are. I asked her if we could have a support group for people with disabilities that are in IHSS so we could solve some problems ourselves and save the government money, and we could work together and have support with each other.

Kelly Dearman told me this would not be possible because we would not be able to be monitored, and I have a real concern about that kind of attitude that clients shouldn't have a say in he program, and that we should be monitored like children and not given the same opportunities to be included in the decisions that affect our lives.

The Public Authority has denied me the things I need for mentorship, help for getting help with a provider. I have gone for more than six months without a provider. I had to conduct 40 interviews, 40 in-person and on the phone interviews because the provider lists that they give are so outdated. They have a lot of people that aren't even working for IHSS

anymore or people that have worked for me in the past or people that are grossly unqualified.

I've had people going through my trash, casing my place, looking for things to steal, really scary things when I do interviews with people on those provider sheets. They're not screened very well. Not only that, but they also have a really hard time giving them to me. I've had to involve city officials just to get the Public Authority to give me the provider list in the first place. Sometimes it takes weeks or months to get a new provider list emailed, which should only take a day or two at the most.

These are some of the issues I've had. There's been others as well like trying to get—my social worker told me recently she would increase my hours, and then when I got my statement, it said the hours are exactly the same. The appeal information is really confusing. It also doesn't say that there's accommodations to appeal remotely because I don't have a wheelchair ramp to get out of my home right now, and it's just been really hard.

So, I just hope that this committee can do something about the Public Authority here. I think there's better options available that can save the state money and let recipients be involved in the decisions that affect our lives. Thank you.

Anastasia — Thank you, Zach. We have our deputy and branch chief from the California Department of Social Services here for IHSS, so they're in the room and listening. Again, we're going to have IHSS as a focus on December 2nd.

Okay, back to the room. Do we have any other public comments in the room? Yes, one more in the room, and then we'll go back to the phone.

Jackie — Hi, Jackie Barocio from the Legislative Analyst's office. I just had more of a technical question for Milliman. In your slides you mentioned that the actuarial study would touch on potential state savings to Medicaid, and just hearing comments around the room there's this kind of spend down effect, so those savings would actually be savings to also families.

So, could you just speak more conceptually of how you're calculating these savings, what types of savings are included or accounted for? Is it families that you're preventing them from spending down so they never end up on Medicaid, or you're extending the spend down time period, so

you're just delaying their entry to Medicaid? Or, is it that there are actual savings because they have the resources to get services so they're not advancing in their acuity or level of need, so that in the lifetime they're not advancing to skilled nursing or things like that?

To what extent would your report kind of tease out those types of savings and majority of savings are attributed to eliminating the spend down effect, etc.?

Anastasia — Before you answer, Chris, I'll just say if you'd like you can send me an email, or we can get in touch after the meeting, and then we can get a further deep dive for the LAO. Sorry, go ahead, Chris.

Chris — I probably don't want to bore people with technical details at this meeting, so we should probably just connect offline. The Washington report is available publicly, so we have a little bit of detail on our methodology in there in terms of where the savings came from. Certainly, the delay of the spend down I think is part of it.

Then, also keep in mind the way it was structured in Washington is that the new program was going to pay first, so there's just some instances where people perhaps would have been paid under the Medicaid program before. Now, the new program is going to pay first, so there's just some substitution of dollars as well.

Anastasia — Great. Okay, operator, do we have more folks on the line who want to ask a question?

Moderator — [Operator instructions]. We have a question from Clay Kempf. Please go ahead.

Clay — Hi. My question actually has to do with the template about Information and Assistance systems, and a couple things that I'm just a little concerned about is the overarching goal to build a statewide I&A system, at least what I heard in that discussion was that there needs to be an emphasis on local I&A responses because it's going to be the local I&As that know which services are capped or maxed out or don't exist in any particular region.

So, I think that emphasis is missing from the template. There's a reference to it, but it sounds kind of like that's the secondary priority, and I think the goal—the Alzheimer's Association example was a great one

where they had a statewide system, but the call automatically went to a local agency within reasonable working hours.

Anastasia Thanks, Clay. Patty is here saying that she raised that.

Patty I did raise that, Clay. Yes.

Clay Okay, great. One other point on that. Staffing the I&A with professionals with advanced training in gerontology or disability services, that's a money question, but it's also an availability of workforce question in rural areas.

If you're trying to bring in multiple agencies into being the right door to approach, it might not be realistic to set the standards too high in terms of skills and training, and I'm thinking particularly in rural communities. The resources aren't there, or if the resources are applied, it's going to force the I&A person to make more than other staff of equal or higher positions in that agency which ultimately would mean that there is not a No Wrong Door system. It would create a one-door-only system where there would only be one agency that would have the capacity to hire people at that level.

Anastasia Thank you. Great. Anyone else in the room? Last chance? Gary has one more, and then we're going to wrap up. Two more in the room, sorry.

Jordan Good afternoon, Jordan Lindsey with The Arc of California. We're developing a letter that we're going to submit to the workgroup specifically about victimization of seniors and people with disabilities. A lot of it deals with criminal justice and recommendations, but a lot of it does shave overlap with LTSS.

I don't see another forum where it may be discussed within the Master Plan for Aging outside of this subcommittee including items such as improving mandated reporting, data, and background checks, so if you're going to create a Master Plan for Aging, then that would be a definitely missed opportunity not to address safety and victimization as well.

Anastasia Thank you. So, what we have in mind, I think you're all familiar with the four goal areas that we've talked about, and one of the goal areas is around economic security and safety, and so we plan to have webinars, other ways to have public discussions starting in January around—and, goal four area does include safety issues, mandated reports, that type of thing, so yes, we

want your letter, and we will be very glad to have your feedback for how we can incorporate those topics in upcoming webinars.

Gary.

Gary — This is for Chris from Milliman. I think you mentioned that the State of Minnesota that they were looking at the availability of Medicare Advantage plans providing LTSS. Am I correct that—I mean, I know you talked about Minnesota?

Chris — That's correct.

Gary — I wonder if you could, at some point, either in writing subsequent to this meeting give us some sense of what is being done. Is the state mandating that Medicare Advantage plan available through managed care plans in the state provides certain services? I'm just wondering what leverage is available to the state to influence a Medicare managed care plan.

Chris — Real high level, they're thinking of mandating offering home-care benefits to be attached to Medicare Advantage plans and Medicare Supplement plans. They're still working through that. I think they released a report at the end of 2018 that kind of outlined some of that, so that might be a good resource. I can find that and maybe pass that along to Anastasia.

Anastasia — Okay, great. So, we are going to then wrap up public comments, and then we had reserved 15 minutes at the end here now to talk about recommendations. We don't have to spend all 15 minutes, but I do want to make sure that what I have in my notes and Carrie has in her notes are correctly captured.

So, I think on the first part of the meeting where we talked about Information and Assistance programs, I think we have an email. Carrie, do you have the email from Kim summarizing the recommendations? Okay, I'll come back to you in just a sec for that.

Carrie — My computer just died.

Anastasia — Okay. Here, I found the email. Action items from Kim are the framework with the vision, mission, values, and goals, we'll send that out shortly for review by the full Stakeholder Advisory Committee. As far as the objectives, we have revisions requested ongoing from the LTSS and Research, so we'll try to tie in the Research and the LTSS subcommittees

to make those objectives clear and tied in with the work that the Research subcommittee will do.

More details coming soon for meeting topics, schedule for December and January meetings. We're aiming for having the materials and the agenda three weeks in advance, but not sure. We'll try to our best.

We're going to share a chart with you all with the common findings from the prior master plan efforts. On the recommendation template, we're going to have it updated with additions including discussion on background, local models, strategy, metrics, and evaluations. We're going to address version control issues and use more plain language.

Then, I believe we had a couple more things added on. Okay, back to the Information and Assistance. Again, emphasis on a local model and making sure that that works hand-in-hand with a statewide model. I don't know if I captured the rest of those, but Carrie, I'm sure you probably did on the Information and Assistance recommendations from the subcommittee members.

Then, as far as our main topic for today, I know a lot of it will be thinking about and looking forward to the interim report from Milliman in February, but what I did, certainly you all raised many times the interaction between Medi-Cal and this benefit, and that the study needs to look at that.

Also, that when it comes to the communication about the Medi-Cal Working Disabled Programs or other similar programs, the recommendation is to beef that up, to have better visibility for that program. Even, Ana, I heard you say about expanding the Working Disabled Program if that was correct and looking at, as far as the Milliman study, looking at the asset limits for Medi-Cal and what's a reasonable share of cost, looking that the definitions for the IADL and cognitive impairment, being thoughtful about that in the report. Flexibility in the plan, having flexibility in where to spend the funds whether it's at home, assisted living, nursing facilities.

I know—oh, will the study range from the most generous to the least generous? Got that loud and clear from Kristina. Looking at can we expand CalABLE to put money in for long-term care? Healthcare reform, being careful about—Gary's suggesting being careful about public option and what that means to people. Considering included undocumented

people and adding PACE in the HCBS options for information and referral, following up with the LAO, and what's being done in Minnesota.

So, hopefully, that—yes, Nina.

Nina I just want to add something, too, to the feasibility study that [cough] program that the individual should be able to pay a family caregiver, however that may be family affinity or family caregiver, whoever that might be, should provide those services. I know Washington allowed that.

Anastasia Very good point. Thank you.

Marty Anastasia, I just have a technical question. On that initial release of the Milliman study, you said March.

Anastasia February is what we're asking for so it can go into the March—

Marty Will that be available to the public, or is just available to the administration and—how will that be—

Anastasia Let me get back to that you. I don't know—

Marty If the answer is no—

Anastasia Well—

Marty If would be useful if there could be an initial draft that we could all look at.

Anastasia Right, and I think maybe one of the questions is, is the initial report from Milliman, has it been synced up with what we're hearing from the Commonwealth Fund, so we don't want to have competing numbers. We want to make sure that what we release is okay. Everybody's held hands on it, or you know—

Marty No, that's great. It's on a fast track. Thank you, by the way, for capturing virtually everything that we said.

W You're amazing.

[Overlapping voices].

Marty — We don't need a Master Plan for Aging. It's you, right?

Anastasia — Well, we have a good team. We really have a great team here working on this plan. Anything else for the greater good?

Catherine — [Speaker off mic].

Anastasia — Yes, Catherine.

Catherine — So, we, to date, learned that December 2nd when IHSS was supposed to be presented is actually the Monday after Thanksgiving weekend, and at least some members of the working group putting that together can't attend. So, we were trying to move that back a little bit, but the question for the group is if are other people not available on December 2nd now realizing people might be traveling, and second if we can't find a replacement, it means there will have to be another presentation in January, and does that pose any problems? Kim asked if I could sort of frame that for everybody. So, if you have feedback about that, that would be helpful.

Anastasia — Does anybody—

W — Catherine, I'd maybe add that it would push the IHSS discussion back to December 17th—

Catherine — There's actually something already scheduled on that date, so it has to be a swap—either a swap, and they could do it earlier, but I think Kim is now concerned that saying to somebody else you have to go on December 2nd isn't very reasonable given that date, and that it might then result in one group or another being instead in January. Are people okay with that extra January meeting if December 2nd can't happen?

M — How about meeting longer?

Catherine — On?

M — During the day. I don't know when it would be to meet for five or six hours.

Catherine — To do two presentations? Okay, we can include that in the thinking—

[Overlapping voices].

W I mean, I would just offer that doing two of these in one day just for everyone's brain capacity, particularly on IHSS is probably a challenge. So, I would—

Marty There's other days in December—

[Overlapping voices].

Catherine We're running out of dates.

Marty I feel for you trying to schedule because it's really, really hard. The Research subcommittee—

W I think we're all freed up.

M You can all meet for Christmas.

Catherine So, Kim had just asked that we take the temperature of the room on that.

Anastasia Okay. So, I guess—Susan, go ahead.

Susan I know I will not be available on the 2nd, and I would really like to hear the IHSS presentation. I think it's a hard day for travel. I'm only one person, so don't base it on me. That's my temperature.

W I can't do the 2nd.

W I think the question was if we could swap—

Catherine I think the feedback though in part is December 2nd isn't really a very good day due to travel, and we probably shouldn't schedule anything on that day. Then, the question becomes since we're not going to put something else there because lots of people can't be here, are people okay with that extra January meeting if that becomes necessary because we're kind of running out of time in December. That's the second part.

W January has almost three fifth days in January.

[Overlapping voices].

W January 29th, 30th, and 31st are all fifth weeks. So, it's like the fifth Wednesday—

[Overlapping voices].

W I think January is possible.

[Overlapping voices].

Anastasia Something to consider is the amount of time it will take to write the report, and so if we're trying to have some kind of a draft by the end of February, how much can we cram into February and then late January? So, are you all thinking to maybe to try to meet in early January?

[Overlapping voices].

Anastasia Right, we have January 6th. Yes, Susan.

Susan Because of the weight of IHSS, maybe IHSS could be December 17th, and then the residential settings could be moved to January just because I think the IHSS conversation will yield a lot, and there might be more follow up, not that they're not both important, but that one's—

[Overlapping voices].

Marty It was mentioned in the executive order, and there is budgetary impact to the current—

Anastasia Does December 17th work for everybody already? We sent you the date, and I think there was one issue where we wanted to have a presenter on the 17th, but it's all good.

Susan That's at the following meeting.

Anastasia Oh, on December 6th.

[Overlapping voices].

Anastasia Oh, we're talking about January. Yes, Peter, go ahead.

Peter I got two calendar invites, one for December 2nd and one for December 5th for the LTSS Advisory Committee. I want to confirm that it's the 5th.

Anastasia Yes.

W There's one on the 2nd and one on the 5th.

[Overlapping voices].

W Now, we're considering not doing the 2nd.

Peter Alright.

W For the people who can't make the 2nd, could you call in on the 2nd?

[Overlapping voices].

Catherine Anastasia, I just want to clarify where I think we're going. We will have the meeting on December 5th, which I believe is with DHCS. Move IHSS to December 17th, continue with the Workforce meeting on January 6th, and build in an additional meeting for residential at some point in January, which I think the preference is to do it in early January to allow enough time for the writing of the report. So, it might be a second meeting the first week in January or the beginning of the next week.

Anastasia So, we do have the California Department of Aging meeting room reserved on December 10th for the Research subcommittee. If you wanted to try to meet that day for residential care settings, that's open, but then we'd be bumping the Research subcommittee. Or, if you'd rather push it to January?

W It sounds like everybody is agreeing that the 2nd is just not a good day, so maybe we can send an email about whether the 10th or a January meeting is preferred because there's just not enough of us left. I'm worried about us making a decision—

[Overlapping voices].

Anastasia Okay, then just a flag is that venues get to be difficult, so probably whether it's December 10th or another also in January, we'll be looking at the Department of Aging, their facilities in Natomas unless we can pull some arms or work some magic.

W Also, if we're having two meetings in one week, for those of us who travel here, it's hard, so if they can be like back-to-back, I know it's adding one

more layer of complexity, but it's hard coming to Sacramento, for some of us, twice in a week.

Anastasia Sure. Okay, so again, that means—

[Overlapping voices].

Anastasia Yes, I think we looked into that, and it wasn't quite big enough was our understanding. So, the Department of Aging in Natomas that would be the other location we'll look at. I know it's not next to public transit, but it's a venue, and the dates are getting more important maybe than the venue.

Okay. Let's wrap it up. I think we're good, and we're going to see you then next time on December 5th, and of course, email and other communications before then. Thank you, everyone. Thank you, operator.

Moderator Thank you. Ladies and gentlemen, this does concludes our conference for today. Thank you for your participation and for using AT&T Executive TeleConference service. You may now disconnect.