



**Home and Community-Based Services:
System-wide Coordination to
Improve Care, Hold Down Costs
Centene Corporation
Alliance for Health Reform
Friday, October 9, 2015**

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SARAH DASH: Good afternoon. If everyone could find their seats we're going to go ahead and get started. Thank you for joining us on this beautiful day. I don't know if its summer or fall, but it's certainly nice out. So thanks for joining us on a Friday afternoon.

I am Sarah Dash. I'm Vice President for Policy at the Alliance for Health Reform and I want to welcome you to today's program on Home and Community-Based Services. We are pleased to have the support of the Centene Corporation in making today's briefing possible and it's going to be a great discussion.

I just want to do a quick bit of housekeeping. You can follow us on Twitter with the hash tag HCBS and I'm going to put up the Wi-Fi instructions if you need those.

So this is the second briefing that the Alliance is doing and it's in a series that we're calling Medicaid: Beyond the Silos. Our first briefing in the series focused on the intersection between health and housing and, in case you missed it, the Alliance actually published a toolkit on that subject yesterday so you can find that on our website, allhealth.org.

Today's briefing on HCBS, like the issue of housing and healthcare, is an extremely complex topic and could warrant multiple briefings, so we are going to try to touch on some of the most important issues here today and hope that you will all contribute to the conversation in the Q&A and the discussion and we have wonderful panelists here with us to address the issue and I'm going to introduce them all in a minute.

Before I do that there are a couple of quick things. I borrowed a couple of slides from the Kaiser Family Foundation and then you have this actual brief in your packet. Why do we care about home and community services? It is an essential service for millions of people across the spectrum in the United States but it's really expensive. It's really expensive for people to be able to afford the care that they might need. And so, what you can see in this slide that home health is less expensive than nursing facilities, but still there's a big question on how this fits in with our overall health system. It varies by state, so access to the right kinds of services might vary by state. And it serves a wide range of people with various needs—elderly and non-elderly. And so, without belaboring it, we have real experts here on the panel, I encourage you to take a look in your packets.

So with that, let me go ahead and introduce my co-moderator today, Michael Monson. He's Vice President of Long-term Care and Dual Eligibles at Centene and he has much more experience than I do working on the issues that we'll be discussing today. And I'm going to give Michael a chance to give a few opening remarks and then go ahead and introduce our panelists. Thanks.

MICHAEL MONSON: Thank you, Sarah. It is a real pleasure to be here today and thank you all for coming out and thank you to the panelists for being here, taking time out of

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your day. This is a critical issue for us as a country and we're pleased to be able to have this conversation today.

One of the things that we just wanted to set the frame on is that it's really important to understand that HCBS, Home and Community Based Services, is fundamentally a non-medical model. This is about individuals being able to receive services where they live and able to live the best life possible. As Sarah mentioned, a variety of populations are serviced here, and it cannot be a one size fits all model. So as we think about how we address the problems related to enabling people to live that life in the community we have to think about it in a variety of ways to enable to service each population appropriately and the unique needs that they have to enable them to have that experience.

But, while it's a non-medical model, there are certainly direct impacts on healthcare costs across the system. HCBS can't have the positive and negative downstream repercussions for the healthcare system and what's very important to understand is that HCBS services are services that most people don't have access to through their insurance coverage. Medicare essentially provides no coverage for this benefit. Medicaid provides, depending on your state, coverage of some kind or another but, of course, you need to be in the Medicaid program to have that available to you, and everyone else basically is on their own. That creates tremendous stress on the system. It creates a tremendous stress, quite frankly, on people because everyone probably knows someone who requires some of these services and, if you don't, you will in the non-distant future. And it's important for us to understand that to solve these problems, to understand how we create a world that everyone can have the freedom and the right to live where they want to live, requires us to understand how we do that across the existing financing system that we have and how we broaden and expand that.

And so, with that, I think we're going to throw it over to our panelists.

SARAH DASH: Thank you, Michael. So let me go ahead and introduce our panelists, each briefly. Their impressive bios are in your packet so I'll just be able to do a brief introduction here.

Our first panelist today will be Anne Montgomery. Anne is a senior analyst, Altarum Institute Center for Eldercare and Advanced Illness, and a visiting scholar at the National Academy of Social Insurance, and formerly worked for the Alliance for Health Reform. Welcome, Anne. Next, we will have Bea-Alise Rector. She is the Director of Washington State's long term services and support system and she's going to tell us about their progress that they've made on this issue. And then, next, to my left, Abby Marquand is director of policy research at PHI, the Paraprofessional Healthcare Institute. She leads their research and analysis on policy issues affecting the direct care workforce as well as the eldercare and disability services industry. Finally, Jean Accius, who is an expert in Health and Long Term Care policy with AARP, will be joining us and telling us

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somewhat of AARP's long term services and support scorecard and how these services compare across the country.

So, with that, I'm going to turn it over to Anne and hand her the clicker. Thanks.

ANNE MONTGOMERY: Well, good afternoon everybody. I'm really delighted to be here and yes, I did work for the Alliance for Health Reform, and I think it's one of the best things about Washington, D.C., so glad you're all here.

I'm going to do kind of a 300,000-foot view of Medicare and then move to Medicaid. So I'll start with this first slide, and apologies if it's a bit small but it's in your packet, and it's intended to set the stage for long-term care or long-term services and supports—long-term care is just easier to say—and how it's paid for. And most of us assume, I think, that the government pays the lion's share but actually it's us. It's you and I, our parents, our grandparents. Because, if you add up, if you look at the left-hand column, the percentage of private spending, which is out of pocket and a little bit of private long-term care insurance, you'll see it's about 55% and, in comparison, the government spending is about 45%. A major reason for this is that historically long-term care has been seen as the province of the family, so family caregivers serve on the front lines, really, of long-term care that's provided in the home. This might have to change because work that AARP and others have done show us that the very same demographics that are transforming our country are also going to result in a plummeting in the number of available family caregivers in the first half of this century so I think families are going to need a good bit more support in the way of formal services.

So how many of us will really need long-term care? The answer is about half, those of us who are lucky enough to grow old, and this estimate, by the way, is tied to a significant degree of disability, meaning a need for assistance with the ADLs, the Activities of Daily Living, which are: eating, toileting, dressing, bathing, mobility, and cognitive impairment. A lot of people actually find they need assistance with only one ADL, but just sticking with the two ADL trigger, the total spending, if you do end up needing long-term care, is about \$266,000, that's in 2015 dollars. So what that means is that if you're 65 years old today you'd need to be able to set aside about \$134,000. That's a figure that's sensitive to assumptions and includes room and board, for example, which home community based services don't, but it's still a lot of money no matter how you calculate it.

So, this is another fast fact. I happen to love Henry Matisse and it just is meant to remind us all that women are the face of long-term care. They're going to be 55% of the population of older adults over the age of 65 by 2030 and 62% of those over 85 by 2050. They live longer, they also tend to have more disability and, therefore, they need more long-term care. And the savings, in general, for my generation, the Baby Boomers and subsequent generations, are not robust so this is one of our many challenges.

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This brings us to Medicaid, because Medicaid is a program for individuals who are lower income and, in order to even access services through Medicaid, you have to meet very stringent income and asset tests. The federal asset test hasn't changed for many years. It's \$2,000, although states can establish higher levels if they wish. And remembering, from the previous slide, that Medicaid pays for about 34% of all long-term care spending, this is a slide from Truven and it displays the different kinds of waiver authorities that exist under Medicaid. This is sort of an alphabet soup. There are a number of them; the granddaddy of them all is the 1915(c) waiver that was put in place in legislation, enacted in 1981. I'll talk a little bit about some of the other options. The 1915(i) option which initially was enacted as part of the Deficit Reduction Act was widened in the context of the Affordable Care Act and it allows states to provide a tailored package of services to all individuals across the state. That is an expansion relative to the 1915(c) waivers, which are time limited and limited to a particular group of people in a particular part of the state. The (j) option that you see on this slide is a self-directed services option for personal care and related services, meaning that a Medicaid beneficiary can hire his or her own aide and manage a budget and purchase care as opposed to receiving services from an agency.

So here's another way of looking at the various waiver authorities on this chart. This is the (k) option that you can take a look at, that's also known as the Community First Choice program. It's a state-wide option for attendant services for all eligible populations, not just physically disabled or developmentally disabled, for example, so it's challenging for states but it does come with more money. It comes with a 6 percentage point increase over the states normal FMAP, or Federal Medicaid Assistance Percentage rate that comes from the federal government.

I should note that the different waiver authorities, and there are quite a few of them in Medicaid, come with different income limits. For example, the (k) option has an upper income limit of 150% of the federal poverty level, that's \$17,655 for an individual in 2015, and that's lower than the income limit for other Medicaid authorities and waiver options, which can go up to 300% of the SSI level, or \$2200 per month. So, as states look to create comprehensive systems, or more comprehensive systems over time they really do have to sort of wade through the specific rules and limitations of different waiver authorities.

The Medicaid Health Home option is another option that comes with an enhanced payment for states for two years and it aims to provide them with a way to coordinate primary, behavioral health, and long-term care services for a range of populations, including children and older adults. There are also a few even broader authorities that we now have in our arsenal. They're not on this slide, but I'll just mention them really quickly. One is the State Innovations Models, or SIM grants, that are being administered by the Center for Medicare and Medicaid Innovation. They're in the planning stage now but they are amazingly broad and they potentially encompass changes in delivery that can reduce costs, not only in Medicaid, but also the CHIP program and Medicare. Those SIM

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grants might lead into states using Section 1332, sometimes called the Wagner Waiver for the Senator who proposed them, which will allow states, if they decide to go this route and get approval from CMS to rearrange some of the coverage pieces of the Affordable Care Act along with waivers in the publicly financed programs like Medicare, CHIP, and Medicaid. There are rules associated with the 1332's like coverage can't drop and costs can't rise. So we'll see how that plays out.

This is a program that I think you all should know about. It's called the Balancing Incentive Program or BIP for short. It's been very successful in giving states an enhanced Medicaid match to create a better infrastructure for consolidating waiver authorities, those that you saw on the previous slides, and coordinating access across Medicaid plan options that basically ask states to put in place no wrong door application and eligibility determination processes, conflict free case management, and also standardized assessments. And states got either a 2% or a 5% additional bump in their FMAP payments if they qualified for this program, which you can see, is quite a bit of money. It was a 5-year program and it has come to a close as of September 30th and it would be great to see the evaluation—I think it's due out soon—and see exactly what it has accomplished. Maybe some of our panelists will be talking about that.

So another very important part of this study is managed care – managed long-term care. Centene, of course, is involved in that, and according to the National Association for States United for Aging and Disabilities, or NASUAD, 17 states now offer a managed long-term supports and services program and another 10 are preparing to contract for delivery of services to some of their populations in some part of the state or, perhaps, statewide. This can be controversial. Some populations would rather be in a waiver authority as opposed to a broad sweeping managed care program across the state but managed care can be a wonderful delivery system. It offer states more certainty in terms of the budgetary predictability and it can also serve as a way of getting people off of waiver waiting lists which, in some cases, can be years long.

This final slide, I just want to show you, indicates how far we've come in terms of the Medicaid program itself, its coverage for long-term care. The federal entitlement is for nursing home coverage and all of the other authorities for home- and community-based services are optional. But, you can see that the home- and community-based services trajectory is up. The nursing home trajectory is pointing downward. They crossed in fiscal year 13 and, if we were to project, I would assume that that X shape will emerge strongly in the future. I think the future of long-term care is certainly in the community, in people's homes. That's where they want to be and they've made that very clear. The real challenge ahead of us, I would say, is to build a more robust and a more equitable series of programs that can serve everybody in need of those services because the population, as we well know, is going to double and then ultimately quadruple.

Alright. Thanks so much. I'll let others pick up the rest of the story.

[Applause]

BEA-ALISE RECTOR: Good afternoon. My name is Bea Rector, and I am the Director of the home and community services division which operates the long-term services and support system in the state of Washington. Really happy to be here this afternoon to share kind of a state experience related to transforming the long-term services and support system to home- and community-based care.

Since the 1990's, Washington State has been very intentional about moving and diverting people away from expensive institutional care towards more cost effective and popular home- and community-based services. While the AARP scorecard ranks us as second in the nation in overall choice and quality, it's notable that we ranked 34th in the country in terms of long-term care spending per capital. So, as a result, we like to say that our system is both better and cheaper than many other state systems. This is due, in no small part, to strong legislative direction both at the federal and the state level, and continual commitment to the clients living in Washington around honoring choice and helping people live independently in the setting of their choice.

I'm going to also be likely at a 300,000-foot level because this is a complex topic. We've worked on this for 30 years and I'm trying to tell you about it in 10 minutes. So I'm going to spend a couple of minutes talking about our history and our state's evolution in this arena and then move towards current and future efforts that we're taking to improve both the cost trends and the quality trends in HCBS.

So this is what we like to call our Mountain Chart. It really is a chart that shows the census of the Medicaid nursing home population in Washington State from 1972 to present. At its peak, in 1993, our Medicaid nursing home case load was about 18,000 which represented 44% of the individuals we served in the long-term services and support system, meaning then, in 1993, we served 56% of clients in home- and community-based settings. Now, in 2015, our Medicaid nursing home case load is below 10,000, which is 16%, meaning that we're serving 84% of the individuals receiving Medicaid long-term services and supports in their own home and in their community. This is at the same time that the state population in Washington of individuals over age 65 has grown 168%, so we're pretty proud of this rebalancing that we've been able to do.

I want to talk just a little bit about some of the uniqueness of each state, including Washington. In Washington we have a very diverse population. We're diverse in our geography. We have 29 federally recognized tribes and clients served in our system speak 74 languages, so it's incredibly important that, as we move to home- and community-based services, that we found ways not only to meet the personal care and the skilled nursing needs of individuals in the community but we also had to find ways to provide culturally competent and linguistically competent care for a wide variety of individuals.

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Key to our shift was a shift in our policy decision that allows clients the choice and flexibility of hiring family and friends to be their personal care worker and that policy has been in effect in Washington State since 1983 when we had our first 1915(c) waiver approved by the federal government.

Another thing I just want to talk about is there's a common misperception that people move from one setting to another as they age or as their disability increases, that they start out at home and then they move to a residential setting and then ultimately they end in a nursing facility. In Washington that really is no longer the case. People with significant health challenges and levels of disability can, and are, served in all of our settings and particularly in their own home. This level of rebalancing requires continual effort and innovation because as you build quality options to institutional care the complexity and diversity of the individuals served in the community and in nursing homes all change, so it's a continual evolution of a process. And I just quickly want to say that folks have talked about the different populations served. In our long-term services and support system in Washington, 60% of the clients we serve are age 65 and older and 40% are age 18 to 64.

Folks have mentioned the fact that rebalancing is good for people. It's good for people because it allows them to maximize their autonomy, their choices, and their ability to remain with their families and in their own communities. It's also good for both the state and the federal government because it saves taxpayer dollars. So what this chart is showing you is that if in Washington State we serve the same number of people that we serve today but we serve them with a service mix that we had in 1999 which was 66% community and 34% nursing home that we would have had to spend 2.7 billion dollars more in taxpayer dollars by now. Alternatively, and what's happened in a lot of states, is that you create wait lists and, as Anne mentioned, those wait lists can be years for folks to come off the wait list. These dollars are total dollars, both federal and state, and in Washington our FMAP is a 50% FMAP.

So, lots of reasons for Washington's success. I want to quickly just talk about a few of them. The values that have driven our system are really clear values from the very top, the governor and the legislature, as well as our executive leadership. Choice, self-determination, innovation, and safety have always been key as we build our system. We've done a good job of leveraging funding. We have state plan options that are entitlements. We have 1915(c) waivers. We participate in the Money Follows the Person Demonstration project. We implement a Community First Choice, the K option in the alphabet soup, in July of this year. We've done a really good job of applying lessons learned in our state-only programs and our Older Americans Act Aging Network programs, and when they work and they save money we then bring them into the Medicaid program. We also have a global budget from our legislature which allows us to more easily move money into home- and community-based services when we no longer need it in the nursing home budget. We've developed strategic services; the continuum of services that are available as alternatives to nursing homes is continually changing.

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We've build specialized services for individuals with complex needs, including individuals with dementia, challenging behaviors, individuals with geriatric needs, individuals with traumatic brain injury, and the population needs change all the time. We also make really intentional choices about what we do, where we put our staff, and what procedures we put in place so we've had conflict-free case management for years. We have nursing home staff that are put in every single nursing home in Washington State, which there are 220. We talk to every client about the opportunity to live in the community. We have a universal assessment that collects a really wide variety of information about diagnoses, medications, treatments, as well as ADL needs and we make continual investments in new providers and in workforce. And, just as an example in terms of our personal care workers, we have state qualifications that include state and FBI background checks, we have a 70-hour training requirement, we have a certification test requirement, we pay benefits such as healthcare, vision, and dental for our personal care workers, paid time off, and our average hourly wage right now is \$12.87, which is about \$3.00 above the state's minimum wage. And, of course, we have leadership and partnerships that have been key to our success, as well.

So where are we today in Washington? We're really concerned about sustainability. We're concerned that the hallmark of Washington's system, which has been built on meeting the personal and skilled needs of clients, does not provide the right incentives to clients or caregivers to prevent decline, maintain or improve functioning levels. That, coupled with the growth in spending, which is averaging 12% per bi-annum in Washington and long-term services and supports is 6% of the state general fund spend. That, and the next population growth, which is another doubling of the population in the 20 years, has caused us to really look at how can we deliver care differently in the future.

What are we doing in home- and community-based services around improving outcomes and controlling costs? We're using HCBS authorities to assist clients and caregivers to increase their skills around chronic care management, disease prevention, person-centered planning, and health improvement. We do this by using data from our comprehensive assessments to individualize and target wellness education materials that are sent to our clients that participate in our 1915(c) waiver. For example, out of that data we know that half of the clients that have compromised respiratory functioning—asthma, COPD, or emphysema—are still active smokers, so we can use that information to target again, education and strategies. Washington implemented the 1915(k) state plan option in July of this year that allows states to provide skills acquisition training so that individuals can become more independent in the performance of their ADLs. We also offer optional assistive devices under that program, again, to try and support clients who want to be more independent and not rely on human assistance. In both our in-home and our adult family home collective bargaining agreements we've negotiated pilots that would tailor caregiver training to work with individuals who are high cost, high risk with a goal of reducing emergency room use, hospital use, increasing satisfaction and participation in meaningful daily activities. And 40% of the LTS population is considered high cost high risk.

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Through our state's family caregiver program we've demonstrated statistically significant reductions in caregiver depression and stress and burden as well as a delay in the need for their care recipients to enter the formal Medicaid systems. And I could go on and on with other things that we're trying to do but what I want to say is that in order for us to achieve this next level of innovation we really need some increased flexibility on the part of our federal partners.

One of the challenges of Medicaid is the ability to target services to subpopulations of clients. Without that ability, states who want to add different options and services are simply faced with spending more on populations they are already serving instead of being able to serve new populations. So we are in the process of working with CMS to try to get approval for an 1115 demonstration waiver. There are long-term services and supports aspects in that waiver, including wanting to target services to unpaid family caregivers who are the backbone of LTSS system. And when those services and supports would be in place that would be in lieu of people coming onto the more expensive personal care and nursing home options. We also want to target care to at risk populations so that they don't spend down to Medicaid as quickly, and we think it's time to de-link eligibility between nursing home and community-based care.

[Applause]

SARAH DASH: Thank you. Abby.

ABBY MARQUAND: I'm going to be spending a few minutes telling you a bit about the workforce that provides HCBS, paid and unpaid. I won't belabor this point. Anne actually mentioned it, but we all know about our demographic aging and what that means for our economy at large. It means something very significant in the context of home- and community-based services. We are going to have far fewer people available to provide care to the people who will need it as our demographics show. And what this means is, we have a lot to grapple with in terms of how we support the people who are doing this work now and how we think about recruiting more people to provide home- and community-based services in the future.

This is an infographic from AARP, so thanks to Jean. Family caregivers are actually providing the bulk of home- and community-based services and most of them are doing it unpaid and with very little support. As you can see from this slide, one in four workers over the age of 25 is a family caregiver and, on average, people are providing 18 hours of care a week. That's very significant and these are people doing it with very little support, whether financial or respite or training, and this is really an untenable situation so the lost economic productivity associated with family care giving is significant and the value of what family caregivers are providing to our economy is estimated to be around 470 billion dollars. So this is a very important part of our economy—the unpaid worker family caregivers, but we need to figure out ways to support them better.

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On the paid side of home- and community-based service provision is the homecare workforce, and that's kind of an umbrella term for a bunch of different occupations you may have heard of including home health aides, personal care aides, direct support professionals, personal attendants—these all, collectively, are considered part of the homecare workforce and this workforce is charged with serving people with disabilities and elders in their homes and communities and providing the services that they need to stay in their homes and communities and live safely and independently to the extent that they want to. What they do, technically, is provide assistance with IADLs, those are the instrumental activities that Anne talked about, activities of daily living, which is more of the hands-on personal care tasks, but they're also providing a lot of paramedical assistance to people who have complex medical conditions or co-occurring chronic diseases with functional limitations, so they're doing very skilled work in homes and communities. A lot of people who are living in homes now would have otherwise been nursing home eligible but now they reside in homes, so homecare workers are really providing services to keep them there. And another important thing about homecare is this is where the jobs are. This is where they're going to be in the future so homecare workers are expected to increase by another million over this decade and that's going to be more jobs than we will need in retail or RNs or teachers, so this is significant job growth projected in homecare. And also, with rebalancing efforts, over the past 10 years we've seen the number of homecare workers between 2004 and 2014 more than double and that's because a lot more people are being served in their homes and communities and no longer in the institutions.

You would think that the upward demand on homecare aid jobs, the occupational growth, would mean an upward pressure on wages as it might in other industries, but that has not been the case for homecare jobs. So, over the past 10 years, we've seen wages stagnate for homecare workers. If you adjust for inflation they've actually declined. This is for a number of reasons but I'd say chief among them is the fact that the bulk of homecare is funded through Medicaid programs, as you've heard from Bea and from Anne, and homecare and Medicaid reimbursement rates really do not factor in the cost of labor. They don't factor in a sufficient wage or benefits for this workforce. That's not really how they're structured. And also, I think a lot of people would agree that, in most cases, the reimbursement rates for home- and community-based services across the country are not enough and they haven't changed in a long time so there just isn't a lot of upward pressure on these wages because of that limitation. So, even the best employers, the best agencies, or the best individuals who want to pay a better wage to their worker they are often limited by what Medicaid will pay for and that means that these jobs have come to be characterized by their poor quality, so they're associated with low wages, a lack of employer-sponsored benefits, like health insurance or paid leave. Actually more than 30% of the homecare workforce was uninsured in 2013. Hopefully that's gone down with the Affordable Care Act, but generally speaking, they don't have access to a lot of benefits that come with other jobs. A quarter of homecare workers are living under the federal poverty line and more than half of them are relying on some sort of public

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assistance to make ends meet for their families, so as these jobs are structured now they're not family-sustaining jobs and that's where I think we need to make change if we expect to recruit enough people to this work in the future.

When we think about what needs to happen in the future and what's happening now, one important thing is support for family caregivers and we do really need to think about how to do that more comprehensively and AARP and other organizations are really grappling with that. And what we mean by support is a number of things. Compensation is one thing and there are a lot of state programs, Medicaid programs, that will pay family caregivers to provide support. In Washington State that's very significant. In California that's very significant. Another thing that family caregivers could benefit from is training, especially in cases where they're serving family members who have complex medical needs and they're providing that kind of care to them without any training.

And then, respite, to ensure that family caregiver burden is ameliorated. When it comes to homecare workers you may have heard it's a big deal in our world that the Fair Labor Standards Act has finally been extended to cover homecare workers for the first time. So they had been carved out of basic federal minimum wage and overtime protection for decades and starting next week it will become effective that they are now going to be protected under federal minimum wage and overtime law. And this seems, you know, kind of like a minimal threshold in terms of job quality but what it is, is it's basically a subfloor for wages for direct care workers, for homecare workers specifically. And from that we hope to be able to think more about how we can improve job quality and wages for these workers. The Fair Labor Standards Act also means that we need to work with state Medicaid programs to figure out how to pay for this so there are concerns, especially across the country where we're seeing Medicaid funding cut, that this could mean reduced services if, all of a sudden, employers have to pay more to homecare workers. So this is another case where we really need to think about how to better fund the system so that everybody can benefit from this change.

Another potential for improving job quality for homecare workers is thinking about how to optimize their role in the context of the larger healthcare system and the long-term care system as well, and there are a lot of skills that homecare workers already possess, but that they could also benefit from additional training to improve serving specific populations, like people with dementia or people with behavioral health needs. And if we can improve the quality of training to homecare workers to improve those skills we can think of better ways to deploy them in the system at large. And also, in the context of managed long-term care, so you can imagine a role for a home care worker that would actually take advantage of the unique perspective that they have being with a client all day every day.

So, those are just a couple of things and we talk forever about all these things as well, but I'm going to turn it over to Jean now, so thank you.

[Applause]

JEAN ACCIUS: Thank you, Abby. So I would like to do two things. The first is actually to try to humanize a lot of what we've heard today in an article that was released in the Washington Post earlier this week from a caregiver; and then, the second is to share with you the work that we've been doing at AARP along with many of our partners, both in terms of public and private sector partners around really trying to raise expectations as relates to the delivery of long-term service and supports. I think this might be helpful. I also want to acknowledge two people that are in the room. One is Rhonda Richards, who actually worked on our advocacy work on this issue, as well as with Glenn Flykes [Phonetic] who works on some of our state issues as well as it relates to LTSS.

So, earlier this week there was an article that was released in the Washington Post by a caregiver, her name is Ronna. And she said that, "my father had begged me not to dump him into a nursing home. It was an easy promise to make, but in May of last year, 6 weeks after my dad turned 98, I broke my promise. I thought I had no choice. He was doing bizarre things. At night he would get up every 90 minutes or so to search for monsters he knew were lurking. His behavior left me tired and drained. Dad's nursing home turned out to be less horrible than I had imagined, still it wasn't home. Alarms rang every time dad twisted in bed, or shifted in his wheelchair, and he had to wait for someone to take him to the bathroom. I agonized over my decision. Had I abandoned him? He never abandoned me. The answers were hardly comforting because care giving is hard, because at 67 I don't have the energy to pull all-nighters and still function the next day because I never had a lot of patience. Despite my doubts, though, it wasn't a change of heart that forced me to bring my dad home; it was money pure and simple. After three months it was becoming apparent that the facility's \$250 daily rate was non-sustainable. Like many middle class people, dad had saved too much money to qualify for Medicaid but not enough to pay for a good nursing home for a long length of time. He also had no long term care insurance. I faced a harsh choice. Empty both of our nest eggs to pay for his facility or bring him home. I chose to bring him home."

So, this story highlights many of the issues and challenges that we've talked about on this panel and Ronna's story is not necessarily unique, in part because many people are facing some of these similar issues. Several years ago we actually at AARP, in working with many different experts, wanted to figure out what would be considered a high performing long-term support delivery system? What factors would we think would be extremely important to help assess the performance of the delivery systems to help promote a dialog, raise awareness, and spark some type of action? So, in 2011, we released our first scorecard that had about 5 dimensions – with the first one it was 4 dimensions – and 26 indicators and we released our second scorecard last year. The intent was to really think about ways in which we could promote action, help states assess their performance; really have some form of a dialog that would help us move this along. As many of the panelists mentioned earlier, the demographics are changing and that is one of the key things that

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we found in our report is what is an acceptable pace of change in light of where systems are today relative to some of the demographic changes?

The five different compositions include affordable in access, choice of setting and providers, quality of life, and quality of care, support for family caregivers, and effective transitions. For the purposes of our conversation today I just want to focus on choice of setting and provider, in part because that's where the discussion around home- and community-based services actually takes place. But, nevertheless, a lot of these dimensions are interrelated. Affordability in access has potential implications in terms of choice of setting and provider access.

This slide actually illustrates to you some of the things that were discussed by our moderators that where you live actually matters. It matters in terms of the ability to access certain types of services, it matters in terms of the ability to pay for certain types of services, and it has, again, implications in terms of choice. Washington State, as Bea indicated before, was one of the states that ranked as one of the top states, and she did a great job articulating some of the features that has placed Washington as one of the pioneer states in the delivery of long-term services and supports. Other states include Minnesota, Oregon, Colorado, Alaska, Hawaii, Vermont, and Wisconsin. Now, what's interesting about our scorecard is that it's not just one-dimension. It's multidimensional, and there's 26 indicators, so even in some of the states that are considered top performers based off the data that we have, there's always room for improvement in terms of some of the key indicators.

You can definitely see here, and we have the report online, and we're happy to give you a copy as well, where your state might actually rank across these five major dimensions. As relates to choice and setting, so this dimension measures the ability for people to choose the setting in which they receive services and who actually provides those services. Some of the key indicators for this dimension include the balance between institutional and home- and community-based services, the use of community services first, the extent of participant direction, as Bea talked about earlier, and the supply of home health aides and the availability of nursing homes.

As you can see, again, variation across the country and where you live actually has some implications for that. There are three points that I would like to make with this slide. One is the fact that, as Anne mentioned, and others, is that with nursing home, that's a required benefit and home- and community-based service is an optional service, so you're seeing some factors that are playing into that. And while most states are actually shifting toward more home- and community-based services the pace of that change is slow relative to the increase in the aging of the population.

The second thing that I would like to discuss is the extent to which individuals have the ability to choose who provides their services and, as someone on the panel indicated,

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oftentimes if a consumer has the choice they're likely to hire a family member, and that also has implications in terms of some of the economic opportunities that might exist.

And third is just around expenditures in terms of rebalancing. As we talked about before, while we're seeing an increase in greater utilization and spending particularly on HCBS, there are variations in terms of different target populations and it'll be extremely important, as Anne mentioned earlier on, to ensure that we are providing services for all the different populations who need them.

This just kind of shows you the variation in terms of the top states. So five states actually spent about 65% of their Medicaid long-term supports dollars on home- and community-based services but we also see that there's a great variation. One state, in particular, spent about 16% of its Medicaid dollars on home- and community-based services. The other indicator that I would like to highlight is what we measured was Medicaid's first-time users who actually utilized home- and community-based services instead of nursing home. And, as you can see, there is a great variation there, particularly between the top five states and the bottom five states. So, again, there is much work to be done.

So major findings is the fact that while states are making progress there is great room for improvement, even among some of our top performing states, that the gradual pace, in terms of improvement, needs to accelerate in light of the aging of the population. Twenty-four states did increase their proportion of LTSS spending for home- and community-based services but, again, what is an acceptable pace of change? And, the biggest indicator in our report was Medicaid performance, both in terms of the reach as well as in terms of balancing of the dollars.

The report is available on AARP.org, the Public Policy Institute, and I'm looking forward to the conversation.

[Applause]

SARAH DASH: Well, thank you to all of our panelists and to Michael for laying out this issue so well.

We are going to enter into the Q&A portion of the conversation and I know it's freezing in here so if you're cold stand up at one of the two mic's and ask a question, or if you feel more comfortable, please write your question on a green card and people will be walking around to send it up. I already see one hand raised and I will get to you, ma'am, but before I do that we want you all to stay here until 1:30 but we know sometimes you've got to leave early. If you have to leave early please fill out your blue evaluation before you leave.

With that, ma'am, did you have a question? And can you just try to speak up, or, if you're able to go to the mic. Thanks.

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DONNA ABRAHAM: I'm Donna Abraham, I'm an editor with the Journal of Health Affairs, and I'm very, very, very happy to thank all of you for the tremendous work you've been doing because it's really paying off.

One of the questions I have is about appropriate housing. In order for somebody to stay in the community they have to have homes that are properly equipped, sometimes with nothing more than railings on the staircases, or they really need to live in places that have accommodations for wheelchairs, various other things. I'm not ashamed to say I live in senior housing for good reason. However, it seems that the boom in senior housing is aimed at people who have quite a bit of money in the bank and can afford to pay for private care. What is happening in terms of Affordable Housing for people who would be in the asset range to qualify for HCBS and is it enough?

BEA-ALISE RECTOR: I'll start that. Housing is a critical issue—accessible and affordable housing particularly on the income and resource levels of a Medicaid recipient are a challenge at best. I would say no, it's not enough. There has been work in partnership, I know, between the Centers for Medicare and Medicaid Services and HUD related to vouchers that assist people coming out of nursing homes to find affordable housing. We're a participant of that in Washington State. We're working actively with our Department of Commerce around the development of accessible and affordable housing. We have some trust funds to be able to do that that are used primarily by individuals with intellectual and developmental disabilities, but we need to do more of that around individuals who are older adults.

In our waivers, we do help pay for things like adaptations to bathrooms, ramps, rails, things like that to make homes safe. The Older Americans Act is also critical in this in terms of home modifications. There's not enough money there, as we all know, the Older Americans Act has been very stagnant compared to the growth in the population. But a few dollars go a really long way to keep people in their own homes, but it is a critical issue.

MICHAEL MONSON: I would add to that – I mean, housing is an absolutely critical issue and in the Medicaid program part of the challenge is that the only place that housing is paid for by the Medicaid program is via the nursing home, and there is a very strong policy perspective, I actually think it's legislative, that you cannot pay for housing with Medicaid dollars.

So one of the things that we need to do is obviously work with folks like HUD to create more affordable housing for folks, but I think we shouldn't forget, I want to pick up on what Bea was saying, is the need to make sure that we make people's existing homes accessible to them and states all vary, but usually states have some version of a home modification benefit and that can be critical. And if you think about what you want to do is, the moment someone leaves their house and goes to a nursing home, getting them

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back out to the home can be very difficult because they potentially have sold their home, they've changed their lives, and so the ability to make sure that we can put ramps in, lifts in, grab bars, and any number of other modifications to a home to make it available to an individual with these types of needs, means that we won't have to find them housing later. So in many ways what we need to do is get ahead of the problem and this is, again, states are doing this. As a health plan, we certainly do this. We do home modifications all the time because we don't want people to go into the nursing home. And there are certainly dollars that go against that. Those are dollars that pay for themselves in spades because it's much less expensive to do a home modification up front than to pay for several years of nursing home and, oh, by the way, it's way better for the individual. So let's not forget that.

ANNE MONTGOMERY: I would just add that Money Follows the Person is a program that does have some money in it to help people transition from nursing homes to the community and has help with regard to setting up a household. The Community First Choice program also incorporates those kinds of spending flexibilities and, in general, self-directed services, in which you end up administering your own budget, hiring your own aide, and spending money on services that have been approved, often can also include some home modification and those are authorities that are built into several different kinds of Medicaid home- and community-based service waiver authorities and state plan options. So there is some money out there—not nearly enough. I know that the assisted living industry would like to have more help, if you will; figuring out financing for affordable assisted living so that it isn't just high end. We had a whole forum on that when I was on the Aging Committee several years ago and we need to pick that up and make it more possible to finance these kinds of arrangements and subsidize them appropriately.

SARAH DASH: Thanks. I think we have a question over here.

RON MANDERSCHIED: Ron Manderscheid from the County Behavioral Health Directors, so I appreciate the presentation because we need to increase the focus in this area because of the tremendous aging of the U.S. population; however, my question is different. We have other subgroups in here. We have adults with serious mental illness in this population; we have adults with intellectual and developmental disabilities that have somewhat different needs. They are not likely to be coming from nursing homes, they may be coming from large scale facilities, they may be homeless currently. There are very different needs than the framework you would use for an elderly population, so I'd appreciate comment on that.

BEA-ALISE RECTOR: I can certainly comment on that. In Washington State, in our 1915(c) waivers and our Community First Choice option, we serve a pretty significant population of individuals with behavioral health needs and their primary reason for being on those waivers or state plan are their mental health needs that also mean that they need help with organization and activities of daily living.

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You're right; it is a different population with a different set of needs. One of the things that we would like to see happen is allow states to operate waivers as an alternative to state psychiatric hospitals. There's some IMD issues that prevent that, but without being able to do that you're stuck with the cost neutrality of a nursing home and we know that, in Washington State, a bed at the state psychiatric hospital is about \$600 a day as opposed to a nursing home bed that's about \$220. We do significant relocation out of our state psychiatric mental health hospital into our long-term services and support system. What we've had to do is develop specialty training around mental health needs for our providers, which we do. We've also had to build specialty providers and new licensing categories in order to get the kinds of services and supports necessary to really serve the persistent mentally ill population.

MICHAEL MONSON: What I would add, to pick up on the individuals with intellectual and developmental disabilities, this is certainly a population that has historically not been – has been kind of off on the side in its own programs and I think that there's an increasing awareness that, first of all, there's a lot of people who live in institutions with that population who have no business being in an institution and there are substantial wait lists around that, but if you can get them out of an institution and into the home and use models like a shared living model, so several states have shared living types of models which it's almost like an adult foster care model, and you actually understand what people's issues are. You know, the person-centered approach, in many ways, came out of this population and understanding what the needs are of these individuals and developing care plans and plans around how to take care of them and have them take care of themselves and the community take care of them, and enabling all that together is what's really critical. And that population, if you look at the dollars on the Medicaid side, is the second biggest pool of dollars. And these are individuals who are fully capable of living in the community and, quite frankly, not only just living in the community but working in the community. Supportive employment programs are tremendously important. This is going to be the next frontier for HCBS. Some states are already kind of going down that path. Kansas is one of those. We operate in Kansas and it has been really heartening to be able to work with individuals and actually see them and bring them out into the community and be able to have full lives. And I think that that's what we have to think about, these programs, as I said before, it's not a one size fits all as you mentioned, and we sometimes paint this broad brush across the whole program. And, as we think about the policy solutions, and as we think about how we move forward, you have to address them for each population. But fundamentally, and if you look at the new regulations that have been proposed around Medicaid mega waiver that came out over the summer, the idea of having person-centered planning, working with the individual to figure out what they want, and what is critical for them, if you start with the individual and then you work backwards from there, that's how you end up making sure that you don't have a cookie cutter that puts people in the wrong place.

ANNE MONTGOMERY: And I would just add that this is not just a Medicaid issue, of course, and there is some work going on with these populations in the context of the Duals Demonstration which, I think, 26 states started out taking advantage of and some withdrew—I think 11—but there is a good bit of work going on since many of these folks also qualify for Medicare, being permanently unable to work. So, I think it is the frontier, and housing, you know, coming back to that previous question, becomes one of *the* most critical issues when you're talking about this population.

SARAH DASH: Joe, do you have a question?

JOE CASTIGLIONI: Yes, thanks, Sarah. My name is Joe Castiglioni. I am with the National Committee for Quality Assurance and I want to thank the panelists and the Alliance for another really great briefing.

At NCQA we're paying a lot of attention to the Medicare and CHIP Reauthorization Act as well as the LTSS provisions in the recent Medicaid Managed Care proposed rule earlier this year. And one of the things that we're thinking a lot about is how to effectively measure quality across delivery settings and payment models, especially given that a lot of this community does receive their care through these alternative settings and models. And my question for you guys is what role do you guys see for person-centered patient reported outcome measures for this population and do you guys have recommendations for an alternative means of measuring the quality of care that this community receives?

SARAH DASH: Thanks for asking that question and we had it on a card as well so hopefully we'll answer that person's question as well.

ANNE MONTGOMERY: I'll take a stab at it. It's an incredibly important question and I would say that we need to pick up on the work that we've done through the balancing incentive program and other programs where we are trying to standardize assessments so that across populations and across different settings you're basically assessing people in a uniform and rational way. But, after that, you need to get to the care plan and that's something that we do a lot of work on where I work and the care plan, in order to be person-centered, does have to include the person's treatment preferences and their goals and those goals, of course, will differ from person to person, from population to population and essentially assessing whether the services help somebody meet that goal or partially help them to achieve that goal, whatever it may be, I think is a critical element that we need to build into our system. It's not that you need to have a thousand or a million different goals because everybody's different, but you should measure whether the services actually help somebody meet that goal. So I think that that is sort of the next big leap that we need to make and chair plans are still not built into meaningful use standards, although they are in, I think, the meaningful use trajectory, three – meaningful use three. So, hopefully we'll get there but we still need to design standardized care plans and make them universally available.

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JEAN ACCIUS: I would just add to that that Anne is absolutely correct. I think that with respect to the quality measures, you know, what is important to the consumer? What is important to the family members who are providing the care and how do we measure that in a very meaningful way in a very standardized way, in order to get the results that we're looking for? If we are really thinking about and talking about and trying to operationalize what it means to be person and family centered well how does that look? What are the measures that are going to reflect that?

BEA-ALISE RECTOR: What I would add is this is a really rich area for work and in Washington State, our legislature passed, a couple of years ago, two bills: 5732 and 1519, calling for shared performance outcome measures across the systems of care which would include acute care, long-term services and supports, and behavioral health and we did a pretty significant body of work around a huge steering committee across those different specialties coming up with 51 measures, some of which are long-term services and support specific, but the legislation called out five areas and they were the kind of typical health improvement, reduction in cost, but they also included reductions in criminal justice utilization, increases in employment, increases in meaningful daily activities, and quality of life. And in the quality of life domain there was a lot of research around what kind of tools exist out there and what would be the best one across the spectrum, and the recommendation of the steering committee was to go with the World Health Organization Quality of Life Survey with some additional questions. And there are reports out on these 51 measures that are accessible on our legislative website, so you could contact me and I can get you that information.

MICHAEL MONSON: The only thing I would add is that richness is a really good way to describe what's happening right now, but there's work that NQF is doing around trying to develop measures right now. The National Core Indicators, I think, are getting a lot of traction. Take a look at that. TEFT is doing work, which is a grant that came out of CMS, so there's a lot of action happening right now and I think that what we'll see is, I'm not sure – it'll be a while till we coalesce around one model. If we coalesce around one model it'll be incremental and I think that we have to realize that it will take time, and even just getting to uniform assessments, which will be critical, is no small task.

So we had a question come in on a card for Ms. Rector: What wage level can family members receive for caring for an older relative? Would it be enough to enable a family caregiver to leave a paid job that includes benefits?

BEA-ALISE RECTOR: That's a great question. It's probably a subjective answer in terms of whether it's enough but what I would say is our minimum for somebody starting is \$11.37 an hour, after working at least 80 hours a month for three months people qualify for a pretty good health benefit package—dental and vision. We also have paid time off and the way that our wage scale works is that folks move up that wage scale based on lifetime hours of work and also based on every six month increments, so the average this

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year is \$11 – I’m sorry, \$12.87 would be our average. Our up at the top end is \$15.00 an hour, and if you’ve been watching the news there’s a lot of conversation in Washington State about the minimum wage being \$15.00 an hour.

SARAH DASH: Great. Thank you. Another question at the mic.

LISA UPDIKE: My name is Lisa Updike and my question is mainly for Ms. Rector. I was wondering, in your transition from serving clients in assisted living care facilities and other facilities to home, how you built the long-term care workforce in Washington State in order to serve this larger population at home and in the community?

BEA-ALISE RECTOR: Great question. I mean, keep in mind we’ve been at this for 30 years and so you take baby steps and so right now I think we have a system that we feel really good about, but we also see areas that we can improve. So resource development is a significant issue, obviously making the choice to pay family members and to have clients be able to choose the individual that they’re most comfortable providing the care is key for us, providing training to those individuals so that they understand adult protective services and their responsibilities, their mandated reporters, client rights, etcetera, etcetera, was something that we began in about 1995 with about 26 hours of required training, and then there was a voter initiative passed that increased training to 70 hours of training with a certification requirement. So we’ve built this over time. We also have 12 hours a year of continuing education that has been around. It was 10 hours and moved to 12 hours with that initiative, so specialty training in mental health, developmental disabilities, dementia, and traumatic brain injury and we’re kind of growing that suite of training.

What it takes in a state like ours that is geographically quite diverse and large, is we have resource developers that work out in our regions and they are consistently looking at our assessment data around what’s changing, what’s the new upcoming population. Our languages change all the time with new immigration trends, and going out and actually finding providers, actual recruitment of providers, whether that’s adult family homes, assisted living facilities, or in-home providers. Our area agencies on aging also play a very large role for us in provider network development and oversight, and because they are local entities they also work consistently on trying to find where are our gaps and what are we going to do about our gaps. So it’s not an easy answer and it’s one that takes continual work, and I could tell you, we still have gaps in our system that we work on every day.

ANNE MONTGOMERY: And, as long as we brought up the topic of training, which I know PHI is heavily invested, and so maybe Abby will tell us a little bit about that, but we also put in place a National Demonstration program, it’s called the Personal and Home Care Aide State Training program, because personal and home care aides don’t have any national standards whatsoever for what they do. And this 6-state demonstration has just ended and is being evaluated and the report is in clearance so you may want to

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take a look at it when it comes out. I think it will offer a lot of hope for the kinds of training that is possible without a lot of money, just with good careful assessment of what the skills are that are really needed to serve a variety of populations as well as to put career ladders in place that make this kind of direct care worker career an enjoyable one and a valuable one and also specialization. None of that do we really have well enough developed but I think we're on our way.

SARAH DASH: Abby, do you want to comment?

ABBY MARQUAND: I'm glad you mentioned that, Anne, because that is a pretty significant achievement, that Demonstration project, and we're very hopeful of what will come out of it, and hearing from Bea today, I mean, what Washington State has done in terms of workforce development around long-term workforce is really exceptional so we really look to them because across the country, as Anne mentioned, there is no federal minimum training requirement for a personal care aide and in large parts of the country the work they do is completely unlicensed, unregulated, and this is becoming more of an issue and something that we really want to take a look at. So hopefully these PCAST demonstrations are going to be instructive to other states that are engaging with improving standards for training for workers.

SARAH DASH: We have two questions at this mic and then the young lady over here.

MIKE DEAN: Hi. My name is Mike Dean. I'm with ASME. My question is sort of towards the wage stagnation component and then about any sort of specifically personal care or home care attendants and then cost overhead with the nonprofit or for-profit vendors, any sort of standardization of what's a reasonable cost overhead. In our experience, we've seen where the reimbursement rate has gone up on the state side but that money has not made its way down to the frontline staff.

ABBY MARQUAND: I think that's common, depending on the provider, but there have been initiatives in states, there's been legislation that passes any kind of reimbursement rate directly onto the provider so there are wage pass-throughs and rate increases that need to be targeted to workers, and I think that's a really important tool for states to explore when they want to improve compensation to workers and they don't have a union to collectively bargain on behalf of the workers. We've seen that happen across the country. It's been a while since that kind of legislation has passed and definitely during the recession I would say it was a non-starter, but as we grapple with a shortage in this workforce in certain parts of the country we have to think about things like that and hopefully we'll see more efforts at the state level to ensure that any Medicaid reimbursement increases really go directly to workers.

BEA-ALISE RECTOR: What I would add to that is, our legislature uses, all the time, the requirement through legislative direction that the funding that they're increasing go to direct care worker wages, not just in HCBS but also in nursing homes. The difference

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that we see in Washington State between an individual provider that's hired by the client and a home care agency that is also an option that hires clients is a \$5.00 difference per hour, and that \$5.00 does everything from pay for the folks who supervise the homecare worker recruit, do payroll, etcetera, etcetera, and some of that is overhead.

ANNE MONTGOMERY: I would just note that some of this also could be affected by quality measures, going back to that line of thought. I mean, if we are measuring the outcomes of individuals then the quality of their care will reflect, obviously, the investment that we make in the workers. So I think if we're smart about it we can create the kind of performance outcomes that will take that into account.

DEBBIE PLOTNICK: Hi. I'm Debbie Plotnick from Mental Health America. I have a question about the (k) option and if that can be used, whether there's been some thought about using this for skill building training using peer specialists in the community, especially for skills for not only getting around the community and more daily living skills but skills like supported education.

SARAH DASH: Thanks. And, in answering that question, can somebody please review again what the (k) option is.

BEA-ALISE RECTOR: The 1915(k) is a state plan option that states can elect to ask CMS to approve and, in there, there is a required service of skills acquisition training, although it is limited to skills acquisition training related to activities of daily living and instrumental activities of daily living, so I know when legislation was first passed around the 1915(k) there was a lot of hope amongst advocates that it would include things like habilitation skills training which it does not. In terms of whom the providers are, states are able to have the flexibility to name who their qualified providers are in the state plan options or waiver options, and so peers, as being one way of helping someone acquire skills related to ADLs or IADLs would be an acceptable provider type if the state chose to go that way.

NADIE ALSATO [Phonetic]: Hi. I'm Nadie Alsato and I'm from NCQA as well. So my question is for Bea. You talked about some of the qualification requirements, I think it was FBI, state, other background checks, so I was wondering who is accountable for ensuring that the providers are actually qualified and then what do you do, in turn, when you find out that someone may not be qualified and how you guys deal with that and then how it impacts issues around access that Abby also brought up.

BEA-ALISE RECTOR: That's a great question, so the access issue is one that is a challenge because there are a number of people who are disqualified from being qualified personal care workers based on our background check requirements which, in our state, are in statute so we have a list of disqualifying, permanently disqualifying crimes as well as time limited disqualifying crimes. In terms of the responsibility of who does that, the contracting entity does that, which is either a state employee and/or an Area Agency on

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Aging case manager. We also have requirements that background checks have to be rerun every two years but our employees or our individual providers or home care agencies or residential PCAs, all of which have to do these background checks, can begin work pending the outcome of the fingerprint-based FBI check. So the name and date of birth check, which is our state background check, is immediate. We can do that and we can tell you today if you're disqualified. The FBI check takes longer to get those fingerprints run so typically folks start their work and then we get the results back. If, indeed, that disqualifies somebody then we go through the administrative hearing process to let a client know that we are denying their choice of provider and that they have to find another provider.

Training is also critical. We've all talked about the need for that but I will say that having high training requirements also does impact access. So the time it takes to get through that training and folks can start work in Washington and they have 120 days to complete their 70 hours of training, but there are folks who don't get through that training and/or they get through the training and they're not able to pass the certification test to continue to be qualified and, again, we're in a situation in Washington where we then deny the choice that the client's made of their provider and have to find another provider.

JEAN ACCIUS: I just wanted to say that at AARP, in the Public Policy Institute, we actually did a report that looked into this issue around criminal background checks and across the states we worked with the National Conference for State Legislatures to actually develop this report in which we find is that, again, there is variation across the country and states actually have different approaches. Some states actually do a name check and they may start local and then they go regional and then they go state and then they go FBI, which could potentially be a little bit more expensive but it gives you more comprehensive information, as well as what might actually disqualify someone and if there is any time periods involved.

The other thing that I would actually probably mention is that CMS is actually doing a demonstration looking at criminal background checks, and I'm not sure exactly when we'll get the evaluation, and maybe Anne may know more about this, but maybe you could speak to that a little bit.

ANNE MONTGOMERY: Sure. The National Background Check program was part of the Affordable Care Act and it gave states up to 3 million dollars to basically modernize their background check systems which were, in many cases, kind of a mess. You had a registry with reports of abuse here that didn't talk to the state police and other parts of the system that were completely disconnected and then the FBI national criminal check was not connected to anything that the states were doing. So if you wanted to do a rapid workforce check and just weed out people who were clearly unsuitable it was really difficult to do. So I think states have taken advantage, about 27 or 27 I believe at last count, of this program, which has now ended, it was time limited, and done that—modernized their background check programs. That said, to what Bea was indicating the

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disqualifying crimes or convictions are a state decision, they are not a federal decision. The FBI check just reflects back whether that criminal background was also reported to the FBI. And I would also note that I think it's important, or we thought it was important enough in the context of the legislation that we wrote into the Affordable Care Act, to include an appeals process, essentially, to make sure that there is due process; that, you know, a minor crime at the age of 18 doesn't knock somebody out who really wants to become a direct care worker, a nurse, whatever, later in life. So that's a feature of that particular law. I don't know that it's a feature of other laws, but I would think that it should be.

SARAH DASH: Thanks. So I think that the Alliance is going to have to consider doing a briefing on the long-term services and supports workforce, possibly in the near future, because there's a lot to talk about. We have had people waiting patiently at the mic. I just want to also note, we have about 10 minutes left, so if you could keep your questions and answers as brief and pointed as you can that would be great.

KIMBERLY FOX: Hi. Kimberly Fox with Kaiser Foundation Health Plan. Talking about the long-term workforce and workforce development, not just about resources but resourcefulness, and talking to nonprofits, for-profits, philanthropy at large, and organizations with corporate social responsibility programs that could help invest in the direction of this future to be innovative with policy programs and the resourcefulness, and also how you're engaging the millennials because that is a big topic of the day. I'm sorry it's so high level, but.

ABBY MARQUAND: I'll take a stab at it but that's high level, for sure. In terms of engaging the millennials we've seen, across the country, a lot more efforts to reach out to millennials in terms of recruiting them to be direct care workers and actually we were just discussing this yesterday that where we've seen a lot of success in that area is really around serving people with intellectual and developmental disabilities and really looking at peer relationships in direct support and I think that that could be expanded. Those efforts could definitely be expanded but in certain states where they're experiencing shortages they definitely are looking at vocational programs that recruit people who are interested in healthcare professions. But I think there's a lot more work to be done there, for sure.

SARAH DASH: And let me throw in a question that we received on a card which is in terms of resources: What's the role of the Aging Network, and when we talk about home- and community-based services what are some of those community services and what's their role in ensuring the provision of home- and community-based services and particularly with respect to family care givers?

ANNE MONTGOMERY: I'm a big fan of the Aging Network and they are essential. There are, I think, more than 600 and some odd area agencies on aging. They've been around since 1972, the Older Americans Act, which was passed along with Medicare and

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Medicaid in 1965, is the foundation of the Aging Network. They provide respite care, transportation, legal assistance, respite care for family caregivers, food and nutrition services, Meals on Wheels, a whole host of things that are absolutely fundamental and essential to any vulnerable adult, whether older or disabled, who's living in the community and trying to stay out of crisis. The Older Americans Act is up for reauthorization, some of you may know that, and we very much hope that the House acts swiftly. The Senate has acted and reauthorizes the statute this fall.

It is underfunded, at least in my opinion, relative to need, and the need is rising. So I think we need to pay attention to that because no matter how much we try to fix our healthcare system if we completely neglect the social services and supports people will end up in the hospital or they will end up prematurely placed in a high cost setting, if we leave people abandoned, essentially, in their own homes. So we can't do that. We can't afford to do it and some of the work that we do at the Center for Eldercare and Advanced Illness is trying to figure out how to create more comprehensive care systems that would be anchored in communities and composed not just of healthcare providers but also of social services providers who would then be able to offer a broader package of services, save more money on the healthcare side, and repurpose some of that for social supports and services. So I'm a big fan, like I said, of the Aging Network and think it needs to be put on steroids in this coming aging era.

SARAH DASH: Speaking of social services, and then I will get to your question, ma'am, before you leave. We have about 5 minutes left. Please fill out your evaluation. If we receive 50% participation or more there will be a donation made to the Meals on Wheels program. So before you leave please fill that out, but let's take a few more questions.

CARLA RAWLINGS: I'd like to first thank the panel for this very important topic. My name is Carla Rawlings and I'm a geriatric social worker for Seabury Aging and I guess this question is for Ms. Rector, since you've been doing this for 30 years, and although this is home-based community and we know this does not include everyone, what have you seen to help people who are kind of in the middle of the road, they're not poor enough to be on this program, but then they can't afford to pay for care to stay in their home? What have you seen?

BEA-ALISE RECTOR: Well, that's a growing piece of the population, I think, that gap is widening, and the Older Americans Act and in Washington State, the general fund state programs that the legislature has appropriated are kind of where people turn when they don't qualify for Medicaid and they don't have the resources out of pocket to be able to pay for their own care, and access to those programs is definitely not what it used to be because of the growth in the population.

I think what ends up happening, what we see far too often, is that folks have very meager savings. They end up in a nursing home, spend down quite quickly, and come onto

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Medicaid, so their life resources that they have saved for are exhausted and they do end up on Medicaid whether that's longer term or shorter term, which is really why Medicaid is picking up so much of the ticket right now for long-term services and supports.

JEAN ACCIUS: I do want to acknowledge some key experts that are actually in the room because I think you bring up a very important question; and that is, that over the last 30 plus years the delivery side of home- and community-based services, we've seen great improvement and we saw a lot of the data today. One of the challenges that we're still struggling with is how do we pay for long-term service and supports, and there's been a group that has been looking at this issue and I believe that there's going to be some form of a briefing with some data results later this year, but that is really a fundamental question that we have to try to solve for.

SARAH DASH: Okay. You've been waiting a while.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. My question is really similar to the last couple of questions about not so much standards of care for people who are on Medicaid which, I guess, is what home- and community-based services ultimately means, but the larger population that is often not on the Medicaid program and what innovations are you seeing at a community level or at a state level for addressing those needs in non-medical and effective ways that ultimately result in savings of Medicaid dollars? It seems to me that that focus needs to be out there so that we can begin to change culture and not so much Medicaid budgets but culture where people start thinking differently about the way they relate to their neighborhoods and community, and I'm not hearing that focus. I mean, you started by talking about HCBS being a non-medical model and yet, to qualify for the Medicaid program you sort of need medical criteria as well as income criteria, but this larger population out there, the demographic changes that you're obviously aware of in the Medicaid program, is happening outside too and I'm just wondering what innovations we're seeing in other countries in the way aging is dealt with?

SARAH DASH: That's a long and very important question and with only a minute left I just want to do something a little bit different and ask this gentleman, who's also been waiting a long time, if you can state your question so that the panelists can try to answer both at the same time in 30 seconds.

WALT SEDLECEK: Thank you. And thank the panel and it's been a really great event here today. I work for IBM. My name is Walt Sedlecek, and as I look at the problems that you guys are facing, thinking from the person's standpoint, thinking about sub-populations, thinking about how to scale your workforce and create better engagement throughout the system, whether it's the steroid-based Aging Network or how do you enable caregivers and care workers and social networks and stuff. I was wondering around the idea of innovation, it seems like there's a fundamental shift in how you think about programs around people, where are the investments in technology? Where are the

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blue sky opportunities? What are the things that are working now? And I'm really interested because I think in other industries, in other problems technology if thought from the client or the person base can really help with care delivery. Thank you.

ANNE MONTGOMERY: Those are such huge questions and they're so important so we ought to have three or four more briefings on those. I guess I would say that, given the challenges that we face in the 21st century they're really challenges of scale. We've built programs to do certain things and serve certain populations and they have certain rules and, to a certain extent, we're going to have to break some of that down and have multi payer, multi program approaches and move much faster than we have, you know, with rapid cycle evaluation, with plugging in, whether it's telemedicine or some other kind of innovation, and scale it up as rapidly as we can. We really need to prevent Medicaid spend down. I mean, that's pretty clear. Medicaid is a fragile program in some respects and we can't afford to let it be the only source of paying for long-term care. We need to figure out some other solutions and we can become more efficient. The workforce can become a lot more efficient and the way that we communicate across settings can become a lot more efficient. Typically, you know, somebody calls 911, they go to the ER, there's a very expensive episode, they come out of the hospital, they go home and there's not a whole lot there that's available for them. There was even a call made by a veteran several months ago to 911 because he didn't have any food. Well, you know, the Aging Network does that. They provide that, and yet there was no communication, obviously, to let people know, in the Meals on Wheels program, that they needed to be there for that gentleman when he returned home.

So, I would say that this is entirely possible, it just requires serious creativity, a lot more flexibility, in some respects, at both the federal and the state level carefully crafted. And we have some models out there, whether it's independence at home program, for all inclusive care for the elderly that begin to show the way, but they're tiny and we have to figure out how to break down the barriers and scale this all up.

MICHAEL MONSON: The one thing I would just say on the technology question is—and I'm a big fan of technology—technology is an enabling tool, though, and I think people sometimes see it as a panacea. And the second thing I would say is that for the core of what these programs are, whether they're Medicaid or non-Medicaid and you don't need to have a medical need to be on Medicaid. It's an income-based test is what's gets you into Medicaid, and what gets you into these programs inside of Medicaid is a functional assessment, not a medical assessment, so it's an ADL-based test, just to clarify that for everybody.

But what I think we need to think about what technology is, that the core services that exists for HCBS programs are those activities of daily living. They're labor, right? It's a labor activity, and obviously, when you think about technology, you know, where you have technology, capital will replace labor, I think the challenge is you're all in a distributed setting. And so it's how do you get that capital into a home in a cost effective

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manner? And no one has really solved that problem yet but what would actually help people with their ADLs? That does not mean there's lots of things that can happen around the margins and where there is an intersection of the non-medical model and the medical model there's a real role for technology, but if you think about just providing those ADL supports, the technology answers have not been created yet. But the answers have all been around enabling caregivers or enabling health information to transmit back and forth, all important things, but if you want to get at what drives the expenditures in this, and we talk about where the real dollars need to be is, we need to pay someone to help someone go to the bathroom. That's what we need to do. And so if you want a challenge for the technology industry, well then how do you create an assistive device or an assistive technology that's cheap enough that you could put in someone's home that would solve the problem of how do you help someone go to the bathroom, amongst other ADLs.

SARAH DASH: Thanks. Well we have reached and exceeded the end of our briefing. I want to ask you all to join me in thanking our panelists and Centene for their support. Thank you.

[Applause]