



State of California—Health and Human Services Agency  
Department of Health Care Services



GAVIN NEWSOM  
GOVERNOR

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Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, MD 21244-1850

MEDICAID HOME- AND COMMUNITY-BASED SERVICES (HCBS) SPENDING PLAN: QUARTERLY REPORTING for Federal Fiscal Year 2021-2022 (Quarter 2) PURSUANT TO SECTION 9817 OF AMERICAN RESCUE PLAN ACT OF 2021 (ARPA)

Submitted electronically via [HCBSincreasedFMAP@cms.hhs.gov](mailto:HCBSincreasedFMAP@cms.hhs.gov)

As originally submitted on July 12, 2021, and as updated on September 17, 2021, and October 27, 2021, the Department of Health Care Services (DHCS) presented California's Initial Spending Plan Projection and Initial Spending Plan Narrative as two initiatives for California's home- and community-based services, in accordance with guidance from the Centers for Medicare & Medicaid Services (CMS) related to Section 9817 of the American Rescue Plan Act, as issued on May 13, 2021, via the State Medicaid Director Letter # 21-003 (SMD Letter #21-003).

Consistent with the directives outlined in the SMD Letter #21-003 and by CMS as to an extension of time offered to all states, DHCS hereby supplies its first Quarterly Spending Plan Projection and Quarterly Spending Plan Narrative for these HCBS initiatives, due by November 1, 2021, representing the quarterly report for Quarter 2 of Federal Fiscal Year (FFY) 2021 to 2022.

On behalf of the participating California departments, DHCS provides the following assurances for the updated submissions:

- The state is using the federal funds attributable to the increased federal medical assistance payments (FMAP) to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;

- The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021.

If you or your staff have any questions or need additional information regarding this HCBS Spending Plan Quarterly Reporting Assurance Letter, please contact Saralyn M. Ang-Olson, JD, MPP, Chief Compliance Officer, by phone at (916) 345-8380, or by email at [Saralyn.Ang-Olson@dhcs.ca.gov](mailto:Saralyn.Ang-Olson@dhcs.ca.gov).

Sincerely,



Jacey Cooper  
State Medicaid Director  
Chief Deputy Director  
Health Care Programs

Enclosures: California's Quarterly HCBS Spending Plan Projection and Quarterly HCBS Spending Plan Narrative, for Quarter 2 of Federal Fiscal Year 2021-2022

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**State of California  
Department of Health Care Services**



**American Rescue Plan Act  
Increased Federal Medical Assistance Percentage (FMAP)  
for Home- and Community-Based Services (HCBS)**

**Quarterly Reporting on HCBS Spending Plan Projection**

**For**

**Federal Fiscal Year 2021-2022, Quarter 2**

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## Introduction

California’s quarterly HCBS Spending Plan Projection for Quarter 2 of Federal Fiscal Year 2021-2022 includes additional information about the amount of increased FMAP currently expected to be claimed by quarter (referring to Table 1 below). Projections for state spending equal to the amount of increased FMAP claimed have not been updated from the Department’s initial submission (as updated on September 17, 2021 and on October 27, 2021) (referring to Table 2 below), since work to schedule out implementation is ongoing. Quarterly spending projections will be provided with the next quarterly update.

## Estimate of Funds Attributable to Increased FMAP Anticipated to Be Claimed

As provided below, California anticipates claiming approximately \$3 billion attributable to increased FMAP for the quarters from April 2021 through March 2022. For Q2 of FFY 2021-2022, the following chart applies:

**Table 1. Estimate of Increased FMAP Anticipated to be Claimed**

<i>(In Millions)</i>	Federal Fiscal Year 2021		Federal Fiscal Year 2022		Later Quarters (Due to Claiming Lags)	Total
	April - June 2021	July - Sept 2021	Oct-Dec 2021	Jan-March 2022		
Line 12 - Home Health Services /c	\$5.1	\$4.7	\$5.2	\$6.0	\$8.8	<b>\$29.8</b>
Line 19A - Home- and Community-Based Services - Regular Payment (Waiver) /c	\$88.9	\$143.7	\$126.6	\$145.3	\$212.8	<b>\$717.3</b>
Line 19B - Home- and Community-Based Services - State Plan 1915(i) Only Payment	\$17.1	\$30.1	\$24.9	\$30.3	\$45.4	<b>\$147.9</b>
Line 19C - Home- and Community-Based Services - State Plan 1915(j) Only Payment	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	<b>\$0.0</b>
Line 19D - Home- and Community-Based Services State Plan 1915(k) Community First Choice	\$128.0	\$157.7	\$186.1	\$209.2	\$278.5	<b>\$959.5</b>

**Table 1. Estimate of Increased FMAP Anticipated to be Claimed**

<i>(In Millions)</i>	Federal Fiscal Year 2021		Federal Fiscal Year 2022			
Line 22 - Programs of All-Inclusive Care for the Elderly	\$14.1	\$16.7	\$19.1	\$21.8	\$21.0	<b>\$92.7</b>
Line 23A - Personal Care Services - Regular Payment	\$69.5	\$76.8	\$91.0	\$105.7	\$121.5	<b>\$464.5</b>
Line 23B - Personal Care - SDS 1915(j)	\$6.4	\$7.0	\$8.3	\$9.6	\$10.6	<b>\$41.9</b>
Line 24A - Targeted Case Management Services - Community Case Management	\$7.8	\$11.4	\$12.4	\$14.8	\$22.6	<b>\$69.0</b>
Line 24B - Case Management Statewide	\$0.5	\$0.9	\$1.1	\$1.5	\$3.1	<b>\$7.1</b>
New Line - Managed Long-Term Services and Supports	\$11.9	\$14.5	\$14.6	\$16.9	\$18.8	<b>\$76.6</b>
New Line - Rehabilitative Services /c	\$75.1	\$85.8	\$81.2	\$90.7	\$67.8	<b>\$400.7</b>
New Line - School Based Services	\$2.0	\$2.9	\$3.4	\$4.1	\$7.3	<b>\$19.8</b>
<b>TOTALS</b>	<b>\$426.5</b>	<b>\$552.2</b>	<b>\$573.9</b>	<b>\$655.9</b>	<b>\$818.4</b>	<b>\$3,026.8</b>

a. Service categories tie to lines in the CMS-64 and CMS-37 forms.

b. Adjusted to assume only 5 percent increased FMAP for adult group expenditures matched at the "newly eligible" FMAP.

## Anticipated Expenditures for Activities to Implement, Enhance, Expand, and Strengthen HCBS

Table 2 below, as submitted in the Updated Initial HCBS Spending Plan Projection, outlines expenditures the state anticipates making equivalent to the amount of increased FMAP estimated to be claimed. More details on these expenditures are included in the Spending Plan Narrative. Note that amounts are approximate and subject to updates in the coming months as increased FMAP is claimed and new expenditures are ramped up.

<b>Table 2. Estimate of Anticipated Expenditures</b>				
<i>(In Millions)</i>				
<b>Expenditure Item</b>	<b>State Funds <sup>a</sup></b>	<b>Federal Funds</b>	<b>Total Funds</b>	<b>One-Time/Ongoing</b>
<b>WORKFORCE: RETAINING AND BUILDING NETWORK OF HOME- AND COMMUNITY-BASED DIRECT CARE PROVIDERS</b>				
<b>In-Home Supportive Services (IHSS) Career Pathways Proposal</b>	\$295.1	\$0.0	\$295.1	One-Time
<b>Direct Care Workforce (Non-IHSS) Training and Stipends</b>	\$150.0	\$0.0	\$150.0	One-Time
<b>IHSS HCBS Care Economy Payments</b>	\$137.3	\$137.3	\$274.6	One-Time
<b>Non-IHSS HCBS Care Economy Payments</b>	\$6.3	\$6.3	\$12.5	One-Time
<b>Increasing Home and Community Based Clinical Workforce</b>	\$75.0	\$0.0	\$75.0	One-Time
<b>PATH funds for Homeless and HCBS Direct Care Providers</b>	\$50.0	\$50.0	\$100.0	One-Time
<b>Traumatic Brain Injury (TBI) Program</b>	\$5.0	\$0.0	\$5.0	One-Time
<b>HOME- AND COMMUNITY BASED SERVICES NAVIGATION</b>				
<b>No Wrong Door/Aging and Disability Resource Connections</b>	\$5.0	\$0.0	\$5.0	One-Time
<b>Dementia Aware and Geriatric/Dementia Continuing Education</b>	\$25.0	\$0.0	\$25.0	One-Time
<b>Language Access and Cultural Competency Orientations and Translations</b>	\$27.5	\$18.3	\$45.8	Ongoing
<b>CalBridge Behavioral Health Program</b>	\$40.0	\$0.0	\$40.0	One-Time
<b>HOME- AND COMMUNITY-BASED SERVICES TRANSITIONS</b>				
<b>Community Based Residential Continuum Pilots for Vulnerable, Aging and Disabled Populations</b>	\$110.0	\$187.7	\$297.7	One-Time
<b>Eliminating ALW Waitlist</b>	\$84.9	\$169.8	\$254.7	Ongoing

<b>Table 2. Estimate of Anticipated Expenditures</b>				
<i>(In Millions)</i>				
<b>Expenditure Item</b>	<b>State Funds <sup>a</sup></b>	<b>Federal Funds</b>	<b>Total Funds</b>	<b>One-Time/Ongoing</b>
<b>Housing and Homelessness Incentive Program</b>	\$650.0	\$650.0	\$1,300.0	One-Time
<b>Community Care Expansion Program</b>	\$348.3	\$0.0	\$348.3	One-Time
<b>SERVICES: ENHANCING HOME- AND COMMUNITY-BASED SERVICES CAPACITY AND MODELS OF CARE</b>				
<b>Alzheimer's Day Care and Resource Centers</b>	\$5.0	\$0.0	\$5.0	One-Time
<b>Older Adult Resiliency and Recovery</b>	\$106.0	\$0.0	\$106.0	One-Time
<b>Adult Family Homes for Older Adults</b>	\$9.0	\$0.0	\$9.0	Ongoing
<b>Coordinated Family Support Service</b>	\$25.0	\$16.7	\$41.7	Ongoing
<b>Enhanced Community Integration for Children and Adolescents</b>	\$12.5	\$0.0	\$12.5	One-Time
<b>Social Recreation and Camp Services for Individuals with Developmental Disabilities</b>	\$78.2	\$42.9	\$121.1	One-Time
<b>Developmental Services Rate Model Implementation</b>	\$650.0	\$315.0	\$965.0	Ongoing
<b>Contingency Management</b>	\$31.7	\$26.7	\$58.5	One-Time
<b>HOME- AND COMMUNITY-BASED SERVICES INFRASTRUCTURE AND SUPPORT</b>				
<b>LTSS Data Transparency</b>	\$4.0	\$0.0	\$4.0	One-Time
<b>Modernize Regional Center Information Technology Systems</b>	\$6.0	\$1.5	\$7.5	One-Time
<b>Access to Technology for Seniors and Persons with Disabilities</b>	\$50.0	\$0.0	\$50.0	One-Time
<b>Senior Nutrition Infrastructure</b>	\$40.0	\$0.0	\$40.0	One-Time
<b>Totals</b>	<b>\$3,026.8</b>	<b>\$1,622.1</b>	<b>\$4,648.9</b>	

a. Expenditures are anticipated to ultimately meet or exceed the amount of increased FMAP claimed by the state. Estimated expenditure amounts will be updated over time as implementation of new initiatives proceeds.

**State of California**  
**Department of Health Care Services**



**American Rescue Plan Act**  
**Increased Federal Medical Assistance Percentage (FMAP)**  
**for Home- and Community-Based Services (HCBS)**

**Quarterly Reporting on HCBS Spending Plan Narrative**  
**For**  
**Federal Fiscal Year 2021-2022, Quarter 2**

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## OVERVIEW

A variety of health and human services can be delivered through home- and community- based services, which comprise person-centered care delivered in the home and community. In turn, HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, serving as a source of assistance to many individuals, including seniors and those with physical disabilities and serious behavioral health conditions.

California's HCBS Spending Plan builds on the bold health and human services proposals that were anchored in [California's Comeback Plan](#), by expanding on or complementing the proposals to achieve improved outcomes for individuals served by the programs. Historically, these proposals independently provided one-time investments to build capacity and transform critical safety net programs to support and empower Californians.

It is this tradition of investing in such programs and services that propels California's HCBS Spending Plan. Rooted in both the Olmstead Supreme Court decision of 1999 [(*Olmstead v. L.C.*, 527 U.S. 581 (1999))] and in California's values of inclusion, access, and equity, California's HCBS Spending Plan manifests the state's deep and longstanding commitment to advancing the health and well-being of all in our state, promoting economic mobility and overall social stability.

### **Enhanced Federal Funding Authorized by the ARPA**

On March 11, 2021, President Biden signed ARPA (Pub. L. 117-2). Section 9817 of the ARPA provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS programs from April 1, 2021 through March 31, 2022.

This law requires states to use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021. In addition, states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.

States will be permitted to use the equivalent to the amount of federal funds attributable to the increased FMAP through March 31, 2024, on activities aligned with the goals of section 9817 of the ARPA and as listed in [CMS' guidance](#). Under ARPA, states can implement a variety of activities, including enhancements to HCBS services, eligibility, infrastructure, and reimbursement methodologies, to enhance, expand, or strengthen Medicaid HCBS.

### **Initial Submission of California's HCBS Spending Plan**

On July 12, 2021, the Department of Health Care Services (DHCS) submitted to the Center for Medicare and Medicaid Services (CMS) California's original Initial HCBS Spending Plan Projection and original Initial HCBS Spending Plan Narrative as to certain

initiatives for Medicaid home- and community-based services, consistent with the directives set forth in CMS' letter, "Implementation of American Rescue Plan Act of 2021 Section 9817," dated May 13, 2021 (State Medicaid Director (SMD) Letter #21-003).

On September 17 and October 27, 2021, responsive to CMS' feedback as of September 3 and October 26, 2021, respectively, regarding certain initiatives and request for additional information, California submitted updates of the foregoing documents and anticipates CMS' further response or approval.

Of the 29 initiatives originally presented, only one was denied by CMS. Therefore, at present, California focuses on 28 initiatives related to five categories of HCBS services. Notably, the enhanced federal funding provides California with an opportunity to make substantial investments in the programs that serve our most vulnerable Californians, including populations that are aging, disabled, and homeless, and those with severe behavioral health needs. These investments further bolster the investments made in health and human services programs as part of the 2021 state budget that are designed to begin addressing the health, economic, and racial inequities that were exacerbated by the COVID-19 pandemic. Collectively, these investments chart a path to a system where social services—such as housing supports, food and childcare—are linked to the health and behavioral health services. Because these services are person-centered, they will help address the social, cultural and linguistic needs of the individuals they serve. Finally, these proposals independently help bolster critical safety net programs that support and empower Californians.

### **Quarterly Reporting on California's HCBS Spending Plan**

CMS requires participating states to report quarterly on the activities that the state has implemented and/or intends to implement to enhance, expand, or strengthen HCBS under the Medicaid program, to demonstrate that the state is supplementing, but not supplanting, existing state funds expended for Medicaid. (See SMD Letter #21-003 at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>.)

This multi-department, quarterly report on California's HCBS Spending Plan updates CMS on the remaining 28 initiatives in the following five categories of services:

- Workforce: Retaining and Building Network of HCBS Direct Care Workers
- HCBS Navigation
- HCBS Transitions
- Services: Enhancing HCBS Capacity and Models of Care
- HCBS Infrastructure and Support

As noted in its initial submission, California's HCBS Spending Plan reflects stakeholder feedback, having incorporated suggestions from advocates, providers, consumers, caregivers, community-based organizations, managedcare plans, and foundations. The state's Spending Plan also reflects priorities from the state Legislature. Further, the initiatives included in this Spending Plan will be sustained through many ongoing investments, reflecting the collective vision of the state and its stakeholders.

## CATEGORIES of SERVICES and HCBS SPENDING PLAN INITIATIVES

### **Workforce: Retaining and Building Network of Home and Community-Based Direct Care Workers**

Critical to all endeavors to expand home- and community-based services is a robust direct care workforce. The state recognizes this workforce's cultural and linguistic strengths as valuable and finds it serves as a model as the state develops this network. Without an investment in the state's workforce, the HCBS initiatives and services discussed later in this document would not be viable.

In addition, turnover among the workforce who are directly involved with consumers prevents the development of trusting relationships and causes instability in services for the consumer. Targeted investments are needed to recruit, train, and retain a network of high-skilled workers to improve consumer experience and outcomes.

These proposals work to expand workforce supply and HCBS provider types, including homeless service workers; providers of HCBS wrap services to keep people in their homes and community; and home-based clinical direct care. In addition, these proposals will increase training, ensuring a skilled and linguistically and culturally responsive workforce, while supporting a career ladder that allows HCBS workers to develop their skills and training.

Initiatives include:

- In Home Supportive Services (IHSS) Career Pathways
- Direct Care (Non-IHSS) Workforce - Training and Stipends
- IHSS HCBS Care Economy Payments
- Non-IHSS HCBS Care Economy Payments
- Increasing Home and Community-Based Clinical Workforce
- Providing Access and Transforming Health (PATH) funds for Homeless and HCBS Direct Care Providers
- Traumatic Brain Injury (TBI) Program

#### **IHSS Career Pathways**

Funding: \$295.1M enhanced federal funding (\$295.1M TF) One-Time

Lead Department(s): California Department of Social Services (CDSS), with DHCS

In consultation with stakeholders, CDSS will expand upon existing training and identify additional opportunities to support the specialized training of IHSS providers to further support consumers with complex care needs and to be utilized, when possible, in the proposed Community Based Residential Continuum Pilots for vulnerable, aging and disabled populations. CDSS will provide one-time incentive payments to providers for completion of training and/or to incentivize providers working for IHSS recipients with complex care needs in the areas of their training.

The training opportunities will be voluntary and include, but not be limited to, learning pathways in the areas of general health and safety, caring for recipients with dementia,

caring for recipients with behavioral health needs, and caring for recipients who are severely impaired. The objectives of the learning pathways include: promotion of self-determination principals and the dignity of the recipient and the provider; the advancement of health equity and reduced health disparities for IHSS recipients; assisting in the development of a culturally and linguistically competent workforce to meet the growing racial and ethnic diversity of an aging population; increasing IHSS provider retention to maintain a stable workforce; the improvement of the health and well-being of IHSS recipients, including quality of care, quality of life, and care outcomes, and to ensure meaningful collaboration between an IHSS recipient and provider regarding care and training.

CDSS will determine the process by which any required contracting and payment to identified training programs occurs. Efforts will also be made to ensure that specialized training is linked to existing career pathways, licensing, and certification to further expand IHSS providers' opportunities for career advancement.

County IHSS programs and/or IHSS Public Authorities will provide outreach to providers regarding training opportunities, assist interested providers to connect with training, track completion of training, and issue stipend payments, as well as any other identified administrative activities. Additionally, Public Authority registries should be enhanced to capture completed training pathways for registry providers.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

CDSS held stakeholder meetings to define career pathways and program objectives in July and September 2021. Representatives from the California Association of Public Authorities, the County Welfare Directors Association, the California State Association of Counties, and the Unions attended.

Assembly Bill 172 added Welfare & Institutions Code (W&IC) section 12316.1 to administer the Career Pathways Program for the IHSS providers. It outlines a pilot project for the Career Pathways Program that will be implemented no later than September 1, 2022, and remain operative until March 1, 2024. Providers who have completed provider enrollment and are eligible to work for a recipient, including registry and emergency backup providers, may participate in the Career Pathways Program. Providers who successfully complete coursework in their selected career pathway and those who then apply the coursework to the IHSS programs will be eligible to receive incentive payments.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report. The Career Pathways Pilot Program will be implemented no later

than September 1, 2022, and remain operative until March 1, 2024.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

The objectives and pathways outlined in the Updated Initial HCBS Spending Plan Narrative were further defined through Stakeholder discussions and were added to the W&IC as outlined below.

The objectives of the career pathways will include, but not be limited to:

- Promotion of recipient self-determination principles
- Dignity in providing and receiving care through meaningful collaboration between the recipient and provider
- Advancement of health and service equity including the quality of care, care outcomes and life
- Promotion of a culturally and linguistically competent workforce to serve the growing racial and ethnic diversity of an aging population
- Increasing provider employment retention to maintain a stable workforce for recipients.

The department shall offer five career pathways:

- The basic skills career pathways include:
  - General health and safety
  - Adult education topics
- The specialized skills career pathways include:
  - Cognitive impairments and behavioral health
  - Complex physical care needs
  - Transitioning from homelessness

Furthermore, the requirements to receive the incentive payments have been defined. Providers shall be eligible to receive an incentive payment, the amounts to be determined by the department, when any of the following are met:

- 1) A provider successfully completes 15 hours of course work for a specific career pathway;
- 2) A provider successfully completes 15 hours of course work in a specialized skills career pathway, subsequently begins working for a recipient who needs that type of specialized care, and has provided 100 hours of care to that recipient in the first month of service;
- 3) A provider successfully completes 15 hours of course work for a specialized skills career pathway, subsequently begins working for a recipient who needs that type

of specialized care and has provided 100 hours of care to that recipient per month for at least 6 months.

Providers shall only be eligible to receive an incentive payment for no more than two career pathways annually.

### **Direct Care Workforce (non-IHSS) Training and Stipends**

Funding: \$150M enhanced federal funding (\$150M TF) One-Time

Lead Department(s): California Department of Aging (CDA), with DHCS, CDSS, Office of Statewide Health Planning and Development (OSHDP), now newly named as the Department of Health Care Access and Information (HCAI)

Training and stipends will be available to Direct Care Workforce (non-IHSS) that provide services to Medicaid participants in a range of home and community-based settings, in order to both improve care quality, respond to severe worker shortages in the sector, and prevent unnecessary institutionalization. These training and stipends for Direct Care Workers (non-IHSS) that serve people who are participating in Medicaid and receiving services to remain living in the home and community and avoid institutions will improve the skills, stipend compensation, and retention of direct care workforce sector that is either employed by Medicaid HCBS waiver programs (e.g., CBAS, MSSP, PACE) or delivering the direct care services to Medicaid participants that are referenced in Appendix B.

Quarterly Report for Quarter 2 of FFY 2021-2022

1. *Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

Nothing to report.

2. *States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for these one-time expenditures.

3. *Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **IHSS HCBS Care Economy Payments**

Funding: \$137M enhanced federal funding (\$275M TF) One-Time

Lead Department(s): CDSS

As reported in the Initial Spending Plan Narrative, this funding would provide a one-time incentive payment of \$500 to each current IHSS provider that provided IHSS to program recipient(s) during a minimum of two months between March 2020 and March 2021 of the pandemic. The payment would be issued through the IHSS automated system (the Case

Management, Information and Payrolling System, or CMIPS) and would focus on payment for retention, recognition, and workforce development.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

CGI Technologies and Solutions, the vendor that maintains and operates CMIPS on behalf of the State, designed and is in the process of implementing system changes to the CMIPS in order to process the one-time IHSS HCBS Care Economy Payment. A newly created special transaction type, known as the Provider One Time Payment (POTP), will be used to pay out the Care Economy Payment.

Notices will be emailed to all IHSS Providers informing them of the upcoming IHSS Care Economy Payment. Paper letters will be mailed to IHSS Providers that do not have an email address. Each notice will include the qualifications required to receive the payment.

Last but not least, the date the one-time payment will be issued is to be determined.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report. This is a one-time incentive payment.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

The eligibility requirements have been updated since the Updated Initial HCBS Spending Plan Narrative was submitted, which originally had projected payments to be provided to IHSS Providers that rendered IHSS Services to program recipient(s) for a minimum of two months between March 1, 2020 and March 31, 2021. At this time, the one-time incentive payment will be provided to IHSS Providers that rendered IHSS Services to program recipient(s) for a minimum of three months between March 1, 2020 and December 31, 2020.

### **Non-IHSS HCBS Care Economy Payments**

Funding: \$6.25M enhanced federal funding (\$12.5M TF) One-Time

Lead Department(s): DHCS, with CDA

This funding would provide a one-time incentive payment of \$500 to each current direct care, non-In Home Supportive Services (IHSS) provider of Medi-Cal home and community-based services during the specific timeframe of at least two months between March 2020 and March 2021. Providers eligible for this incentive payment are currently providing, or have provided, the services listed in Appendix B of the SMD Letter #21-003, including, but not limited to, Personal Care Services (PCS), homemaker services and Case Management. This proposal will expand access to providers and could increase retention of current providers, covering 25,000 direct care HCBS providers in the

Multi-purpose Senior Services Program Waiver (MSSP), Community Based Adult Services program (CBAS), Home and Community-Based Alternatives (HCBA) Waiver, Assisted Living Waiver (ALW), HIV/AIDS Waiver, Program of All-Inclusive Care for the Elderly (PACE), and the California Community Transitions program (CCT) and would focus on payment for retention, recognition, and workforce development. This effort can help alleviate financial strain and hardships suffered by California's HCBS direct care workforce, which were exacerbated by the COVID-19 Public Health Emergency (PHE). The PHE has worsened the direct care workforce shortage, driven by high turnover, and limited opportunities for career advancement. This proposal, coupled with California's other proposals, can lead to a more knowledgeable, better trained, and sufficiently staffed HCBS workforce to provide high-quality services.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

Nothing to report.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

This initiative is a one-time payment meant to help alleviate financial strain and hardships suffered by California's HCBS direct care workforce during the COVID-19 PHE and expand access to providers and incentivize retention of current California's existing HCBS direct care workforce.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

This is a complex initiative that crosses multiple providers and payment systems. DHCS is currently working to develop a scope of work to secure a contractor to assist with developing a payment identification and processing plan. DHCS will move forward with securing the contractor upon full CMS approval of the spending plan. DHCS projects implementation of this initiative no sooner than January 2022.

### **Increasing Home and Community Based Clinical Workforce**

Funding: \$75M enhanced federal funding (\$75M TF) One-Time

Lead Department(s): OSHPD/HCAI, with DHCS, California Department of Public Health (CDPH), CDA

Currently in California, there is variety of HCBS providers, including but not limited to, licensed and certified Home Health Agencies, individually licensed HCBS Waiver Providers, and/or unlicensed caregivers. Additionally, other organizations, such as Personal Care Agencies, non-profit organizations, professional corporations, and nursing facilities can apply to become HCBS Waiver service providers. This proposal includes grants to a mix of providers who are providing services listed in Appendix B of the SMD Letter #21-003 (home health aides, certified nurse assistants, licensed vocational nurses, private duty nursing, etc.).

Furthermore private duty nursing providers are delivering services in a beneficiary's own home or a location necessitated by normal life activities. Per Welfare and Institutions Code (W&IC) 1743.2(b)(2), "private duty nursing services" must meeting specific requirements, including that services be provided to the patient in his or her temporary place of residence of other community-based setting and includes one or both of the following locations: the patient's home or outside the patient's home, as necessitate by normal life activities. This aligns with CMS' guidance provided in the SMD Letter#21-003 (Appendix B) regarding Private Duty Nursing.

This proposal would increase the home and community-based clinical care workforce, including, but not limited to, the home health aide, certified nurse assistant, licensed vocational nurse, and registered nurse workforce in Medi-Cal. The proposal focuses on increasing the number of providers and expanding training for home-based clinical care providers for children with complex medical conditions, individuals with disabilities, and geriatric care for aging adults. Grants would be provided to clinics, physician offices, hospitals, private duty nursing providers, home health providers, or other clinical providers who authorize home and community-based services and/or directly provide services to Medi-Cal clients. To be eligible for funds, the provider would need to demonstrate significant Medi-Cal patient caseload. Grants can pay for loan repayment, sign-on bonuses, training and certification costs, etc.

Funding for loan repayments, sign-on bonuses, and training and certification costs for California's home and community-based clinical workforce providers can supplement current HCBS workforce recruitment strategies. These incentives will help recruit and retain home health workers and direct support professionals providing home and community-based services to California's most vulnerable populations.

#### Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

In terms of cross-departmental collaboration, on August 26, 2021, OSHPD/HCAI conducted a HCBS Spending Plan Cross-Department kick-off meeting with CDA, CDPH, and DHCS to coordinate among state agencies regarding the HCBS project goal related to increasing clinical workforce, to start identifying data needs and other stakeholders, and identify next steps across departments. Moreover, OSHPD/HCAI will continue to engage other departments when doing the stakeholder engagement and data needs analysis.

Additionally, the goal of the OSHPD/HCAI initiative in the HCBS Spending Plan is to increase the HCBS clinical workforce of Home Health Aides (HHAs), Certified Nurse Assistants (CNAs), Licensed Vocational Nurses (LVNs), and Registered Nurses (RNs), to increase racial and language diversity and to increase access to health services in rural communities, children with complex medical conditions, individuals with disabilities, and geriatric care for aging adults for the Medi-Cal population.

To attain this goal, OSHPD/HCAI is working with a consulting firm to develop and execute a contract, specifically to conduct a needs assessment, stakeholder engagement, HCBS program planning, design, and implementation.

Once a contract is in place, the consulting firm will conduct a needs assessment and stakeholder engagement to identify data needs and gaps, and to inform and develop HCBS clinical workforce objectives, recommendations, proposed timelines, and a project implementation plan.

OSHPD/HCAI anticipates that the contract will be in place by November 1, 2021.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

OSHPD/HCAI is engaging a consultant to assist in developing a multi-year plan beyond March 31, 2024.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

Note: OSHPD/HCAI's spending plan projection for Q2 FFY 21-22 is based on current estimated costs of the proposed contract with a consulting firm.

**Providing Access and Transforming Health (PATH) funds for Homeless and HCBS Direct Care Providers**

Funding: \$50M enhanced federal funding (\$100M TF) One-Time  
Lead Department(s): DHCS, with CDSS and OSHPD/HCAI

PATH funds will support a multi-year effort to shift delivery systems and advance the coordination and delivery of quality care and services authorized under DHCS' Section 1115 and 1915(b) waivers. This complements the \$200 million (\$100 million General Fund) proposal in the state budget to build capacity for effective pre-release care for justice-involved populations to enable coordination with justice agencies and Medi-Cal coverage of services 30 days prior to release.

California is proposing a significant expansion of the homeless system of care that will create over 2,000 direct service jobs for those providing services to homeless and formerly homeless individuals through investments in California Department of Social Services programs. Additionally, Medi-Cal is planning to expand Enhanced Care Management (ECM) and long-term services and supports statewide through CalAIM In Lieu of Services (ILOS) (now known as Community Supports). To successfully implement these new investments, local governments and community based organizations will need to recruit, onboard, and train a new workforce. In particular, there is a need for a workforce with experience/expertise in working with the disabled and aging populations. Funding will support outreach efforts to publicize job opportunities, workforce development strategies to train staff in evidenced-based practices, implement information technology for data sharing,

and support training stipends. Funds will also support ECM and ILOS/Community Supports provider capacity building (e.g., workflow development, operational requirements and oversight) and delivery system infrastructure investments (e.g., certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities).

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

With California having requested expenditure authority for this program through the renewal of DHCS' Section 1115 Waiver, with funds associated with this initiative beginning in Q3 of 2022, California continues to work with CMS regarding federal approval of the program through negotiations related to the anticipated approval of DHCS' Section 1115 Waiver.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

The activities funded in this initiative are foundational to the successful implementation of Enhanced Care Management and ILOS/Community Supports such as Respite Services, Day Habilitation Programs, Community Transition Services, Personal Care and Homemaker Services, and Environmental Accessibility Adaptions, by building further capacity and infrastructure. The services are being implemented in California's Medi-Cal Managed Care Delivery System, with the goal of implementing Managed Long Term Services and Supports statewide in 2026.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Traumatic Brain Injury (TBI) Program**

Funding: \$5M enhanced federal funding (\$5M TF) One-Time

Lead Department(s): Department of Rehabilitation (DOR)

The DOR Traumatic Brain Injury (TBI) Program provides five core services designed to increase independent living skills to maximize the ability of individuals with TBI to live independently in a community of their choice. These core services are also preventative as many TBI survivors who do not have access to a network of services and supports are at a higher risk of chronic homelessness, institutionalization, imprisonment, and placement in skilled nursing facilities due to an inability to perform activities of daily living and impaired emotional regulation. State law requires that 51% of the individuals served in the TBI program must be Medi-Cal recipients.

The Home and Community-Based Services (HCBS) Expanding TBI Provider Capacity

Proposal will expand the capacity of existing TBI sites and stand up new TBI sites in alignment with HCBS surrounding transition and diversion through community reintegration, personal care services through supported living services, and other supportive services to improve functional capabilities of individuals with TBI.

The proposal includes funding to expand capacity of six (6) existing TBI sites and to award up to six (6) additional TBI sites in unserved/underserved areas.

Quarterly Report on HCBS Spending Plan Narrative for the Initiative:

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

DOR currently has six (6) TBI Program sites funded under the authority of the California Welfare and Institutions Code (WIC) section 4357.1 through December 31, 2021. DOR has issued a Request for Application (RFA) for the selection of new TBI Program sites under WIC section 4357.1 to be awarded with an effective date of January 1, 2022 through June 30, 2024.

HCBS Spending Plan funding for TBI will be provided to the TBI Program sites selected through the current RFA process to expand their capacity beginning in early 2022 for encumbrance or expenditure until March 31, 2024. Through an additional RFA process, DOR will award up to six (6) additional TBI sites in unserved/underserved in early 2022 for encumbrance or expenditure until March 31, 2024.

DOR will hire an Associate Governmental Program Analyst position to support the TBI Program HCBS Spending Plan initiative with anticipated expenditures beginning November 2021.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

The HCBS Spending Plan TBI Program is anticipated as a one-time investment to build the capacity of TBI services providers to serve individuals with TBI. TBI services will be provided on-going through WIC section 4357.1 and as appropriated through the budget process.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

## Home and Community Based Services Navigation

To improve access to HCBS, these HCBS Navigation initiatives work to development a variety of statewide HCBS navigation systems, including screening and assessment tools, referral and navigation systems, coordination of services, and outreach campaigns.

HCBS Navigation Initiatives include:

- No Wrong Door System/Aging and Disability Resource Connections (ADRCs)
- Dementia Aware and Geriatric/Dementia Continuing Education
- Language Access and Cultural Competency Orientations and Translations
- CalBridge Behavioral Health Pilot Program

### **No Wrong Door/Aging and Disability Resource Connections (ADRCs)**

Funding: \$5M enhanced federal funding (\$5M TF) One-Time

Lead Department(s): CDA, with DHCS, DOR

California is establishing a state-wide “No Wrong Door” system (or Aging and Disability Resource Connections), so the public can easily find information, person-centered planning, and care management for older adults and adults with disabilities across the range of home and community services provided by health plans (i.e., CalAIM “In Lieu of Services”) community-based organizations (CBOs), homeless Continuums of Care, and counties. This investment supports the interoperability between the proposed ADRC technology and data systems with CBOs, health plans, and counties in line with the CalAIM goals for statewide Managed Long-Term Services and Supports for all Californians participating in Medi-Cal and with the new Office of Medicare Innovation and Integration.

Quarterly Report for Quarter 2 of FFY 2021-2022

1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.

Nothing to report.

2. *States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for these one-time expenditures.

3. *Updates or modifications to the quarterly HCBS narratives concerning California’s HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Dementia Aware and Geriatric/Dementia Continuing Education**

Funding: \$25M enhanced federal funding (\$25M TF) One-Time

Lead Department(s): DHCS, with OSHPD/HCAI, CDPH

The state budget addresses the recommendations put forward by the Governor's Task Force on Alzheimer's Prevention and Preparedness. This spending plan makes additional investments to further this work by screening older adults for Alzheimer's and related dementias to ensure early detection and timely diagnosis, while also connecting individuals and families to community resources.

**Dementia Aware:** Develop an annual cognitive health assessment that identifies signs of Alzheimer's disease or other dementias in Medi-Cal beneficiaries. Develop provider training in culturally competent dementia care. Develop a referral protocol on cognitive health and dementia for Medi-Cal beneficiaries, consistent with the standards for detecting cognitive impairment under the federal Medicare Program and the recommendations by the American Academy of Neurology, the California Department of Public Health's Alzheimer's Disease Program, and its ten California Alzheimer's Disease Centers (CADC).

**Geriatric/Dementia Continuing Education, for all Licensed Health/Primary Care Providers:** Make continuing education in geriatrics/dementia available to all licensed health/primary care providers, in partnership with Department of Consumer Affairs and OSHPD/HCAI, by 2024. This education of current providers complements the Administration's geriatric pipeline proposals for future providers; it is needed to close the gap between current health professionals with any geriatric-training and the rapidly growing and diversifying 60-plus population.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

On August 25, 2021, in further cross-departmental collaboration, DHCS conferred with its partner departments (listed above) to review the components of this and other related dementia initiatives and establish the preliminary milestone of DHCS' outreach to CADCs to assess provider training needs.

Subsequently, in anticipation of developing the aforementioned provider training, DHCS met with the CADC directors on September 17, 2021, to solicit further input. The directors expressed enthusiasm in partnering with the state for this initiative and shared with DHCS their Assessment of Cognitive Complaints Toolkit, a document that serves to enable accurate diagnosis of dementia in a primary care setting and to help primary care providers make appropriate referrals. Since there is currently no standard of care nationally for dementia care, as the directors noted, they recommended that the group consider establishing such standard of care through this initiative. DHCS will review the toolkit and the directors' other recommendations when working with a contractor to develop the online provider training. DHCS will continue to solicit input and feedback from the CADC directors as the initiative unfolds.

2. *States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for this one-time expenditure.

3. *Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Language Access and Cultural Competency Orientations and Translations**

Funding: \$27.5M enhanced federal funding (\$45.8M TF), \$10M GF Ongoing

Lead Department(s): DDS

COVID-19 highlighted the continued need to assist families of children who are regional center consumers from underserved communities to navigate systems – to improve service access and equity and meet basic needs. The Budget includes funding for language access and cultural competency orientations and translations for regional center consumers and their families. This additional investment may be used for identification of vital documents for translation, regular and periodic language needs assessments to determine threshold languages, coordination and streamlining of interpretation and translation services, and implementation of quality control measures to ensure the availability, accuracy, readability, and cultural appropriateness of translations.

Quarterly Report for Quarter 2 of FFY 2021-2022

1. *Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

DDS has assembled an internal team that will lead this initiative and will have an operational plan available by next quarter. DDS will also coordinate with California Health & Human Services Agency on this initiative.

2. *States should explain how they intend to sustain such activities beyond March 31, 2024.*

Funding beyond March 2024 is included in the multi-year budget plan.

3. *Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **CalBridge Behavioral Health Pilot Program**

Funding: \$40M enhanced federal funding (\$40M TF) One-Time

Lead Department(s): DHCS

The CalBridge Behavioral Health Navigator Pilot Program provides grants to acute care

hospitals to support hiring trained behavioral health navigators in emergency departments to screen patients and, if appropriate, offer intervention and referral to mental health or substance use disorder programs. Applicants will include general acute care hospitals or health systems, hospital foundations, or physician groups. The funding would also support technical assistance and training for participating emergency departments and support for DHCS to administer the program.

While CalBridge is not a new program, the proposed funding is dedicated to new activities (expanding the role of the navigator to better address mental health conditions as well as substance use disorders), new services (covering the costs for hospitals already participating in CalBridge to add a new navigator and expand hours of coverage or patients served), and new grantees (expanding CalBridge to hospitals that have not yet participated).

While the funding will affect services that are not themselves included in the State Plan services listed in Appendix B, such affected services are nonetheless directly related to the services listed in Appendix B. Specifically, BH Navigators in emergency departments provide screening, brief assessments, and referral to ongoing SUD and mental health treatments on release from the ED, all of which fall into and count among the rehabilitative services identified in Appendix B. While the services of the BH Navigators are not billable as rehabilitative services, they are serving to enhance and strengthen HCBS in Medicaid, by identifying patients who could benefit from rehabilitative treatment (both MH and SUD treatment) and then helping the patients access those services.

#### Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

Nothing to report.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

While the focus of the CalBridge BH Navigator Program is to specifically fund salaries of BH navigators in the hospital setting, it is the DHCS expectation that many of the funded hospitals will continue to support navigators beyond the conclusion of this initiative. A core component of the CalBridge BH Navigator Program is to have DHCS' third-party administrator, Public Health Institute (PHI), perform technical assistance on sustainability to hospital grantees as part of their contracted activities. Additionally, PHI, through their State Opioid Response-funded California Bridge Program, has developed and promoted a number of technical assistance resources on sustainability of BH navigators, which will be made available to CalBridge BH Navigator Program grantees.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

## Home and Community-Based Services (HCBS) Transitions

The HCBS Transition initiatives expand and enhance community transition programs to additional populations or settings and facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a homeless shelter) to a variety of community-based, independent, living arrangements. The proposals include transitions from skilled nursing facilities to home or assisted living environments, preventing long-term care placements, transitions from homeless to housed, transitions from incarceration to home or residential programs, and diversion for those at risk of incarceration as a result of their health care (primarily behavioral health) needs.

These HCBS initiatives invest in reducing health disparities among older adults, people with disabilities, and homeless individuals. They include initiatives to test alternative payment methodologies or the delivery of new services that are designed to address social determinants of health and inequities. These new services may include housing-related supports, such as one-time transition costs, employment supports, and community integration as well as providing more intensive care coordination for individuals with significant socioeconomic needs.

HCBS Transition Initiatives include:

- Community Based Residential Continuum Pilots for Vulnerable, Aging and Disabled Populations
- Eliminating the Assisted Living Waiver Waitlist
- Housing and Homelessness Incentive Program
- Community Care Expansion Program

### **Community Based Residential Continuum Pilots for Vulnerable, Aging, and Disabled Populations**

Funding: \$110M enhanced federal funding (\$298M TF) One-Time

Lead Department(s): DHCS, with CDSS

The Community Based Residential Continuum Pilots would provide medical and supportive services in the home, independent living settings including permanent supportive housing, and community care settings (home, ARFs, RCFEs, affordable housing) in order to avoid unnecessary healthcare costs, including emergency services and future long-term care placement in a nursing home. This program would ensure individuals are able to live in the least restrictive setting possible by ensuring access to home-based health and other personal care services for vulnerable populations, including seniors and people with disabilities.

While this program does not provide capital funding, these resources further support the investments made in the budget for the Community Care Expansion program which will provide capital funding for the construction, acquisition and/or rehabilitation of adult and senior care facilities to both expand and preserve these facilities through physical

upgrades and capital improvements.

Focus populations include individuals with serious mental illness; homeless individuals; individuals needing additional housing and supportive services but not meeting an institutional level of care; individuals in an institution who could be served at home or in a community care setting; individuals with disabilities; and individuals being diverted or released from prisons, jail, state hospitals, or juvenile justice systems. Additional focus populations may be considered based on stakeholder input.

These services would be provided to individuals who do and do not meet institutional level of care, and who require medical and/or behavioral health and supportive services to live successfully in the community. Funds may be used to provide medical and personal care services, but will not be used to pay for room and board. DHCS would determine the eligibility criteria for these pilots and managed care organizations would make individual eligibility determinations.

Pilot funding would be provided to managed care plans to provide these benefits to members and coordinate with county partners. Managed care plans would contract with licensed providers to provide needed medical and/or behavioral health services to beneficiaries in their own home, in coordination with any authorized IHSS services or personal care/homemaker services. For individuals residing in or needing the support of a community care setting, managed care plans would contract either directly with the licensed community care setting to provide these services or with a licensed provider who would deliver services onsite.

This proposal creates new models of care for those who need personal care, medical, and/or behavioral health supports to live either in their own home or a community care setting. The proposal is well aligned with CalAIM and other DHCS, DDS, and DSS efforts to support individuals living in the least restrictive setting possible and maximizing their dignity, privacy, and independence. DHCS will work with stakeholders to further develop details and guidance and ensure alignment with existing efforts.

For the Prison, Jail, and Juvenile Justice Re-entry and Diversion Populations, this proposal will establish interim housing or board and care settings where medical, behavioral and social services are available or on-site, as re-entry hubs for this population. Funding from this program will pay for the cost of medical and personal care services, but will not fund the cost of room and board. Placement and supportive services will be coordinated with state and local justice partners. Services provided will include peer supports, job-training preparation, employment services, and education linkage (trade schools or GED programs as examples). Funding may also support housing interventions to ensure placements into permanent housing upon exit, though they will not directly pay for room and board. These interventions may include connection to affordable housing, rapid rehousing, permanent supportive housing as well as linkage to homeownership support as appropriate. Participants may also receive an economic stimulus payment alongside employment services to support the transition after reentry into the community. The efforts described here build off the Administration' Returning Home Well Initiative, a COVID-19 response effort to support the increased number of individuals who were released from state prison during the pandemic. The initiative provided treatment, shelter, safe transportation, direct assistance, and connection with

ongoing employment and health services. This program will be provided in addition to the services offered under the Returning Home Well Initiative, building upon the Returning Home Well Initiative, which provided initial transition services. The Continuum Pilots will offer additional reentry supports that include peer supports, job-training preparation, employment services, and education linkage (trade schools or GED programs as examples). Further, DHCS will leverage the local partnerships built through the Returning Home Well Initiative and incentivize the Medi-Cal managed care plans to contract with community-based re-entry service providers.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

Nothing to report, as the Continuum Pilot initiative will commence July 1, 2022.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for this one-time expenditure.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Eliminating Assisted Living Waiver Waitlist**

Funding: \$85M enhanced federal funding (\$255M TF), \$38M Ongoing  
Lead Department(s): DHCS

California's Assisted Living Waiver (ALW) is a Medicaid Home and Community-Based Services (HCBS) waiver program, authorized in §1915(c) of the Social Security Act. The ALW is designed to assist Medi-Cal beneficiaries to remain in their community as an alternative to residing in a licensed health care facility. Adding 7,000 slots to ALW will help in the effort to eliminate the current Assisted Living Waiver waitlist while furthering the vision of the Master Plan for Aging. The current Assisted Living Waiver capacity is 5,744 slots; of which 5,620 are filled as of May 1, 2021. There are approximately 4,900 beneficiaries on the waitlist as of May 1, 2021, and an additional 1,300 beneficiaries approved for enrollment in the Assisted Living Waiver but waiting for an available assisted living facility placement to complete enrollment. The proposed addition of 7,000 slots will enable DHCS to provide sufficient Assisted Living Waiver capacity to enroll all waitlisted beneficiaries and to clear pending enrollments while still providing a cushion for continued growth.

Additionally, DHCS intends to temporarily modify enrollment criteria for the additional 7,000 slots to promote flexibility. In order to promote cost neutrality, as well as significant savings to the State by transitioning clients out of Skilled Nursing Facilities (SNFs), California

requires new enrollments into the ALW to be processed at a ratio of 60% institutional transition to 40% community enrollments. DHCS plans to temporarily remove this requirement until the existing waitlist has been cleared. DHCS does not plan on modifying services offered to ALW clients in the current [CMS-approved ALW](#). Current services align with Appendix B of the SMD Letter #21-003 for Section 1915(c), listed under HCBS authorities. Current ALW services include:

- Assisted Living Services - Homemaker; Home Health Aide; Personal Care
- Care Coordination
- Residential Habilitation
- Augmented Plan of Care Development and Follow-up
- NF Transition Care Coordination

Notably, ALW-eligible individuals are those who are enrolled in Medi-Cal and meet the level of care provided in a nursing facility due to their medical needs. The proposal to eliminate the ALW waitlist will not impact eligibility requirements and will not allow enrollees who are not already Medicaid eligible to enroll into the waiver program. DHCS does not intend to provide funding for services other than those listed in Appendix B). The proposed commitment to Assisted Living Waiver growth will also likely encourage participation of residential care facility for the elderly (RCFE) and adult residential facility (ARF) providers in the Assisted Living Waiver program, as the waitlist has been previously cited as a barrier to provider participation. DHCS will work with stakeholders to ensure care coordination and transition as beneficiaries are enrolled in ALW.

#### Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

DHCS intends to submit an Assisted Living Waiver technical amendment to increase the maximum number of waiver slots, as well as remove the 60%/40% institutional to community enrollment ratio. The amendment will be submitted to CMS by October 31, 2021, with an effective date of July 1, 2021..

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

DHCS intends to continue funding the 7,000 additional ALW slots on a continual ongoing basis beyond March 31, 2024, to meet the needs of eligible Medicaid beneficiaries. DHCS plans to integrate the ALW services into the existing Home and Community-Based Alternatives (HCBA) Waiver upon the February 28, 2024, expiration of the current ALW term.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

DHCS is developing the implementation framework for this initiative. Implementation of the initiative to eliminate the ALW waitlist will be facilitated through a waiver amendment; submission to CMS thereof is pending approval of the HCBS Spending

Plan. After submission and approval of the waiver amendment, DHCS will begin enrolling additional beneficiaries who are on the waitlist into the program.

### **Housing and Homelessness Incentive Program**

Funding: \$650M enhanced federal funding (\$1.3B TF) One-Time

Lead Department(s): DHCS

As a means of addressing social determinants of health and health disparities (as listed in Appendix D of SMD Letter #21-003), Medi-Cal managed care plans would be able to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. Housing instability is a key issue in the Economic Stability domain of Healthy People 2030, negatively affecting physical health and making it harder to access health care including services in Appendix B of SMD Letter #21-003. There would be a requirement that 85% of the funds go to beneficiaries, providers, local homeless Continuum of Care, and/or counties. Funds would be allocated by Point in Time counts of homeless individuals and other housing related metrics determined by DHCS. Managed care plans would have to meet specified metrics to draw down available funds. The target populations for this program would be aging adults; individuals with disabilities; individuals with serious mental illness and/or SUD needs at risk for, or transitioning from incarceration, hospitalization, or institutionalization; families; individuals reentering from incarceration; homeless adults; chronically homeless individuals; persons who have/had been deemed (felony) incompetent to stand trial; Lanterman-Petris Short Act designated individuals; and, veterans. This furthers the proposals included in the state budget relating to housing and homelessness.

Managed care plans and the local homeless Continuum of Care, in partnership with local public health jurisdictions, county behavioral health, Public Hospitals, county social services, and local housing departments must submit a Homelessness Plan to DHCS. The Homelessness Plan must outline how Housing and Homelessness Incentive Program services and supports would be integrated into the homeless system. This would include a housing and services gaps/needs assessment and how these funds would prioritize aging and disabled homeless Californians (including those with a behavioral health disability). Plans should build off of existing local HUD or other homeless plans and be designed to address unmet need. In counties with more than one managed care plan, plans would need to work together to submit one plan per county.

The Homelessness Plans must include mapping the continuum of services with focus on homelessness prevention, interim housing, (particularly for the aging and/or disabled population), rapid re-housing (families and youth), and permanent supportive housing. While the funding will be based on incentive payments, managed care plans may invest in case management or other services listed in Appendix B of SMD Letter #21-003, as well as other services that enhance HCBS by supporting housing stability such as home modifications or tenancy supporting services.

The Homelessness Plans must identify what services will be offered, how referrals will be made, how other local, state, and federal funding streams will be leveraged, and how progress will be tracked towards goals, including numbers served and other incentive performance measures. The Plans should build on existing homelessness plans and

articulate how CalAIM services are integrated into homeless system of care and how they will address equity in service delivery.

The funding under this incentive program would not include payment for room and board; instead, the funds will be utilized to incentivize managed care plans to meet operational and performance metrics as authorized under 42 CFR § 438.6(b)(2).

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

California awaits CMS' approval of this initiative as part of California's HCBS Spending Plan. During this time period, DHCS is working to finalize the operational and performance metrics that Medi-Cal managed care plans will be required to meet to receive incentive funding through stakeholder engagement.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for this one-time expenditure.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Community Care Expansion Program**

Funding: \$348.3M enhanced federal funding (\$348.3M TF) One-Time

Lead Department(s): CDSS

The Community Care Expansion (CCE) Program provides \$805M over a three-year period to counties and tribes for the acquisition, or rehabilitation, or construction of Adult and Senior Care Residential Facilities (ARF), Residential Care Facilities for the Elderly (RCFEs) and Residential Care Facilities for the Chronically Ill (RCFCIs). These facilities provide a structured home-like environment for people who might otherwise require institutional care. Funded settings will be fully compliant with the home and community-based settings criteria to ensure community integration, choice, and autonomy, and will thereby expand access to community-based care.

ARFs, RCFEs and RCFCIs are part of a continuum of long-term care supports providing non-medical care and supervision to adults who may have a mental, physical or developmental disability and to those age sixty and over who require additional supports. Many of the residents in these settings are age 65 or older, are blind and/or have disabilities, and may receive Supplemental Security Income/State Supplementary Payment (SSI/SSP). California has a shortage of ARFs, RCFEs and RCFCs that accept SSI/SSP recipients and has experienced a decline in the number of SSI/SSP recipients who reside in adult and senior care facilities. The goal of the CCE program is to expand

and preserve Adult and Senior Care facilities that can serve people experiencing homelessness as well as stabilize existing settings that serve people at risk of homelessness or unnecessary institutionalization in skilled nursing facilities.

Funds will be prioritized for the creation of new and expanded settings but may also be used to fund capital investment and rehabilitation costs for existing settings at risk of closure. Applicants will be required to demonstrate commitments to supportive services to assist with the stability of those placed in assisted living settings. Facilities that receive acquisition funding may be purchased and owned by the grantee or may be transferred to a new owner/operator and facilities that receive rehabilitation funding may continue to be owned by an existing owner/ operator. Facilities will maintain covenants to certify their intended use/resident population and the length of the covenants associated with the facilities will be tiered based on the level of funding awarded.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

The Community Care Expansion Program is currently coordinating with DHCS, planning for stakeholder engagement, and planning to release a Notice of Funding Availability (NOFA) in early 2022. Further updates are anticipated in the next quarterly HCBS Spending Plan Narrative for Q3 of FFY 2021-2022.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Applicants will be required to demonstrate commitments to supportive services to assist with the stability of those placed in assisted-living settings. Facilities that receive acquisition funding may be purchased and owned by the grantee or may be transferred to a new owner/operator, and facilities that receive rehabilitation funding may continue to be owned by an existing owner/operator. Facilities will maintain covenants to certify their intended use/resident population. Moreover, the length of the covenants associated with the facilities will be tiered based on the level of funding awarded.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

Note: The projected funding for the CCE program is expected to be released via a NOFA in early 2022. Projected expenditures by quarter will be available by mid-2022.

## Services: Enhancing Home and Community-Based Services Capacity and Models of Care

By innovating and improving HCBS models of care to meet the needs of the individuals it serves, the state can increase capacity in the HCBS system, allowing more individuals, particularly those in the aging and disabled communities, to access services. In addition, some of these initiatives will allow existing HCBS programs to serve existing clients better as well as expand to serve more individuals who meet eligibility criteria.

Initiatives include:

- Alzheimer’s Day Care and Resource Centers
- Older Adult Resiliency and Recovery
- Adult Family Homes for Older Adults
- Coordinated Family Support Service
- Enhanced Community Integration for Children and Adolescents
- Social Recreation and Camp Services for Regional Center Consumers
- Developmental Services Rate Model Implementation
- Contingency Management

### **Alzheimer’s Day Care and Resource Centers**

Funding: \$5M enhanced federal funding (\$5M TF) One-Time  
Lead Department(s): CDA, with CDSS, CDPH, DHCS

These funds would be used to provide dementia-capable services at licensed Adult Day Programs (ADP) and Adult Day Health Care (ADHC) centers, allowing for community-based dementia services that would include, but not be limited to: caregiver support and social and non-pharmacological approaches that would expand and enhance HCBS services by preventing or delaying the need for individuals with dementia and Alzheimer’s to be placed into institutional care settings. These activities will include a one-time payment to providers (i.e., ADP and/or ADHCs) for operational and administrative expenditures in providing services by a qualified multidisciplinary team within the funding period through March 2024.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

Nothing to report.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for these one-time expenditures.

3. *Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Older Adult Resiliency and Recovery**

Funding: \$106M enhanced federal funding (\$106M TF) One-Time

Lead Department(s): CDA

The one-time augmentation of \$106 million, to be spent over three years (2021-22, 2022-23 and 2023-24), will strengthen older adults' recovery and resilience from the severe isolation and health impacts from staying at home for over a year due to the Coronavirus pandemic. Funding allocations are proposed as follows: Senior Nutrition (\$20.7 million); Senior Legal Services (\$20 million); Fall Prevention and Home Modification (\$10 million); Digital Connections (\$17 million); Senior Employment Opportunities (\$17 million); Aging and Disability Resource Connections (\$9.4 million); Behavioral Health Line (\$2.1 million); Family Caregiving Support (\$2.8 million); Elder Abuse Prevention Council (\$1 million); and State Operation Resources (\$6 million).

Quarterly Report for Quarter 2 of FFY 2021-2022

1. *Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

Nothing to report.

2. *States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for these one-time expenditures.

3. *Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Adult Family Homes for Older Adults**

Funding: \$9M enhanced federal funding (\$9M TF), \$2.6M Ongoing

Lead Department(s): CDA, with Department of Developmental Services (DDS)

Adult Family Homes offer the opportunity for up to two adult individuals to reside with a family and share in the interaction and responsibilities of being part of a family unit, while the family receives a stipend and support from a local Family Home Agency (FHA) for caregiving for the adult individual(s). California will pilot Adult Family Homes for older

adults in one county, with the Department of Developmental Services (DDS) assisting the Department of Aging (CDA) in developing and operating the program. This pilot is based on the successful program serving adults with developmental disabilities currently run by the DDS. Interested family homes are assessed and receive background clearances from a non-profit FHA under contract with a Regional Center. DDS performs oversight over the Regional Center and the FHA. CDA will mirror this model with Area Agencies on Aging and the existing non-profit FHAs.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

Nothing to report.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for this ongoing funding investment.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Coordinated Family Support Service**

Funding: \$25M enhanced federal funding (\$42M TF); One-Time, \$25M GF Ongoing  
Lead Department(s): DDS

Currently, adults living outside the family home have more coordinated supports than individuals living with their family. DDS data shows a significantly higher percentage of adults who identify as non-white (75%) live with their family as compared to adults who are white (52%). To improve service equity for adults who live with their family, and improve individual supports at home, this proposal would pilot a new service for families similar to supported living services provided outside the family home. The pilot would assist families in coordinating the receipt/delivery of multiple services.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

DDS has assembled an internal team that will lead this initiative. An operational plan is in development.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

This pilot program will be reviewed for equity in consumer access and outcomes. Ongoing funding will be determined through the state's annual budget process.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Enhanced Community Integration for Children and Adolescents**

Funding: \$12.5M enhanced federal funding (\$12.5M TF) One-Time  
Lead Department(s): DDS

Children with intellectual and developmental disabilities (IDD) are frequently left out from participation in community programs, but both the child with IDD and children without IDD greatly benefit from opportunities to develop friendships. This proposal would support community social recreational connections for children through a multi-year grant program. The grant program will be for regional centers to work with CBOs and local park and recreation departments to leverage existing resources and develop integrated and collaborative social recreational activities.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

DDS has gathered preliminary stakeholder feedback, assembled an internal team that will lead this initiative and anticipates an operational plan available by next quarter.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

DDS anticipates programs started through these grants will continue beyond the grant period through collaboration with local entities, regional centers, and families, to sustain integrated social recreational activities.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

## **Social Recreation and Camp Services for Regional Center Consumers**

Funding: \$78.2M enhanced federal funding (\$121.1M TF) Ongoing

Lead Department(s): DDS

This proposal would support expanded options for individuals who have a developmental disability to include camping services, social recreation activities, educational therapies for children ages 3-17, and nonmedical therapies such as social recreation, art, dance, and music. Additionally, the proposal provides increased options for underserved communities.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

DDS has gathered preliminary stakeholder feedback, assembled an internal team that will lead this initiative, and will have an operational plan available by next quarter.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

DDS anticipates regional centers will have ongoing funding to sustain these services after this funding expires.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

## **Developmental Services Rate Model Implementation**

Funding: \$650M enhanced federal funding (\$965M TF); \$1.2B Ongoing

Lead Department(s): DDS

This investment will improve and stabilize the services directly impacting consumers, build the infrastructure to support consumers and their families through person-centered practices and supports. Additionally, a prevailing need and challenge within the developmental service system is moving from a compliance-based system to an outcome-based system. To accomplish this conversion, DDS will need to build infrastructure and modernize methods for collecting and analyzing information about consumer services and outcomes. This proposal implements rate models recommended by the 2019 Rate Study completed by DDS, with the help of a consultant. The state will maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021; however, rates may be adjusted based on reviews or audits. The rate models would allow for regular updates based on specified variables, address regional variations for cost of living and doing business, enhance rates for services delivered in

other languages, and reduce complexity by consolidating certain serviced codes. To improve consumer outcomes and experiences and measure overall system performance, the rate reform reflects the following goals:

- Consumer experience
- Equity
- Quality and outcomes
- System efficiencies

The department will implement a quality incentive program to improve consumer outcomes, service provider performance, and the quality of services with input from stakeholders.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

DDS has gathered preliminary stakeholder feedback, assembled an internal team that will lead this initiative and has an operational plan under development. This is a multi-year effort.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

The 2021-22 budget for DDS identified multi-year funding to implement the 2019 Rate Study by July 1, 2025, and includes an ongoing quality incentive program.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Contingency Management**

Funding: \$31.7M enhanced federal funding (\$58.5M TF) One-Time  
Lead Department(s): DHCS

Unlike alcohol and opioid addiction, there are no medications that work for stimulant use disorder. Overdose deaths from stimulants equal deaths from fentanyl in California, and rates continue to rise, causing high social costs (in terms of criminal justice involvement and foster care placement) and high medical costs (stimulant use disorder leads to high ED and hospital costs for infections, lung and heart disease). The lack of effective community-based treatments for stimulant use results in increased utilization of residential treatment services, particularly in the Medi-Cal program. DHCS proposes to offer contingency management via a pilot, as it is the only behavioral therapy repeatedly shown in studies to work for stimulant use disorder.

Contingency management (CM) uses small motivational incentives combined with behavioral treatment as an effective treatment for stimulant use disorder. The Department proposes to implement the motivational incentives through Drug Medi-Cal Organized Delivery System. Counties will apply to opt into the pilot program, and will designate participating providers in their network. The providers will assess patients, determine that they meet criteria for the program (a diagnosis of stimulant use disorder), and offer counseling services and urine drug testing. The motivational incentives will be offered to patients through a mobile app, accessible to patients through smart phones, tablets or computers. For patients without access to a smart phone, the motivational incentives will be managed through a statewide database, accessed through the treatment provider.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

The Department will use the January – June 2022 period to issue applications for counties, applications for vendors to manage the incentives through a statewide DHCS contract, and to provide guidance and training for counties and providers. CM services will launch July 2022 and continue through March 2024. DHCS would conduct a robust evaluation and, if the program is demonstrated to be effective, submit a proposal through the budget process to allow contingency management to be an ongoing Medi-Cal benefit, as part of the Drug Medi-Cal Organized Delivery System. By increasing the availability of community-based treatment, this proposal will reduce demand for residential treatment services, reducing costs and allowing individuals with substance use disorders to recover in the community and further builds on the behavioral health delivery system reforms in California Advancing and Innovating Medi-Cal (CalAIM).

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Pending confirmation of successful implementation in pilot counties, DHCS would propose in our budget process to extend the contingency management benefit to all counties as a mandatory service in our Drug Medi-Cal Organized Delivery System.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

## **Home and Community-Based Services Infrastructure and Support**

The following infrastructure investments will support the growth of HCBS services, to

allow existing HCBS programs to serve existing clients better as well as expand to serve more individuals who meet eligibility criteria.

Initiatives include:

- Long-Term Services and Supports Data Transparency
- Modernize Developmental Services Information Technology Systems
- Access to Technology for Seniors and Persons with Disabilities
- Senior Nutrition Infrastructure

### **Long-Term Services and Supports Data Transparency**

Funding: \$4M enhanced federal funding (\$4M TF) One-Time

Lead Department(s): DHCS, with CDPH, CDSS, CDA, OSHPD/HCAI

This is a multi-department initiative to improve long-term services and supports (LTSS) data transparency, including utilization, quality, and cost data. This will be accomplished by creating a LTSS Dashboard linked with statewide nursing home and HCBS utilization, quality, demographic, and cost data. The goal of increased transparency is to make it possible for regulators, policymakers, and the public to be informed while we continue to expand, enhance and improve the quality of LTSS in all home, community, and congregate settings. Nationwide core and supplemental standards for HCBS quality measurements do not exist, are long overdue, and would go a long way in improving our understanding of what works, where there are quality gaps, etc. As such, there are no current outcome-based HCBS quality measures or routine data publishing for HCBS in use at DHCS. Including HCBS quality measures in the LTSS Dashboard will enhance and strengthen the provision of HCBS under Medi-Cal. Similarly, including HCBS utilization measures will enable us to examine and ultimately improve access and reduce disparities in who utilizes these vital HCBS services in Medi-Cal.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

On September 30, 2021, through cross-departmental collaboration, the Chief Quality Officer and Chief Data Officer from DHCS met with Carrie Graham, Director of Long Term Services and Supports at the Center for Healthcare Strategies, who has been working for the California Department of Aging and was heavily involved in the creation and finalization of the California Masterplan on Aging to better understand community and stakeholder needs for an LTSS dashboard.

Moreover, on October 6 and October 20, 2021, various internal divisions within DHCS (namely, DHCS' Enterprise Data and Information Management division, the

Health Care Delivery Systems division, the Health Care Financing division, the Office of Medicare Innovation and Integration, and the Directorate) will further develop a work plan for this initiative to consider which quality and utilization measures can be leveraged for the dashboard.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Beyond March 31, 2024, activities for this initiative will be sustained by the continued maintenance of the LTSS dashboard. Moreover, DHCS leverages the data from the measures being tracked on the dashboard to assess utilization and conduct statewide quality improvement.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

### **Modernize Developmental Services Information Technology Systems**

Funding: \$6M enhanced federal funding (\$7.5M TF) One-Time

Lead Department(s): DDS

The one-time investment supports the initial planning process to update the regional center fiscal system and implement a statewide Consumer Electronic Records Management System.

- a. Uniform Fiscal System – The current information technology systems for billing and case management are disjointed and unable to quickly adapt to changing needs given the age of the systems and lack of standardization. Changes require DDS and regional centers to create and apply patches independently to each individual regional center (RC) system. The process for reporting data from the regional centers to the department is delayed, resulting in significant data lags that can delay identification of problems and hinder decision-making given outdated information. The existing fiscal system was implemented in 1984. Replacement of the RC fiscal system, which processes provider payments, will improve efficiencies as the system is modernized and provide more detailed expenditure data consistent with CMS payment system expectations.
- b. Consumer Electronic Records Management System – The regional centers do not have a statewide standardized client case management system. Securing timely and accurate data is extremely challenging due to system differences. Additionally, there is not an outward-facing option for self-advocates and families to access their information, such as IPPs, current authorizations, appointments, outcomes data, etc.; instead, that information is being delivered by mail or email. This proposal will increase the availability and standardization of information to include, measures/outcomes, demographics, service needs, special incident reports, etc.

Lastly, the system will allow consumers, via the web or app, to access their records. This investment will also support the efforts to develop an outcomes-based system for purchase of services.

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*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

DDS has gathered preliminary stakeholder feedback, assembled an internal team that will lead this initiative and will develop an operational plan for this multi-year effort, including State of California's information technology protocols.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

The 2021-22 budget for DDS identified the initial multi-year funding for this effort. Additional resources will go through the State of California's budgeting process for information technology projects.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

#### **Access to Technology for Seniors and Persons with Disabilities**

Funding: \$50M enhanced federal funding (\$50M TF) One-Time

Lead Department(s): CDA

This initiative includes \$50 million to fund the Access to Technology Program for Older Adults and Adults with Disabilities pilot program. The purpose of this program is to provide grants directly to county human services agencies that opt to participate in the pilot program and to increase access to technology for older adults and adults with disability in order to help reduce isolation, increase connections, and enhance self-confidence. California proposes to pay for devices, training, and ongoing internet connectivity costs for low-income older and disabled adults for two years, as part of the activity to provide Access to Technology for Seniors and Persons with Disabilities. Internet connectivity will enhance, expand, and strengthen HCBS services and outcomes by providing low-income older adults and individuals with disabilities in community settings access to vital services on-line such as telehealth, social engagement/isolation prevention, and information about services in their communities such as nutrition, transportation, and long-term services and supports.

Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

Nothing to report.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for these one-time expenditures.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

**Senior Nutrition Infrastructure**

Funding: \$40M enhanced federal funding (\$40M TF) One-Time

Lead Department(s): CDA

This initiative includes \$40 million to fund capacity and infrastructure improvement grants for senior nutrition programs under the Mello-Granlund Older Californians Act. The grants shall prioritize purchasing, upgrading, or refurbishing infrastructure for the production and distribution of congregate or home-delivered meals, including, but not limited to, any of the following: Production-scale commercial kitchens; warming, refrigeration, or freezer capacity and equipment; food delivery vehicles; improvements and equipment to expand capacity for providers of meals; and technological or data system infrastructure for monitoring client health outcomes. Congregate meals sites are based in the community, offered in senior centers, schools, churches, farmers markets, and other community settings. In addition to a hot meal, congregate meals in the community offer participants opportunities for socialization and building stronger informal support networks in the communities in which participants live. Grants are intended to be awarded through Area Agencies on Aging (AAAs). All contracted meal-providers and AAAs are directed to work collaboratively to develop a coordinated and consolidated request for proposal on behalf of each Planning and Service Area to obtain funding through this grant program. CDA may make additional grants, to CBOs or local governments, if needed to ensure equitable access to funds. California does not plan to pay for major building modifications or ongoing internet connectivity as part of the Senior Nutrition Infrastructure activities.

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Quarterly Report for Quarter 2 of FFY 2021-2022

*1. Please provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS.*

Nothing to report.

*2. States should explain how they intend to sustain such activities beyond March 31, 2024.*

Nothing to report as yet for these one-time expenditures.

*3. Updates or modifications to the quarterly HCBS narratives concerning California's HCBS initiatives should be highlighted for ease of CMS review.*

Nothing to report.

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