HCBS Integration Planning Workgroup

HCBS Integration Planning Workgroup Kickoff

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Note: These materials are pre-decisional and subject to change pending State budget and policy considerations

May 2, 2025

Meeting Purpose and Agenda

Purpose: Kickoff the HCBS Integration Planning Workgroup by discussing the goals and purpose of the Workgroup and setting expectations for collaboration within DHCS, CDA, and CDPH. Discuss federal authorities for HCBS integration and options to integrate select HCBS waivers into managed care.

Today's agenda:

Time Allocated	Topic
9:00 – 9:25 am	Welcome and introductions
9:25 – 9:35 am	Overview of Medi-Cal HCBS managed care integration
9:35 – 9:40 am	Workgroup expectations
9:40 – 10:00 am	DHCS's goals to expand access and authorities to do so
10:00 – 10:25 am	Options and considerations to integrate select HCBS waivers into managed care
10:25 – 10:30 am	Next steps and wrap up

Welcome and Introductions

Joseph Billingsley

Assistant Deputy Director, Health Care Delivery Systems, DHCS

Denise Likar

Deputy Director of the Division of Home and Community Living, CDA

Kaye Pulupa

Special Programs Section Chief, HIV Care Branch, Office of AIDS, CDPH

Patricia Rowan

Principal Researcher, Mathematica

Meg Maxwell

Senior Managing Consultant, Mathematica

Workgroup introductions

Name, role, organization (if applicable)

Project Roles

- **Department of Health Care Services (DHCS)**
  - Lead state agency responsible for administering the Medi-Cal program
- **California Department of Aging (CDA)**
  - Sister state agency responsible for operating the Multipurpose Senior Services Program (MSSP)
- **California Department of Public Health (CDPH)**
  - Sister state agency responsible for operating the Medi-Cal Waiver Program (MCWP)
- **Mathematica**
  - DHCS contractor supporting HCBS integration planning

Overview of Medi-Cal HCBS Managed Care Integration

Goals for Integrating HCBS Programs into Medi-Cal Managed Care Plans (MCPs)

- Strengthen California's success in rebalancing its long-term services and supports (LTSS) system toward HCBS by giving MCPs the ability and incentive to offer members home and community-based alternatives to institutional long-term care
- Integrate and coordinate members' LTSS with health care services covered by MCPs
- Place accountability with one entity (the MCP) for LTSS member outcomes (access, quality, costs)
- Create greater financial predictability of Medi-Cal HCBS costs by including them in managed care capitation rates

Multi-year Roadmap to Move Select HCBS Programs into Managed Care

- Roadmap will include specific steps to transition select HCBS programs into managed care and associated timelines
  - Informed by the HCBS Gap Analysis report
- Preliminary recommendations were reviewed with DHCS leadership and relevant sister departments in January 2025
- Continued input from stakeholders will inform Roadmap development and implementation of the Medi-Cal HCBS transition to managed care

Medi-Cal HCBS Program Integration into Managed Care: Current Plans

- HCBS programs under consideration for managed care integration
  - Multipurpose Senior Services Program (MSSP)
  - Home and Community Based Alternatives (HCBA)
  - Assisted Living Waiver (ALW)
  - Medi-Cal Waiver Program (MCWP)
- HCBS programs not currently planned for managed care integration, but will require coordination with managed care:
  - In-Home Supportive Services (IHSS)
  - California Community Transitions (CCT)
  - Programs for individuals with developmental disabilities, including the HCBS-DD waiver and the Self-Determination Program

Workgroup Expectations

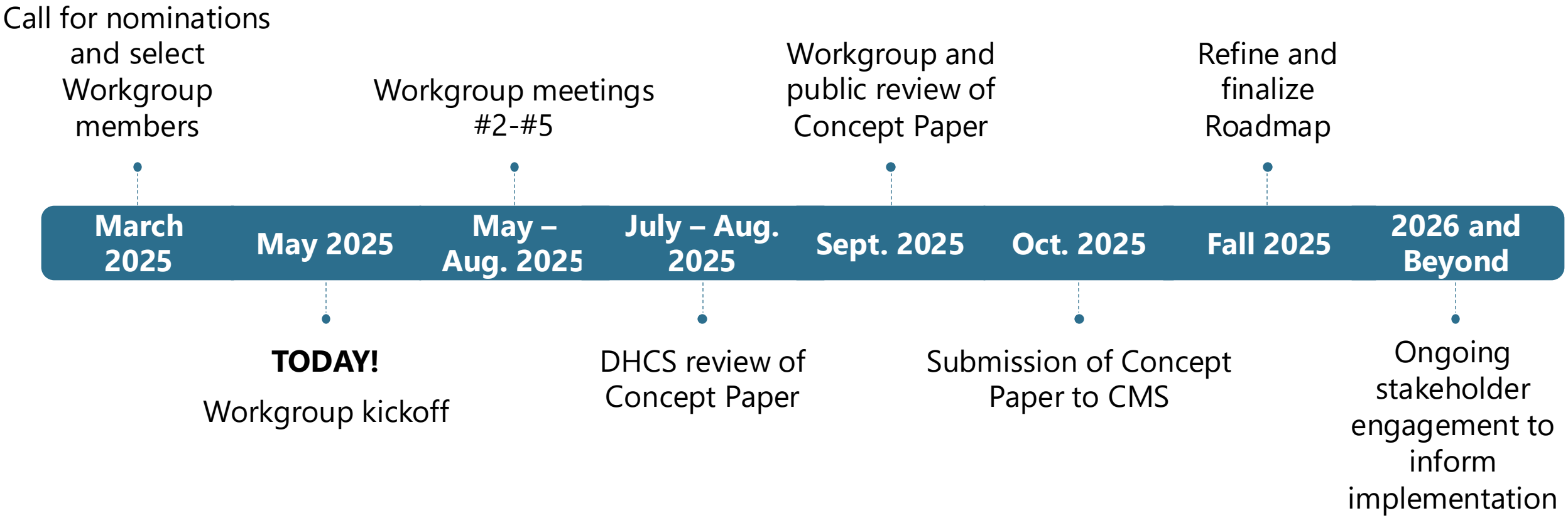
Workgroup Purpose

- Provide feedback on design decisions and implementation considerations related to the integration of select Medi-Cal HCBS programs into managed care
- Each meeting will be used to discuss key features to inform direction for HCBS integration
  - The project team will meet with agency leadership regularly to share the recommendations emerging from the Workgroup
  - Feedback from the Workgroup will also inform the Multi-year Roadmap and a Concept Paper that will outline plans and steps for the state's HCBS transition to managed care

Workgroup Meetings

- Meetings scheduled approximately monthly
  - All meetings will be held virtually via Teams
  - Meeting agendas and pre-reading materials will be prepared and shared in advance to ensure a productive meeting
- Rules of engagement
  - Attend and actively participate in meetings
    - Represent your organization's views, and share your own experience and concerns
    - Alert HCBSGapAnalysis@dhcs.ca.gov if you're unable to attend a Workgroup meeting
  - Review meeting materials in advance of each meeting and come prepared with questions and considerations

Workgroup Timeline



Workgroup Schedule for First Five Meetings

Session	Date and Time
Session 1	May 2, 2025, 9:00 – 10:30 am PT
Session 2	May 13, 2025, 9:00 – 10:30 am PT
Session 3	June 18, 2025, 10:00 – 11:30 am PT
Session 4	July 16, 2025, 10:00 – 11:30 am PT
Session 5	August 12, 2025, 10:00 – 11:30 am PT

Please email Anna Ostrander (Anna.Ostrander@dhcs.ca.gov) if you are missing any meeting invitations.

DHCS's Goals to Expand Access to HCBS and Authorities to Do So

Barriers to Accessing HCBS in California

» The Gap Analysis report revealed broad and program-specific access gaps

- Gaps in how individuals receive information about HCBS programs
  - Examples: limited referrals, inaccessible program information hindering individuals' knowledge of programs
- Gaps in how individuals enroll in HCBS programs due to opaque, inaccessible, and variable enrollment steps
  - Example: some HCBA waiver agencies require specific application components to be sent only by fax or mail; there is no online option, and accessing a fax machine or the materials and transportation needed for physically mailing a document can be challenging
- Gaps in accessing providers and services once members are enrolled in waivers and programs
  - Example: individuals enroll in ALW from waitlist only to be added to another provider-run waitlist for an ALW bed

How Can Managed Care Integration Expand Access to HCBS?

- Including institutional care and HCBS as managed care covered services gives managed care plans (MCPs) the ability to substitute HCBS for more costly institutional care
  - When only institutional care is carved in, plans have less ability to provide HCBS to people who meet institutional level of care; including HCBS as covered services allows plans to provide lower cost services in the community
  - DHCS could create additional financial incentives to continue rebalancing toward HCBS
  - MCPs can use enhanced care management (ECM) and community supports (CS) to support individuals at-risk of institutionalization who cannot get immediate access to HCBS waiver services
- Reductions in institutional spending could allow for slowly increasing waiver slots over time

Federal Authority Options for Expanding Access to HCBS

Flexibilities/Requirements	1915(i)	1915(c)	1115 Demonstration*	1905(a) State Plan authority**
Can cover populations below an institutional level of care?	Yes	No	Yes	Yes
*Can expand financial eligibility limits?****	No***	Yes	Yes	No
Can target populations?	Yes	Yes	Yes	No
Can waive statewideness?	No	Yes	Yes	No
Can cap enrollment?	No	Yes	Yes	No
Can establish individual spending limits?	No	Yes	Yes	No
HCBS regulations apply?	Yes	Yes	Yes	No
Must be cost or budget neutral?	No	Yes	Yes	No

*CMS may direct the state to use an HCBS-specific authority unless the state's goals can only be achieved through an 1115 demonstration.
**Some 1905(a) state plan benefits are more limited in amount, scope and duration than HCBS authorities.

***SMDL 21-004 describes additional flexibility to expand financial eligibility for people who need HCBS based on the "construction rule."
Note that there are other flexibilities available to states to expand access to HCBS, but those flexibilities are not as relevant to DHCS's needs.

Key Differences Between 1915(i) and 1915(c) HCBS Authorities

- Unlike 1915(c) authority, 1915(i) state plan authority can be used to serve people who do not require an institutional level of care
  - States are required to establish needs-based eligibility criteria for 1915(i) that are less stringent than the existing state-established criteria to meet institutional level of care*
- Unlike 1915(c) authority, states cannot cap enrollment under a 1915(i) or set individual spending limits
  - 1915(i) authority creates a statewide entitlement that is available to anyone who meets the needs-based criteria and has an income below 150% of the FPL**

Key Takeaway: 1915(i) authority would create a statewide entitlement without the ability to cap enrollment or per-person spending **leading to significant budget implications**

*In 2020, 16 states (plus D.C.) operated a 1915(i) state plan HCBS option and 46 states (plus D.C.) operated at least one 1915(c) waiver.

**CMS has recently described an option under all HCBS authorities - including 1915(i) - to increase income and resource limits to align with that of 1915(c) waivers. See SMD #21-004 for more information.

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Use of Managed Care Authorities for HCBS

Option	Considerations
1. Operate HCBS 1915(c) waiver(s) concurrently with the existing 1915(b) waiver Most common approach	• Allows mandatory enrollment and selective contracting with MCPs • CMS approval timeline is 90 days • Federal approval for 5 years if dually eligible individuals are enrolled • Cost effectiveness requirements apply • Builds upon recent transitions to consolidate managed care delivery system programs
2. Amend CalAIM 1115 demonstration special terms and conditions	• Allows mandatory enrollment and selective contracting with MCPs • Opportunity to streamline administration, oversight, and monitoring • Federal approval is typically for 5 years • Budget neutrality requirements apply

Of the 22 states that cover at least some HCBS under managed care, 11 states use concurrent 1915(b)/(c) waivers, nine states use 1115 demonstrations, and two states use some combination of both.

Federal Authority for HCBS Integration

- The state is gravitating toward operating HCBS 1915(c) waiver(s) concurrently with California's existing 1915(b) waiver
- Rationale for 1915(b)/(c) concurrent authority
  - Common authorities used by other states with managed LTSS programs
  - New CMS administration policy priorities for 1115 demonstrations are still unknown, adding complexity to this authority option
  - Limits administrative complexity of CMS review and approval

Discussion Question: Are there other factors DHCS, CDA, and CDPH should consider to determine which federal authority to use for HCBS integration?

Note that during a future meeting, we will discuss enrollment caps with stakeholders

Options and Considerations to Integrate Select HCBS Waivers into Managed Care

Key Decision: Maintain or Blend HCBS Waiver Programs Selected for Managed Care Integration?

The state could take two approaches:

Option 1	Option 2
"Lift and shift" approach • Amend the four existing HCBS waivers to require individuals in the HCBS programs to receive services through managed care plans under the state's existing 1915(b) managed care waiver.	"De novo" waiver • The new waiver could include some combination of the existing services that are available under the current waivers, though new services could also be considered. • The new waiver could be a "blank slate", though DHCS, CDA, and CDPH could choose for the waiver to share some/many of the characteristics of the existing waivers, as appropriate. • The new 1915(c) waiver would be designed to operate concurrently with existing 1915(b) managed care waiver.

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Option 1: Lift and Shift Approach

- Maintain the four existing 1915(c) waivers, but transition to operating them concurrently with the 1915(b) waiver in managed care
- Strengths
  - Can more easily make incremental changes (e.g., enrollment caps, service packages) as budget permits to expand access to services to address gaps
  - Can continue to design service packages and establish cost limits based on the unique needs of target populations
  - Can maintain current waivers and use a geographic or single waiver phased integration approach for managed care implementation
  - Can make modifications using waiver amendments instead of developing a new waiver application
  - Would shift some of the burden of building systems to comply with the Access Rule onto managed care plans

Option 1: Lift and Shift Approach, cont'd

» Limitations
  - DHCS would continue to be responsible for determining eligibility and enrollment in waivers, but it could be administratively and operationally challenging for MCPs to operate four separate waivers with different services, provider networks, service limitations, and eligible provider types

» Timeline
  - Go-live no sooner than January 1, 2028

Option 2: De Novo Waiver

- Design a new 1915(c) waiver that would operate concurrently with the 1915(b) waiver
- Strengths
  - Designing a new waiver gives DHCS, CDA, and CDPH a "blank slate" to design a new program that can share characteristics with the existing waivers but may be better designed to meet the needs of Medi-Cal members who are receiving, or in need of, HCBS
  - MCPs will only need to administer one new HCBS waiver instead of four
  - Could be designed to streamline some of the administrative challenges of the current programs (e.g., billing codes, data sharing requirements)

Option 2: De Novo Waiver, cont'd

» Limitations

- Designing a waiver that meets the needs of multiple populations with differing needs is complex
- Would increase administrative burden on DHCS to determine eligibility and enrollment
- Designing a new waiver would likely require more lengthy negotiations with CMS*
- Fee schedule changes will likely be needed for new or modified services
- DHCS, CDA, CDPH, and providers will need to update policies, procedures, materials, IT systems, and the Medicaid Management Information System (MMIS) to align with new program changes

*If some individuals are transitioning from existing waivers to the new waiver, CMS will also require a written transition plan (See page 57 of the 1915(c) Technical Guide.)

Option 2: De Novo Waiver, cont'd

- Designing the new 1915(c) waiver involves waiver design decisions and working through managed care implementation approaches
  - Key waiver design decisions include: which population(s) to serve; which services to offer and how services are offered*; geographic offering; individual cost limits and average per capita cost targets to meet cost-neutrality requirements; enrollment caps
- Timeline
  - Timeline for go-live date would be determined based on inputs throughout the design process as well as timeline for federal review and approval
    - Assuming the design phase would last through Q1 2026, go live would be no sooner than Q1 2028

*Similar services are currently offered in different ways under different waivers; DHCS will need to align services across waivers for services that will be included in the de novo waiver.

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Discussion: Maintain or Blend HCBS Waiver Programs Selected for Managed Care Integration?

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Discussion Question: What are the advantages and disadvantages of the two options?

Next Steps

- HCBS Integration Planning Workgroup session #2: May 13, 2025 from 9:00-10:30am PT
- Contact the team with questions, suggested topics for discussion, or other input
  - **HCBSGapAnalysis@dhcs.ca.gov**