



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



GAVIN NEWSOM
GOVERNOR

September 17, 2021

Centers for Medicare & Medicaid Services
Department of Health & Human Services
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Baltimore, MD 21244-1850

IMPLEMENTATION OF THE AMERICAN RESCUE PLAN ACT (ARPA) OF 2021
SECTION 9817: ADDITIONAL SUPPORT FOR MEDICAID HOME AND
COMMUNITY-BASED SERVICES (HCBS) DURING THE COVID-19 EMERGENCY

Submitted electronically via HCBSincreasedFMAP@cms.hhs.gov

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), the Department of Health Care Services (DHCS), in its role as the single state agency administering Medicaid in California, submitted its Initial HCBS Spending Plan Projection and Initial HCBS Spending Plan Narrative for California's home and community-based services on July 12, 2021.

By letter dated September 3, 2021, CMS conveyed to California that one initiative was denied, some initiatives were approved, and certain other initiatives were partially approved pending additional information requested.

To reflect the denial and incorporate California responses to CMS' additionally requested information, DHCS hereby submits its updated Initial HCBS Spending Plan Projection and updated Initial HCBS Spending Plan Narrative.

In compliance with the requirements of ARPA Section 9817 and in accordance with SMD Letter #21-003, 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 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.

Sincerely,

Original signed by

Jacey Cooper
State Medicaid Director
Chief Deputy Director
Health Care Programs

Enclosures: California's Initial HCBS Spending Plan Projection and Initial HCBS Spending Plan Narrative, as updated and consistent with CMS' September 3, 2021 directives.

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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)**

Initial HCBS Spending Plan Projection

Originally Submitted on July 12, 2021

Updated on September 17, 2021

Introduction

As directed in State Medicaid Director letter #21-003, this document provides an estimate of the total amount of funds attributable to the increase in FMAP that the state anticipates claiming between April 1, 2021, and March 31, 2022, as well as anticipated expenditures for activities the state intends to implement to enhance, expand, and strengthen HCBS. Along with this document, the Department is providing a spending plan narrative to provide additional detail on anticipated expenditures for new activities.

Estimate of Funds Attributable to Increased FMAP Anticipated to Be Claimed

As shown in Table 1, the Department of Health Care Services (DHCS) estimates that it will claim approximately \$3 billion attributable to increased FMAP for the quarters from April 2021 through March 2022.

Table 1. Estimate of Increased FMAP Anticipated to Be Claimed

<i>(In Millions)</i>	Federal Fiscal Year 2021 ^a		Federal Fiscal Year 2022 ^a		Total	
	Total Estimated Spending on Eligible Services	Estimated Increased FMAP	Total Estimated Spending on Eligible Services	Estimated Increased FMAP	Total Estimated Spending on Eligible Services	Estimated Increased FMAP
Line 12 - Home Health Services ^c	\$178.5	\$17.7	\$122.2	\$12.1	\$300.7	\$29.8
Line 19A - Home- and Community-Based Services - Regular Payment (Waiver) ^c	\$4,210.3	\$420.9	\$2,964.3	\$296.4	\$7,174.6	\$717.3
Line 19B - Home- and Community-Based Services - State Plan 1915(i) Only Payment	\$881.5	\$88.1	\$597.3	\$59.7	\$1,478.8	\$147.9
Line 19C - Home- and Community-Based Services - State Plan 1915(j) Only Payment	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0

<i>(In Millions)</i>	Federal Fiscal Year 2021 ^a		Federal Fiscal Year 2022 ^a		Total	
Service Category ^b	Total Estimated Spending on Eligible Services	Estimated Increased FMAP	Total Estimated Spending on Eligible Services	Estimated Increased FMAP	Total Estimated Spending on Eligible Services	Estimated Increased FMAP
Line 19D - Home- and Community-Based Services State Plan 1915(k) Community First Choice	\$4,829.3	\$482.9	\$4,765.7	\$476.6	\$9,595.1	\$959.5
Line 22 - Programs of All-Inclusive Care for the Elderly	\$448.6	\$44.9	\$478.6	\$47.9	\$927.2	\$92.7
Line 23A - Personal Care Services - Regular Payment	\$2,298.2	\$229.8	\$2,346.7	\$234.7	\$4,645.0	\$464.5
Line 23B - Personal Care - SDS 1915(j)	\$207.5	\$20.8	\$211.9	\$21.2	\$419.4	\$41.9
Line 24A - Targeted Case Management Services - Community Case Management	\$360.6	\$36.1	\$329.6	\$33.0	\$690.2	\$69.0
Line 24B - Case Management Statewide	\$37.2	\$3.7	\$34.0	\$3.4	\$71.3	\$7.1
New Line - Managed Long-Term Services and Supports	\$406.2	\$40.6	\$359.9	\$36.0	\$766.2	\$76.6
New Line - Rehabilitative Services ^c	\$2,534.5	\$212.4	\$2,245.7	\$188.2	\$4,780.1	\$400.7
New Line - School Based Services	\$104.7	\$10.5	\$92.8	\$9.3	\$197.5	\$19.8
TOTALS	\$16,497.3	\$1,608.4	\$14,548.8	\$1,418.4	\$31,046.1	\$3,026.8

a. Amounts are presented on an accrual basis. Providers have up to one year to submit claims so actual claiming will likely occur over a longer time period.

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

c. 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 outlines anticipated 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 document. Note that amounts are approximate and subject to updates in the coming months as increased FMAP is claimed and new expenditures are ramped up.

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

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

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)

Initial HCBS Spending Narrative

Originally Submitted on July 12, 2021

Updated on September 17, 2021

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OVERVIEW

Introduction

As directed in CMS' "Implementation of American Rescue Plan Act of 2021 Section 9817" letter, dated May 13, 2021 (State Medicaid Director (SMD) Letter #21-003), this document provides information on the state's required activities under Section 9817 of the American Rescue Plan Act of 2021 (ARPA). Along with this document, the Department is providing a spending plan projection that provides quantitative information about estimated total funds attributable to the increase in federal medical assistance percentage (FMAP) that the state anticipates claiming, as well as a summary of estimated expenditures on items described in this document.

California's proposed spending plan builds on the bold health and human services proposals included in [California's Comeback Plan](#) by expanding on or complementing the proposals to further achieve improved outcomes for individuals served by the programs. These proposals independently provide historic one-time investments to build capacity and transform critical safety net programs to support and empower Californians. Taken together, these investments advance the health and well-being of our entire state, promoting economic mobility and overall social stability.

Home and Community-Based Services (HCBS) are types of person-centered care delivered in the home and community. A variety of health and human services can be provided in this way. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities. This includes individuals who may have a disability, including a serious behavioral health condition, and seniors.

These programs and services further California's commitment to community living for all, rooted in both the Olmstead Supreme Court decision of 1999 and in California's values of inclusion, access, and equity. This spending plan alongside the 2021 state budget lays the foundation to make this commitment a reality, changing the life trajectory of children so they grow up to be healthier—both physically and mentally—and better educated with higher paying jobs and lower rates of justice involvement. It empowers older adults and people with disabilities to thrive in homes and communities of choice, and it includes proposals that lift homeless and formerly-incarcerated Californians to build back stronger and more resilient.

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. States must 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.

A state may claim the increased FMAP for the following expenditures:

- Home Health and Private Duty Nursing
- Personal Care
- Case Management
- Certain School-Based Services
- Behavioral Health Rehabilitative Services
- 1915c Waiver Services
- 1915(i) State Plan Services
- Program of All-inclusive Care for the Elderly (PACE)
- Managed Long-Term Services and Supports (MLTSS)

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.

The time period allowed to expend funds attributable to the increased FMAP will provide states with sufficient time to design and implement short-term activities to strengthen the HCBS system in response to the COVID-19 Public Health Emergency (PHE), as well as longer term strategies to enhance and expand the HCBS system and to sustain promising and effective programs and services.

Examples of activities that states can initiate as part of this opportunity include, but are not limited to:

- New and/or additional HCBS
- Payment Rates
- HCBS workforce recruitment or training, expanding provider capacity
- Assistive technology, including access to additional equipment or devices
- Community transition and coordination costs
- Expanding HCBS capacity
- Support for individuals with HCBS needs and their caregivers
- Building No Wrong Door systems
- Quality Improvement activities
- Reducing or eliminating HCBS waitlists
- Institutional diversion
- Addressing social determinants of health (SDOH) and health disparities
- Enhancing care coordination

- Creating incentives for managed care plans or providers to develop partnerships with social service agencies, counties, housing agencies, public health agencies, and/or community-based organizations
- Testing alternative payment methodologies or the delivery of new services that are designed to address SDOH that may include housing-related supports such as one-time transition costs, employment supports, and community integration, among others

CMS indicates that states are not limited to using state funds equivalent to the amount of the increased FMAP for services that are otherwise covered in Medicaid; however, Federal Financial Participation (FFP) is only available for covered services.

To demonstrate compliance with the prohibition on supplanting existing state funds expended for Medicaid HCBS, states must:

- Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021
- Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021
- Maintain HCBS provider payment at a rate no less than those in place as of April 1, 2021

CMS requires participating states to submit both an initial and quarterly HCBS spending plan and narrative to CMS 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. States must submit the initial HCBS spending plan and narrative by June 12, 2021, or receive a 30 day extension, to July 12, 2021. CMS will review and approve the initial state spending plan and narrative within 30 days of a state's submission.

Home and Community-Based Services Spending Plan

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, 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 which are designed to begin addressing the health, economic, and racial inequities that were exacerbated by the 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. Furthermore, these services are person-centered and 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. Taken together, these investments advance the health and wellbeing of all

Californians, as well as their social and economic mobility. Furthermore, the investments made using these funds will help revamp and reimagine stale programming and administrative practices, helping shuttle California into a more modern and forward leaning set of practices focused on outcomes and value.

This document serves as a multi-department proposed HCBS Spending Plan, including 30 initiatives, totaling approximately \$3B in enhanced federal funding for the following 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

This HCBS Spending Plan will invest in a number of initiatives, across a range of state HCBS programs to build a modern, inclusive HCBS system that provides robust health and human services to California's most vulnerable residents, in their communities, in ways that ensure that California's HCBS workforce has the training and support necessary to provide the highest level of service to those in their care. This spending plan reflects stakeholder feedback, incorporating a number of suggestions from advocates, providers, consumers, caregivers, community-based organizations, managed care plans, and foundations, provided from March through June 2021. The state's spending plan also reflects priorities from the state Legislature. Further, the initiatives included in this 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): DSS, with DHCS

In consultation with stakeholders, the State 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. More specifically:

- Building on the state budget investments to transform California's behavioral health system and to address the housing needs of those that are currently

unsheltered, IHSS providers will gain additional competencies in meeting the behavioral health needs of those they support through this effort.

- Pilot projects will also build capacity for IHSS providers to serve recipients with Alzheimer's or related dementia. The Master Plan for Aging indicates that by 2025, the number of Californians living with Alzheimer's disease will increase 25% from 670,000 today to 840,000 in 2025. Most persons with Alzheimer's or related dementia live at home, in the community, relying on a network of family caregivers and home care providers.
- Finally, pilot projects will focus on meeting the needs of IHSS recipients who are severely impaired.

This furthers the \$200 million included in the state budget to incentivize, support and fund career pathways for IHSS providers, allowing these workers to build their skills to better serve IHSS recipients and/or obtain a higher-level job in the home care and/or health care industry.

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 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 State 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.

This proposal includes funding to support county IHSS programs and/or IHSS Public Authorities, which 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.

Finally, this proposal includes automation and state operations costs to support CDSS' implementation of the efforts described above, as well as the costs for a contractor to evaluate the effectiveness of the efforts (e.g. in terms of provider retention and recipient satisfaction).

Direct Care Workforce (non-IHSS) Training and Stipends

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

Lead Department(s): CDA, with DHCS, DSS, OSHPD

Direct care jobs are central to the economy: they are the largest (approximately 696,000 jobs) and fastest growing occupation in the State. Direct care is also essential to aging and disabled adults maintaining health and well-being while living at home; especially during the pandemic, direct care workers have provided critical care for adults staying home and staying safe from COVID-19. However, these care economy jobs often have limited training, compensation, and career paths and, as a result, inequitably burden the women, immigrants, and people of color who largely perform this work. These sector challenges also can lead to HCBS program providers and care recipients experiencing high turnover and staffing shortages. A new statewide Direct Care Workforce Training and Stipends Program – leveraging on-line learning innovations, rooted in adult learner principles, and delivered in multiple languages with cultural competency – will be provided to direct care workers caring for adults in HCBS (non-IHSS) programs. A statewide Direct Care Workforce Training and Stipends Program provides the foundation for and drives many positive outcomes in HCBS. For the direct care worker, these benefits include increased skills, satisfaction, and retention, as well as opportunities to advance on career and wage ladders. For the older and/or disabled adult, including adults with severe and persistent behavioral health conditions, the benefits include increased health and well-being from high-quality care and the prevention of unnecessary institutionalization. This also furthers the state budget priority to incentivize, support, and fund career pathways for non-IHSS direct care HCBS providers, to build on their experience to obtain a higher-level job in the home care and/or health care industry.

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. (See SMD Letter #21-003, Appendix B, at pp. 14, 16, and 17 (referencing Home Health Care, Personal Care, Private Duty Nursing, and PACE services as allowable under ARPA section 9817 temporary increased FMAP funding).)

IHSS HCBS Care Economy Payments

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

Lead Department(s): DSS

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 (CMIPS) and would focus on payment for retention, recognition, and workforce development.

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-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 MSSP, CBAS, HCBA, ALW, HIV/AIDS Waiver, PACE, and 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.

Increasing Home and Community Based Clinical Workforce

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

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

Currently in California, there is a 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 meet specific

requirements, including that services be provided to the patient in his or her temporary place of residence or 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.

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 DSS and OSHPD

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). 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 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).

Traumatic Brain Injury (TBI) Program

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

Lead Department(s): DOR

The Department of Rehabilitation's (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 Medical 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 existing TBI sites and to award up to six additional TBI sites in unserved/underserved areas.

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. This will further the various aging proposals included in the state budget and help to deliver on the vision of the Master Plan for Aging, which calls for California communities to build a California for All Ages where people of all ages and abilities are engaged, valued and afforded equitable opportunities to thrive as we age.

Dementia Aware and Geriatric/Dementia Continuing Education

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

Lead Department(s): DHCS, with OSHPD, 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.

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, 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.

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.

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.

Home and Community-Based Services 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 DSS

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 to

on-going 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.

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.

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 and 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 CFR 438.6(b)(2).

Community Care Expansion Program

Funding: \$348.3M enhanced federal funding (\$348.3M TF) One-time
Lead Department(s): DSS

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.

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

The COVID-19 pandemic has masked and accelerated cognitive decline in older adults and increased the isolation and stress of older adults and caregivers living with dementia. More than 690,000 older adults and 1.62 million family caregivers in California are living with dementia, with women and people of color disproportionately susceptible to the disease and overwhelmingly providing the care. Dementia-capable services at licensed Adult Day and Adult Day Health centers provide services in the community vital to the health and well-being of diverse older adults and families, prevent institutionalization, and advance health equity. This furthers the recommendations of the Governor's Task Force on Alzheimer's Prevention and Preparedness.

Moreover, 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. Specifically, these dementia-capable services could include services listed in Appendix B of the SMD Letter #21-003, Long Term Services and Supports.

Older Adult Resiliency and Recovery

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

Lead Department(s): CDA

California's older adult population was the first demographic to be asked to stay-at-home, due to their high-risk of death from COVID-19. Since that population has been home for over a year, the need for services that are specific to isolation, health, and well-being at home have increased. The one-time augmentation of \$106 million, to be spent over three years (2021-22, 2022-23 and 2023-24), 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.

The state plans to pay for devices, training, and ongoing internet connectivity costs for low-income older and disabled adults, for two years, as part of the Older Adult Resiliency and Recovery (OARR) Digital Connections activities. 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, consistent with Appendix B in the SMD Letter #21-003 at p. 14 (referencing home health care and personal care services as eligible for ARPA section 9817 temporary increased FMAP). California does not intend to pay for room and board under the OARR activities.

Adult Family Homes for Older Adults

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

Lead Department(s): CDA, with 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. Moreover, this furthers the vision and recommendations of the Master Plan for Aging.

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.

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.

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.

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.

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 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 a mobile application that will be accessible to patients through smart phones, tablets or computers.

The Department proposes to start the pilot in January 2022 and continue the pilot 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).

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, DSS, CDA, OSHPD

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.

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 system. The process for reporting data from the regional centers to the department is delayed, resulting in significant data lags which 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 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.

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. (See Appendix B in SMD Letter #21-003 at p. 14 (referencing home health care and personal care services as eligible for ARP section 9817 temporary increased FMAP).)

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. 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 capital investments or on-going internet connectivity as part of the Senior Nutrition Infrastructure activities.

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