Department of Health Care Services

2022 Home and Community-Based Alternatives (HCBA) Waiver Renewal

Change Concepts

The Department of Health Care Services (DHCS) held the first of three HCBA Waiver Renewal Technical meetings on October 28, 2020. The meeting was attended by DHCS staff, workgroup members, and members of the public. The following change concepts were received from the public and technical workgroup members and have been organized by subject, DHCS has added indications where additional information is needed.

Recommended Change	Support	Concerns	DHCS Notes
Actionable Changes through Waiver Renewal			

1. Modify the requirement for including a social workers with at least a Master's degree (MSW) on every Care Management Team (CMT), to allow social workers with Bachelor's (BSW) degrees ***and*** medical and/or case management experience to provide Comprehensive Care Management (CCM) services (in partnership with a Registered Nurse (RN)), as long as they are supervised by an MSW
Variations:
• Community service worker to f/u on calls
• Allow other disciplines (e.g., gerontology, psychology) to provide CCM
	• Difficult to find MSW social workers, consider years of experience with populations
	• Waiver Agency cost saving
	• [Agencies have] successfully run other closely-related care management programs while employing bachelor's and master's-level trained social workers
	• Many of the more rural as well as the areas with higher-wage workers struggle to employee MSWs and would benefit from hiring other qualified staff
	• After administering the program for over two years, we have seen that the duties of the social worker could be effectively completed by a bachelor's level staff and have seen no specific duties that would be specific to an MSW
		• There have been instances where beneficiaries are "Care Managed" by the MSW who is not looking to the Level of Care (LOC), nor appropriately authorizing services to "meet the medical care needs" of the Waiver participant. The RN needs to be the case manager.
		  ○ Allowing "community service workers/interns" to provide medical case management is like a "Candy Striper" triaging a patient in a hospital. Issues get missed and the clients are put at potential risk.
			Options:
			• MSW supervising BSW
			• MSW supervising individuals with related degrees (e.g., gerontology, psychology)
			• Option 1 or 2 ***and*** allow community service workers/interns to make follow up calls
			
			Related decisions:
			• What is the appropriate ratio for supervision?
			• How many years/ hours of experience should be required?
			  ○ What kind of experience?
			• Which degrees should be allowed from "related fields"?

2. Gastrosmy trained respite workers (GTRW) should be available as service providers. It is a new classification of health professional and vendorized		• As a parent of a ventilator dependent / G-tube dependent child, I understand that parents may choose to utilize a Waiver Personal Care Services (WPCS) provider	• The HCBA Waiver must honor the standards of practice and licensure requirements of providers.

Recommended Change	Support	Concerns	DHCS Notes
under Regional Centers. Governor Duekmajian signed this legislation that we worked on back in the 1980s. This allowed home health agencies to train non licensed staff to provide both tube feeding and medication via a G-tube due to a shortage of LVNs. I believe it is vendor code 862 under Regional Centers.		instead of an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Licensed Vocational Nurse (LVN) when no LVN staffing is available. Having some help is better than having no help at all where no nursing agencies accept pediatric patients. But I am opposed to substitution of unlicensed care providers for EPSDT skilled nursing services that children under 21 are entitled to, under both federal EPSDT policies and the I.N. v. Kent. I am also opposed to any extension of the existing G-tube policy to patients with tracheostomy / invasive ventilation / noninvasive ventilation. Ventilator dependent children are extremely medically fragile, and the main priority in staffing these cases should be finding ventilator trained LVNs. • The GTRW would not be able to work with vent dependent children or adults b/c of complexity of necessary care. • Concerned about the interplay of the I.N. v. Kent settlement regarding home nursing care with substitution of a lower skilled care provider. Don't include language that undermines the I.N. v. Kent settlement.	○ Orders for WPCS workers must fall within the defined scope of WPCS in the HCBA Waiver, which does not include suctioning, g-tube care, medication administration, etc.
3. Modify the home set-up service so it can be utilized by those living in the community, when they require goods or services to make their home safe (i.e., to purchase smoke detectors/carbon	• Have seen success in the Multipurpose Senior Services Program (MSSP) Waiver, keeps individuals safe in home (e.g., grab bars, refrigerator for medication)	• Need clear guidance on home-set up costs that are the responsibility of property owners, as well as goods/services that are available under the State Plan: For example, Grab Bar Procedure	• Update the service description in the Waiver • Request for OIL [Operating Instruction Letter] (RFO) would be required to create a community cost cap for service, and

Recommended Change	Support	Concerns	DHCS Notes
dioxide detectors, cleaning products, clean linens, etc.)		Codes include: E0241= Bathtub Wall Rail, Each $14.62; E0243=Toilet Rail, each $42.76 • Should the cap be lower for people living in the community? • Should allowable home set-up costs be limited to specific items? • Difficult to define what is required for safety vs. not safety related (e.g., linens)	residence • Will need to develop clear distinctions on what would fall under one-time household set up
4. Remove restrictions to Habilitation and Respite for children – the services are not available through EPSDT; more information is available in the [EPSDT: A Guide for States](), published by the Centers for Medicare and Medicaid Services (CMS).	• Respite services would go a long way t help unpaid caregivers (parents & spouses) prevent burnout	• Potential for increasing the overall cost of the Waiver	• Remove age restrictions for Habilitation and Respite within Appendix C. • Would require a policy on order of fiscal responsibility (for example, for children receiving services through a Regional Center – respite would need to be obtained through the Regional Center first) • Habilitation will most likely only be medically necessary for youth transitioning from EPSDT to the HCBA Waiver, to prepare them for independent living.
5. Remove Transition Coordination from the Comprehensive Care Management per member per month (PMPM) payment so it can be paid based on the actual number of hours it takes to transition a person form a skilled nursing facility (SNF)	• Waiver Agencies could invoice for the actual number of hours of transition coordination they provide to an applicant (up to 180 days prior to a successful transition)	• Waiver Agencies would only be paid for costs and staff time for successful transitions, and for only 180 days prior to the date of transition • Waiver Agencies would provide transition services at their own risk because they would only be paid for services provided to individuals who successfully transition to the community. • The State would no longer include the	• Under the authority of Section 1915(c) of the SSA, the state does not have the same flexibility to pay providers for **un**successful transitions as it has under the Money Follows the Person (MFP) Demonstration / California Community Transitions (CCT)[1]. Other restrictions include: ○ The state can only pay providers for transition services provided after an

[1] The federal MFP Rebalancing Demonstration is known as CCT in California.

Recommended Change	Support	Concerns	DHCS Notes
		transition coordination amount in the PMPM for those people who are not transitioned from a SNF, as they are today.	applicant is discharged to a community-based residence. ○ The state cannot pay for transition coordination services that were provided outside of 180 days from the date of transition.
6. Allow non-medical transportation under one-time home set-up costs (when required to obtain legal documentation, sign leases, view an available residence, etc.) when required to secure housing			• Costs associated with pre-transition transportation required to secure housing would not be reimbursed unless the beneficiary successfully transitions and then for only 6 months (180 days) prior to the date of transition)
7. Add in Personal Protective Equipment (PPE) for independent nursing providers caring for HCBA Waiver participants. This could be one of the reasons that we are having difficulty recruiting nursing staff for those clients at home who are not affiliated with an "agency".		• Why isn't PPE available to Medi-Cal providers through the state plan?	The state did not anticipate the cost to providers for continuous PPEs when determining pay rates waiver services. • Cost analysis would be required, as well as a gap analysis to determine where PPE is not available to Waiver providers.
8. Additional services to be added to the waiver are as follows: • Congregate and/or Home Delivered Meals • Transportation to medical appointments • Purchased items such as incontinence supplies, gloves, PPE, home safety items	• Under the MSSP Waiver, all of these services are paid for (if the client has a verified need and cannot obtain these services through another means) • The client population in these two waivers [HCBA and MSSP are] … very similar and we've seen both a demonstrated need from our HCBA participants of such services as well as a demonstrated benefit when such services are provided to our MSSP clients	• As the payer of last resort, are any of these costs available to the beneficiary through the Medi-Cal State Plan (e.g., non-emergency, non-medical transportation required to establish housing)?	Transportation to medical appointments is covered under the Medi-Cal State Plan. • Room and board are not permitted to be covered under a 1915(c) waiver. • Authorization requirement/restrictions must be included in the Service Description in Appendix C of the Waiver to clearly identify that when these services are available to eligible participants through other systems, programs, or community-based organizations, they cannot be paid for by the Waiver.

Recommended Change	Support	Concerns	DHCS Notes
9. Require Waiver Agencies to do trainings and updates with the Congregate Living Health Facility (CLHF) they manage?	• Over the last 3 years with my Waiver Agency we just had our meet and greet last week	• This is already a requirement, it just needs to be enforced	• Waiver Agencies are already required to provide HCBA Waiver training to HCBS providers. HCBA Waiver Agencies do not “manage” CLHFs.
10. Clearly define requirements for the Circle of Support within the Waiver, and if a Circle of Support is required to be eligibility for the Waiver.			• “Circle of Support” is mentioned 70 times within the Waiver.
11. If a parent/spouse is authorized to provide RN or LVN services because they produce evidence that there are no other willing and qualified providers in the area, they must: 1) continue to look for, 2) attempt to secure, and 3) document their efforts to obtain, resources to meet the service needs of the participant. • They should have to submit the evidence of the search / efforts with each Treatment Authorization Request submittal.			
12. If a provider receives an overtime (OT) exemption for WPCS because the participant / authorized representative (AR) cannot find other care providers, they must continue to search for care providers and produce evidence to the state, upon request.			• How frequently would they be required to search for care providers? • What evidence would suffice?
Actionable Changes through the Waiver Agency Contract			
13. Allow overlapping service areas with multiple Waiver Agencies ***Variation:*** 14. Let patients choose what agency they would like to go to.	• Potential for participants to have access to more nurses • Allows greater freedom of choice	• Potential for Treatment Authorization Request (TAR) submission confusion for HCBS providers within areas with multiple Waiver Agencies • Today there is no question about who is responsible for working with a participant	• Would require a Waiver Agency Contract update • Would require a function within MedCompass for Waiver Agencies to verify if a beneficiary is working with another Waiver Agency

Recommended Change	Support	Concerns	DHCS Notes
		in each County/Zip Code – who will be held responsible for an applicant if multiple Waiver Agencies cover the same area?	• Under Title 22, more than one HHA can be involved in a case if they agree (Title 22, Section 74719).
15. Social isolation and loneliness assessments should be included during assessments so these issue can be included in the POT			• Social and geographic isolation are included as measures in the Care Management Acuity Tool; however, if additional information needs to be included to assess "loneliness" we can look at revisions to the tool.

16. Case Management Acuity levels shall not be tied to the Case Management PMPM payment. The Case Management PMPM payment shall be a flat rate	• The Case Management Acuity Tool does not accurately measure the amount of case management activities and staff time spent on clients
	• Several clients that are measured at an acuity level two require high levels of case management intermittently as well as more frequent home visits
	• It will be far more efficient for Waiver Agencies to budget for flat rates rather than fluctuating payments
	  • At the time that [we] applied to become a Waiver Agency, we budgeted for a mixture of 1-4 acuity levels, however, most of our clients are level 2 which has forced the County … to aid in funding this program
	• Staffing ratios are confusing since RNs and MSWs have a mix of level two and level three clients and do not see only one acuity level
	• The Plan of Treatment and Annual Assessments can be easily conducted on
			• Case Management Acuity Tool was developed to help the CMT assess and establish the Acuity Level that is the basis for the PMPM CCM payment. If done correctly it should indicate how much "care management" a member is requiring based on their unique strengths, supports, and risks.
			  ○ It is true that it is difficult to completely assess an individual's need for ongoing case management at intake. However, if the WA believes the case management acuity level is incorrect, they should complete the tool again when the CMT has a better understanding of the amount of time and attention they have been giving the participant (and if they expect that level of attention to continue).
			  ○ Because the needs of participants change over time, the Case Management Acuity Level should not be expected to remain static.

Recommended Change	Support	Concerns	DHCS Notes
	an annual basis and not tied to the client's acuity level o Assessments are conducted every time a client is in the hospital or has a major health change which is a more accurate and effective method to determine if a more frequent assessment or POT needs to occur		• Comprehensive Assessment do not need to be performed every time a patient is hospitalized, only when there is a major health change.
Actionable Changes through Program Policy, Process, or Systems Update			
17. Include time frames for intake screening and enrollment (those time frames within the control of the WAIVER AGENCY)		This is very difficult to accomplish consistently because there are many variables and contributors in the proves, including, but not limited to: • The responsiveness of the applicant / participant's Primary Care Physician (PCP) working with the beneficiary, family, Waiver Agency, or DHCS to work with the intake nurse? • How much will the applicant/authorized representative help in obtaining signed documentation and back to the WAIVER AGENCY/State? • How quickly can the Assessment be completed and a second level review be completed to verify the correct LOC? • Is the applicant still going in and out of the hospital? • Can we get all the documents we need? (DPOA, Release of Information - if necessary, etc.)	• Which time frame(s) are within the control of the WAIVER AGENCY and which ones are not?
18. Can we explore a WAIVER AGENCY mid-month transfer reimbursement rate?			• Payment processes (e.g., frequency of payment) are not included in the Waiver – this recommendation would be addressed within the Waiver Agency

Recommended Change	Support	Concerns	DHCS Notes
			Contract • Payments are based on the monthly eligibility feed from the MEDS system – as the system of authority • Waiver Agencies are encouraged to work with one another to negotiate transfers, which can include pro-rates transfers of PMPM payments.
19. Waiver Agencies need access to data (e.g., service authorizations, claims/payments) under different care systems for efficient and effective care management.			• This would be achieved through systems updates to MedCompass
20. Modifying capabilities with Med-Compass, Waiver Agencies have to create excel based reporting tools to track performance. (Administrative burden).	• Incorporate requirement for communication agreement.		• Not content to be included in the Waiver renewal – but this has been recorded as a requested program / system improvement
21. Need to improve consistency across Waiver Agencies for HCBS providers working with multiple – policies and procedures are inconsistent		• We agree with the concept, but are unclear about what is being requested as a change to the Waiver.	• What specific change to the Waiver would improve consistency across Waiver Agencies for the HCBS providers? • Could this be addressed through policies, training, and compliance?
22. If persons with IDD (Intellectual and Developmental Disabilities) are included information must be available in Plain Language, the CMS final Rule requires that PCPs are directed by the individual and they actively contribute to their person centered plan. Ensuring access and information is in plain language would help support those HCBA Waiver participants with IDD.			• The contract with the Waiver Agencies requires that Waiver Agencies provide person centered planning that includes "providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient."

Recommended Change	Support	Concerns	DHCS Notes
23. Computer program for WPCS that determines hours, need to be fixed. • Change the Waiver computer model so it doesn't come up with 110 hours/month for a fully disabled adult that everyone on the team says needs 360 hours/month. Don't force recipients and family to consider the appeal process to keep the disabled out of a care facility.	Live up to the Waiver mission the first time around. Do it right the first time. Don't force clients to the "Appeal" alternative. - Won't leave clients without the hours they need just because they don't understand how to appeal, don't have the energy to appeal or have been beat down to think they can't win.		• Unsure what is being referred here. There is no computer program that determines WPCS hours. WPCS hours are determined by the Waiver Agency nurses and based on the medical necessity of the beneficiary, while also accounting for other direct care services received outside of the Waiver. Waiver participants are limited to no more than 24 hours per day of direct care services, and Waiver Agencies must take this into consideration in approving WPCS requests, as WPCS is a direct care service. • If the concern is regarding the system that provides payment to WPCS providers, the payroll system is called CMIPS and is administered by the California Department of Social Services (CDSS). Most specific payment concerns are dealt with on an individual basis. If there is a prevailing concern with Case Management, Information, and Payrolling System (CMIPS), DHCS will need specific information regarding the issue, so that we can connect with CDSS to resolve it.
24. Can we get improvement on the length of time taken to approve/certify Residential Care Facilities for the Elderly (RCFE)? 25. We need to do a better job of informing healthcare plan providers about the 60 day straight to assessment option available for their patients to enroll in	•		These topics relate to Assisted Living Waiver (ALW) services

Recommended Change	Support	Concerns	DHCS Notes
the program. 26. The list of facilities would be better utilized with updated contact information for administrators (the application asks for this, so why not make it available on the updated list).			
Recommended Changes that Require Additional Information			
27. Allow Waiver Agencies to subcontract CMT and intake functions to other Waiver Agencies for specific beneficiaries or zip codes.			• What are the pros and cons of this recommendation? • Why is this change needed?
28. If an intake applicant is only assessed for WPCS services and has no other regular need for skilled care (e.g., Nursing), they should not be eligible for enrollment in the Waiver.	• As defined within the Social Security Act (SSA), eligible individuals are those people who would require care in an institution but for the services they receive under a 1915(c) waiver	• Some people only require WPCS to remain out of an institution because they are dependent on others for their Activities of Daily Living (ADL).	• May require legislative change. Need to consider Welfare & Institution Code (WIC), Section 14132.97(b)(3), which outlines the criteria an individual must meet in order to receive WPCS. One criteria is that, "The individual chooses…to receive waiver personal care services, *as well as* medically necessary skilled nursing services, in order to remain in his or her own home" (italics added). This criteria appears to indicate that the beneficiary cannot be receiving *only* WPCS, but defer to Legal's review.
29. Change WPCS from a distinct service to an extended service.	• Would ensure compliance with the service definition within the Waiver • As a Distinct service, WPCS must not duplicate In-home Supportive Services (IHSS). However, we know WPCS is	• Would require IHSS to max-out before WPCS could be authorized under the Waiver	• Would require a legislative change to WIC Section 14132.97(a)(2)(B), which requires that WPCS shall differ in scope from services that may be authorized

Recommended Change	Support	Concerns	DHCS Notes
	being used to provide "more" IHSS. One of the contributing factors is that it is often difficult to secure private duty nursing services.		under IHSS (WIC Section 14132.95 or 14132.952).
30. Merge Assisted Living Waiver Services into the HCBA Waiver ***Variation:*** 31. Consolidating the services of the HCBA Waiver, MSSP Waiver, and Assisted Living Waiver so that the various services through each waiver are fully available for Medi-Cal eligible adults with qualified functional needs to remain at home and avoid institutionalization	• Would reduce administrative burden • Would simplify access to 1915(c) waiver services	• There is little time to reconcile all of the differences between the administration of the waivers within the existing timeframe	• Would require Medi-Cal budget revisions • Would require amendment(s) to CA's WIC • Would require significant changes to the Waiver Agency Contract, in addition to the Waiver • Would require significant revisions to the Waiver that would need to be reconciled prior to Waiver renewal, which may not be possible within the existing time frame
32. Expand Waiver capacity and remove any extraneous criteria, such as age limits			• There are no age limits within the HCBA Waiver – though there are age restrictions for some services because they are available to youth under the age of 21 as EPSDT benefits, which is mandated by federal law.
33. Consider Including Federal COVID-19 Medicaid Regulatory Flexibilities to Strengthen the Service Delivery System and that afford the strongest consumer choice and protection. ***Variation:*** Add the consideration of allowing some assistive devices, given what we have seen during COVID-19			• All COVID-19 response flexibilities, or specific flexibilities? • Are there assistive devices that are not covered by the state plan? • What types of assistive devices?
34. Need to improve care coordination between service providers - to	• Structured standard way to work with managed care, in a way that won't be an		• Waiver Agencies are already required to coordinate all care, whether or not

Recommended Change	Support	Concerns	DHCS Notes
coordinate between medical, dental, and waiver care/services.	administrative issue • Consideration of behavioral health, some participants may have behavioral needs that may be met through other plans • Look at access to dental health, behavioral health (submitted by DHCS), to find if people are accessing this care if they need it. (care coordination)		covered under the HCBA Waiver—including dental and mental health—“The CMT works with the participant to identify and coordinate State Plan and HCBA Waiver services, and other resources necessary to enable the participant to transition to the community or remain in his or her own home.” • The timeframe that would be required to implement this recommendation across systems of care would extend beyond the waiver renewal timeline. The CalAIM initiative is working towards a similar goal with a target of 2026 for full-integration. • What specific changes to the Waiver would improve care coordination between service providers?
35. Flexibility in payment (who we pay, and what we pay for).	• Rural vs cities • Program flex		• Waiver service providers must be paid at least the State Medi-Cal rate
36. Include a generic option for a generic program flexibility to be developed as part of the overall rework of the HCBA Waiver. This generic program flex would be helpful in meeting new crisis that we have not anticipated yet and would provide you with a generic ability to create flexibility in meeting the states needs and reduce administrative burden on placing updates to a waiver program.			• In the event of an Emergency, states may request flexibilities to respond to the need of waiver participants and providers to help protect health and safety during the emergency. • If longer-term changes are needed, states may develop waiver amendments prior to the end of the 5-year waiver term for CMS review and approval. • Federal law does not allow for such “generic options”
37. HCBA enrollment date shall be the date the RN conducts the initial assessment, not the date that the DHCS RN reviews	• CMT staff and supporting staff / managers conduct intensive amounts of		• DHCS is currently researching federal requirements pertaining to this

Recommended Change	Support	Concerns	DHCS Notes
the enrollment packet	work (for weeks if not months) ahead of the official enrollment date that DHCS provides ○ This includes the assessment, home visits, correspondence with the applicant and their circle of support, correspondence with prospective providers and other referrals, coordination with other Waiver Agencies and/or discharging facilities, applications for supportive services, plan of treatment creation and coordination, requests for records, and countless hours spent on communication between all involved parties • [Our Agency] operates a similar 1915(c) waiver program, the Multipurpose Senior Services Program (MSSP) in which the RN is able to certify the applicant's eligibility for the program at the time of assessment whereby marking that date as the enrollment date • If final LOC determinations must be made by the Medicaid Agency (e.g. DHCS), we recommend utilizing a similar approach as with MSSP enabling the RN to enroll the client, independent of the LOC determination • Option to utilize retroactive Medi-Cal for up to 90 days prior to DHCS' final enrollment approval to negate some of the costs accumulated prior to enrollment should also be available HCBA enrollment date shall be the date		recommendation and will be able to provide the workgroup with additional information as soon as it is available.

Recommended Change	Support	Concerns	DHCS Notes
	the RN conducts the initial assessment, not the date that the DHCS RN reviews the enrollment packet		
Higher-level Statewide Effort beyond the Scope of the HCBA Waiver Renewal			
38. To develop a more person-centered approach, the state should incorporate all HCBA Waiver services within the managed care delivery system. We recommend DHCS develop a plan to increase access to fully-integrated care throughout the state that includes HCBA Waiver services. The 1915(c) waiver system should reflect a more integrated, coordinated approach to care with access to services across the continuum of health and long-term services and supports (LTSS). Utilizing the basic Dual Eligible Special Needs Plan structure and managed long-term services and supports (MLTSS) is a solid first step in expanding access to integrated, coordinated care throughout the state. The state and health plans should examine all potential pathways to offer fully-integrated care options for dual eligible Californians.			• The timeframe that would be required to consider and implement this recommendation would extend beyond the waiver renewal timeline, and is beyond the scope of a 1915(c) waiver.
39. Require coordination between California children services, regional center, schools, HCBA, EPSDT			• Waiver Agencies are required to coordinate with other entities providing case management services – what change to the Waiver would help strengthen this requirement?
40. Provide management tool to recipients with multiple providers and/or multiple programs (IHSS and Waiver for	• Ease the stress on recipients and families trying to comply with the multiple		• This is a great idea; however this is not a proposal for changing the Waiver. It's

Recommended Change	Support	Concerns	DHCS Notes
instance). 12 month Excel spreadsheet state maintained and downloadable?	hour and OT requirements. • Decrease the time reporting error rate.		a proposal for DHCS to create a care management tool to assist participants with managing their providers' hours. Waiver Agencies are paid to provide care management services to Waiver participants and should be assisting recipients with care management plans, including creating schedules and instructing providers regarding their duties.
41. Increase the current 1-2-you're-suspended IHSS / Waiver rule to 1-2-3-4-you're-suspended. (Most providers are not rocket scientists.)	• Ease the stress on providers, recipients and families trying to comply with the multiple hour and OT requirements		• This is not an issue that can be addressed in the waiver renewal. The overtime requirements and sanctions are set forth in statute, and can only be addressed through legislation.
42. For long term recognized recipients reduce the every-year-re-sign-up bureaucracy to a minimum (income statement and "Has anything else changed?" list).	• Reduce recipient stress and time/attachment requirements. • Increase social worker efficiency.		• Medi-Cal eligibility yearly re-verification requirements are established in law, and are not possible to address in renewal of the HCBA Waiver.
43. Immediately (!) decrease the new provider vetting TAT from 2.5 months to 1 week! Recipients must hire providers immediately or lose them but providers must work "for nothing", unpaid, until they appear on the timesheet system! Unconscionable!	• Improve the acceptance rate of providers to jobs. • Eliminate recipients having to extend personal loans to new providers so they can survive until the state sends them their hiring balloon payment wages after 2.5 months. • Minimize the recipient financial liability if the provider fails the vetting process. The provider is still due the wages for the time they worked but the state will not pay them so the recipient must. • Eliminate what in the private sector would be an illegal hiring practice. • Remove this state "black eye" in the		• Federal law mandates that all furnishing providers be enrolled as Medi-Cal providers prior to receiving payment for Medi-Cal services. The disclosures and reviews for enrollment are established by federal and state law, and not through the HCBA Waiver. Some provider types, including WPCS, require fingerprinting and background checks prior to enrollment. The provider enrollment requirements are established through federal and state law, and cannot be addressed or changed through the waiver renewal process. Finally, once enrolled, providers must complete the process to bill and be paid

Recommended Change	Support	Concerns	DHCS Notes
	treatment of new state employees.		through the Medi-Cal fiscal intermediary. This process cannot be shortened or changed through the HCBA Waiver.
Recommendations for Rate Increases			
44. Increase rates for WPCS – in the Bay Area they are paid less than minimum wage.			• IHSS / WPCS provider wage rates are locally negotiated with the provider unions and determined at the county level. • Most IHSS / WPCS providers are also eligible for other work-related benefits, such as health insurance, through the counties in which they are employed. • Current IHSS / WPCS provider wage rates can be found here. California's minimum wage is currently $13.00/hour and San Francisco, which has the highest minimum wage, is currently at $16.07/hour. IHSS / WPCS providers in San Francisco County are currently paid $17.25/hour. All counties are required to submit wage rate change requests in order to at least meet, if not exceed, the current minimum wage.
45. CLHF requesting rate increase to align with increases in cost of care.	• There is a large problem with CLHF rates, we have a very difficult time placing participants when they meet the U1 level of care vs U2/U3		• The rate paid to CLHFs for CNSS is not specified in the HCBA Waiver; however, the HCBA Waiver renewal is an appropriate time to consider rates.