Department of Health Care Services

2022 Home and Community-Based Alternatives (HCBA) Waiver Renewal
Technical Workgroup #1 Summary and Questions and Answers

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. This resource includes a summary of the discussions as well as a Questions and Answers section.

Technical Workgroup Discussion Summary

Deep Dive Presentation Halfway Point Q&A

Topic 1: Is there a restriction from providing services to people with mental health diagnoses?

> **Response 1:** There isn't a restriction from providing services to people with mental health diagnoses, but a person would not qualify for a 1915(c) waiver if mental illness was the only reason he or she was receiving care in an institution.
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> > **Follow Up 1:** ALW and HCBA are in alignment, a person receiving mental health care can still be eligible for the waiver as long as their mental health needs are not the basis for their need for waiver services.

Topic 2: Is cost neutrality determined on a macro and micro application? Does each client have to demonstrate cost neutrality between their total expenses and in-facility care?

> **Response 2:** Cost neutrality is determined at the macro level. Cost neutrality is demonstrated to CMS based on waiver costs as a whole, not per person or service. The current version of the HCBA Waiver does not include cost caps on individual waiver participants.

Topic 3: How do you differentiate cost between low-level and high-level patient on the waiver, since some require more supplies/care than others? Some require more supplies or care, and it does cost more than daily rate and we go out of pocket most of the time.

> **Response 3:** Cost component is demonstrated at a larger level. Regarding levels of care, we have acute levels of care, sub-acute levels of care. There are several levels of care on the HCBA waiver and when looking at cost neutrality we look at costs across the levels of care, comparing the waiver population at each level of care to the population receiving care in institutions at the same level of care. We compare waiver cost + non-waiver state plan cost and compare it to institutional costs to check for cost neutrality, not individuals.

Topic 4: Similar to ALW, the HCBA Waiver requires that for every 2 individuals transitioning out, 1 individual can come in from the

community. This is relatively new policy. When this is the policy, it almost incentives institutionalization. Easier to get into waiver from institution. What is the state cost neutrality requirement?

Response 4: Waiver cost neutrality is a federal requirement. Have expanded waivers in the past by making ratios that require a certain amount of institutional transitions to community enrollment. This ensures that when they transfer to a community setting, waiver is generating cost neutrality. As we increase enrollments onto waivers, and we will ensure savings through that expansion, it generates cost savings. The current ratio is 60/40 of institutional transitions, compared to community enrollments.

Topic 5: How do you calculate the institutional cost?

Response 5: Assuming cost neutrality calculation, for each of the levels of care take a representative sample of the population in those settings and their cost and total state plan cost, and compare against the waiver population.

Topic 6: Is there any danger of losing aggregate cost neutrality? Did previous versions of waiver get based on level of care to help with cost neutrality?

Response 6: When we transitioned to the HCBA Waiver, we shrank the number of levels of care so we didn't have so many subgroups. We went from 9 LOC to 3 LOC (nursing, acute, etc.). The current waiver does not look at cost neutrality under each level of care separately, but all levels of care as a whole.

Topic 7: Is the implementation of triage / prioritization in intake of new consumers from the waiting list considered benefiting one client over another?

Response 7: Application of policy must be consistent. Waivers allow states to address specific populations for prioritization for entrance into the waiver to address gaps in care, need for continuation of care, to address risks or barriers that are specific to some populations.

Topic 8: Are participants able to get hospice services while participating in the waiver?

Response 8: It depends on specific hospice services being received. Please provide more detail and we can come back to this topic.

Q&A after Deep Dive Presentation:

Topic 9: The enrollment cap was raised in 2017, but is there any sense of the actual need that exists for the Waiver beyond the cap. What is the actual need that exists in California, looking at Medicaid?

Response 9: There is an unmet need for HCBS services, in the aging population, etc. Want to identify how we can best work through that in most coordinated way possible. Typically small rural counties. We have also flagged for discussion the expansion of waiver agencies and service areas where there is no Waiver Agency.

Follow Up 9: As we have seen in recent work in master plan on aging, there is definitely a need for HCBS services, and

this effort is to try to meet need in most coordinated way possible.

Topic 10: Have you considered allowing people to stay in HCBA Waiver, but with self-determination program. There are challenges getting HCBA waiver and still have access to SDP waiver.

Response 10: It isn't something we've looked at yet, but could during this renewal process.

Topic 11: A question about prohibition on family members being IHSS providers. Maybe explore this being approved and made permanent due to app K being approved.

Response 11: Family members could provide services under other programs, but not HCBS programs under 1915c waiver. Waiver Programs' authority to pay legally responsible adults for providing personal care services fall under different sections within the Social Security Act; and based on the authority we operate under, 1915c, some family members can provide personal care services for payment, but states cannot draw on federal funding for care provided by parents of minors or spouses.

Topic 12: Are WPCS providers not able to be paid until they are fully vetted and in the system a federal or state requirement? When I hire someone off the street to work for my daughter, they have to be finger printed and enter a contract that needs to be signed and uploaded, and that one-page contract needs to be signed before they get their paychecks. I can't hire a person and wait 3.5 months for them to start work. I have to give them personal loans till the bureaucracy completes the vetting process. I'm differentiating between IHSS (CA system) vs WPCS (impacted by federal). Does this affect this group or is this the feds? Please confirm.

Response 12: I understand your question. There is a clear distinction between IHSS and WPCS, and both operate on federal funding. IHSS is Medicaid program. Different authority than WPCS. Both draw down federal funding and are subject to federal requirements. We can approach in more detail in the stakeholder process. Increasing efficiency on bringing on new providers, and it'll be interesting to see if parts of the process that aren't federally required where we can address the state process and efficiency. Some goals of this workgroup are to increase efficiency in the process; this is a good opportunity to do that.

Overview of Change Concepts Received To Date:

1. Modify the requirement to include an MSW on every Care Management Team (CMT) to allow BSWs with medical and/or case management experience to provide services as long as they are supervised by an MSW

Workgroup comments:

- We cover 23 counties, having a hard time finding MSW in our counties. We use bachelor prepared staff and it would be beneficial to use bachelor prepared staff and still have masters prepared supervision would be beneficial.
- BSW staff are helpful and can successfully run the case management component, with MSW as a supervisor.
- A lot of issues between assessments and reassessments that can be managed by BSW. Just talking to insurance for Durable Medical Equipment, or PCP for signature, monthly calls that can be appropriately done by Bachelors prepared

social worker. Families will have better contact because MSW are so busy with paperwork and assessments and families are waiting a day or 2 for a call back. Another layer of BSW will provide additional layer of resources to families.

- We have a few programs within agency and they can supervise interns. Is there opportunity to add in a community service worker, or follow up calls or admin functions on CMT?
- It is a good idea because it would make it easier for people who are getting services to get into contact with care team quicker than we can now.
- Is there any reason why we are limiting to just social workers? Lots of MFT have same skills as a social worker in running care management teams.
- I would suggest not to limit the type of person to a bachelors or masters in social worker, but to include multiple other types of like type of health professionals. They can include MFT, gerontology, housing specialists, social work extenders. If training was to be substituted, be consistent in the definition of what that means so we have consistency across the state.
- I support this idea, consider using trained paraprofessionals are in that category that don't have a formal education and have been trained through experience. We use LCSW and MSW, but we use lots of community health workers to interact with patients and their family members.
- Accessibility in language, often difficult to recruit masters level social workers. Also add, especially with MSW supervisory, to have an experience level equivalent.
- Might result in a cost savings, and if there is, we could utilize with care coordination for more people on CMT or expanding the realm of what the social workers will be doing as well. IHSS and regional centers.
- I agree a variety of health professionals should be considered. I would also suggest MSW interns- working with local universities providing they are supervised of course.

2. 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 (e.g., to purchase smoke detectors/carbon dioxide detectors, cleaning products, clean linens, etc.)
    - We support this with our agency. We have the MSSP waiver, and we've been able to provide this under MSSP and see lots of benefit from the service because their homes are now safer and they don't have to move or go to SNF. Have been able to apply in MSSP waiver with success. Fairly similar, with different population. This keeps them safe in their homes, they don't see increased risks of going back into SNF, etc.
    - Should we have restrictions where landlords have requirements/restrictions, is carbon monoxide detector a requirement of a landlord?

- It's both. It's on the land lord, but there are little things like a refrigerator that make a difference to clients.
- Are there similar restrictions or requirements from MSSP/landlord?
- Housing developments must take care of some of those things. But some other things can really benefit the client, like refrigerator that can hold freezer meals, etc.
- I support this proactive measure, we work with property owners before using our funds.
- Since it's intended for safety, it's hard to identify the boundary between the two sides. For example, clean linen.

[Discussion paused for remaining change concepts to go through the list.]

Workgroup Change Concepts Discussion:

Topic 13: Concerned about recommendation to exclude people who only use WPCS from the waiver. You don't get a waiver slot; it would mean some of our IHSS WPCS consumers move into institutionalized. We try to avoid integration, go for coordination. Same wages and benefits as IHSS providers; not state minimum wage. Higher WPCS wage than IHSS wage could create a lot of confusion. Would be helpful to have a subgroup or committee with Dept. of Social Services. Regarding MCP taking bigger role, especially with IHSS consumers, controversial because this leads to integration rather than coordination.

Response 13: Thank you, lots of good points. Work group members, we are counting on you to provide all of your input, but we will be asking to respond with additional feedback regarding concepts we already put out and additional recommended changes.

Follow Up 13.0: Seconding concern about removing patients requiring WPCS and add to the waiver? Family members can properly care for patient. 40% of our patients require WPCS; not necessarily nursing services. Don't think it's a good idea to remove the patients that only require WPCS services and nothing else from the waiver. Many of the patients don't require nursing services, family can care for the individual, costs less to pay WPCS than nursing, they can stay at home and family will care for them. 40% of our patients require WPCS but no nursing. With Covid-19, they don't want any extra people at home.

Follow Up 13.1: My daughter doesn't need a nurse, that person needs to be with her 24/7, I need to hire caregivers to be in the home overnight. Not understanding the rationale of that suggestion other than throw off the quadriplegic people, which will force them to be institutionalized. Daughter and other quadriplegic people who cannot take care of themselves should have a nurse there when they wake, not be left alone and confused.

Follow up 13.2: RE: Clients who use only WPCS and not any other services. To what extend do those clients actually *need* home nursing care, but WPCS is being substituted as a practical matter because of the chronic home nursing shortage. If the patient doesn't have any care needs that require nursing level care, then they wouldn't qualify for admission to a nursing facility and wouldn't qualify for the waiver. But if the patient *does* qualify for nursing care, but such care is simply unavailable, it's reasonable to substitute WPCS care.

Topic 14: I would like to suggest a laundry list of items that stakeholder would like to be consistent across the state. We have variation in not only waiver agency processing TARS, but the staff assigned to the waiver agency and the RNs processing the TARS at the state, that create these variances. We all need to be trained and held to the same rules with specific training that is held for all parties together.

Topic 15: Will we have the opportunity to talk through all of the change concepts? I think it would be helpful to hear comments on each item.

> **Response 15.0:** Agree that conversation on each change concept is good. I propose to add a 4th call to provide time for more conversation. There's a lot of wisdom and experience in this workgroup, and our final product will benefit from more conversation.
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> **Response 15.1:** I agree, and the list of recommendations could change with further insight of those on the workgroup which is why these discussions on each point are so important.

Topic 16: Would also want to include the issue of state's definition of cost neutrality and enrollment onto waiver. Institutional vs community. Where can we find the policy written? And then can we have waitlist and the breakdown of the people on the waitlist and how it compares to contrast of cost neutrality? State's definition of cost neutrality, and ratio enrollment (institutional vs community).

> **Response 16:** There is a distinction of this waiver vs. ALW. The 60/40 is not specific to institutional transitions, but rather reserve capacity as a whole.
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> > **Follow up 16:** Could DHCS provide information before the next meeting on how much the cost neutrality drives structural decisions about the waiver? For example, does DHCS need a certain mix of WPCS only participants vs. people who need nursing? Also, how would this be affected by integrating this with the ALW? Thanks!

Topic 17: In regards to #16, the need to improve care coordination; does it include improving managed care? Don't want WAs to gain administrative burdens. Feel it should include communication with MCP. Managed Care organizations have lots of resources they can provide and similar to how CCI counties are established now. Want to bring it up to not be an administrative burden, but a help, not only to staff but beneficiaries. Health Plans can provide HRA, additional contact information.

> **Response 17.0:** From a managed care perspective, we think the communication and collaboration is very much needed. Don't want to add admin burdens, communication needs to be improved. MCP doesn't know who is enrolled and receiving services. We have a lot of collaboration with a lot of sites, CCI in 4 counties. Minimal duplication of services, better communication, and better coordination of care equals minimal but necessary touchpoint with beneficiary that's not overwhelming for them. Being able to share information will help streamline care. Maybe a MOU or similar would be beneficial. Can speak to HCBA wavier agencies we have AA with. We are hearing different perspectives and able to come and share info. Goal is to streamline services, minimal communications such as a BAMOU.
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> **Response 17.1:** Also relating to #16. Want to see consideration of behavioral health there as well, and see if needs can also be

met by managed care plans. Support the argument for giving WAs the day-to-day needs to do a better, more informed job of care coordination; can DHCS encounter claims data to look at access to dental health, etc. See if people are reliably accessing those types of care based on individualized care plan. Would be helpful for DHCS to provide snapshot of Care Coordination issues.

Via chat: Wanted to add to my previous comment on making data available on the utilization of various Medi-Cal services by current HCBA participants: Is there also data the workgroup could review on program participant demographics? I'm wondering about race, ethnicity, language access, SOGI, etc.? This seems important to consider given DHCS' overarching focus on identifying health disparities and improving equity within Medi-Cal. I think the waiver agencies on this group no doubt know who they are serving, but more descriptive information on the population could be really helpful for others and for the discussion as a whole.

Response 17.2: Please include CCS, Regional Center, in those organizations.

Response 17.3: Please include hospital acute care discharge planning teams.

Topic 18: Wanted to add another item: modifying capabilities with MedCompass. WAs have to create additional excel based reports to track performance. WA having more access to MedCompass reporting would benefit the WA.

Topic 19: Think having a subgroup to talk about WPCS would be helpful. Issues with overtime exceptions. Giving participants the choice of more than 1 waiver agency, and maybe capacity of more than 1 coming online. There's an issue of getting private nurses, and HHA are not ok with sharing a case. What can DHCS do for people who need 24 hours of nursing? Maybe we need a 4th meeting to hear from a provider perspective. Ask WAs what they think is needed, what challenges people face getting what they need, etc. What are the barriers, and what could be done?

Topic 20: I agree with opening up WAs to let clients choose what agency they go to. We had a patient in a different county that was coming to our facility. Suggested a different facility take over that application. We were denied that opportunity.

Topic 21: For the waiver, there is no specific diagnosis to qualify. Creates difficulties to see who does qualify. Have seen quite a few people get denied that we thought were qualified for the program. Would like to see the denial process in place.

Response 21: Regarding last comment. Always appeal options for people who are denied. State hearing can be requested. There are always appeal options for enrolling in a program.

Topic 22: I wanted to comment on [change concept] 12; also 9 and 11. Work on how to integrate these programs for consumers so they don't have to go to lots of providers, but rather go to the consumer. Working with MCPs and the duals noted in item 12. As we think about where this waiver is going, how do we tie them together and make them work as one?

Topic 23: We need a little more flexibility in how we pay for services, and who we pay for services. In some rural counties, maybe we need a paraprofessional, not a nurse. Would have to be done safely, etc. Could do the same thing caring for complex needs under the

waiver. If we had more control over how we pay for the providers and what kind of provider we can get.

- Respite trained worker: can use a respite worker to provide gastrostomy services.
- A lot of the issues we've identified can be solved if we have this flexibility.

Topic 24: If something isn't on the list, is it safe to assume it won't get changed?

Response 24: No, it's just what we have received to date. So we are asking for input.

Public Input and Open Forum:

- Institution vs. community based priority. In order to qualify to be assessed for waiver, there is 60-day waiting period for application to be processed. Waiting list for my WA is currently 3-5 years long, so really hard to enroll anybody in HCBA waiver. Can 60-day waiting period be decreased? Can we expedite the enrollment process? Not good for patient outcome, in my opinion.
  - We are contracted with them, discretionary benefit. They have often asked why HCBA Waiver can't be a benefit in LA Care, merged together in some way.
  - Level of Care between Acute and Subacute: have asked them to please give descriptions and breakdowns, keep going back and forth on whether patients are one or the other. Would love to have a written description.
  - Thank you, identified between WA and MCP. There are things we can improve that don't require a waiver change.
- I have 2 children who are served in Santa Cruz County. Nurses have been getting a substandard rate for a long time. They should be getting holiday pay, PTO, etc. because they are essential. Consumers don't always need nursing, but they deserve quality personnel. Need to make sure needs are met. We are trying to work with regional center to meet our needs but are not being met. I haven't had any respite for my son, who does not need nursing, in over 9 months. Getting respite over Zoom is not respite. Benefits on a waiver probably cannot access zoom, so parents have to run it. Need to make sure that patients are being served in their homes.
  - Is it possible to see the # of participants and expenditures by waiver service?
  - The information is available in regular 372 reporting to CMS, that we are required to make public on an annual basis. Available by request.
- Ask on 3rd potential change: What do you mean by governmental entities?
  - Referring to WPCS and individual providers and how wages and benefits are negotiated at the county level.
  - Is it possible see number of participants and expenditures by waiver service?
  - Info available in 372 reporting given to CMS on an annual basis. Publically available by request, that can be provided.

- Regional centers – consumers have to go through medical dept. and be directed by medical director. If they only have a G-tube, they qualify; any more issues and they require LVN.
    - Self-determination program is a new waiver coming out in June 2021. Gives flexibility to consumers and families, support to better meet their needs.
    - How do we coordinate people on the HCBA waiver who want to be in self-determination?
    - Their challenge is the coordination of care; our WAs do that. Right now, regional centers are overseeing implementation of SDP waiver, but perhaps other agencies could help assist.
    - SDP = person-centered plan, similar to Plan of Treatment.
    - Those with developmental disabilities really need to be a part of developing care plan.
    - Social and emotional needs are not being met; directly impacts health and well-being.
    - Social isolation and loneliness assessments should be included during assessments so these issue can be included in the POT.

Technical Workgroup Questions and Answers

Question	DHCS Response
1. What is the State's definition of cost neutrality, is it based on enrollment into the waiver from an institution vs community enrollment?	The state uses the same definition for cost neutrality as the Centers for Medicare and Medicaid Services (CMS): In summary, cost neutrality is based on the total cost to provide care to an individual in the community when compared to providing the same level of care (LOC) (i.e., skilled nursing facility (SNF) A/B, subacute, and acute) to the individual in an institution. For more specific information, see pages 273-282 of the CMS "Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria" However, beneficiaries residing in their homes/communities also enroll into home and community-based services (HCBS) waivers based on their SNF LOC and who are at-risk of institutionalization. Enrolling community-based beneficiaries into

Question	DHCS Response
	the waiver constitutes cost avoidance which is based on the potential for costs, which is less concrete than cost savings and a primary reason why DHCS is typically required to establish slot limitations for the 1915(c) HCBS waivers it operates. The current 60:40 ratio of institutional transitions to community enrollments helps ensure the state meets federal cost neutrality requirements. §1915(c)(2)(D) of the Act requires that the state assure that the average per capita expenditure under the waiver during each waiver year not exceed 100 percent of the average per capita expenditures that would have been made during the same year for the level of care provided in an institution. For more information on cost neutrality, please refer to the section on Appendix J, beginning on page 286 of the CMS "Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria"
2. Is the implementation of triage / prioritization in intake of new consumers from the waiting list considered benefiting one client over another?	Identification of persons eligible for reserve capacity enrollment is not considered benefiting one beneficiary over another. A state may reserve a portion of a waiver's capacity for specified purposes. Reserving waiver capacity means that some waiver "slots" are set aside for persons who will be admitted to the waiver on a priority basis for the purpose(s) identified by the state. Reserving capacity is only a means to hold waiver openings for the entrance of specific sets of individuals to the waiver. For more information, see pages 75-76 of the CMS "Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria"
3. How do you calculate the institutional cost?	Institutional cost, in summary, is the average cost of all Medi-Cal state plan services, including the cost of care in an institution, provided to Medi-Cal beneficiaries each month. Cost of institutional care is stratified by LOC to coincide with those

Question	DHCS Response
	included in the HCBA Waiver. For a detailed explanation of how "institutional cost" is calculated, please refer to pages 273-282 of the CMS "Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria"
4. If the balance of patients shifts to have more patients at the SNF A LOC and fewer patients at the SNF B / Subacute / Acute LOC, is the HCBA Waiver program in danger of losing aggregate cost neutrality? Am I correct that previous versions of the waiver had different waiting lists based on LOC to account for cost neutrality?	Cost of institutional care is stratified by level of care to coincide with the levels of care included in the HCBA Waiver. Previous version of the waiver did have different waiting lists for applicants based on LOC, however, the waiting lists were not to ensure cost neutrality. Instead, the state reserved waiver slots for beneficiaries with higher levels of care (e.g., those with sub-acute care needs) to help ensure they were not excluded from the waiver simply because they require more care than beneficiaries with lower care needs.
5. I am wondering if there will be a slide that will show the number of participants and expenditures by waiver service.	Monthly HCBA Waiver enrollment totals are available on the HCBA Waiver webpage dashboard, available here. The projected average cost of waiver services are available in Appendix J of the HCBA Waiver, by waiver year. Actual waiver costs are determined on an annual basis, 18 months in arrears, for federal reporting purposes.
6. I have read that parents and spouses can be a provider if they are hired by a Medi-Cal Personal Care Agency (PCA).	Parents of minor children and spouses cannot receive payment for providing personal care services to their legally dependent Waiver participant. 42 CFR §440.167. The 1915(C) restriction applies across all waiver services and all waiver provider types. PCAs should not be hiring parents of minor children or spouses to provide personal care to the legally dependent Waiver participant. DHCS has flagged this misinterpretation as an area within the Waiver that needs to be clarified through waiver renewal.
7. I've noticed that kids who qualify for the I/DD Waiver are switching over to the HCBA Waiver because the HCBA Waiver Agencies do a better job of connecting families with	Under Medicaid, individuals who meet HCBA Waiver enrollment criteria have the choice to enroll in the Waiver, or choose other HCBS available to them.

Question	DHCS Response
needed Early and Periodic Screening, Diagnostic and Treatment (EPSDT) home nursing services. It's great that the HCBA Waiver Agencies are doing such a good job! But it creates a problem that children who could be served by income based Medi-Cal or the nearly unlimited capacity I/DD Waiver are moving to the limited capacity HCBA Waiver to get services that they *should* be able to access without being in the HCBA Waiver. This is a problem that has been created by the HCBA Waiver Agencies doing such a good job... so it's a good problem to have. Buts kids on income based / I/DD Medi-Cal are supposed to have the same rights to EPSDT home nursing! I'm worried that as we move to lean budget times and waiting lists, kids who *don't* need to be on the HCBA Waiver will be taking up slots for adults who can't receive services any other way.	PDN services are not a covered waiver service for youth under the age of 21. The Waiver Agency may assist the Regional Center with securing PDN providers, but the cost of the service must be paid by the Regional Center and/or managed care plan first. Federal EPSDT requirements provide that children under the age of 21 must be provided case management to arrange for approved PDN services, and the HCBA Waiver Agencies play a part in meeting that requirement.
8. I wanted to ask about responsibility of the waiver program to work with managed care programs. I assume participants are Medi-Cal only or Duals...and therefore managed care plans would also be paying attention to participants needs and might be providing their own case management. Likewise if person is a Dual what is the practice or policy to work with Medicare providers or even Medicare advantage plans?	You are correct that HCBA Waiver Agencies and Medi-Cal Managed Care Plans are responsible for "shared" members/participants, and that case management is required to be provided by both. HCBA Waiver Agencies are contractually obligated to collaborate with Medi-Cal Managed Care Plans to ensure the needs of "shared" members/participants are being met in the community. Managed care plans are also contractually required to provide case management for all the medical needs of the enrollee. With respect to dual eligible, beneficiaries cannot be enrolled in the HCBA Waiver if they are enrolled in Cal MediConnect.
9. Can you please elaborate on the third potential change - Identify that Financial Management Services (FMS) for participants directing Waiver Personal Care Services (WPCS)	The recommendation is to change the response to Appendix E, Question E-1 (h) so it identifies that FMS is provided by government entities. CMS technical guidance states that "[i]n almost all cases, the

Question	DHCS Response
are provided by governmental entities. Who are the FMS providers and what do you mean by governmental entities?	provision of FMS is a necessary feature of participant direction of waiver services." The current employment and payment process for WPCS in the HCBA, as described in the waiver application and in WIC Section 12302.2, constitutes government provided FMS and the application should reflect this. This treatment would be consistent with how this same payment process is reflected in State Plan documents for the PCS, IPO, and CFCO programs, where the state indicates the government providers FMS.
10. Would changing WPCS from a distinct service to an extended service allow spouses to be able to be paid as providers?	Changing WPCS from a distinct service to an extended service would not allow spouses to be able to be paid as providers under the 1915(c) authority. 42 CFR §440.167
11. So many of our healthcare partners have clients who have no capacity, no power of attorney or conservator, but are suitable to move to a community but the SNF or hospital staff (bioethics team) is not allowed to complete the waiver paperwork for them.	Correct. Waiver enrollment must be based on personal choice, or the choice of the applicant/participant's legal representative.
12. It was mentioned that each patient gets a $5,000 cap on funds for transition costs, accessibility adaptions, etc. How can I get more information on this and the treatment authorization request (TAR) process for it? We were unaware of this and we have been paying out of pocket for our patients to transition into our community including transportation, which can be costly because some of our patients come from other counties.	Under the Waiver, Community Transition Service costs and Environmental Accessibility Adaptation costs cannot be claimed by Congregate Living Health Facilities (CLFH). The Waiver provides that HCBA Waiver Agencies may purchase and receive reimbursement for home set-up and home modification expenses that are medically necessary to maintain the health and safety of a participant who is transitioning to the community from an institution. Non-medical, non-emergency community transportation is not currently covered under Community Transition Service, but it was recommended for inclusion through the Waiver Renewal.
13. On the Self Determination Waiver will the Regional Centers be the administrators of this waiver?	The Self Determination Waiver is a separate 1915(c) waiver operated by the California Department of Developmental Services

Question	DHCS Response
	(CDDS). Participants may only be enrolled in a single 1915(c) waiver at a time.
14. Social isolation and loneliness assessments should be included during assessments so these issue can be included in the POT.	Geographical and Social isolation is included as a component of the Care Management Acuity Tool; however, if additional information needs to be included to assess “loneliness” we can look at revisions to the tool. If HCBS need to be secured to mitigate loneliness to ensure the health and safety of a waiver participant in the community, then those services and supports should be included in the POT.
15. Will there be an increase in the number of WA's and what is the next opening date for applying to become one.	Waiver Agency expansion and coverage is an appropriate topic for discussion by the workgroup and is included in the Change Concept tool. Based on stakeholder feedback and recommendations, DHCS anticipates that a new Solicitation for Application release would begin immediately after the 2022 HCBA Waiver Renewal is approved by CMS.
16. RE: Eliminating age restriction for Respite and Habilitation – Respite should be included as part of the EPSDT entitlement – we are confused as to why this is a recommended change.	Respite and habilitation are not included as EPSDT services; more information is available in the EPSDT: A Guide for States, published by CMS. This change is to allow children under 21 who are enrolled in the Waiver the opportunity to receive respite and habilitation under the Waiver.
17. Change the 60% max reserve rule to allow the rest of the existing waiting list to get services. 3,000 spots lying unused for “emergencies” is too many. Any system that thinks they need that many is being run too loosely. 1,000? Maybe.	The current waitlist is not impacted by the reserve capacity. Existing waitlists continue to be reduced by WAs and at this point it is a matter of WA capacity. Since 2018, the WAs have reduced the original waitlist of 3,600+ to around 500, and the waitlist shrinks each month. Actual reserve capacity for each waiver year:

Question	DHCS Response
	Capacity Reserved 600 600 600 1200 1800