Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The following are updates that have been made to the Waiver:
• Increased overall waiver capacity
• Revised minimum requirements for Social Workers providing Comprehensive Care Management Waiver services as a member of the Care Management Team (CMT)
• Eliminated the age restriction for Respite (provided at home or in a facility) and Habilitation services, which are not available to youth as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit – to make the services available to all participants enrolled in the Home and Community-Based Alternatives (HCBA) Waiver based on medical necessity
• Included Pediatric Day Health Care (PDHC) centers licensed to operate a Transitional Health Care Needs Optional Service Unit (TCU), as a provider type for private duty nursing (PDN) for eligible participants who have turned 21 years of age
• Included PDHC centers as a provider type for Facility-based Respite Services
• Removed Transition Coordination from the Comprehensive Care Management per member per month (PMPM) payment
• Defined the role of the Circle of Support within the Waiver, and HCBA Waiver Agency requirements when a participants does not have a Circle of Support
• Included telehealth as an alternative to the in-person requirement for a Physical or Occupational Therapist (PT or OT) to evaluate the need for, and appropriateness of, home modifications when a provider is not available within the service area
• Included additional requirements for HCBA Waiver Agencies to collaborate with Managed Care Plans (MCPs) for coordination of care, including entering into Memoranda of Understanding (MOU)
• Added Assistive Technology as a Waiver service, to maintain the participant's health and safety when medically necessary Assistive Technology is not available through the state plan nor other payment sources
• Added a paramedical service for participants who have maximized the amount of in-home supportive services (IHSS) available through the state plan
• Allowed annual re-assessments to be completed via telehealth after the end of the public health emergency, in accordance with DHCS' telehealth policies for Medicaid State Plan services
• Included anticipated EVV implementation timeline in Appendix I
• Made a variety of less significant revisions throughout the Waiver to correct identified mistakes and/or clarify waiver content

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **California** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Home and Community Based Alternatives Waiver

C. Type of Request: renewal

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: CA.0139
Waiver Number:CA.0139.R06.00
Draft ID: CA.016.06.00

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

01/01/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☒ **Hospital**

Select applicable level of care

◉ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Individuals must meet the criteria for hospital level of care (LOC) and the medical care criteria as described in Appendix B-1.

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Nursing Facility (NF)-A, NF-B, and NF-Subacute LOC

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

Subcategory: ICF/DD-Continuous Nursing (CN) non-ventilator dependent and ICF/DD-CN ventilator dependent LOC

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs)

approved under the following authorities
Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the HCBA Waiver, hereafter referred to as the "Waiver", is to provide Medi-Cal-eligible individuals who have long-term medical conditions and meet one of the designated LOC in subsection F, above, the option of returning to and/or remaining in a home or home-like community setting in lieu of institutionalization.

The goals of the Waiver are to: 1) facilitate a safe and timely transition of Medi-Cal eligible individuals from a medical facility or institutional setting to a home or community setting utilizing Waiver services; 2) offer eligible individuals who reside in the community but who are at risk of being institutionalized within the next 30 days, the option of utilizing Waiver services to develop a care plan that will safely meet their medical care needs outside of an institution; and 3) maintain overall cost neutrality of HCBS when compared to services that would be provided to the same population in an institution. The HCBA Waiver is the payer of last resort except where otherwise specified by law. A medically-necessary Waiver service may only be authorized as a Waiver service when it is not available to the participant through any other source, including but not limited to private insurance.

California's Department of Health Care Services (DHCS) is the State's Single Medicaid Agency responsible for statewide administration and monitoring of the Waiver. Organizationally, DHCS' Integrated Systems of Care Division (ISCD) administers the Waiver. DHCS is responsible for reviewing and approving initial Waiver eligibility, LOC determinations, and ongoing monitoring and oversight of Waiver Agencies and HCBA Waiver service providers. DHCS maintains sole administrative responsibility for managing Waiver expenditures against approved levels; establishing rates; and the development of policies, and procedures governing the Waiver program.

DHCS' primary model for the administration and operation of the Waiver is through contracted Waiver Agencies responsible for local Waiver administration functions and for the delivery of the Comprehensive Care Management Waiver service provided by a CMT.

Waiver Agency administration functions include: evaluating applicants' eligibility for the Waiver; submitting enrollment applications and supporting documentation to DHCS for approval; conducting annual LOC evaluations; reviewing and approving participants' person-centered POTs; authorizing Waiver services; managing service utilization; developing and maintaining an HCBS provider network; engaging in quality assurance activities; and billing the DHCS fiscal intermediary (FI) when authorized by DHCS to provide direct care services (defined in "Additional Needed Information" of the Waiver).

Waiver Agency's provide Comprehensive Care Management through a CMT comprised of a Registered Nurse (RN) and a Social Worker with at least a Bachelor's degree, as well as those with Bachelor's level degrees in related fields, including: gerontology, marriage and family therapy, psychology, etc., when supervised by a Social Worker with at least a Master's degree (MSW). Both members of the CMT must be directly employed or contracted by the Waiver Agency. The CMT works with the participant to identify and coordinate State Plan and Waiver services, and other available resources that are necessary to enable the participant to transition to the community or remain in their own home. Only Waiver Agencies are authorized to receive payment for Comprehensive Care Management services within their contracted service areas. All other Waiver services are authorized by the Waiver Agency and delivered by willing and qualified Medi-Cal HCBS providers. In areas of the state where there are no willing and qualified HCBS providers, the Waiver Agency may provide Waiver services when pre-authorized to do so by the State, and only after they have clearly demonstrated compliance with 42 CFR 441.301(c)(1)(vi), including: 1) the Waiver Agency and/or an affiliate is the only willing and qualified provider to provide direct Waiver services within the service area; 2) the Waiver Agency developed and implemented thorough conflict of interest provisions to separate service plan development from the direct provision of Waiver services within their organization; 3) participants are provided with a clear and accessible alternative dispute resolution process to dispute the assertion that there is not another willing and qualified provider available to provide direct Waiver services included in the person-centered service plan; and 4) the CMT continues to search for willing and qualified HCBS providers to provide the medically necessary direct care service(s) included in the participant's care plan, document their recruitment efforts in the participant's case notes, and attached to each direct care TAR submitted to DHCS for approval. Waiver Agencies may not authorize direct care TAR for their own staff or affiliated businesses.

Waiver Agencies provide Comprehensive Care Management Waiver services to assist Waiver participants develop a person-centered care plan; identify and secure the medically necessary services of available Waiver providers; provide continuous case management of Waiver services; and coordinate with Medi-Cal MCPs and other community-based programs to help participants have full access to the benefits of community living and receive services in the most integrated setting of their choice.

In areas not covered by a Waiver Agency, DHCS is responsible for the Waiver administration functions. Under DHCS, case management is provided by willing and qualified HCBS providers enrolled in Medi-Cal to provide Waiver case management services. Waiver case management service providers receive the existing case management rate in the Medi-Cal fee schedule. All other Waiver services are provided by willing and qualified Medi-Cal providers approved to provide Waiver services, as outlined for each service in Appendix C.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver

and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

DHCS conducted an extensive public engagement process to inform the development of the 2022 HCBA Waiver renewal application. In addition to fulfilling federal obligations, DHCS hosted a series of public engagement webinars to:
1. Notify the public about the State's intent to renew the HCBA Waiver for an additional five-year term, while also providing an overview of the HCBA Waiver to increase public knowledge of the goals, mechanics, and associated outcomes of the Waiver.
2. Solicit subject matter experts representing diverse stakeholder groups to participate as members of a Technical Workgroup to discuss solutions to identified challenges, as well as ways to expand on best practices and stakeholder priorities.
3. Improve the transparency of DHCS' decisions about changes to the Waiver.

DHCS issued public invitations to attend the webinars through provider networks, advocates, associations, Legislative "Save the Dates", and scheduled Department stakeholder announcements.

The first public engagement webinar held on September 17, 2020, provided an overview of 1915(c) waivers, the waiver renewal process, and information about opportunities for stakeholders to participate in the development of the Waiver renewal application.

Between October 28, 2020 and February 26, 2021, DHCS hosted three technical workgroup webinars, plus three additional workgroup breakout sessions, to collect targeted input from stakeholders representing:
- Participants and Families
- Advocates and Associations
- Contracted HCBA Waiver Agencies
- HCBS Providers
- Medi-Cal Managed Care Plans

A final webinar was held on August 24, 2021, one week after DHCS posted the 2022 HCBA Waiver renewal application for the 30-day public comment period, to summarize DHCS' takeaways from the technical workgroups, and walk through the changes made to the Waiver.

DHCS reserved time for open forum sessions at the end of each webinar.

In addition to the widespread electronic notifications DHCS utilized to announce the public engagement opportunities, DHCS coordinated with the Office of Administrative Law to issue a print notice in the California Regulatory Notice Register to announce the 30-day public comment period. The proposed 2022 HCBA Waiver renewal application was posted on DHCS' website for public comment from August 16, 2021 through September 16, 2021.

On August 25, 2021, CMS confirmed tribal notice was not necessary for the 2022 HCBA renewal application.

DHCS received 128 written comments submitted by stakeholders, including: parents and family members, legal advocates, associations, union representatives, HCBS providers, HCBA Waiver Agencies, and Members of Congress.

Based on the incredibly valuable input DHCS received during the waiver renewal stakeholder engagement process and the 30-day public comment period, DHCS has committed to convening ongoing stakeholder engagement forums to address identified barriers and build upon best practices. Many of the comments received during the 30-day public comment period will be included as agenda items for discussion by the stakeholder workgroup.

The following content includes the comments that were received during the 30-day comment period. Repeat comments have been consolidated and DHCS' responses are included below each topic.

1. Include a WPCS overtime exemption denial appeals process and clear standards that explain eligibility for an exemption. (1 comment)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will address this recommendation via HCBA policy letters, as appropriate.

2. Add PDHCs as a PDN provider for the PDHC TCU population. (1 comment)
Response: DHCS made updates to the Waiver language to address this recommendation.

3. Apply Prop 56 supplemental payments to PDHC, as provided to Home Health Agencies and ICF/DD-CNCs. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must first be authorized through the State Budget process.

4. Request that the PDHC hourly rate for facility-based respite provided by PDHCs be identical to the hourly rate for home health agency home respite tied to the LVN rate. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must first be authorized through the State Budget process.

5. Request removing PDHC as a service included in the definition of direct care in the "Additional Needed Information" section. PDHC is a provider type furnishing direct care services to beneficiaries. (2 comments)
Response: DHCS made updates to the Waiver language to address this recommendation.

6. Increase the per diem rates for Congregate Living Health Care (CLHF) facilities. CLHF have not had rates increased since 2017, while business expenses have increased 55-65% because of increases in the cost of labor and supplies. (4 comments)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must be authorized through the State Budget process.

More public input and DHCS responses are included in the "Additional Needed Information" section of the Waiver, after the definition of "Direct Care".

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Billingsley

First Name: Joseph

Title: Integrated Systems of Care, Program Policy and Operations Branch Chief

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue

Address 2:

PO Box 997413, MS 4502

City:

Sacramento

State: **California**

Zip:

95899-7413

Phone:

(916) 713-8389 **Ext:** ☐ **TTY**

Fax:

(916) 552-9149

E-mail:

Joseph.Billingsley@dhcs.ca.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **California**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and

certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: JACEY COOPER

State Medicaid Director or Designee

Submission Date: Sep 29, 2021

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Cooper

First Name: Jacey

Title: Chief Deputy Director and State Medicaid Director

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue

Address 2: PO Box 997413, MS 0000

City: Sacramento

State: **California**

Zip: 95899-7413

Phone: (916) 440-7400 **Ext:** ☐ **TTY**

Fax: (916) 440-7404

E-mail: Jacey.Cooper@dhcs.ca.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures that this Waiver renewal will be subject to any provisions or requirements included in the State's most recent and/or approved HCBS Statewide Transition Plan. The State will implement any required changes by the end of the transition period as outlined in the HCBS Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

For the purposes of this Waiver, "direct care" is the provision of services that involves hands-on care provided to a Waiver participant. Examples include, but are not limited to, the following hands-on, medically necessary services, regardless of funding source:
• IHSS personal care services, including paramedical services, medical appointment accompaniment, and HCBA Waiver Personal Care Services
• HCBA Waiver paramedical services
• CBAS, or Adult Day Health Care (ADHC) services
• PDN and shared PDN
• Continuous Nursing and Supportive Service
• Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services
• CC/CNC, Ventilator Dependent Services
• Habilitation services
• Home or Facility respite
• Therapies that require hands-on interaction with the member (e.g., PT, OT, Speech Therapy (ST), Applied Behavioral Analysis (ABA))

Direct care services can be provided by a parent, spouse, personal caregiver, licensed healthcare provider, therapist, para-professional, educational or home health aide, etc.

Indirect care services do not require hands-on interaction between the care provider and the participant. Examples include, but are not limited to:
• Comprehensive Care Management
• Case Management
• Consultation between care providers
• IHSS that does not involve hands-on care, such as meal prep and clean up, shopping/errands, laundry, domestic care, yard hazard abatement, heavy cleaning, etc.
• Community Transition Services
• Environmental Accessibility Adaptations
• Family/Caregiver Training
• Medical Equipment Operating Expense
• Personal Emergency Response (PERS) Installation and Testing
• PERS Monthly Service
• Professional services that do not include the provision of hands-on personal or custodial care

Whether or not specific professional services qualify as direct or indirect services is within the discretion of the Department.

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Continued from the "Public Input" Section:

7. Increase the number of Waiver slots and explain the methodology used to calculate enrollments slots. (7 comments)
Response: The waiver application includes an increase in the number of Waiver slots beginning in waiver year three. DHCS used current enrollment and attrition trends to project the number of waiver slots that would be needed for each year of the Waiver Term. In the future, DHCS will engage stakeholders to obtain additional input regarding this recommendation.

8. Align the CLHF care level definitions, and rates, with the amount of care required by/provided to participants. Because of recent re-interpretations of the levels of care provided in CLHF, care coordinators have been telling CLHF that U3 is no longer being approved. Because of this misclassification, most congregate facilities don't take waiver patients anymore since it's infeasible to provide high-level care of patients under U2 reimbursement. (4 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will continue to engage stakeholders to obtain additional input and determine appropriate next steps.

9. Include the Pediatric Subacute LOC as a targeted population in addition to the Adult Subacute LOC; and, make it explicit that in addition to Pediatric Subacute level of care, children who meet either NF/AB or Acute care levels of care are eligible for the Waiver, particularly if they are children without Intellectual or developmental disabilities or are not regional center eligible. (3 comments)
Response: DHCS made updates to the Waiver language to address this recommendation.

10. Reinforce the prioritization of the U21 population for intake processing and that children cannot be placed on a waitlist by

adding at the beginning of "f. Selection of Entrants to the Waiver": "Applicants under the age of 21 cannot be placed on the waitlist, and must be routed for priority enrollment / intake processing per HCBA PL-19-001. The requirements under HCBA PL-19-001 must be followed." (2 comments)
Response: No update to the Waiver language is necessary to address this recommendation. Waiver agencies are currently required to comply with all policy letters, as well as the term of the contract.

11. It is unclear how DHCS determined the number of needed slots and whether those slots are being equitably approved across race, age, disability, gender identity and sexual orientation. (2 comments)
Response: No update to the Waiver language is necessary to address this recommendation, at this time; however, DHCS will continue to engage stakeholders to obtain additional input. DHCS is committed to health equity and is developing strategies to address equity issues across all Medi-Cal programs.

12. Reduce the amount of time it takes to enroll eligible beneficiaries in the Wavier by adding timeframe requirements. (4 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will continue to engage stakeholders to obtain additional input and determine next steps, as appropriate.

13. Include additional subpopulations to those identified for reserve capacity and prioritized intake processing, including: adults at the subacute level of care who are living in the community, individuals who are at imminent risk of institutionalization, and individuals experiencing homelessness. (5 comments)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input.

14. Reduce the facility residency requirement for prioritized intake processing from 60 days in an institution to 20 or 30 days in an institution. (4 comments)
Response: No update to the Waiver language is necessary to address this recommendation. The intent of the 60-day residency requirement for prioritized intake processing is help ensure that individuals who have been in an institution longer than others are not overlooked because those who have been in a facility for less time experience fewer barriers to returning to the community. Waiver agencies can still enroll residents who have been in an institution for fewer than 60 days.

15. Children should be able to receive WPCS and paramedical services through the HCBA Waiver when they do not have access to those services through other service delivery systems. (18 comments)
Response: DHCS made updates to the Waiver language to address this recommendation. The HCBA Waiver provides access to Medi-Cal EPSDT benefits for children with complex medical needs who are not eligible to access those services through other systems of care. For many families, but especially those who live in rural parts of the state, the Waiver is the only option available to ensure their children receive essential services such as WPCS and paramedical services, to ensure their children can continue to live and receive care outside of an institution.

16. Spouses and parents of minor children should receive payment for providing WPCS permanently, post-pandemic. (6 comments)
Response: DHCS made updates to the Waiver language to address this recommendation.

17. Increase the Waiver Agency reimbursement rate to pay for comprehensive care management services and to address gaps in care. (2 comments)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation. HCBA Waiver Agencies receive a monthly comprehensive care management payment based upon the waiver participant's assessed care management acuity level. Note: Rate changes must first be authorized through the State Budget process.

18. DHCS should allow Waiver Agencies to pay for services to fill gaps in care, as needed. (2 comments)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must first be authorized through the State Budget process.

19. Enroll additional Waiver Agencies to expand the capacity and variety of specialties, and to include providers with expertise in serving children living with medical complexity as well as ventilator dependent adults, and seniors with Alzheimer's disease or dementia. (2 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will continue to engage stakeholders to obtain additional input.

20. Automate the Treatment Authorization Request (TAR) process. (3 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will continue to engage stakeholders to obtain additional input.

21. Work with HHAs to find a solution to the liability issues preventing shared cases (2 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will continue to engage stakeholders to obtain additional input.

22. Enhance back-up provider capacity including through higher wages for emergency shifts. (2 comments)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must first be authorized through the State Budget process.

23. DHCS should seek avenues for funding leave pay for LVNs/ WPCS providers so that a participant's hospitalization does not lead to their loss of providers. (2 comments)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must first be authorized through the State Budget process.

24. Increase community awareness about the HCBA Waiver and provide trainings on the Waiver for community groups serving seniors and people with disabilities. It is critical that DHCS increase outreach and awareness regarding the HCBA Waiver benefit to Counties, Managed Care Organizations, hospitals, nursing facilities, and community organizations. (2 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will continue to engage stakeholders to obtain additional input.

25. Expand waiver goal to include: "The goals of the Waiver are to: 1) facilitate a safe and timely transition from a medical facility or institutional setting to a home or community setting…" (1 comment)
Response: DHCS made updates to the Waiver language to address this recommendation.

26. Include "functional support" data when determining LOC need. (1 comment)
Response: No update to the Waiver language is necessary to address this recommendation. Evaluation of applicants'/participants' need for assistance with Activities of Daily Living (ADLs) / Instrumental Activities of Daily Living (IADLs) is currently included in the assessment to determine the LOC. DHCS will address this recommendation via HCBA policy letters and/or contract amendments, as appropriate.

27. Services in POT should include individual's preferences related to specific goals. (1 comment)
Response: DHCS made updates to the Waiver language to address this recommendation.

28. Specify mechanisms for sharing information and coordinating care with MCPs as well as other non-waiver HCBS providers, including but not limited to: Community-Based Adult Services (CBAS), IHSS, and Regional Centers. (2 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will address this recommendation via HCBA policy letters and/or contract amendments, as appropriate.

29. Require that Waiver Agencies work with their local Aging and Disability Resource Connection (ADRC) programs; and ensure that the "No Wrong Door" effort outlined in DHCS' Home and Community-Based Services Spending Plan includes access to the HCBA Waiver. (2 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will address this recommendation via HCBA policy letters and/or contract amendments, as appropriate.

30. Include person-centered outcome measures in the Quality Improvement Strategy. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input.

31. Require WAs to actively arrange for EPSDT home nursing instead of providing a list of phone numbers as a component of Comprehensive Care Management. (3 comments)
Response: No update to the Waiver language is necessary to address this recommendation. Existing Waiver language requires Waiver Agencies to arrange for all approved Medi-Cal PDN services. See section "Comprehensive Care Management Services for Private Duty Nursing Services Authorized for Medi-Cal Beneficiaries Under the Age of 21":
The Waiver Agency is required to provide Comprehensive Care Management Services, including, upon the request of an HCBA

Waiver enrolled EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal PDN services, arranging for all approved Medi-Cal PDN nursing services desired by the beneficiary.

32. Provide additional support to children discharging from hospitals. Children who need EPSDT nursing care are routinely discharged from children's hospitals without ever being referred to the HCBA Waiver program. Hospitals still routinely tell families that if they are over income for Medi-Cal, that no help is available. (2 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will continue to engage stakeholders to obtain additional input.

33. The paramedical services authorization should mirror the IHSS paramedical services authorization process. (3 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will address this recommendation via HCBA policy letters and/or contract amendments, as appropriate. DHCS will also continue to engage stakeholders to obtain additional input.

34. Because of overtime rules, change language re: paramedical provider requirements to allow more than 1 provider. (2 comments)
Response: DHCS made updates to the Waiver language to address this recommendation.

35. Remove ICF/DD-CNC facilities as an HCBS setting. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input.

36. Allow for the delivery of site-based services by care teams that work with groups of participants who live in the own housing unit in the same location. (1 comments)
Response: No update to the Waiver language is necessary to address this recommendation. DHCS will continue to engage stakeholders to obtain additional input.

37. Increase provider rates (emphasis on PDN and WCPS provided by Personal Care Agencies). (6 comments)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must first be authorized through the State Budget process.

38. Include community care licensed facilities as eligible residences under HCBA. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input.

39. Include home-delivered meals under the waiver. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input.

40. Increase monitoring and oversight conducted by the State. (1 comment)
Response: A Waiver update is not necessary to address this recommendation. DHCS will engage stakeholders to obtain additional input and determine appropriate next steps, if any.

41. Participants should have a choice between Waiver Agencies when a waiver agency declines to serve a participant or a participant asks for a different waiver agency. (1 comment)
Response: A Waiver update is not necessary to address this recommendation. DHCS will engage stakeholders to obtain additional input and determine appropriate next steps, if any.

42. Create a Waiver Ombudsman. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input.

43. Allow for higher thresholds for Medical Equipment Operating Expenses. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must first be authorized through the State Budget process.

44. It is critical that WAs be held accountable for accurately and timely adjudication of TAR. (1 comment)

Response: A Waiver update is not necessary to address this recommendation. DHCS will engage stakeholders to obtain additional input and determine appropriate next steps, if any.

45. What does DHCS mean when stating, "DHCS may, at its discretion, contract with local public agencies to perform waiver operational and administrative activities/functions, as HCBA Waiver Agencies. These entities must meet DHCS' performance standards and requirements, including demonstrated organizational, administrative, and financial capabilities to carry out the contractual responsibilities/obligations of the HCBA Waiver"? (1 comment)
Response: There are separate sections within the Waiver for States to identify the types of entities that are authorized to perform Waiver Administrative functions. DHCS contracts with several types of entities for local administration of the Waiver, including: non-profit, for-profit, and local government agencies.

46. Explain how providers who choose to contract with the WA will receive a negotiated rate. (1 comment)
Response: This is no longer applicable. DHCS removed the referenced language.

47. Explain how case management and the provision of direct care services are separated. (1 comment)
Response: DHCS requires contracted Waiver Agencies to develop policies and procedures (that must be submitted to DHCS for approval), that describe how they will fulfill conflict of interest requirements within 42 CFR §441.301(1)(vi) and in accordance with Appendix D-1-b. WA's policies must address the agency's administrative structures and information management systems, staff training requirements, and how they will monitor for ongoing compliance.

48. DHCS should deploy a patient experience of care or quality of life survey. (1 comment)
Response: A Waiver update is not necessary to address this recommendation. DHCS will engage stakeholders to obtain additional input and determine appropriate next steps, if any.

49. Offer supplemental and enhanced payments for waiver services. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must first be authorized through the State Budget process.

50. Include Assisted Living services for statewide expansion. (1 comment)
Response: At this time, DHCS declines to make updates to the Waiver to address this recommendation; however, DHCS will continue to engage stakeholders to obtain additional input.

51. Take additional steps to ensure married waiver applicants, recipients, and waitlisted individuals know about and are properly assessed for Medi-Cal using the spousal impoverishment methodology. (2 comments)
Response: A Waiver update is not necessary to address this recommendation. Spousal Impoverishment protections are included in the Waiver and DHCS has issued notices to County Eligibility Offices and Waiver Agencies.

52. Publish more regular data about the HCBA waiver program. As a model, DHCS should look to the California Department of Social Services' (CDSS') monthly IHSS program data. (2 comments)
Response: A Waiver update is not necessary to address this recommendation. DHCS will engage stakeholders to obtain additional input and determine appropriate next steps, if any.

53. Include more-specific timeframes for TAR adjudication and case closure. (2 comments)
Response: A Waiver update is not necessary to address this recommendation. DHCS will engage stakeholders to obtain additional input and determine appropriate next steps, if any.

54. Do not require DHCS' pre-approval to use telehealth [post-public health emergency]. (1 comment)
Response: DHCS updated the Waiver language to address this requirement. Telehealth provided under the Waiver will align with DHCS' telehealth policies for Medicaid State Plan services.