Department of Health Care Services
2022 Home and Community-Based Alternatives (HCBA) Waiver Renewal

Technical Workgroup Recommendations that would Require a Waiver Change

Workgroup Recommendation	Rationale	Other Questions / Considerations
Allow social workers with Bachelor's (BSW) degrees, as well as those with Bachelor's level degrees in related fields; including, gerontology, marriage and family therapy, and psychology, to provide comprehensive care management services (CCM) as a member of the Care Management Team (CMT), when they are supervised by a social worker with a Master's degree who has community-based care management experience.	Waiver Agencies would have access to a much larger pool of candidates if BSWs and individuals with Bachelor's level degrees in related fields, are authorized to provide Comprehensive Care Management services, in partnership with a Registered Nurse. With relevant and ongoing training and supervision by a Master's level Social Worker, DHCS and the WA would be able to maintain quality assurance efforts.	1. What is the appropriate ratio for BSW caseload? 2. What is the appropriate ratio for MSW supervision? 3. How many years/ hours of experience should be required for the BSW? For the MSW? Also, what kind of experience?
Modify the home set-up service so it can be utilized by those living in the community, when they require goods or services to make their home safe (i.e., to purchase smoke detectors/carbon dioxide detectors, cleaning products, clean linens, etc.)	Enrollees' existing, community-based homes could lack essential items necessary to maintain health and safety in the community, and to keep the individual from entering an institution.	1. What is an appropriate maximum amount for home set up costs for individuals enrolling from a community setting? 2. Must provide clear guidance on costs that are the responsibility of property owners, as well as goods / services available under the State Plan
Remove age restrictions to Habilitation and Respite for the Under-21 population – the services are not available through EPSDT; more information is available in the EPSDT: A Guide for States, published by the Centers for Medicare and Medicaid Services (CMS).	At home and facility-based respite would help prevent unpaid caregivers (parents & spouses) burnout - for families who do not have access to the supports through other programs or benefits	The state must assure 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.
Remove Transition Coordination from the Comprehensive Care Management per member per month (PMPM) payment	Would reflect real cost of resources spent transitioning beneficiaries	Recognize that WAs are also CCT LOs and using CCT for Transition Coordination reduces risk and allows the state to draw down enhanced FFP Removing TCM from the CCM PMPM will have a "to be determined" impact on the CCM PMPM
More clearly define requirements for the Circle of Support within the Waiver, and if a Circle of Support is required to be eligible for the Waiver	A more detailed explanation of the roll of the Circle of Support is needed in the waiver; but it should not be used as an eligibility criteria for the waiver	For participants without a Circle of Support, WAs need to work with the individual to develop backup plans with multiple options - in the event a care provider does not show up

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Remove the requirement for a Physical Therapist (PT) to evaluate the need for, and appropriateness of, home modifications	Difficult to get PTs to come to the home, in some counties PTs are not readily available	ALL HCBA Waiver Agencies must also be enrolled to provide CCT services to maximize FFP drawdown and should secure home modifications for participants through CCT What are the requirements for determining medical necessity of home modifications when assessed by an RN
Include more specific requirements for WAs to collaborate with Managed Care Plans (MCPs) for better coordination of care	Foundation for future collaboration with managed care	What should be included as Waiver Agency requirements?
Prioritization of the homeless population with nursing level of care needs And/or Prioritize individuals enrolling from the community who have sub-acute level of care needs And/or Prioritize individuals at imminent risk of institutionalization	At risk populations should be prioritized without being admitted to an institution	Would require a community-based residence to be available. How is the population identified (outside of an institution) - to be eligible for the waiver an individual must have at least skilled nursing care needs; what would differentiate them from a person at imminent risk of institutionalization? If not yet receiving services in an institution, how is cost savings determined?
Allow Enrollment without a signed POT	The current enrollment process takes too long	In other programs, Plans are at risk for the care of the beneficiary with or without a signed care plan For beneficiaries transitioning from an institution, authorized services must be available on the day they return to the community and the POT serves as the Doctor's Orders for Waiver services. Are there ways to improve the enrollment processes?
Add assistive devices as a Waiver service (including: generators for those reliant on life-sustaining equipment, tablets or smart phones for telehealth, etc.)	There are areas of the state without reliable infrastructure that put technology-dependent participants at risk if and when power is switched off. Current backup plans are primarily limited to relocating participants, which can be complicated/delayed if and when NEMT is required to transport a beneficiary.	What is currently not accessible under the state plan and waiver (i.e., what would be purchased)? What would be an appropriate maximum cost? What would be required to approve assistive devices (e.g., minimum criteria/documentation)?

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Adjust CLHF rates based on the cost of living within county	This is would require an budget process apart from Waiver Renewal	Are there examples of rates for other Medi-Cal facilities that are based on the cost of living?
Add the following as waiver services when it is verified they are not available through the State Plan or other means: 1. Congregate and/or Home Delivered Meals 2. Transportation to medical appointments 3. Purchased items such as incontinence supplies, gloves, PPE, home safety items	Care coordination is important for ensuring Participants are receiving the services they need through the programs that are intended to provide them	Authorization requirement/restrictions must be included in the Service Description in Appendix C of the Waiver to clearly identify that when these services are available to eligible participants through other systems, programs, or community-based organizations, they cannot be paid for by the Waiver (for example, NEMT and DME are state plan services)
WPCS workers should be able to do the same things as IHSS workers - add the language from WIC to authorize paramedical services as part of WPCS Include gastrosmy trained respite workers (GTRW) as service providers	Individuals who rely on life-sustaining equipment require trained care providers to maintain their health and safety and IHSS has demonstrated that paramedical services can be provided by unlicensed caregivers who receive training	Paramedical services offered through (suite of services) would require IHSS to be maxed out Up to 24 hr/day Shouldn't be an impact to the budget Would need to work with DSS
Include a paramedical service under the waiver (separate from WPCS)	Individuals who rely on life-sustaining equipment require trained care providers to maintain their health and safety	If paramedical services are included as a waiver service, they could only be added as an extended state plan service, which would require IHSS to be exhausted before waiver paramedical services could be authorized under the waiver - how would this requirement impact the existing waiver population receiving WPCS when IHSS has not been exhausted? How would Waiver Agencies mitigate those impacts?
Full integration of ALW into the HCBA Waiver through the 2022 HCBA Waiver Renewal	Would reduce some public confusion when selecting between available waivers Would reduce administrative burden of managing separate waiver programs	Leaves very little time to address differences between the waivers and implement a full integration

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Full integration of ALW into the HCBA Waiver through a waiver amendment following the HCBA Renewal - phased to align full integration with the ALW end date (2/28/24)	Would still reduce some public confusion when selecting between available waivers, but not as quickly Would reduce administrative burden of managing separate waiver programs Delaying the integration would allow for the time needed for additional planning and stakeholder engagement to reconcile differences between the two waivers for a more intentional and higher-quality integration	Create a new workgroup to begin work on integration, beginning late summer - Assessments (Acuity/Tier, tools, etc.) - Payments - Providers - Transition plan - phase-in plan/timeline
Adding assisted living services into HCBA (as is in ALW) without touching the ALW and evaluating integration of ALW to coincide with end date of current ALW term	Would not impact existing ALW participants, RCFE, or CCA Could help reduce ALW waitlists by enrolling some of those beneficiaries into HCBA to receive similar services	Would not reduce public confusion when selecting between available waivers - has the potential to increase confusion if services are offered under two waivers Would not reduce administrative burden of managing separate waiver programs
Disconnect Acuity and Comprehensive Care Management (CCM) per member per month payment (PMPM)	Makes it too difficult to determine income	Can look at ways to improve the CM Acuity Tool Assessment. How would the state ensure beneficiaries with greater need for case management are still enrolled in the waiver? The acuity payments are to help ensure beneficiaries with complex care management needs are not excluded from the waiver.

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Remove the restriction preventing Parents of Minor Children and Spouses from receiving payment for providing Waiver Personal Care Services to their minor children or spouse	CMS policy is that payments for personal care or similar services delivered by legally responsible individuals (as defined in state law but typically the parent of a minor child or a spouse) are not eligible for federal financial participation. Legally responsible individuals do not include the parent of an adult beneficiary (including a parent who also may be a legal guardian) or other types of relatives, except as provided in state law). 42 CFR §440.167 prohibits FFP for payments to legally responsible individuals for the provision of state plan personal care services. This prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide. See also Section 4442.3.B.1 of the State Medicaid Manual.	If allowed, paying legally responsible adults to provide care to their spouse or child under the age of 18 would create a significant impact to the state general fund to pay for services that are, assumedly, being provided through uncompensated care. Legally responsible caregivers are excluded from Medicaid compensation based on a general presumption that legally responsible individuals may not be paid for support that they are ordinarily obligated to provide. Through HCBS waiver authority, state policymakers can decide to allow legally responsible caregivers to be compensated, but it is limited to instances of extraordinary care needs, though CMS allows states broad latitude to define what constitutes extraordinary care. The payment of family caregivers raises several important questions regarding how to structure consumer directed personal care services. The first challenge relates to oversight responsibility to ensure the quality of care that is delivered to Medicaid beneficiaries and establishing training, qualifications, or credentialing requirements that must be met by family caregivers who are hired. Second, substitution of paid for unpaid help by family caregivers raises budgetary considerations for states due to the potential for reimbursing family caregivers for services that would have been willingly provided in the absence of payment. Third, the blurred lines between family caregiver and paid personal care attendant presents challenges for interpreting labor laws given that family caregivers may provide care both on and off the clock.

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Examine the potential for allowing high school ROP students interested in social services to provide unlicensed care	Would expand the network of available providers It could be a way for students to explore an educational process for those who are interested in becoming a social worker	Would need additional information about ROP requirements and restrictions for consideration.
Examine the potential for allowing developmentally disabled adults to work as WPCS providers	Could help reduce lack of staff. Path for those interested in healthcare	Could be included as a consideration for Gap Analysis
Allow assessments to continue to be allowed to be completed virtually after the end of the public health emergency	Would reduce the time CMTs are on the road in larger service areas Has proven to be effective during the public health emergency	Align with telehealth proposal (Synchronized telehealth, i.e., real-time face-to-face interaction) Likely through an amendment prior to Waiver Renewal

Technical Workgroup Recommendations that would Not Require a Waiver Change

Recommended Change	Rationale	Where Outside of Waiver Renewal?	Other Questions / Considerations
DHCS should convene regular and ongoing stakeholder meetings specific to the HCBA Waiver and ALW	Would provide ongoing input into the waiver and prioritize goals	Public Webinar	How frequently should the workgroup meet? How should the workgroup be structured?
Develop standard, minimum requirements for MOUs between WAs and MCPS to outline care coordination responsibilities, processes, etc.	A step closer to creating consistent, statewide collaboration	WA contract	A template or minimum requirements could be developed, but cannot make it mandatory - recognizing the need for flexibility Also need to consider implementation of CalAIM
Include time frames for intake screening and enrollment - those time frames within the control of the Waiver Agency	The enrollment process takes too long, delaying provision of waiver services	Policy Letter	What can be done to streamline processes to reduce the amount of time required to enroll participants and providers? At what points in the enrollment process? What are realistic timeframes? How should extenuating factors be addressed?
Social isolation and loneliness assessments should be included during assessments so these issue can be included in the POT	Critical issue to be assessed to identify necessary services and supports to maintain the health and wellbeing of participants in the community	Within POT and/or Care Management Acuity Tool	What criteria should be used by the CMT to assess social isolation and loneliness?
If a parent/spouse is authorized to provide RN or LVN services because there are no other willing and qualified providers in the area, Waiver Agency they must: 1) continue to look for, 2) attempt to secure, and 3) document their efforts to obtain, resources to meet the service needs of the participant.	Licensed parents/spouses should only be authorized to provide services if they are the only option available, and only until an other provider can be secured	Policy letter, training, and compliance	How frequently would the WA be required to search for care providers? What evidence would suffice? What are the minimum "search" criteria?

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If a provider receives an overtime exemption for WPCS because additional care providers cannot be secured, the WA must continue to search for care providers and document their efforts to obtain, resources to meet the service needs of the participant	Overtime exemptions should only be authorized as long as it takes to secure additional providers	Policy letter, training, and compliance	How frequently would the WA be required to search for care providers? What evidence would suffice? What are the minimum "search" criteria?
Implement an appeal process WPCS overtime exemption denials	Participants must have the ability to challenge denials	DHCS Process Development and Implementation	Are there concerns with the IHSS appeal process that should be considered?
Would like DHCS to continue to provide training on the Waiver to Public Authorities, County Medi-Cal Offices, MCPs, and potentially others	With frequent staff turnover, training should be provided on a regular basis to maintain effective partnerships	In-person training conducted by DHCS	Training is currently available on DHCS' website
Improve DHCS oversight of: - Waiver Agency compliance with prioritization of intake processing to ensure internal waitlists are not being maintained - Waiver Agencies refusing to process EPSDT age-out's paperwork until 90 days before the child's 21st birthday even when the application is submitted a full year ahead of that date	When the application doesn't get done in the 90 day window, it can lead to dangerous, entirely preventable interruptions in home nursing care for vulnerable patients	Training and compliance	
Improve support for children who are aging out of EPSDT and CCS; suggest a HCBA Transition Team at each HCBA Waiver Agency, that deals specifically with EPDST, CCS and other waivers	Need to create processes that support streamlined continuation of care for participants transitioning between systems of care	As a best practice, but not a requirement	Are there examples of transition teams from other programs that could be replicated?
Need to expand the use of habilitation/supported living services (SLS), similar to the Regional Center system	HCBA waiver agencies can contract with organizations providing habilitation/SLS currently, but increasing this option/learning from those organizations would help support waiver participants	As a best practice, but not a requirement	How are SLS through Regional Centers different from habilitation available through the waiver?

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Allow non-medical transportation under one-time home set-up costs when required to secure housing (to obtain legal documentation, sign leases, view an available residence, etc.)	Participants have higher cost caps for home set-up available to them through CCT, and the state is able to draw down enhanced FFP for those services.	Through CCT or Managed Care Plans	ALL HCBA Waiver Agencies must also be enrolled to provide CCT services. Managed Care Plans are required to provide NEMT
Clearly define Acute and Subacute CLHF Tiers	There is confusion about the two levels	Policy letter, training, and compliance	Provide clarification of existing statute - cannot exceed or expand what is in statute
Waiver Agencies need to have increased functionality within MedCompass to pull data on performance without having to duplicate data in Excel	Current functionality within MedCompass is limited and does not allow Waiver Agencies to pull information that would help them to identify trends, deficiencies, etc.	WA access to Tableau Funding and licenses	
Including requirements for Managed Care Plans to collaborate with WAs in MCP contracts (Look at MSSP contracts with MCPs as an example)	A clear agreement between Waiver Agencies and MCPs could help to: · clearly identify responsibilities and the order of authority · create processes to identify shared beneficiaries · prevent duplication of services · establish dedicated contacts within each organization · create a framework for care coordination	This will be a core function of CalAIM	
Explore platforms and apps in the private sector that work to coordinate care between multiple providers	The apps provide the person's schedule and assist in managing care to coordinate across delivery systems to address the whole person's needs	Gap Analysis	Recommended apps/platforms?
Create a state-wide referral platform for care management providers in different systems of care	HIPPA is a barrier, as well as acceptance of information release forms by different agencies	Gap Analysis	
WA Directory - Have DHCS to provide [and maintain] HCBA Waiver Agencies' (WAs') contact information	CDSS has a website that has contact information for the counties	Webpage	How does CDSS maintain the directory? Are the counties responsible for notifying the state when updates are required?

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Create a system indicator for Waiver participants	Would improve care coordination for providers to see who is enrolled in Waivers	Systems update	Gap Analysis will examine this and explore options for better data sharing /care coordination
Waiver Agencies need better access to data (e.g., service authorizations, claims/payments) under different care systems for efficient and effective care management	Would provide a complete picture of the person's care	Systems development	Gap Analysis will examine this and explore options for better data sharing /care coordination
Allow Waiver Agencies to administer the HCBA Waiver in overlapping service areas	Would allow for greater consumer choice & address capacity limitations	Contract	Should the overlap be limited to neighboring counties, or extended statewide? How would responsibility for applicants within shared service areas be determined/assigned?
Move enrollment date to the date of the assessment – retroactive enrollment to ensure services can be provided on the day the beneficiary goes home OR Allow WAs to determine eligibility after they complete the assessment to enroll the beneficiary into the waiver	The current enrollment process takes too long	Reexamination of current process, potential revisions to policies and procedures	What would happen if a beneficiary is determined not to be eligible for the waiver after services have been provided? Would the WAs be responsible for paying for the services? How would the beneficiary be sustained without the services that were being provided?
Create a mid-month participant transfer reimbursement process for WAs	Would compensate WAs for participants who relocate mid-month	Medi-Cal systems changes	The current reimbursement cycle is based on the Medi-Cal eligibility cycle, changes to the reimbursement cycle would require significant systems changes

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Allow WAs should be able to pay and claim on behalf of providers to ensure timeliness, or on an interim basis until the provider is enrolled in Medi-Cal	Would help to have services in place on the day of transition to the community/enrollment into the Waiver	Claiming process and systems updates	What would happen if a beneficiary is determined not to be eligible for the waiver after services have been provided? Would the WAs be responsible for paying the provider for their services? How would the beneficiary be sustained without the services that were being provided? WAs have the option to pay providers and claim reimbursement for those services (if the WA is an authorized provider of the service). However, the system of payment cannot be made mandatory
Address the gap in services upon beneficiary's 21st birthday – especially when individual is enrolled in CCS, an MCP, or when a beneficiary also has private insurance - More outreach to provide hospitals with information on the Waiver - Letter of intent for a 6-month period if they intend to stay on the Waiver - Work with CCS to identify beneficiaries who should receive information on/application for Waiver	Would help to prevent gaps in private duty nursing services when the beneficiary turns 21-years old	Outreach, letter of intent, collaboration with CCS	Gap Analysis The state currently sends notices to the Under-21 population receiving private duty nursing services one year in advance of their 21st birthday to inform them of the waiver and how to apply
Ensure participants get the mental and substance abuse care they need	Mental health and substance abuse care is essential for maintaining participants at home or in the community - decentralized care can create gaps	Stakeholder workgroup, collaboration with CO. Mental Health	Gap Analysis
Expand the number of HCBA Waiver Agencies	Would support participant choice	Solicitation and contract	Standardization and compliance would be essential if more WAs contract to provide services