Assembly Budget Subcommittee No. 1 Oversight Hearing on

The Administration's Long-Term Care at Home Pending Proposal and Skilled Nursing Facility COVID-19 Emergency Response

Monday, August 17, 2020, 10 am, Capitol Room 4202

Attachments

- May 26, 2020 – Master Plan for Aging Long-Term Services and Supports Subcommittee Stakeholder Report Executive Summary (6 pages)
- July 17, 2020 – Draft Medi-Cal Long-Term Care At Home Benefit Design from the Department of Health Care Services and the California Department of Aging (12 pages)
- July 17, 2020 – Statement of the Master Plan for Aging's Long-Term Services and Supports Subcommittee on the Proposed Long-Term Care at Home Benefit (1 page)
- August 4, 2020 – Master Plan for Aging's Long-Term Services and Supports Subcommittee Recommendations for Immediate Action/Consideration in this Legislative Cycle (14 pages)

May 2020

Master Plan for Aging
Long Term Services and Supports
Subcommittee Stakeholder Report
Executive Summary

Preface | May 26, 2020

The Master Plan for Aging Stakeholder Advisory Committee (SAC) unanimously approved the final draft of the Long-Term Services and Supports (LTSS) Subcommittee report in March 2020 - just before the COVID-19 pandemic fundamentally altered California lives, disproportionately impacting older adults and people with disabilities while also creating a massive budget shortfall. Since that time, the COVID-19 crisis has dramatically revealed and exacerbated the shortcomings in California's LTSS system. We are deeply concerned that the state's response to the crisis has been to propose cuts and program eliminations that stand to decimate the system of services and supports that Californians rely on to remain in the community and maintain dignity and independence.

Instead of cuts to the critical programs and services in California's LTSS system, we ask that you use the recommendations in this report to guide your thinking and approach. The response to the crisis should be driven by the values in the Master Plan and be forward-thinking about the future LTSS system.

The Master Plan for Aging should serve as the state's guardrails during challenging budgetary times, providing a lens from which to view any proposal for its impact on this population. Yet, what we see in the May Revision does not live up to the ideals outlined in the articulated values and goals of the Master Plan. In fact, all of the proposed cuts and eliminations negatively impact progress towards reaching each of these goals and contradict what is outlined in the Governor's Executive Order.

In this report, the LTSS Subcommittee affirms the importance of equity in addressing the LTSS needs of older adults and people with disabilities, with specific recommendations to eliminate disparities and increase equity, accessibility, and affordability in the LTSS system. We continue to stand by these recommendations. Further, we recognize that the COVID-19 crisis has laid bare tremendous system inequities and health disparities that directly result in racial and ethnic populations being at disproportionate risk to contract, to be hospitalized and to die from COVID-19. It has also highlighted the widespread ageism and ableism that infiltrate societal views of older adults and people with disabilities and diminishes their value.

Despite the system's shortcomings, this crisis has demonstrated that California absolutely can rise to meet the challenge of transforming its LTSS system when leaders at the state and local levels work together and move with urgency towards a shared goal. While not perfect in its execution, the response to COVID-19 has unleashed the power of creative problem solving and a willingness to act expeditiously to ensure people have the services they need to stay safe and healthy.

The devastating impact COVID-19 has had on the state's fiscal outlook cannot dampen the urgency for creative thinking, bold planning and prompt action to transform California's LTSS system. This pandemic was preceded by an acute need to accelerate preparedness for the state's aging population and increased incidence of disability. Bold planning does not require immediate resources, but it does require strong leadership that outlines a vision for what California's LTSS system should look like well beyond this moment to better meet the needs of all Californians.

It will take time to fully understand the COVID-19 crisis and its lessons, but it is clear today that the LTSS Subcommittee report offers many recommendations that are critically relevant now.

1. At the Gubernatorial level, there is need for coordinated, engaged leadership addressing issues impacting older adults and people with disabilities across all agencies.
2. In spite of efforts to temporarily expand access to health and social services information during COVID-19, ongoing challenges remain in how and where the public can learn about vital LTSS programs and services in the community.
3. The issues confronting both paid caregivers and unpaid family caregivers remain central to both the COVID-19 crisis and LTSS during ordinary times. This issue deserves focused attention with solutions identified in this report.
4. The shortcomings in licensed residential and skilled nursing care demand prompt scrutiny and systemic reform, with new models of care that prioritize funding, testing and support to further home and community-based living over institutional care.
5. COVID-19 has forever altered how services are delivered in the community, and LTSS programs have quickly demonstrated success using alternative methods. These innovative approaches should not be abandoned or limited to times of crisis and should enable more flexible, creative and person-centered approaches to meet people's needs for the longer-term.

At this critical juncture, it is incumbent upon all of us to seize this crisis as an opportunity to commit to equitable LTSS system reform and transformation because California's older adults, people with disabilities, and their caregivers deserve nothing less.

LTSS Subcommittee Stakeholder Report | Executive Summary

California's population is aging, and it impacts each of us —as individuals, family members, friends, and community members. It also affects our collective ability to pay for and provide the range of services and supports needed for California's increasingly diverse populations of older adults and people with disabilities.

This demographic shift provides an opportunity to design, develop and deliver a blueprint for California that is age-and disability-friendly for all. We embrace the gift of a diverse and growing populations of older adults and people with disabilities representing many races, ethnicities, sexual orientations, gender identities and languages. We believe older adults and people with disabilities are what make us rich as a state; people with vast life experience who contribute greatly to the fabric of our society. Unfortunately, to date, California has fallen short in investing in these populations - resulting in a fragmented and under-funded system of care, with services and supports that have not kept pace with these populations' needs.

In June, 2019, Governor Gavin Newsom signed an Executive Order to create a Master Plan for Aging (MPA). The opportunities offered by a Master Plan for Aging are momentous; never before has a California governor committed to a sweeping system review and long-range plan for the state's aging and disabled populations.

To inform the Master Plan for Aging, the Long-Term Services and Supports Subcommittee (Subcommittee) was asked to look at the challenges and identifying the policy opportunities related to California's long-term services and supports (LTSS) system. To this end, the Subcommittee examined how the system is (and isn't) working for our diverse populations of older adults, people with disabilities, their families, and their caregivers; and how we might build a strong foundation to create a person-centered system that ensures all Californians can live where they choose with the necessary services and supports they and their families need.

To ensure an inclusive and well-informed process, the Subcommittee is represented by a diverse membership representing consumers, LTSS providers, advocates, and caregivers. The Subcommittee convened 10 times in public meetings between October 2019 and March 2020, while also reviewing hundreds of comments and recommendations from key stakeholders and the public.

The Subcommittee identified five core areas of need: Navigation, Access, Affordability, Workforce, and Infrastructure. Accordingly, the Subcommittee urges California to commit to **five bold statewide Objectives,** as defined below and further expanded upon in the body of the report.

Aging is all of us and we all stand to benefit from making California a place where everyone has the chance to age with dignity and independence.

OBJECTIVE 1: A SYSTEM THAT ALL CALIFORNIANS CAN EASILY NAVIGATE

California will have in place an understandable, easy-to-navigate linguistically and culturally responsive LTSS system that includes both home and community-based and residential options. Californians will know how to quickly connect to services they need, no matter where they live or their economic status. People will find what they need wherever they enter -- whether through the health care system, the public benefits system, disability service system , including Regional Centers, or the community-based system.

OBJECTIVE 2: ACCESS TO LTSS IN EVERY COMMUNITY

California will have the country's most comprehensive LTSS system where people and their caregivers can find and afford the services they need and choose, where and when they need them. California must act urgently to fund statewide access to LTSS to ensure sufficient services exist to meet the growing needs of older adults and people with disabilities.

OBJECTIVE 3: AFFORDABLE LTSS CHOICES

California will shift the historical bias for institutional care toward Home and Community-based Services, (HCBS), thereby enabling all Californians who need these services the ability to access them. In addition, California will have in place a statewide universal LTSS benefit program that helps people pay for the Long-Term Services and Supports they choose, at home, in the community, or in residential settings. The LTSS benefit program will be available to people at all income levels and will help delay or prevent the need for people to exhaust all their personal resources in order to access Medi-Cal, including IHSS, for their LTSS needs. California must act now to fund its core programs while creating new sources of LTSS funding to help people avoid the need to spend down to poverty level.

OBJECTIVE 4: HIGHLY VALUED, HIGH-QUALITY WORKFORCE

Recognizing personal preferences and labor market challenges, the state must: 1) provide maximum support to family caregivers who have additional jobs outside the family caregiving setting through family leave policies, including job protections, that allow unpaid caregivers the flexibility to continue to earn while providing needed family support and; 2) accelerate growth of the paid workforce to meet increasing demand for LTSS.

To further address this challenge, public and private partners, including educational institutions, should commit to a statewide goal of attracting, training and retaining workers to fill 1 million high-quality direct care jobs. These jobs will be valued by providing livable wages and benefits, as well as training, education

and advancement opportunities. Intentional policy and budget actions will result in improved job retention and satisfaction, thereby leading to a more stable workforce with less turnover.

OBJECTIVE 5: STREAMLINED STATE AND LOCAL ADMINISTRATIVE STRUCTURES

The California Health and Human Services Agency will have a dedicated cross-department unit focused on LTSS that has authority to develop an effective LTSS system that meets the needs of California's older adults, people with disabilities, caregivers and families; align administration of LTSS across departments; coordinate LTSS, including IHSS, to promote seamless access to services; promote integration and coordination of care for California's Medi-Cal/ Medicare enrollees; and drive innovation in LTSS service delivery.

NEXT STEPS AND THE IMPORTANCE OF STATE & LEGISLATIVE LEADERSHIP

Each of these five big objectives is followed by specific recommendations detailed in the attached report. As such, this report provides a broad 10-year vision for LTSS in California while making concrete recommendations for how to move forward toward that vision.

The report's recommendations span all aspects of the LTSS system, with varying timelines for implementation. While some recommendations represent longer-term strategies, others can be acted upon in the immediate future.

Recognizing the urgency for action, the Subcommittee identified 37 recommendations that are ripe for immediate action and system-wide investments. We can no longer afford to wait.

We believe that the Newsom Administration and Legislative leaders are well-positioned to act boldly now to address the pressing and long-neglected LTSS challenges facing older adults and people with disabilities, families and communities. We stand ready to work as community partners to advance the Governor's Master Plan for Aging.

MEDI-CAL LONG-TERM CARE AT HOME
BENEFIT DESIGN

BACKGROUND AND OVERVIEW

On May 22, 2020, the Department of Health Care Services (DHCS) and California Department of Aging (CDA) announced the development of a potential new Long-Term Care at Home benefit. While this new model of care was initially envisioned to address the need to decompress California's skilled nursing facilities (SNFs) in response to the COVID-19 public health emergency, DHCS believes that this benefit will provide a more holistic, coordinated, and bundled set of medical and home and community-based services, allowing qualifying Medi-Cal beneficiaries across the state an option to stay healthy at home. The following information provides an overview of Long-Term Care at Home, including its key goals, target populations, model of care, financing structure, Federal authority, and public stakeholder process.

DHCS will administer the Long-Term Care at Home benefit, which is intended to support home care for qualifying Medi-Cal beneficiaries by allowing them to transfer from a hospital or SNF to their home, or by preventing SNF stay altogether. It will increase consumer and family choices in where to live and how to receive care. This benefit intends to increase the availability, affordability, and coordination of wrap-around health care services, allowing qualifying Medi-Cal beneficiaries to receive skilled nursing care at home, as an alternative to congregate residential facilities. The medical care and home and community based services (HCBS) provided under this benefit will be tailored to the needs of the individual based on a person-centered assessment and care plan.

With significant input from public stakeholders, DHCS and the California Department of Public Health (CDPH) are partnering to determine the types of organizations that will be best suited to provide the Long-Term Care at Home benefit. Licensing flexibilities may be leveraged in the start-up phase of this benefit to allow existing licensed organizations to participate to the extent consistent with scope of licensure as well as current state and/or federal requirements, as applicable. Organizations that meet applicable DHCS Long-Term Care at Home requirements will be responsible for delivering all applicable bundled Long-Term Care at Home services for qualifying Medi-Cal beneficiaries.

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DHCS intends to implement Long-Term Care at Home to the extent the State determines it is cost-effective and otherwise consistent with the quality and efficiency goals of the Medi-Cal program. DHCS intends to seek federal approval of this proposal from the Centers for Medicare and Medicaid Services (CMS) through Section 1915(i) of the federal Social Security Act[1]. This benefit would be available statewide to qualifying beneficiaries in Medi-Cal's fee-for-service (FFS) and managed care delivery systems. DHCS will develop this benefit with input from CDPH, Department of Social Services (DSS), Department of Developmental Services (DDS), CDA, the Master Plan for Aging Long-Term Services and Supports Subcommittee, and other valued stakeholders. At this time, DHCS anticipates implementing the Long-Term Care at Home benefit in calendar year 2021.

KEY GOALS

Through the creation of Medi-Cal's Long-Term Care at Home benefit, DHCS intends to develop and implement a person-centered alternative care model that improves the patient experience by allowing qualifying Medi-Cal beneficiaries to live at home while receiving long-term care services. To this end, Long-Term Care at Home aims to accomplish the following key goals:

- Provide qualifying Medi-Cal beneficiaries and their families with more choices in living situations and long-term care settings;
- Allow additional options for qualifying Medi-Cal beneficiaries currently residing in SNFs licensed by the State to safely move from a facility to a home;
- Allow qualifying Medi-Cal beneficiaries that may require SNF services in the future to avoid institutionalization;
- Allow qualifying Medi-Cal beneficiaries to be discharged from a hospital to at-home placement in lieu of a SNF stay; and
- Support efforts to decompress residency at SNFs licensed by the State.

These goals will guide DHCS, CDA, other State Departments, and participating stakeholders throughout the course of this effort.

TARGET POPULATIONS

Long-Term Care at Home will be available to qualifying Medi-Cal beneficiaries based on an individual, person-centered assessment, who would otherwise require skilled nursing or skilled

[1] 42 U.S.C. § 1396n(i).

therapy services to treat, manage, and/or observe a condition at a SNF. This includes those who are full-scope Medicaid eligible, and individuals 21 years of age or older who are enrolled for benefits under Medicare Part A, Medicare Part B, or both, and are eligible for medical assistance under the Medi-Cal State plan. Medi-Cal beneficiaries who receive this benefit will be able to transfer from a hospital to their home, transfer from a SNF to their home, or potentially avoid a SNF stay altogether. This model is designed for home care with wrap-around services and does not include transition to Community Care Licensed facilities such as, Residential Care Facilities for the Elderly (RCFE), Adult Residential Facilities (ARF), or privately operated 'Room and Board' or "Board and Care" housing.

DHCS has identified below the three primary categories of skilled nursing or skilled therapy care that may be provided at home through this new benefit. These services would be furnished under the direction of a registered nurse in response to the orders of an attending physician or primary care provider.

- **Short-term skilled nursing** resulting from hospital-to-home transfers. This category may include more temporary/intermittent therapies or clinical services, for someone who is recovering from an illness, injury or surgery. This category includes unskilled assistance with activities of daily living (ADLs) and household tasks. This category may also include but not be limited to skilled care for dressing wounds, dispensing medications, monitoring vital signs, or providing physical, speech, or occupational therapies.

    - **Case Example:** RM is a Medi-Cal dual eligible, 85-year-old woman who received bilateral total knee replacements. She lives alone at home with support from her children who live in the Bay Area. She did well during and after the surgery, but the discharge planner realized she did not have anyone in the home to assist with various ADLs and other related health care services. The physician and discharge planner arranged a plan of care for her. After discharge from the hospital, she was transferred to a SNF for rehabilitative care. At the SNF, she received personal care services for assistance with ADLs and routine physical and occupational therapy services for three weeks before returning home.

- **Long-term skilled nursing** resulting from hospital-to-home transfers, SNF-to-home transfers, or as a means to prevent a SNF stay. This category may include, but not be limited to, clinical personnel who provide continuous medical and nursing services, support, and equipment for prevention, diagnosis, or treatment of acute illness or injury for chronically ill patients whose primary need is for availability of more intensive skilled nursing care and/or skilled therapies on an extended basis.

    - **Case Example:** AT is a 75 year old grandfather and widower, originally from Lithuania, with English as a second language has been diagnosed with depression, hypertension, and diabetes. He was discharged from the hospital after suffering a stroke while at home. He has a primary care physician and sees

a psychiatrist monthly for his depression. Both his hypertension and diabetes have been out of control. His children have been called in to assist with medication management. After being discharged from the hospital, arrangements were made for bi-weekly visits to a rehabilitation clinic for physical and occupational therapy services. He lives alone and will need IHSS services, nursing visits for medication management, meal preparation and potentially additional personal care services beyond what IHSS may authorize.

- **Low-acuity skilled nursing** resulting from hospital-to-home transfers, SNF-to-home transfers, or as a means to prevent a SNF stay. This category may include but not be limited to clinical personnel who provide less intensive, time-limited and/or intermittent, medical and nursing services, support, and equipment for prevention, diagnosis, or treatment of acute illness or injury for ambulatory or non-ambulatory patients who may have recurring needs but who do not require the availability of continuous skilled nursing care. This category may or may not include intensive skilled therapies.

    - **Case Example:** AD is a 65-year-old woman with pancreatic cancer who underwent surgery for Gastrostomy tube (G-tube) placement, which is surgical procedure to insert a tube through the abdominal wall and into the stomach. She was losing weight due to the cancer and had the G-tube placed for nutritional supplementation. She needs assistance with G-tube feedings and maintenance of the site, personal care services and medication administration, which includes oral chemotherapy. She is weak and requires the use of a walker; she can ambulate with the walker with bouts of instability and is at risk for falls. She has a single daughter who works fulltime and assists her with care in the home during her off hours/weekends.

Not all Medi-Cal beneficiaries who require long-term care services will be eligible for this benefit. Some may not have medical needs that meet the threshold for the skilled nursing level of care, while others may have high-acuity needs or conditions that will not be a good fit for this benefit, e.g., their condition is not suitable for home-based care due to safety or other similar concerns.

Duplication of Services

Since many of the long-term care services provided under this benefit may be available through other avenues and/or programs, DHCS will also evaluate and provide clear written policy guidance as to when it may exclude Medi-Cal beneficiaries to avoid duplication of services. For example, a beneficiary of the Home and Community Based Alternatives 1915(c) Waiver services would not be eligible to receive this benefit due to many services being duplicative. This same policy would apply to any other 1915(c) Home and Community-Based Waivers or 1915(i) State Plan Options currently operated by the State. The Long-Term Care at Home policy may, therefore, exclude Medi-Cal beneficiaries who would concurrently receive other services that

are the same in nature and scope regardless of source, including Federal, State, local and private entities to prevent potential duplication of services, though they may transition between programs as their care needs change.

The following are a few case examples in which an individual is better served by other programs/services:

- **Case Example - Hospice:** ES is a 70-year-old woman with end-stage liver disease, and her attending physician informed her that she has six months to live. She elects hospice in lieu of curative treatment. She completed the election package and her attending physician and the hospice medical director (or the physician member of the hospice interdisciplinary team) certified that she is terminally ill. She elected hospice on September 1st and began receiving hospice care in her home. She receives nursing services, counseling services, and home health aide and homemaker attendant services. Her initial certification date was September 1st through November 29th. She was recertified from November 30th through February 27th, and recertification will continue every 60 days until death. At each recertification, the Hospice provider must document the patient still qualifies for hospice care in the patient's medical record.

- **Case Example - Home Health:** EB is a 21-year-old female who gave birth to a baby girl. The baby girl was placed in the Neonatal Intensive Care Unit (NICU) for respiratory distress with an umbilical hernia and drug exposure at birth. The physician was concerned about the care of both mother and child after discharge from the hospital as she has no support system at home. Upon discharge, the physician and discharge planner created a plan of care for a referral to a Home Health agency to evaluate the mother-infant bonding and provide eligible services in the home. Nursing services for the mother and child included a case evaluation and initial treatment plan for the month of delivery and one subsequent month. Nursing services included maternal and child education in nutrition and appropriate child development. Home health aide services were arranged to assist her in the home and community referrals to La Leche Program (breastfeeding support group), mother support group, early child development group, and/or other public health programs.

Enrollment in Existing Home and Community-Based Services

- **1915(c) and 1915(i) waiver programs:** In general, 1915(c) waiver and 1915(i) State Plan programs have many services similar to those proposed under the Long-Term Care at Home benefit. To avoid duplication of services the state does not allow participation in more than one 1915(c) or (i) program at the same time. If a beneficiary qualifies for multiple 1915(c) or (i) programs, the beneficiary may choose the one program that most

appropriately meets their needs and circumstances. For a list of California's 1915(c) and 1915(i) programs, please see the Continuum of Care document.

- **Community Based Adult Services (CBAS):** The CBAS program is authorized under the state's 1115 waiver, Medi-Cal 2020, primarily within the Medi-Cal managed care delivery system. CBAS provides a bundle of services in an outpatient setting, with a per diem payment to the CBAS center. Many CBAS services are similar to those proposed under the Long-Term Care at Home program. Due to the bundled payment structure of both programs, a beneficiary who qualifies for both may choose the one program that most appropriately meets their needs and circumstances.

- **Program of All-Inclusive Care for the Elderly (PACE):** Due to the similarities between PACE and Long-Term Care at Home benefits and service delivery model, a beneficiary who qualifies for both programs may choose the one program that most appropriately meets their needs and circumstances.

- **In-Home Supportive Services:** For individuals who qualify for In-Home Supportive Services (IHSS), the IHSS provider hours will be coordinated with the Long-Term Care at Home benefit through the development of the person-centered care plan. The county social service agency will continue to conduct assessments and reassessments for IHSS, and the Long-Term Care at Home organization will coordinate with the county, the individual, and their providers regarding medically necessary services needed in addition to IHSS. This coordination process is similar to the approach used by Regional Centers for services under the 1915(c) waiver for individuals with developmental disabilities.

Dual Eligible Beneficiaries

DHCS will continue to invest additional time and consideration to analyze and clearly articulate those instances in which it would be appropriate for dually eligible beneficiaries, e.g., those with both Medicare Part A and/or Part B and Medicaid eligibility, to access and/or utilize this benefit to the extent any necessary federal approvals are obtained by the Department for this purpose. For dually eligible beneficiaries, Medi-Cal covers institutional long-term care benefits and costs that go beyond Medicare coverage for medical care and behavioral health. DHCS intends for dually eligible beneficiaries to be eligible for the Long-Term Care at Home benefit, as long as there is no duplication of services, regardless of payer source. Further, DHCS will collaborate with CMS to incorporate the Long-Term Care at Home benefit into Cal MediConnect health plan benefits and contracts, and will explore how this benefit could be provided in partnership with Dual-Eligible Special Needs Plans and other Medicare Advantage plans, as well as Medicare Fee-for-Service.

DHCS and CDA will continue to refine the target populations of this new benefit through a thorough stakeholder engagement process, which is discussed further in this document.

MODEL OF CARE

This model of care will provide a holistic, culturally appropriate, person-centered approach that is aimed at improving the overall Medi-Cal beneficiary experience. The Long-Term Care at Home benefit will do this by providing applicable services and leveraging existing health care organizations that will provide all aspects of the benefit, in consultation with the beneficiary's primary care provider or other treating physician, along with their Medi-Cal and/or Medicare managed care plan. The array of services provided will take into consideration social determinants of health and culturally competent services in planning for the care needs of the beneficiary. Under this model the referring provider, managed care plan or Long-Term Care at Home organization performs an assessment of the medical and psychosocial needs of the individual (including family members), and provides skilled nursing care and related therapies as part of a suite of services. The Continuum of Care attachment provides more information on services provided under the various Home and Community-Based Services offered under Medi-Cal, and how those services relate to the Long-Term Care at Home model.

Long-Term Care at Home will not require a new and distinct CDPH licensure process for organizations that seek to enroll with Medi-Cal to provide the benefit; instead, as described above, DHCS intends to leverage and utilize existing state licensure categories and appropriate organizations to deliver Long-Term Care at Home services. Throughout the stakeholder process, DHCS will continue to solicit input and further refine the types of organizations (e.g., HHAs, PACE organizations, hospitals, hospice, etc...) that may be best suited to provide this benefit. Organizations that successfully meet all applicable Medi-Cal Long Term Care at Home requirements and become enrolled Medi-Cal providers will then be eligible to provide the benefit to Medi-Cal FFS beneficiaries through a direct relationship with DHCS, and to Medi-Cal managed care beneficiaries if contracted through provider network agreements with Medi-Cal managed care health plans (MCPs). For beneficiaries enrolled in Medi-Cal managed care, Long-Term Care at Home will be carved-in to DHCS' contracts with MCPs, who will be responsible for the provision of the benefit to their members. MCPs will be expected to establish provider network agreements with Long-Term Care at Home organizations that meet the provider requirements established by DHCS for this benefit.

DHCS envisions a Long-Term Care at Home benefit that integrates three primary components: individual, person-centered assessment; care coordination; and medical and HCBS. If a qualifying Medi-Cal beneficiary needs transition services, separate eligibility criteria will be required. The organization providing the Long-Term Care at Home benefit will be responsible for providing and coordinating all components of the benefit through interdisciplinary care teams that work directly with qualifying Medi-Cal beneficiaries, and their families, caregivers, PCPs, and MCPs.

Individual, Person-Centered Assessments
An individual, person-centered assessment will be conducted for each potential recipient through physician and/or MCP referrals to Long-Term Care at Home organizations. Based on the individual assessment, a person-centered plan will be provided. This person-centered service planning process includes but is not limited to participation of people chosen by the beneficiary, timely execution, reflects cultural consideration, and includes a process for the beneficiary to request updates to the plan.

The Long Term Care at Home organizations will evaluate each individual's health care needs along with their social, emotional, and physical capacities to reside safely at home in their communities. These organizations will conduct assessments through standardized tools to ensure appropriate utilization of the benefit. If the level of care and other program requirements are met, the benefit will be provided at the option of the Medi-Cal beneficiary.

Care plans for individuals who receive this benefit will be developed with input from the person, their family and/or caregivers, their circle of support, the person's care team, and their clinicians. The care plan must be approved and signed by a physician and should include the following considerations:

- Diagnosis, symptoms, complaints, and complications indicating the need for the benefit;
- Description of individual's functional level;
- Objectives;
- Orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures;
- Plans for continuing care; and
- Plans for discharge or, in this case, discontinuation of the benefit.

The assessment and subsequent service plan shall include documentation demonstrating there is no duplication of services being provided through the state plan or other waiver programs.

Care Coordination
The Long-Term Care at Home organization will provide comprehensive, whole-person care coordination, which ensures the Long-Term Care at Home services are not duplicating other services already being provided. The organization will utilize inter-disciplinary care teams consisting of physicians, nurses (RN/LVN), social workers (LCSW/MSW), and personal care assistants to coordinate medically necessary Medi-Cal services and ensure the beneficiary is receiving designated social services. The care team will maintain an ongoing relationship with each individual and their PCP and managed care plan.

Medical and HCBS

The Long-Term Care at Home organization will provide all medically necessary Long-Term Care at Home services in the home and community setting. For this reason, individuals who require care that cannot be provided under these circumstances may be considered ineligible for this benefit. Utilizing the assessment and person-centered care plan, the care coordination team may arrange for health care services that may include:

- Physician services
- Nursing services
- Physical, occupational, and speech therapy services
- Social worker services
- Medical equipment
- Medical supplies
- Personal care, transportation assistance, and homemaker services
- Short-term respite for caregivers
- Assistive and medical technology
- Dietary counseling and nutrition services
- Services for Mild-to-Moderate mental health conditions
- Family/Caregiver training
- Personal Emergency Response Systems
- Laboratory services

Transition Service

Qualifying Medi-Cal beneficiaries from residential facilities or other applicable settings who meet specific eligibility criteria through the assessment process may be eligible to receive transition services, as outlined below, to support transition from the residential facility to the home. Additional eligibility criteria will apply to these services, limiting them to more substantial transitions, such as Medi-Cal beneficiaries returning home from long-term SNF stays who require coordination, home placement, and/or home modifications.

For those who meet the additional eligibility criteria, the beneficiary's primary care provider or other treating physician, and/or the Long Term Care at Home organization along with their Medi-Cal and/or Medicare managed care plan will arrange for transition services. The transition service provider will conduct a housing assessment for the appropriate level of community living, which may range from full to partial independence utilizing caregivers and other supports. Following the assessment, the transition service entity provides all medically necessary transition services, including but not limited to services such as wheelchair ramps,

grab-bars, or other adjustments to the home that will enable each individual to safely remain at home. Transition services will be billed separately from the per diem rate by the appropriate entity or provider. Transition services will not include monetary assistance to secure housing such as rent or the like. However, many other federal, state, and local programs provide subsidies for rent.

Since being a beneficiary of waiver services does not preclude someone from participating in the Money Follows the Person/California Community Transitions Grant (MFP/CCT) Program, when a qualified Medi-Cal beneficiary has met the requirement of a 90-day institutional stay, the beneficiary's primary care provider or other treating physician, and/or the Long Term Care at Home organization along with their Medi-Cal and/or Medicare managed care plan will prioritize the coordination of transition services in accordance with the MFP/CCT Program.

LONG-TERM CARE AT HOME PROVIDER NETWORK AND LICENSING

DHCS understands the importance of having a sufficient provider network in place to render the Long Term Care at Home benefit and work remains underway within DHCS, in collaboration with CDPH, on this front in assessing the requirements that must be met for organizations providing Long Term Care at Home services. Additionally, where applicable, DHCS will leverage existing network requirements for the MCPs to help ensure network capacity for those who may be eligible for this benefit. DHCS is proposing that Long-Term Care at Home organizations must be Medi-Cal enrolled providers, and for those serving dual-eligible beneficiaries, must be Medicare enrolled providers.

DHCS, in partnership with CDPH, and in response to stakeholder feedback, is not proposing that a new licensure category be established for this benefit; instead, the planned approach is to leverage and utilize existing licensure categories and appropriate organizations to deliver Long-Term Care at Home services. Organizations that successfully meet all applicable Medi-Cal Long Term Care at Home requirements and become enrolled Medi-Cal providers will then be eligible to provide the benefit

FINANCING AND COST

Once the benefit scope is sufficiently developed, based on the amount of benefits and intensity included, DHCS will seek to establish a FFS per diem payment in the Medi-Cal State Plan. The FFS per diem will be paid to Long-Term Care at Home organizations to provide any of the medically necessary services enumerated in the benefit. DHCS will consider other financing nuances such as the potential of tiered acuity rates—either as a percent increase/multiplier in the established per diem or as a separately calculated and defined per diem for each acuity level. DHCS will use current FFS and waiver rates for similar services, including hospice and institutional rates, to inform an appropriate per diem. The impact of the benefit will be appropriately considered and accounted for in the development of MCP capitated rates.

DHCS considers clinically appropriate utilization management policies to be a critical component of this benefit, as a means to ensure qualifying Medi-Cal beneficiaries receive a level of care that is appropriate for their needs, dynamic to meet any changes in their condition, and cost effective. Further, Long-Term Care at Home is envisioned to be an alternative for skilled nursing home placement to give Medi-Cal members additional choices in their care while also being a cost effective option in lieu of institutional placement. At minimum, DHCS intends to apply criteria that limit this benefit to those Medi-Cal beneficiaries who require skilled nursing level of care. The benefit structure and all-inclusive rate is intended to provide any necessary routine care related to the person's condition that makes them eligible for skilled nursing level of care. This will limit the ability for service providers to separately bill for services included in the all-inclusive per-diem rate to avoid any duplication of benefits or reimbursement. The Long Term Care at Home organization will be fully financially responsible for the benefits defined and will either directly provide or contract with service providers for the provision of covered benefits. Only those covered benefits not included in the all-inclusive per diem will be able to be separately billed; however, the primary care provider or other treating physicians, Long Term Care at Home organization and/or the managed care plan will be responsible for coordinating those "carved-out" wrap benefits.

DHCS is exploring what services, if any, create risk volatility in establishing a per diem and therefore would be more appropriately reimbursed separately. This benefit is intended for those individuals who can safely reside within their own home with the support of these services, and is not intended for individuals whose condition requires them to remain in facilities. It is also important to note that Long-Term Care at Home benefit and the per diem will not fund services that are not Medi-Cal benefits such as rent, room and board, etc.

FEDERAL AUTHORITY

At this time, DHCS considers the Section 1915(i) State Plan as the preferred vehicle for obtaining the requisite federal approval for this concept. Section 1915(i) will allow Medi-Cal to offer a variety of services under a statewide HCBS State Plan benefit for both FFS and managed care beneficiaries, without capping the number of qualifying beneficiaries served. Individuals who meet state- and federally-defined eligibility criteria, based on need, may receive a combination of acute-care medical services (e.g., skilled nursing services) and long-term services (e.g., respite, case management, and environmental modifications) in home and community-based settings. In addition, the Section 1915(i) vehicle will provide DHCS the following flexibilities when developing the Long-Term Care at Home benefit:

- A benefit targeted towards one or more specific Medi-Cal populations;

- Expansion of the benefit to individuals who require less than institutional level of care and, therefore, are ineligible for HCBS under section 1915(c) waivers, in addition to serving individuals who have needs that would otherwise require institutionalization.

Section 1915(i) explicitly provides that State Plan HCBS may be provided without determining that individuals would require the level of care provided in a hospital, a nursing facility (NF), or an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Once approved, the Section 1915(i) authority does not require the State to subsequently renew the program, except when states choose to target the benefit to a specific population(s). When a state targets the benefit, approval periods are for five years, with the option to renew with CMS approval for additional five-year periods.

STAKEHOLDER ENGAGEMENT AND TIMELINE

Despite an ambitious timeline to develop this new benefit, DHCS and CDA will facilitate a thorough stakeholder process in coordination with the Master Plan for Aging Long-Term Services and Supports Subcommittee, other public stakeholders, and partner Departments within the Administration including but not limited to CDPH, DSS, DDS, and the Department of Rehabilitation. Other public stakeholders include but are not limited to consumer advocates, health care providers, health plans, counties, trade associations, and labor unions. DHCS and CDA will convene three public stakeholder meetings with the Long-Term Services and Supports Subcommittee and each will include an opportunity for comment by all members of the public. Telephone and webinar details and meeting materials will be posted on the websites of DHCS, CDA and CHHS' Master Plan for Aging page. In addition, DHCS will make itself available for ad hoc meetings and breakout sessions with valued stakeholders, to the extent possible, for iterative exchanges of feedback and recommendations.

The first phase of intensive stakeholder engagement is planned to occur during the months of June 2020 through August 2020. DHCS will use the feedback gathered during this time to further inform Long-Term Care at Home policy development which may continue through the end of 2020. As necessary, DHCS will facilitate additional periods of stakeholder engagement focused on the more complex aspects of this new benefit through the end of 2020, until the policy is finalized. DHCS will then post the 1915(i) State Plan Amendment for public comment and seek formal approval for this benefit from CMS. Following CMS approval, DHCS will engage stakeholders again to obtain feedback during the implementation stage of Long-Term Care at Home. This stage may include further policy development and outreach in the form of policy letters, provider manual updates, beneficiary notices, and other public announcements. At present, DHCS intends for Long-Term Care at Home to go live in 2021 contingent upon CMS approval. After go live, DHCS will focus its activities on increasing Medi-Cal's statewide network of Long-Term Care at Home organizations to support adequate access to this new benefit.

Questions about Medi-Cal's new Long-Term Care at Home benefit may be directed to LTCatHome@dhcs.ca.gov.

July 17, 2020 Statement of the Master Plan for Aging's Long-Term Services and Supports Subcommittee on the Proposed Long-Term Care at Home Benefit

As noted in its final Report, the Long-Term Services and Supports Subcommittee (LTSS Subcommittee) believes system change is rooted in equalizing access to home and community-based services (HCBS) and assuring that these HCBS are accessible across the state and fully integrated with necessary medical care services. A core principle of the LTSS Subcommittee is improving access to LTSS structures and models that have a successful track record of person-centered, community based care. Today, many Californians are unable to access the services and supports they want and need within their home and community, whether due to long waiting lists or a lack of available options. This lack of access to quality, coordinated health and HCBS causes severe health problems, exacerbates health inequity, and impedes an individual's ability to remain in the community and avoid institutionalization, while resulting in higher costs to the state and federal government.

The proposed LTC at Home benefit has the potential to provide meaningful choice in and access to services in the home and community settings. However, as proposed, the benefit's target population and model of care remain unclear. Meanwhile, COVID-19 continues to wreak havoc on California's older adults, individuals with chronic conditions and their family caregivers, with disproportionate impact on Black, Latinx, and Asian/Pacific Islander populations -- particularly among individuals residing in skilled nursing facilities and congregate settings. The COVID-19 crisis demands immediate action: California cannot afford to wait until 2021 for the eventual and uncertain rollout of a state plan benefit to decompress nursing homes.

Recommendation: Embark on a phased approach: 1) Focus Immediately on Identifying those Most at Risk for Nursing Home Admission while 2) Planning for a Meaningful State Plan Benefit

Much work remains to develop the program components of a meaningful state plan benefit. Recognizing the urgency of the COVID-19 crisis and the need to transition individuals safely from institutions to the community, we propose the following parallel process that focuses immediately on identifying those most at risk for a short or long term nursing home placement, and those who are currently in a facility who could return home with supports while simultaneously planning for a meaningful state plan benefit.

- Immediate Crisis Response: Utilize existing programs and federal flexibilities to achieve this goal now. We believe the state can act now to work with existing HCBS programs to facilitate timely transitions, using federal flexibilities afforded through COVID-19 as the state has done with other program elements. For example, the California Community Transitions Program, the Assisted Living Waiver, Community Based Adult Services, the Home and Community-Based Alternatives Waiver, PACE, Whole Person Care, the Multipurpose Senior Services Program, Regional Center services, Medi-Cal managed care plans and others could be innovated and expanded to address the need for skilled nursing decompression with immediate access to alternative community settings while also providing support for family caregivers. The LTSS Subcommittee will present detailed recommendations on this component by the end of July 2020.

- Short-term Planning for a Meaningful Long-Term Care at Home Benefit. We recommend that DHCS work with federal and state partners to develop a thoughtful approach to state plan and infrastructure development, with implementation based on local capacity to meet network adequacy and readiness standards. In particular, the LTC at Home Benefit should integrate health and LTSS services, with increased access to quality HCBS on a statewide basis and full supports for family caregivers. The LTSS Subcommittee will release a concept paper outlining the core components of a meaningful Long-Term Care at Home benefit, to be released by the end of July 2020.

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Master Plan for Aging LTSS Subcommittee
Recommendations for Immediate Action/Consideration in this Legislative Cycle
August 4, 2020

The LTSS Subcommittee was tasked with reviewing and advising the Department of Health Care Services on its Long-Term Care at Home proposal. As this work progressed, the LTSS Subcommittee decided that it had to do more than respond to the LTC at Home proposal because it did not appear that that proposal could achieve the goal of decompressing nursing facilities in the short term and it needed more time and development.

Given the grave situation with COVID-19 and the very real need to save the lives of older adults and people with disabilities, who are at high risk of dying from COVID, the LTSS Subcommittee committed to producing a list of items that could be quickly implemented, used existing HCBS infrastructure, and would keep people out of nursing homes and other congregate facilities. We worked to create solutions that can be targeted as needed to the communities most at risk. We worked to maximize use of Medi-Cal funded programs, but also provided solutions for those who do not qualify for Medi-Cal.

This packet provides information about 10 of our recommendations. Please note, the proposals below are not listed in priority order. The page numbers are cross-referenced and hyperlinked to each individual proposal.

10.	PACE	- Supplemental Rate and Rapid Approval	12
Increase Health and Safety			
11.	Require COVID testing	-Require COVID testing before admission into a skilled nursing facility	13
12.	Community/HCBS PPE	-Ensure clients/participants/residents and staff have access to PPE	13

As a first step, a rapid assessment of each county LTSS system must be completed to identify local priorities and organizational steps to take to address impacts of COVID-19 on older adults and people with disabilities who are most at-risk for COVID-19. The rapid assessment must include establishing a rapid response team and response plan in order to: 1) identify and assess people in need of transition and diversion supports, 2) scope available services and mitigate gaps in services, and 3) evaluate workforce capacity. The rapid response team and plan should include LTSS providers, Community Based Organizations, hospitals, local government including Health & Human Services, Public Health, and other Access and Functional Needs taskforces. These rapid assessments should also look at disability-specific needs when possible, like those for blind and visually impaired, deaf and hard of hearing, and those with developmental disabilities. Together, these stakeholders will allow each local jurisdiction to collaboratively mitigate, prepare for, respond to, and effectively divert individuals from going into a nursing home and transition individuals back to the community. The rapid response plan will help identify which of the following specific recommendations are needed.

1. **California Community Transitions—Authorize in statute and develop state-only program)**

Program Overview: California's federal Money Follows the Person (MFP) Rebalancing Demonstration, entitled "California Community Transitions" (CCT) enables eligible Medi-Cal beneficiaries the opportunity to transition from a nursing facility setting to the community using support networks and providers to facilitate and monitor their transition. Eligible individuals of all ages must have resided in specified facilities for at least 90 days. Once transitioned, participants live in their own homes, apartments, or in approved community care facilities, receiving services at home and in the community according to their needs and preferences. CCT is a critical component of the state's continued efforts towards compliance with the U.S. Supreme Court's 1999 Olmstead Decision, and affirms California's commitment to ensure persons with disabilities have appropriate access to, and choice regarding, community-based services and placement options.

CCT and COVID Response Needs: High-needs individuals who reside in institutional settings are at significant risk for contracting and being hospitalized for COVID-19. It is critical that individuals residing in institutional settings have access to transition services to enable them to return to the most home-like setting possible. Because approximately 84% of nursing facilities residents stay in the facility for fewer than 90 days, it is imperative that we provide people needing shorter term stays with the ability to transition home so they do not end up staying in a facility longer than is necessary. The CCT program provides the necessary infrastructure to

transition individuals during this time of crisis. This program could be targeted to communities and facilities with high rates of COVID-19 infections.

Program Limitations: Based on the federal requirements, the CCT program is limited to Medi-Cal individuals who have resided at least 90 days in an institutional setting. This requirement prevents shorter-stay individuals from transitioning back to the community.

Recommendation: Amend SB 214 (Dodd) to codify the CCT program in statute while developing a state-only program that enables transition of individuals residing in institutional settings for fewer than 90 days.

2. **California Community Living Fund—Establish flexible fund to help prevent institutionalization**

Background: The COVID-19 crisis demands that California's older adults and people with disabilities who are either institutionalized or at-risk of institutionalization be enabled to remain in or transfer to a community setting.

According to the 2017 Long-Term Services and Supports Scorecard, almost 11 percent of California's 101,000 nursing home residents—or 11,000 --- are identified as having low-care needs. This means that these individuals could be cared for in the community as an alternative to institutionalization. But for many such individuals, the opportunities to transition either don't exist or these individuals and their families do not realize there are other alternatives. Surveys of nursing home residents reveal that a majority of residents do not want to remain in a nursing facility (NF), but thousands of Californians lack the appropriate services and resources necessary to transition. In particular, individuals often need flexible funds to assist with short-term costs including first and last month of rent, or other emergent needs for food, heaters, or related necessities.

COVID and Institutional Transitions/Diversion: The unprecedented COVID crisis requires flexible funding to meet emergent transition needs of institutionalized individuals as well as those who are at risk for institutionalization.

Recommendation: Establish the California Community Living Fund: The state should establish a California Community Living Fund that would serve as a "bridge" program to provide services to individuals moving from an institution to the community, as well as individuals residing in the community who are at-risk of institutionalization. The fund would address special circumstances that arise out of an eligible individual's need for certain goods or services, or other conditions on a non-recurring basis in order to transition individuals from institutional to community settings or to help individuals remain in the community and avoid institutionalization. This concept is modeled off the San Francisco Community Living Fund which helps individuals transition from institutions and remain in the community to avoid institutionalization. This fund is different than the CCT state-only program because it is not restricted Medi-Cal beneficiaries although they can receive goods and services if not paid for

through Medi-Cal, and it is not restricted to those transitioning out of nursing facilities. It is important to note, the Community Living Fund could be a complement or combined with the Department of Rehabilitation Transition Fund, which is a grant program provided pursuant to the State Independent Living Plan. The Community Living Fund could be used as a mechanism to provide grants for securing housing, housing modifications, assistive technology, in-home care, and other items necessary to enable persons with disabilities to transfer to home from a congregate setting or to remain in their own homes.

3. **Rapid Response Intensive Care Management**

Background: One of the barriers to successfully moving individuals from hospitals or nursing to facilities is the lack of targeted care management. California's current LTSS system often operates in programmatic silos which can make it difficult to both assess all of a person's needs as well as ensure that the services, supports and goods and services are available on the day of discharge. The end result are delays in discharge, something that we cannot afford to do during this pandemic.

Recommendation: Establish Rapid Response Intensive Care Management

Use existing HCBS or managed care programs with experience and capacity to create rapid response intensive care management "hubs." These hubs would work with discharge planners in hospitals to ensure patients can come up with the appropriate services and supports. These hubs would help ensure that coming home is a real option for people who would otherwise go to a nursing facility. The hub concept could be beta tested in a community/region where there is need, but also where there are strong HCBS programs and managed care involvement/interest.

4. **Assisted Living Waiver—Increase slots and counties where available**

Program Overview: California's Assisted Living Waiver (ALW) offers a range of health-related services, social services, and supportive services to eligible older adults and persons with disabilities who meet requirements for Medicaid coverage of nursing facility care, but who prefer to reside in a community-based setting. The program is offered in the following settings: Residential Care Facilities for the Elderly, Adult Residential Care Facilities or publicly subsidized housing. Eligibility is limited to Medi-Cal beneficiaries over the age of 21. Services include, but are not limited to: assistance with activities of daily living; health-related services including skilled nursing; transportation; recreational activities; and housekeeping.

The waiver operates in 15 counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma, with a cap of 5,744 enrollees.

Assisted Living Waiver and COVID Response Needs: High-needs individuals, including those meeting the Assisted Living waiver eligibility, are at significant risk for contracting and being

hospitalized for COVID-19. It is critical that waiver-eligible individuals residing in the community or in institutional settings have access to the services and supports in the most home-like setting possible, including Assisted Living. During the pandemic, ALWP staff are having extensive communication with Skilled Nursing facility staff to enable smoother transitions for existing clients re-enrolling into the ALWP after short-term rehabilitation stays as well as facilitating new enrollment in the program. ALW professionals are using telephone and telehealth modalities to continue to provide care including monthly visits, Initial Assessments and Reassessments, to keep people from moving into SNFs. Providing support in a range of residential facilities will ensure that those individuals with lower acuity will be able to avoid SNF enrollment and reduce exposure to COVID-19. It will ensure those currently in publicly subsidized housing remain in the community in non-congregate care while those already in RCFE and ARCF will remain with additional assessments, interventions and care to reduce exposure to unnecessary risk.

Waiver Waitlist: As of June 2020, the Assisted Living Waiver waitlist was 4,803 individuals.

Recommendation: Expand the Assisted Living Waiver by 10,000 slots and geographic reach widened, consistent with the intent of AB 2233 and AB 50 (Kalra 2018, 2019). Of this amount, 5,000 slots should be added by January 2021 and 5,000 slots added by January 2022. These slots can be targeted to communities and counties with high COVID-19 rates and could help solve housing for those who cannot return home or do not have a home to return to. Slots could be added quickly using the Appendix K flexibility provided by CMS.

5. **Home and Community-Based Alternatives Waiver—Increase slots and flexibility**

Program Overview: The Home and Community-Based Alternatives (HCBA Waiver) provides specified Medi-Cal beneficiaries the option of returning to the community from institutional settings and/or remaining in their homes or home-like community settings in lieu of institutionalization. Eligible individuals include Medi-Cal beneficiaries who are eligible for admission into, or who currently reside in, a Medi-Cal funded nursing facility, subacute facility, Intermediate Care Facility-Developmental Disabilities/Continuous Nursing (ICF-DD/CN) or acute hospital. The HCBA Waiver includes the following services:

- Private duty nursing including home health and shared services
- Waiver Personal Care Services (WPCS)
- Case management/coordination
- Habilitation
- Home respite
- Community transition
- Continuous nursing and supportive services
- Environmental accessibility adaptations
- Facility respite, family/caregiver training
- Medical equipment operating expense
- Personal Emergency Response System (PERS) -installation and testing

- Transitional case management for medically fragile and technology dependent individuals of any age

Prioritization for Slots and Waitlist: Eligible applicants who meet the waiver level of care criteria are automatically placed on a waitlist. As of March 2020, the waitlist for the HCBA waiver was 836 slots, despite having excess capacity of total waiver slots. The state reserves 60 percent of slots for people living in institutions over 90 days and for individuals turning 21 and aging out of the EPSDT program. In addition, children who need to be placed on the Waiver to become eligible for Medi-Cal (called "institutional deeming") receive priority review and are not placed on a waitlist. Slots are filled on a rotating basis, alternating between individuals residing in facilities and in the community.

HCBA Waiver and COVID Response Needs: High-needs individuals, including those meeting the HCBA waiver eligibility, are at significant risk for contracting and being hospitalized for COVID-19. It is critical that HCBA waiver-eligible individuals residing in the community or in institutional settings have access to the services and supports in the most home-like setting possible, regardless of age. These slots can be targeted to communities with high COVID-19 rates and could be especially valuable in keeping individuals with a great need for more personal care services hours living in the community. Slots could be added quickly using the Appendix K flexibility provided by CMS.

Recommendation: The HCBA waiver slots should be expanded by 5000 slots to ensure sufficient capacity to meet the needs of all individuals deemed eligible for placement on the waiver, regardless of age or residence in community vs. institutional setting. Priority shall not be assigned for one population over another. Instead, the waitlist should be entirely eliminated for community-residing and institutional transitions. The 5000 additional slots should be able to accommodate current and future need through the waiver's 2022 expiration.

6. In-Home Supportive Services (IHSS)—Expediting Services through Use and Expansion of Preliminary Assessments

Program Overview: The In-Home Supportive Services (IHSS) program provides eligible Medi-Cal beneficiaries with a range of services including personal care, domestic and related services, paramedical and protective supervision with the goal of allowing the person to stay safely in their own home. As the largest HCBS program in California, IHSS is integral to both keeping people out of congregate care and in helping people return to the community after a hospital or nursing home stay.

The IHSS program is administered by the Department of Social Services at the state level and by the county welfare departments at the local level. County welfare departments are responsible for determining whether an applicant is eligible for services as well as determining the number of hours each recipient will receive for each task. Currently, pursuant to MPP section 30-755.12, counties are required to provide a preliminary assessment to determine need for an applicant

who is being discharged from a hospital or nursing facility and who needs IHSS authorized before leaving the facility.[1] However, because of the requirement to assess applicants in-person and the tight timeline between the county learning of the discharge and the actual discharge this provision is under-utilized.

The Problem: People who are being discharged from hospitals and nursing facilities often experience delays between leaving the facility and getting assessed and beginning to use IHSS services. That delay puts people at risk of returning to the hospital or the facility because they do not have the assistance in place in order to remain safely in their own homes.

IHSS and COVID-19 Response: The IHSS program has made numerous changes to its processes and procedures in order to ensure IHSS recipients and applicants have access to the IHSS program during COVID-19. Two changes in particular can be used as a part of the solution described below to ensure individuals being discharged do not experience delays:

1. Pursuant to the section 1135 waiver granted to California, the Department of Social Services issued ACL 20-42 which allowed county welfare departments to conduct an initial assessment through videoconference in lieu of an in-person assessment until June 30, 2020. However, this authority was not extended for initial assessments.[2]
2. CDSS released ACL 20-29, which required counties to set-up emergency back-up provider registries. ACL 20-75 extended that requirement through December 31, 2020. In the same two guidance letters, CDSS established and extended a differential wage rate for emergency back-up providers through December 31, 2020.

Recommendation: California should use and expand the ability of county welfare departments to perform preliminary assessments for applicants who are going to be discharged from hospitals or nursing facilities to ensure IHSS services start immediately upon a return to home. To increase utilization of the preliminary assessment and to increase its effectiveness for recipients, the state should do the following:

1. Require counties to prioritize preliminary assessments requested before discharge.
2. Allow counties to conduct all preliminary assessments through videoconferencing so IHSS social workers do not need to enter hospitals or nursing facilities. The hospital or nursing facility should help facilitate this assessment, including providing the technology necessary for videoconferencing.

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[1] The Department of Social Services has released two All County Letters related to the subject of preliminary assessments before discharge: (1) ACL 02-68 which directs the county welfare departments to perform such assessments and (2) ACL 11-76 which allows IHSS to commence after discharge but before receipt of the health care certification form if the individual received a preliminary assessment. ACL 02-68 can found at: https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2011/11-76.pdf and ACL 11-76 at https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-68.pdf.

[2] This authority was extended for Program Integrity and Quality Assurance reassessments until December 31, 2020 in ACL 20-76. It also included telephonic methods of reassessments.

3. Allow preliminary assessments to remain in effect until at least December 31, 2020. This will give the recipient stability and provide the county with additional time before it must conduct the initial assessment.
4. The initial assessment should also be allowed to take place through videoconferencing or through the telephone.
5. Allow recipients being discharged to use the emergency back-up registry to find a provider, if the person does not already have someone they wish to work as their IHSS provider.
6. Allow any provider hired from the emergency back-up registry to be paid the differential wage until another provider is hired or until at least December 31, 2020.
7. Require the state to outreach to hospitals and nursing facilities to inform them of these changes.

7. Multipurpose Senior Services Program (MSSP)—Slot restoration and rate permanency

Program Overview: The Multipurpose Senior Services Program (MSSP) provides older adults whom are ***certified eligible for skilled nursing home placement*** and are 65 years and older with intensive in-home care management and care coordination services so they can remain living in the community. MSSP meets prescribed standards of care, as well as strict budget neutrality requirements while serving as the community negotiator to make sure that clients have access to community resources and other services even during COIVD. Without this intercession, these individuals or their families are left to navigate an increasingly complicated system of medical and social services alone. The majority of MSSP clients live alone, subsist on approximately $1000 per month or less, and have complex medical and psychosocial needs that require specialized medical and social support services. According to the California Department of Aging, the average amount of time in the MSSP program is four years.

MSSP providers deliver the following services in their communities:

- ***Personal Assessment and Care Planning:*** A registered nurse and social worker conduct a joint, comprehensive assessment to develop a living care plan linking medical and social service's needs. These professional staff identify appropriate community services for each client, ensure compliance with medication and prescribed therapies, and coordinate In Home Supportive Services (IHSS), home-delivered meals, transportation and other appropriate services. Additional services and purchases of goods not available through other programs but critical to helping the older adult remain safe in his or her home can be obtained through MSSP.
- ***Client Monitoring:*** All clients must be monitored by the MSSP Care Team, which entails review and evaluation of the effectiveness of each care plan. The health, safety, and social components of the client and their living arrangement are addressed through comprehensive monitoring.
- ***Waived Services Funding:*** MSSP sites spend up to 28 percent of their overall program allocation purchasing critical services and equipment needed by our clients when other

public or private resources are not available to meet their need. Examples include, appropriate nutrition and food resources, safety equipment, home modifications, and medical supplies, and helping clients make IHSS work for them and purchasing supplemental/gap filling care if needed.

The waiver operates in 43 counties: Alameda, Amador, Butte, Calaveras, Contra Costa, El Dorado, Fresno, Glenn, Humboldt, Imperial, Kern, Kings, Lake, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Sonoma, Stanislaus, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Tehama, Tulare, Tuolumne, Ventura, Yolo, Yuba

Waiver Waitlist as of April 30, 2020: 1,465 individuals.

MSSP's Covid-19 Response: MSSP sites went into immediate action at the beginning of the pandemic and continue to seek opportunities to stay in touch with and support clients. Although social distancing requirements have curtailed required face-to-face visits, MSSP care teams have continued to reach out to clients and have provided an important bridge to needed services. Care managers have been assisting with governmental forms required for housing and food assistance, as an example and working with landlords to prevent potential eviction. CMS has recently allowed the purchase of tablets that will be used to conduct virtual interviews with clients, which will reduce isolation and allow the care manager to get a better sense of what is going on in the client's environment and to monitor health and safety such as medication management. These slots can be targeted to communities with high COVID-19 rates. Slots could be added quickly using the Appendix K flexibility provided by CMS.

Recommendation and Fiscal Impact: Medi-Cal funding for MSSP had been flat for more than 13 years and funding was reduced twice (FY 2008 and 2011) during the recession years. A one-time-only supplemental increase of $24.9 million (GF) over three budget years was appropriated in the 2020 California budget. This funding augmentation is set to expire at the end of the 2022 budget year. Given the impact of COVID on seniors, we must continue to keep our seniors safely at home and out of hospitals and nursing facilities by making this temporary supplement permanent while restoring the 2,497 MSSP slots that were lost in the prior years due to cuts. To increase lost MSSP slots, an additional $6.7 million dollars (GF) is needed for one year starting July 1, 2021. As of July 1, 2022, $15 million dollars (GF) will be required to make the one-time-only increase permanent and to fund the increase in slots for a total annual amount of $31.4 million (GF).

8. **Community-Based Adult Services—Allow for emergency authorizations and rate permanency**

Crisis Background: Responding to the Governor's emergency order for the public to shelter at home and for CBAS to stop providing regular congregate services, CBAS centers worked with the administration to quickly design Temporary Alternative Services (TAS) to continue serving and protecting roughly 37,000 participants, who, by definition, are at highest risk for COVID-19

and death. DHCS submitted an emergency request under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5 dated March 19, 2020, to CMS asking for approval of TAS, but final approval remains pending. Per CMS instructions, DHCS is now preparing an Appendix K document for CBAS separate from the Medi-Cal 2020 1115 waiver one-year extension request.

TAS Guidance and Implementation:

- DHCS All Plan Letters, CDA All Center Letters, and CDPH All Facility letters distributed during April and May describe the TAS framework and provide guidance to the centers and the Managed Care Plans.
- CBAS must have Plans of Operation for TAS, approved by CDA.
- CDA is conducting provider compliance surveys, using remote methods.
- Weekly training webinars for providers ~~were~~ designed and hosted by the California Association for Adult Day Services (CAADS) and the Alliance for Leadership and Education (ALE) began in March 2020 and will continue through January 2021. Managed care plans and state partners have participated and contributed TAS Guidance. CAADS and ALE continue to work closely with state partners and the provider community to successfully implement and refine CBAS TAS.

CBAS TAS Framework: Through TAS, CBAS is being provided via alternative modes, as described below, including in-center or in-home care, limited to what is deemed "essential" and can be safely delivered, due in part to the difficulty in accessing PPE for community providers.
CBAS TAS includes flexibility to:

- Reduce adult day health care center-based activities/gatherings for vulnerable populations
- Offer telephonic, telehealth or live video interactions for social/therapeutic visits, interventions and assessments
- Provide physical therapy or occupational therapy in the home
- Conduct doorstep deliveries of food, meals, supplies, activities, etc.
- Provide or arrange for home delivered meals to ensure nutritional security
- Continue per diem reimbursement in accordance with approved Individual Plans of Care (IPCs)

Barriers to Rapid Deployment of CBAS/TAS Resources:

- For dual eligibles not previously enrolled in managed care, the requirement of managed care enrollment as a condition for accessing CBAS is a barrier to care because of the length of time and specialized tasks required to enroll into Medi-Cal managed care (presently an added step for duals).
- The process for enrollment into Medi-Cal Managed Care is lengthy and complex, which significantly delays access to initiation of CBAS services.

Need for Additional Emergency Flexibility to Maximize Impact of CBAS TAS
New participants can be assessed by CBAS providers using means and methods other than face to face visits, then admitted, with MCP authorization.

- Additional capacity to serve beneficiaries is immediately available. The number of participants who can be served is no longer limited to the licensed capacity of the physical facility, so centers are able to serve participants daily based upon their assessed needs in order to reduce risks for participants and caregivers who are sheltering at home.
- Screened and experienced CBAS health providers are presently employed and working to carry out individually care planned services.

Solutions:

- To enable rapid emergency enrollment of people into CBAS who would otherwise be at risk for nursing home placement when discharged from a hospital to a nursing facility, or who choose to move out of a nursing facility, expedited and retroactive enrollment into Medi-Cal Managed Care and presumptive eligibility and retroactive reimbursement for CBAS is absolutely critical.
- The current CBAS eligibility criteria, which include nursing facility level of care, are sufficient to presumptively qualify a person for CBAS.
- Existing payment mechanisms through Medi-Cal Managed Care or Fee-for Service Medi-Cal can be utilized to authorize payment retroactively.
- CBAS Centers also have the experience and knowledge to provide complex care management to facilitate complex care transitions needed during this public health emergency, and can quickly work with managed care organizations to amend their existing contracts for the purpose of facilitating emergency care transitions.

9. Caregiver Resource Centers—Increase funding and flexibility for respite

Background: 80% of care is provided by unpaid family caregivers. During COVID these caregivers are now more socially isolated, are caring for children and parents, and have increased pressure to minimize chances of older adults going to hospital or SNF. More people are now aware of how isolating caregiving can be and are in need of comprehensive supports. LTC@ home cannot be successful without the statewide caregiver focused services as a core member of the Rapid Response Team (RRT). We have a nationally replicated statewide system with expertise of 30 years providing services to family/informal caregivers. The system would add a new core service, rapid response caregiver specialist (RR-CS) to each CRC statewide. They specialist will coordinate with CCT, MSSP, CBAS and IHSS.

Current Program Limitations: The current funding allocation for CRC's is set to expire in 2022. Currently, we have a high volume of referrals from hospital discharge planners. CRC's would need funding to expand staff to handle the increase in referrals for individualized long term caregiver case management (caregiver intake, assessment and care plan.) Because caregiver issues will not emerge immediately on discharge (beside those associated with setting up the patient/care receiver needs) this would be done 4-6 weeks post discharge, then we can have a more accurate assessment of the caregivers LTSS supports, education, training and emotional

support after discharge. This support includes respite care for unpaid caregivers which is currently paid for through the CRCs.

The coordination would be with the RRT pre-post discharge and since we have an HIPAA online portal we can integrate some aspects of the referral and discharge with discharge planner and all the CCT programs. During COVID the CRC's were able to transition all services and supports on-line within a week of the stay-at-home order because of the recent one-time funding to enhance CRC comprehensive service delivery model and provide innovative on-line access statewide. Also, the pandemic has highlighted new support requests to CRC's including housing assistance, food, PPE's, as well as increased need for respite for caregivers. (this is not a full list of needs). Providing these supplemental services would be part of the RR-CS expansion.

This specialized statewide RR-Caregiver Specialist (RR-CS) would require stable funding of $2.1 in 7/1/2021

Current Funding: Funding for CRC's had been flat for more than 13 years and funding was reduced twice (FY 2008 and 2011) during the recession years. A one-time-only supplemental increase of $30.0 million (GF) over three budget years was appropriated in the 2020 California budget. This funding augmentation is set to expire at the end of the 2022 budget year.

Recommendation and Fiscal Impact: Given the impact of COVID on seniors and the unpaid family caregivers that support them in the community, we must continue to keep our seniors safely at home and out of hospitals and nursing facilities by making this temporary supplement permanent. flexibility with respite funding to use for supplemental services and support to help caregivers assist with complex care needs associated with discharge referrals from crisis team. Additional funding would allow these cases to be prioritized for respite since all the CRC's have a waitlist for respite services.

Moreover, with the increase in LTSS needs, we need an additional $.9 million dollars (GF) for January-July 2021 and $1.8 million dollars (GF) is needed for one year starting July 1, 2021 to provide RRT-Caregiver Specialist (RRT-CS) and supplemental services expansion. As of July 1, 2022, $30 million dollars (GF) will be required to make the one-time-only increase permanent and to fund the RRT-CS for a total annual amount of $32.1 million (GF).

10. Program for All Inclusive Care for the Elderly (PACE): Supplemental Rate and Rapid Approval

Program Overview: Program of All-Inclusive Care for the Elderly is an integrated managed model providing Medicare and Medi-Cal covered benefits to eligible individuals who are age 55 or older, and who are certified to need nursing home care, but who are able to live safely in the community at the time of enrollment.
Required services include:

- Medical care provided by a PACE physician

- Adult day health care (nursing; meals; nutritional counseling; personal care physical/occupational/recreational therapies)
- Home health care and personal care in the home
- Prescription drugs
- Social services
- Medical specialty services, and hospital, plus nursing home care, when necessary

COVID Response Needs: High-needs individuals who reside in institutional settings are at significant risk for contracting and being hospitalized for COVID-19. It is critical that individuals residing in institutional settings have access to a full array of services, both health and social services, to enable them to return to the most home-like setting possible or avoid institutionalization. The PACE program provides the necessary infrastructure to transition individuals during this time of crisis.

Program Limitations: The PACE program currently is limited in the extent of transition services that can be provided for individuals leaving nursing homes or to help stabilize those in the community. Additionally, the rate for PACE programs needs to be adjusted to care for individuals with significant health impairments, such as those coming out of long-term care placement. Additionally, it can take several weeks to process and receive approvals for referrals to the PACE program at the State level, making it difficult to assist those with critical needs. It is also not currently possible to bill for services mid-month.

Recommendation: Approve an acuity based short term supplemental rate adjustment for those coming out of the hospital or skilled nursing facility. Allow for rapid approval (within several days) for PACE referrals at the local level with subsequent State approval for those individuals needing care due to COVID-19 impacts as well as allow for immediate billing for services.

11. Required COVID-19 Testing Before Hospital Discharge

Background: Currently, hospitals are not required to test patients for COVID-19 before discharging them to a congregate facility or to their home. This means that congregate settings do not know a resident's COVID status upon admission which could increase transmission in facilities. For those returning home, it means that family and other caregivers do not know what precautions need to be taken to keep everyone safe and healthy.

Solution: The state should require hospitals to test for COVID-19 before discharging whether discharging to a congregate facility, including a nursing facility or to home.

12. Ensure HCBS Providers Have Access to PPE

Background: At the beginning of the pandemic, it was difficult for community providers to receive the PPE they needed to safely provide services to seniors and people with disabilities. The State has made significant progress in addressing these concerns.

Recommendation: As HCBS services expand and communities re-open, it will be important to ensure that HCBS providers have sufficient access to PPE as programs are expanded. This will help limit the spread of COVID-19 to a highly vulnerable population and help ensure providers stay safe and healthy.