State of California—Health and Human Services Agency
Department of Health Care Services

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Home and Community-Based Services (HCBS) Gap Analysis and Multi-Year Roadmap Stakeholder Engagement Meeting

January 20, 2023
1 p.m. – 3 p.m.

MEETING SUMMARY

Department of Health Care Services (DHCS)
Staff Attended: Susan Philip, Joseph Billingsley, Cortney Maslyn, Nichole Kessel, Delandran Pillay

California Department on Aging (CDA)
Staff Attended: Susan DeMarois, Sarah Steenhausen

Contractors, Mathematica
Staff Attended: Patricia Rowan, Andrea Wysocki, Kathleen Shea, Cayla Roby

Consultants, Center for Health Care Strategies (CHCS)
Staff Attended: Carrie Graham, Sarah Triano, Courtney Roman, Nancy Archibald, Nida Joseph, Matthew Phan, Amy Hoffmaster

Public Attended: 258

Stakeholder Meeting Materials: Meeting Agenda and Slide Deck

I. Introductions and Project Overview

Carrie Graham, CHCS
Welcomed attendees, discussed housekeeping measures for the call, and presented options for participants to voice their feedback throughout the call.

Susan Philip, DHCS
Introduced the goals of DHCS' Medi-Cal Home and Community-Based Services (HCBS) Gap Analysis and Multi-Year Roadmap.

Summary: The goal of this project is to identify gaps between Medi-Cal covered HCBS and managed long-term services and supports (MLTSS) programs, and to work to improve access and quality of care for HCBS in California. Policy recommendations from the Gap Analysis and Multi-Year Roadmap will help the state of California identify where fragmentation exists for long-term care delivery systems and steps that can be taken to close those gaps.

Susan DeMarois, CDA
Introduced CDA's goals for its related non-Medi-Cal HCBS Gap Analysis and Multi-Year Roadmap.

Summary: The Master Plan for Aging (MPA) is launching a new round of initiatives, and this project is part of the MPA's intention to be person-centered, data-driven, and equity focused, with the hope that this will help many consumers throughout the state.

Carrie Graham, CHCS
Introduced the rest of the speakers, went over the purpose and agenda of the call, and discussed the roles of all agencies and organizations involved in this work (e.g., DHCS, CDA, CHCS, and Mathematica).

Joseph Billingsley, DHCS
Presented side-by-side overview of the two projects (DHCS vs. CDA)

Summary: DHCS and CDA are conducting separate but related projects. DHCS will conduct a focused Gap Analysis for Medi-Cal MLTSS, while the CDA project will examine gaps and trends in non-Medi-Cal HCBS. Intersections between the two projects include: quantitative analyses for both projects will use data from various HCBS programs, and approaches for both projects include using stakeholder voices to introduce different and unique perspectives to the analyses.

II. Introduction to DHCS HCBS Medi-Cal Gap Analysis and Multi-Year Roadmap

Joseph Billingsley, DHCS
Introduced DHCS' specific details for the Gap Analysis and Multi-Year

Roadmap work.

Summary: The goal of this project is to support integration efforts that the state and DHCS are currently engaged in and work to identify gaps, and then how to best close those gaps to improve health outcomes, consumer satisfaction, and health equity.

Nichole Kessel, DHCS
Discussed *Money Follows the Person Supplemental Funding* and the HCBS capacity building award.

Summary: The California Community Transitions (CCT) program supports California's work to rebalance its LTSS systems toward community-based care. Supplemental funding through CCT offered DHCS the opportunity to contract with Mathematica and CHCS for assistance with this project.

Cortney Maslyn, DHCS
Discussed the connections between the current scope of work for California's long-term goals for managed care, dual eligible special needs plans (D-SNPs), MLTSS, and HCBS, and how they are interconnected to support the overall goals of the state.

Patricia Rowan, Mathematica
Introduced the five objectives that will guide the Gap Analysis. Discussed the analytic questions and analytic approach that Mathematica will take in addressing each of the five objectives.

Summary: The five objectives are as follows:
1. Reducing Inequities in Access and Services
2. Meeting Client Needs
3. Program Integration and Increased Coordination
4. Quality Improvement
5. Streamlined Access

As part of its work with DHCS, Mathematica will assist in creating a Medi-Cal HCBS/MLTSS Program Inventory, as well as a Medi-Cal HCBS Gap Analysis, with both currently underway.

Cortney Maslyn, DHCS
Discussed the LTSS Dashboard and the LTSS Data Transparency Initiative.

Summary: The initial version of the LTSS Dashboard was released in December 2022 and contains data from 2017-2021. This will be updated to reflect the findings of the Gap Analysis. This will be done in tandem with the LTSS Data Transparency Initiative and allow for a common set of performance metrics for the state to display on its LTSS Dashboard. DHCS will report on quality of care and health equity provided to Medi-Cal members at future meetings.

III. Q&A Session #1

Moderated by: Carrie Graham, CHCS
Participants were able to place questions/comments about the DHCS project in the chat. Questions were read out by Courtney Roman, CHCS, and Carrie Graham, CHCS directed the questions to speakers.

Summary of Discussion:

Comment 1: Can you please speak to the data you'll be using? Is this data within DHCS systems, provider-submitted data, or both?

Response 1: The gap analysis will use administrative claims and encounter data that's submitted by providers, as well as data from licensed nursing facilities, health plans, etc. Mathematica will also look at provider directories and licensed facilities and work cross-departmentally to get other information.

Comment 2: When you reference service gaps in delivery, are you looking at decades-old wage rates and workforce issues?

Response 2: The gap analysis is focused on where there are a lack of providers and service delivery gaps, as well as understanding the drivers behind these gaps. We are also looking at health equity gaps such as where there are providers, gaps in availability, gaps in awareness of facilities, knowledge gaps, and gaps in access. Stakeholders are also a great resource for adding context to gaps that are found when the analysis is conducted.

Comment 3: The transition in Medi-Cal managed care plans in service areas, which will occur Jan 1, 2024, will be important to the process. How is this reflected in the Gap Analysis?

Response 3: For the Gap Analysis, current work includes data from the last few years and doesn't have exact data to address this yet. This work will look at ever-evolving data, and we will update our LTSS Dashboard contingent upon adjustments and what we're learning.

Comment 4: There seems to be a gap in how this proposed assessment is completing data analysis. How do you intend to address the racial inequality gap in access to HCBS?

Response 4: Yes, DHCS has this data at the beneficiary level and will incorporate demographic information, like race/ethnicity, disability status, language, and region, into the analysis. Gaps will be looked at on both the regional level and within sub-populations to see how different groups of beneficiaries may be experiencing the HCBS system differently.

Comment 5: Will DHCS be identifying gaps in HCBS programs outside of the MLTSS structure, i.e., programs that work outside of the managed care model, like PACE [the Program of All-Inclusive Care for the Elderly]?

Response 5: Yes, Mathematica is currently conducting a landscape-

wide assessment and understanding how other MLTSS-type providers like PACE fit into that landscape as well.

Comment 6: One of the data points to consider in getting data from the health plans is where the referrals are coming from. For community supports that fall under LTSS categories, most of the referrals come from a health plan where it is mostly self-referrals from members and not actually coming from the providers.

Response 6: DHCS will look into that data as implementation continues to move forward, as this has been a phased implementation for populations of focus and uptakes for community supports that are adopted/elected by managed care plans.

Comment 7: There is a need to have a means to provide immediate feedback when a barrier is presented (i.e., something akin to an ombudsman system). Is this also being addressed or considered?

Response 7: This is a good point for consideration during the process, at looking at where there are gaps in our service delivery system and how DHCS can work to address issues identified.

Comment 8: Just a reminder of this resource that will be useful for Objective 4: CHCF publication "Understanding What Works: Measuring and Monitoring Quality in Medi-Cal's Home and Community-Based Services": https://www.chcf.org/publication/understanding-what-works-measuring-monitoring-quality-medi-cals-home-community-based-services/

Response 8: Thank you.

Comment 9: IHSS [In-Home Supportive Services] public authorities do not have a list of competent community care providers, including protective supervision.

Response 9: DHCS is looking at multiple HCBS and LTSS systems across the state, including the IHSS program, and working to obtain data related to IHSS as part of this gap analysis.

Comment 10: When the report to DHCS is due in August 2023, will this be available to the public?

Response 10: The draft report will be submitted to DHCS in August 2023 for the agency's review and feedback and will be brought to various stakeholder groups for their input. The goal is for the final report to be made available to the public. It will be available sometime after August, as DHCS needs to review the report internally first.

Comment 11: It wasn't clear to me how non-Medi-Cal providers and consumers will be included (i.e., services that are private pay). Can we elaborate on that a little more?

Response 11: CDA's portion of the presentation will delve deeper into non-Medi-Cal services.

Comment 12: There's a separate home-based waiver workgroup – the HCBA+ALW [Home and Community-Based Alternatives/Assisted Living Waiver] Integration Workgroup – that is looking at a combined universal assessment tool, and we should connect with them on this process.

Response 12: The teams that are working on this project are also the ones working on the HCBA/ALW integration project, so there is synergy between the two efforts.

Comment 13: How will the Gap Analysis look at identification of family and informal caregivers?

Response 13: Data on caregivers will be obtained through the IHSS program, and then Mathematica will conduct qualitative research activities with family and informal caregivers for their feedback. This is also a key topic that CDA hopes to address in their gap analysis.

Comment 14: Are there plans to also study and implement an evidence-based caregiver assessment?

Response 14: This all boils down to how we define the parameters of the Gap Analysis- on the CDA side, we look to caregivers across the state on how we might consider assessments as part of supports.

Comment 15: To understand what is needed to reduce inequities in access, you will need data not just for enrollees, but for people who didn't make it to enrollment. What data or approaches will you use to capture this information?

Response 15: This will be done through qualitative activities and discussion with community-based organizations, that are needed as part of that assessment. Under Objective 5, DHCS will connect with people who are in that position and explore the feasibility of getting assessment information from care plans and providers. We welcome input on the best ways to learn from this population.

IV. Break

Carrie Graham, CHCS
The meeting took a 10-minute break.

V. Introduction to CDA Non-Medi-Cal HCBS Gap Analysis and Multi-Year Roadmap

Sarah Steenhausen, CDA
Discussed the goals of the CDA HCBS Gap Analysis.

Summary: This two-part study was a key recommendation from the Master Plan for Aging's LTSS subcommittee. While this project is just launching, it has the goal of building upon the DHCS Medi-Cal HCBS Gap Analysis for non-Medi-Cal HCBS. Data sources, however, will focus more on publicly available non-Medi-Cal HCBS program data.

Patricia Rowan, Mathematica
Discussed the analytic approach for CDA HCBS gap analysis, deliverables, and timeline.

Summary: Due to the nascent nature of this project, we are still working through timing of activities and deliverables. The key difference is that the CDA project will use program-level, publicly available data, and will go through Spring 2025.

VI. Q&A Session #2

Moderated by: Carrie Graham, CHCS
Participants were able to place questions/comments about the CDA project in the Chat. Questions were read out by Courtney Roman, CHCS, and Carrie Graham, CHCS directed the questions to speakers.

Summary of Discussion:

Comment 16: When we say "non-Medi-Cal" HCBS, who is the payer for these programs?

Response 16: It varies, some of it is general funds, some of it is federal funds, and there are other sources of funding, such as the Older Americans Act (OAA) for services provided through the Department of Aging. (As long as it is not a Medi-Cal covered service or benefit and is an HCBS.)

Comment 17: Can weather and fire emergencies be explored?

Response 17: During times of emergencies, transportation and accessibility options are not as readily available. In discussing transportation, it's going to be crucial how CDA defines and measures it, and CDA anticipates that transportation will be its own separate deep dive altogether.

Comment 18: Home-based palliative care and hospice providers should be noted as a population of consideration.

Response 18: Thank you for the comment. This is where it gets interesting because there's some crossover here with DHCS because these can be Medi-Cal covered services, so CDA will need to work closely with DHCS to best address these overlapping services. Those are also Medicare services, so we will be considering that intersection as well.

Comment 19: How might we find out from I & R (Identification and Referral) folks what services they are not able to help with (i.e., personal care help for those who don't qualify for Medi-Cal but can't afford private pay)?

Response 19: It's important that we work with community partners to see where services are absent. Carrie will talk more about the stakeholder engagement process and how we can reach out to those that we need to.

Comment 20: Can we include respite services through home health agencies?

Response 20: This is another example where it's a benefit offered through CalAIM community supports, but respite is also provided through OAA-funded programs. On the non-Medi-Cal side, respite is a very important component, and we can add it to the list of services, while being clear of where the crossover is.

Comment 21: How do we qualify non-Medi-Cal cases?

Response 21: Difference between the two gap analyses is whether the HCBS is being directly funded by Medi-Cal (state plan or waivers), or if it's not receiving Medi-Cal funding (which is where the service would fall under the CDA project).

Comment 22: For LTSS, should we be looking at tech supports and home modifications?

Response 22: This is key on both sides – CDA and DHCS. For CDA, there are non-Medi-Cal funded supports for home modifications that they would include on the CDA side. This is also definitely something HCBS-related that is available through waivers via CalAIM and other processes.

Comment 23: Suggestion that Gap Analysis looks at how effectively Information and Assistance and related services, including ADRC efforts, work to help people identify services that will be beneficial to them, if not already reflected.

Response 23: Wanted to point out the role of the ADRCs (Aging and Disability Resource Centers) in this effort, but ADRCs are not the only way to get information and assistance. CDA wants to define it as part of the HCBS delivery system and will look to some stakeholder input on how to define Intake and Assessment.

VII. Opportunities for Stakeholder Input and Feedback

Carrie Graham, CHCS

Introduced the goals of the stakeholder engagement process and opportunities for feedback.

Summary: Both projects are in early stages, so there is ample opportunity for stakeholder input. DHCS and CDA are hoping to get input from a diverse group of stakeholders (e.g., those with lived experience, organizations that administer LTSS, committees dedicated to health equity, and internal state agencies and offices that provide or oversee Medi-Cal LTSS eligibility).

There will be two public meetings per year with both DHCA and CDA present, and DHCS will provide quarterly updates to stakeholder groups and committees.

VIII. Public Comment

Moderated by: Carrie Graham, CHCS
Public Comment was open for approximately 20 mins.
Participants were able to continue to put questions/comments in the Chat but also able to raise (virtual) hands where they were called on, unmuted, and able to ask their question/make a comment live.

Summary of Comments:

Comment 24: Three areas of concern/potential improvement: 1) inadequate provider rates in HCBS that have not increased relative to inflation, 2) more publicly released data on equity in CA's HCBS programs, 3) long wait times for enrollment into HCBS programs and processing of treatment authorization requests (over 50% said the timeline between submission of HCBS request and approval was 4+ months).

Comment 25: The state needs to address severely impaired HCBS recipients who need differential pay. Current pay rates make it difficult to find anyone to work on weekends and holidays, as well as lack of 24-hour backup emergency services. The provider caps and exemptions are limited, so people with severe disabilities are telling providers to leave them. It's up to these people to find providers. Excluding consideration of non-familial and friend supports. You have to look at the status of the person if they lose that status. The backup system implemented by the state is not working. It is not reasonable to ask people to pay out of pocket from their disability benefits.

Comment 26: What are the state's plans to increase caregivers and the home health provider pool? There had been talk of a program that was trying to get providers to train for more home health aides in the home and tried to apply for that, but nothing ever came out of it.

> **Response 26:** This is likely referring to CDA's California Grows Initiative – HCBS direct care workforce initiative – there are huge challenges related to recruitment and retention to direct care workers. Application results are forthcoming on this.

Comment 27: How are managed care plans enrolling local providers? Every managed care plan has its own application to become Enhanced Care Management providers – they are not universal. Many of these providers are the most appropriate to provide culturally appropriate care. The approval time also, once these portals are open, can take 6 months. People who are most vulnerable suffer.

Comment 28: We are down to 16 transitions providers that are actively doing transitions. There are several agencies that are eligible to provide this service, and yet we only have 16 providers. Many of these providers are fundraising to provide the state's services because there is not enough funding from the state. It is important that we look at this broken part of the system—there is a very clear reason—we don't pay enough money to provide the services. There

is also a gap in access due to a gap in knowledge because people don't know that the services exist.

Comment 29: It is a problem that providers are subsidizing the state and managed care plans by doing work that is underpaid. We are not going to solve access issues until we solve this problem. As you're looking at CBAS (Community-Based Adult Services) data, there needs to be an ongoing strong communication between CDA and DHCS because access has dramatically changed during the pandemic, and data lag means that you're looking at pandemic-level data which may not be representative of what's going on in the centers now.

Comment 30: A data point that's not really collected is when a user may put in a request for an authorized service, but there are none available. This is a gap that we can work to identify.

Comment 31: One gap that ties into the other domains is the mechanism of how it gets actualized in the real world, i.e., with codes that are changed after the fact. People who are writing policy are not communicating with the billing side. There are opportunities here to solve problems that don't need legislative input, but rather administrative response to help get the pieces together. Example: PERS (Personal Emergency Response Devices) must be purchased in advance before they are approved. TARs (Treatment Authorization Requests) – need to purchase the item and wait for it to be approved. It may then be denied – would like there to be opportunities for DHCS, the people providing the billing, and the people receiving the service to be able to communicate.

IX. Next Steps

Joseph Billingsley, DHCS
Thanked all attendees and closed the meeting.

Meeting adjourned at 3:02 p.m.