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California Home and Community-Based Services Gap Analysis Report

Final Report

January 31, 2025

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Acknowledgements

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Contents

Exhibits

List of Acronyms

ACS	American Community Survey
ADHC	adult day health center
ADL	activities of daily living
ADRC	Aging and Disability Resource Connection agencies
ALW	Assisted Living Waiver
ARF	adult residential facility
ARFPSHN	adult residential facility for persons with special health care needs
CalAIM	California Advancing and Innovating Medi-Cal
CalHHS	California Health and Human Services
CBAS	community-based adult services
CCA	care coordination agency
CCT	California Community Transitions
CFCO	Community First Choice Option
CLHF	congregate living health facility
DHCS	California Department of Health Care Services
ECM	Enhanced Care Management
EPSDT	Early, Periodic, Screening, Diagnosis, and Treatment benefit
HCBA	Home and Community-Based Alternatives Waiver
HCBS	home and community-based services
HCBS-DD	Home and Community-Based Services Waiver for Californians with Developmental Disabilities
HH	home health
HHA	home health agencies
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
IADL	instrumental activities of daily living
ICF	intermediate care facility
ICF/DD	intermediate care facilities for the developmentally disabled
I/DD	intellectual or developmental disabilities
IHSS	in-home supportive services
IHSS-R	IHSS Residual
INP	individual nurse provider
IPO	IHSS Plus Option
LGBTQIA+	individuals who identify as lesbian, gay, bisexual, transgender, queer, or another sexual orientation

LOC	level of care
LTC	long-term care
LTSS	long-term services and supports
MC	managed care
MCP	managed care plan
MCWP	Medi-Cal Waiver Program
MFP	Money Follows the Person
MLTSS	managed long-term services and supports
MSSP	Multipurpose Senior Services Program
Non Prof	nonprofit organization
OT	occupational therapy
PACE	Program for All-Inclusive Care for the Elderly
PCA	personal care agency
PCSP	IHSS Personal Care Services Program
Prof Corp	professional corporation
PSH	publicly subsidized housing
PT	physical therapy
RCFE-ARF	residential care facility for the elderly-adult residential facility
SDP	Self-Determination Program
SNF	skilled nursing facility
ST	speech therapy

Executive Summary: Key Gaps in Access to HCBS and LTSS in California

A. Background

As part of California's transition to an integrated managed long-term services and supports (MLTSS) system, the California Department of Health Care Services (DHCS) contracted with Mathematica to conduct a mixed-methods analysis to identify gaps in the state's Medi-Cal home and community-based services (HCBS) and long-term services and supports (LTSS) programs and service delivery systems that hinder Medi-Cal members' access to HCBS. This report identifies gaps in the availability of programs and services to meet member needs for HCBS and LTSS now and in the next decade, limitations in provider capacity to meet member needs and coordinate care, barriers impeding members' ability to find and obtain high-quality person-centered care, and problems stemming from inefficient program administration and operations.

B. Methods

The populations covered in the analyses include Medi-Cal members who use LTSS either in institutions or home or community-based settings. (See the accompanying box for a list of LTSS programs and services included in this analysis.) Mathematica used Medi-Cal administrative data from 2017 to 2021 provided by DHCS to analyze LTSS users, LTSS providers, and patterns in LTSS utilization over time, and supplemented these data with additional In-Home Supportive Services (IHSS) program data from 2023 to understand additional characteristics of IHSS recipients and providers. To forecast future demand for LTSS, Mathematica used American Community Survey (ACS) data from 2008 to 2019 to model the number of adults in California with an activities of daily living (ADL) limitation, those who might have an ADL limitation and be Medi-Cal eligible, and those who might be Medi-Cal eligible and use LTSS. To characterize the geographic distribution of LTSS users relative to the location of providers, Mathematica produced a series of county-level maps and descriptive tables by county geographic classifications. Mathematica fielded a provider survey to gather information about provider capacity. They completed interviews, listening sessions, and questionnaires with 145 individuals from various organizations to gather qualitative information to inform the underlying drivers of gaps in the state's Medi-Cal HCBS and LTSS programs. A complete description of the data sources and methodology used for each analysis is in the appendices.

LTSS programs and services in this analysis

- People with institutional stays, including those with skilled nursing facility (SNF), custodial care, subacute care, or intermediate care facility (ICF) stays
- People enrolled in select HCBS programs, including in-home supportive services (IHSS), community-based adult services (CBAS), the Home and Community-Based Alternatives Waiver (HCBA), Assisted Living Waiver (ALW), Multipurpose Senior Services Program (MSSP), Program of All-Inclusive Care for the Elderly (PACE), and California Community Transitions (CCT)

C. Key findings on gaps in HCBS programs and the Medi-Cal service delivery system

California's population is aging rapidly, particularly in rural areas where current access to HCBS programs is already limited.

An estimated 745,162—96.5 percent—of all Medi-Cal LTSS users resided in urban areas in 2021.[1] These urban areas have higher proportions of LTSS users who are age 65 years and older, have limited English proficiency,[2] and are non-White than rural areas. Counties projected to have the largest absolute growth in LTSS users are the most populated counties in the southern region of the state—estimated to be over 1.6 million LTSS users by 2040 in Los Angeles, San Diego, and Orange Counties. The shares of all LTSS users who are Hispanic, age 75 and older, and female are expected to grow over the next 15 years. These trends indicate the need for increased HCBS provider capacity to serve more people, as well as a more diverse workforce that can provide accessible, high-quality, and culturally informed care.

At the same time, current rates of Medi-Cal LTSS and HCBS use indicate significant barriers to HCBS access in rural counties. Rates of LTSS and HCBS use, measured by the number of Medi-Cal LTSS users and HCBS enrollees out of 100,000 Medi-Cal members, vary based on HCBS program coverage; that is, whether programs are available[3] at all or have long waiting lists to enroll or receive services. Although some HCBS programs, such as IHSS and HCBA, are available in all 58 counties, most HCBS programs do not operate statewide. In rural counties, where HCBS program coverage is more limited, Medi-Cal members use LTSS at rates that are on average half the rates in urban counties. From 2017 to 2021, rural counties had sizable increases in the proportion of Medi-Cal LTSS users who were age 65 and older (an increase from 51 to 55 percent of total Medi-Cal LTSS users over age 18). Counties in the central Sierra region (consisting of several rural counties) are projected to have the highest rates of growth in LTSS users over the next 15 years.

Taken together, the rapid aging of the rural population, the limited availability of HCBS programs in rural counties, and projected rates of growth in LTSS needs show that rural counties have the greatest gaps in access to HCBS. Without concerted efforts to expand HCBS system capacity in rural areas, their residents' disproportionate use of institutional care will grow over time.

To meet the needs of a growing population of Medi-Cal members in need of HCBS, the number of HCBS providers participating in Medi-Cal must increase.

Across all HCBS programs and throughout the state, providers reported limited capacity to serve all individuals who need HCBS, indicating significant unmet need for services. This unmet need was

[1] Geographic classifications of the 58 California counties were based on the county type designations used in the Medicare Advantage Program (42 CFR 422.116(c)) and previous DHCS reports. Based on the three-way rurality classification and data from 2021, there are 34 urban counties, 10 suburban counties, and 14 rural counties in California.

[2] Limited English proficiency is defined as the person self-reporting that their primary spoken language is not English.

[3] Several Medi-Cal HCBS programs are operated under a waiver granted by the federal Centers for Medicare & Medicaid Services, which allow the state to offer services in select geographic areas or to make them available statewide.

most evident in rural areas, particularly in Northern California; these areas have a shortage of, or in some cases, completely lack certain types of HCBS providers. Mathematica was unable to quantify the magnitude of unmet need due to a lack of data on whether (1) current Medi-Cal HCBS enrollees are receiving all of the services authorized in their service plans; or (2) people with LTSS needs are eligible for but not enrolled in Medi-Cal, or enrolled in Medi-Cal but not receiving Medi-Cal LTSS even though they might need these services. However, based on results of a survey of providers around the state and interviews with providers, consumers, and state officials, provider capacity is inadequate to meet the need.

Even some areas where HCBS waiver programs are available have lower rates of provider participation in Medi-Cal, particularly for the ALW and CBAS programs, which contributes to barriers in access to HCBS. At least for the ALW and CBAS programs, access to the services they cover could be increased for Medi-Cal members if more residential care facilities for the elderly-adult residential facilities (RCFE-ARFs) and adult day health centers (ADHCs) participated in relevant Medi-Cal programs; currently, only an estimated 6 percent of existing RCFE-ARFs (for ALW) and 17 percent of ADHCs (for CBAS) participate.

Limited HCBS provider availability is complicated further by significant staffing vacancies and shortages among Medi-Cal-participating providers. Responses to the provider survey indicate that direct care provider staff had the most open positions within each provider type. In interviews, both providers and consumer listening session participants reported that current reimbursement rates make it difficult to offer competitive wage rates, which are the biggest hurdles to staff recruitment and retention. Consumers and other stakeholders also reported current reimbursement rates as a barrier to finding providers. Because of the low participation in Medi-Cal and ongoing staffing shortages, many providers maintain their own waitlists to manage their caseloads. These waitlists go beyond the formal HCBS waiver waitlists the state maintains for several waivers, such as the HCBA waiver, ALW, and MSSP, and compound the access issues that many Medi-Cal members needing HCBS face.

A fragmented system of HCBS programs with differing eligibility requirements and enrollment procedures makes it difficult for Medi-Cal members to access the care they need in a timely manner.

A persistent theme raised by interviewees and participants in consumer listening sessions is that the Medi-Cal HCBS system is fragmented, complex, and confusing for participants to navigate. Those in need of HCBS often do not know what programs are available to them in their community, and language and cultural differences can pose additional barriers to accessing HCBS. Because of the complicated eligibility rules and different criteria used across HCBS programs, Medi-Cal eligibility workers and health care providers sometimes provide inaccurate information to members about HCBS programs. Interviewees also frequently mentioned that inconsistent processes across HCBS programs—for example, different modes used for applications, waitlist procedures, and eligibility determination processes—can lead to differences in how much effort is involved and how long it takes to enroll in various programs. In addition, even when they are determined eligible, individuals often experience delays between enrolling in an HCBS program and beginning to receive services. Interviewees noted that these challenges are particularly prevalent for people with cognitive impairment, behavioral health challenges, and high care needs.

California's highly decentralized HCBS program design makes it difficult for DHCS to effectively monitor access, unmet need, and the quality of care delivered to Medi-Cal members.

DHCS delegates primary administrative responsibility to other California Health and Human Services (CalHHS) departments for several HCBS programs.[4] Delegating such responsibility to other agencies ensures dedicated expertise and allows for coordination among state and local agencies that interact with members eligible for such programs. However, decentralized administration of these programs and limited technology for systematic data collection make it more difficult for DHCS to effectively oversee the Medi-Cal LTSS system as a whole. For example, DHCS has limited access to timely data for several HCBS program, which creates challenges in tracking service use across the continuum of services and programs at the individual level. This also limits the state's ability to monitor access, unmet need, and the quality of care of all services that Medi-Cal members receive through these programs. Sharing of data and information between provider and HCBS waiver agencies and managed care plans (MCPs) operating in the HCBS system is also currently limited. Finally, DHCS lacks timely access to utilization and assessment data for Medi-Cal members receiving HCBS through programs administered by other CalHHS departments, further limiting its ability to monitor and oversee HCBS access and quality in the Medi-Cal program as a whole.

Beyond data and information sharing, additional operational challenges exist in administering HCBS programs. Specifically, the processes and entities involved for conducting level-of-care assessments vary across HCBS programs, which creates inefficiencies and inequities in HCBS access. This situation is especially prevalent when there is a lack of alignment in the workflows for various components of the application and assessment processes, and members are also attempting to secure housing. For example, some individuals seeking to transition out of institutions have housing to return to, but long wait times for waiver agencies and HCBS programs to assemble complete application packets and processing time for DHCS means these individuals may not be able to retain current housing arrangements for that length of time. The Medi-Cal billing infrastructure and processes also create several challenges, particularly for smaller providers, which stem from different guidance for billing across programs, leaving the provider to reconcile any issues.

D. Related Initiatives and Future Directions

Reducing the barriers to HCBS access and filling the gaps in HCBS program availability will require the state to commit to a substantial and sustained investment. Although gaps exist in the availability of Medi-Cal HCBS programs throughout the state, they are more prevalent now in rural areas and exacerbated by a shortage of HCBS providers. Current gaps in HCBS program capacity and provider availability in urban and suburban areas may not be as serious as in rural areas, but with a growing population of older adults and people with disabilities, they are expected to widen in the future. The current gaps in access will only

[4] The California Department of Social Services administers the IHSS program; the California Department of Public Health administers the Medi-Cal Waiver Program; the California Department of Aging administers the MSSP and CBAS programs; and the California Department of Developmental Services administer several programs for Medi-Cal members with developmental disabilities.

worsen and the costs to the state and families will increase if California delays addressing the critical need for HCBS.

However, California is ahead of other states in the nation in spending a larger share of its Medi-Cal LTSS resources on HCBS relative to institutions. DHCS has begun to address gaps in access to HCBS and make efforts to improve coordination of HCBS with medical services provided to Medi-Cal members through several initiatives, which lay the foundation for further progress. For example, through the CalAIM demonstration, DHCS now allows Medi-Cal managed care plans to offer Enhanced Care Management (ECM) and Community Supports (CS), including several types of HCBS to members at risk of institutionalization or transitioning from an institution to the community.[5] In 2023, DHCS also added skilled nursing facility and other long-term care services to Medi-Cal managed care benefits, which provides a model for transitioning HCBS benefits into managed care. In addition, DHCS has made it easier to integrate and coordinate Medicare and Medi-Cal services for dually eligible individuals by contracting with managed care plans that cover both sets of benefits. Since 2022, California has used $3 billion in enhanced federal funding to invest in a range of initiatives designed to enhance, expand, and strengthen Medi-Cal HCBS. These initiatives include strengthening the direct care workforce, modernizing information technology systems, and adding slots to the Assisted Living Waiver program to reduce the current waiting list.[6]

In addition to these ongoing efforts, Mathematica will draft a Multi-year Roadmap that offers DHCS a set of specific policy options that hold promise for improving access to HCBS and better meeting the needs of older adults and people with disabilities enrolled in Medi-Cal now and in the future. The roadmap will be developed in collaboration with other CalHHS departments, including the Departments of Aging, Developmental Disabilities, Public Health, and Social Services which are the designated operational agencies for several HCBS programs.

[5] More information on the CalAIM initiatives can be found at https://www.dhcs.ca.gov/CalAIM/Pages/Initiatives.aspx.

[6] More information about California's HCBS Spending Plan initiatives can be found in the most recent report (February 2, 2024) at https://www.dhcs.ca.gov/provgovpart/Documents/HCBS-Quarterly-Spending-Plan-Narrative-Q3.pdf.

I. Introduction

A. Statewide HCBS gap analysis—purpose and approach

Although California provides HCBS to its Medi-Cal members through various programs across the state, persistent barriers hinder access to these services and programs. These challenges are compounded by the increasing demand for LTSS among a growing population of older adults and people with disabilities.

To identify gaps in availability, accessibility, and delivery of HCBS, DHCS contracted with Mathematica to conduct a mixed-methods analysis of the state's HCBS programs and service delivery system. To close the gaps and improve access to HCBS, Mathematica will develop a Multi-year Roadmap with recommendations on how to better meet the needs of older adults and people with disabilities enrolled in Medi-Cal. Although this report examines the use of institutional care, the analyses focus on gaps in availability of and access to HCBS because most consumers prefer to live at home and receive LTSS there.

1. Methods

Five objectives (**Box I.1**) that DHCS and stakeholders identified as priorities served as the initial organizing framework for the gap analysis.[7] The results include descriptive and geospatial findings on current and future LTSS use and LTSS provider patterns, as well as responses to a statewide provider survey. The report supplements these results with qualitative findings on provider capacity and perceived barriers to access and service delivery of HCBS. Appendix A lists the full set of analytic questions underpinning this report, along with high-level descriptions of methods for each. A series of appendices provide more detailed information on the analytic methods used for this report.

Box I.1. California Statewide HCBS gap analysis and Multi-year Roadmap objectives

- **Objective 1:** Reduce inequities in access and services
- **Objective 2:** Meet client needs
- **Objective 3:** Improve program integration and coordination
- **Objective 4:** Improve quality
- **Objective 5:** Streamline access

These objectives are presented in Appendix A, along with a full list of research questions.

The definitions of HCBS programs and settings are aligned with those included in the state's Medi-Cal LTSS Dashboard[8] and encompass people in long-term care (LTC) settings and those enrolled in or receiving certain Medi-Cal HCBS programs. For these populations, the analyses include Medi-Cal-covered services delivered between 2017 and 2021.

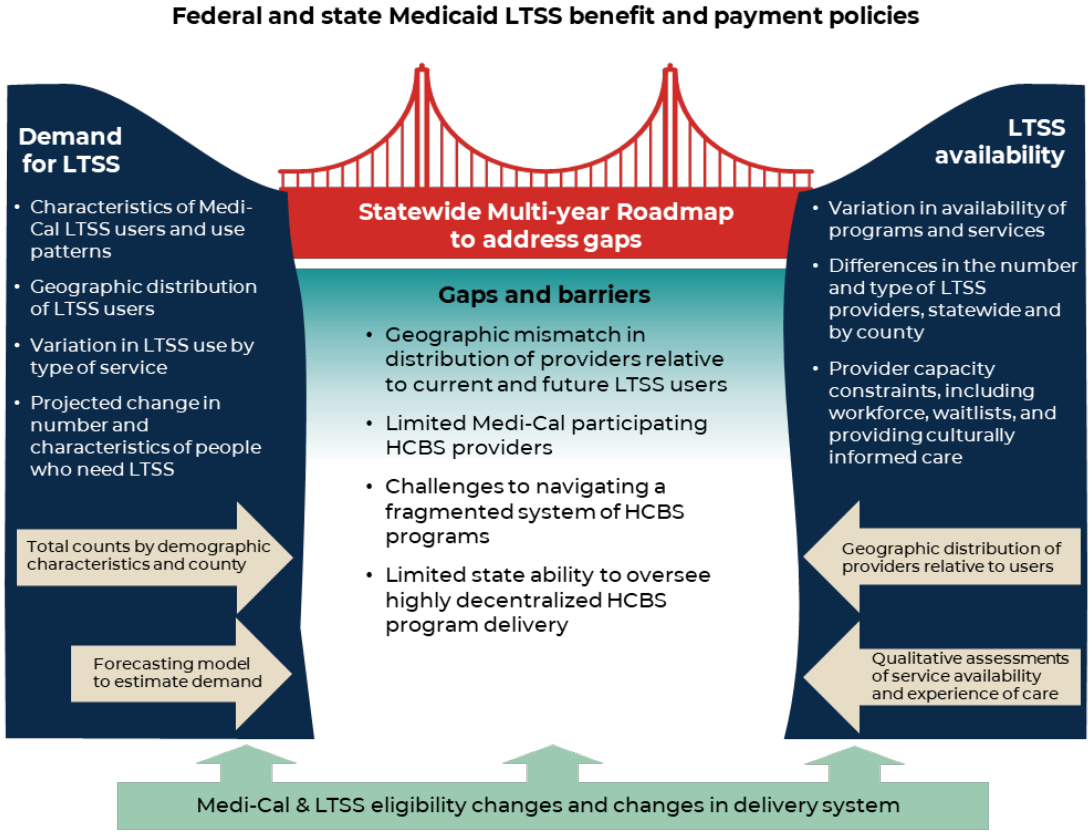
[7] DHCS solicited stakeholder input during the planning stages for the gap analysis. Information about that input and the planning process is available at https://www.dhcs.ca.gov/services/ltc/Pages/-MFP-Supplemental-Funding-Opportunity.aspx.

[8] The LTSS Dashboard is available at https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/LTSS-Dashboard.aspx.

- **HCBS programs** covered in the analyses in this report include IHSS, CBAS, the HCBA waiver, ALW, MSSP, PACE, and CCT.[9] Further descriptions of these programs are given in Chapter II.
- **People in LTC settings** covered in the analyses in this report include individuals residing in a skilled nursing facility (SNF), subacute care facility, or intermediate care facility for the developmentally disabled (ICF/DD), and custodial care, as defined in the LTSS Dashboard.[10] The length of stay in these facilities ranged from one day to 365 days in a given year, as the LTSS Dashboard does not impose any length-of-stay minimums on the populations using these facilities. Consequently, the number of people residing in LTC settings includes both those with short stays, who may have been admitted for post-acute nursing and rehabilitation services, as well as extended (long-term) skilled nursing or custodial care. Because Medicare covers short-term nursing home stays for people who are dually eligible for Medicare and Medicaid, few short-term stays are covered by Medi-Cal.

Exhibit I.1 provides a framework for the identification of gaps in LTSS access in California.

Exhibit I.1. Statewide HCBS gap analysis framework



HCBS = home and community-based services; LTSS = long-term services and supports.

[9] The Medi-Cal Waiver Program (MCWP), HCBS-DD Waiver, and Self-Determination Program (SDP) are not included in analyses for this report because program data were unavailable. Home health is included in the LTSS Dashboard, but populations receiving home health are not included in these analyses.

[10] The LTSS Dashboard is available here: https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/LTSS-Dashboard.aspx. Custodial care is usually provided in nursing facilities, as is subacute care. Because they are shown as separate types of institutional LTC in the LTSS Dashboard, this analysis also shows them separately.

2. Study limitations

Although these analyses provide a strong foundation for understanding gaps in Medi-Cal HCBS delivery in California, several important limitations exist.

- **No administrative data on unmet need for most HCBS programs.** Although Mathematica can analyze current enrollees or users of Medi-Cal LTSS, no administrative data are available on unmet need among current LTSS users in programs other than IHSS, so it is unknown whether these other users are receiving all services authorized in their service plans (Kietzman and Chen 2022).[11] Furthermore, Mathematica has no administrative data about people with LTSS needs who are eligible for but not enrolled in Medi-Cal or enrolled in Medi-Cal but not receiving Medi-Cal LTSS, even though they might need LTSS. Therefore, these analyses likely underestimate potential gaps. To address these data limitations, Mathematica and the Centers for Health Care Strategies conducted interviews, consumer listening sessions, and focus groups with a broad group of stakeholders, including consumers, family caregivers, providers, HCBS waiver agencies, consumer advocates, and MCPs, and administered a provider survey to supplement the assessment of gaps as measured in administrative data.
- **Lack of data on income and assets for forecasting Medi-Cal LTSS users.** Mathematica's estimates of adults with ADL impairment enrolled in Medi-Cal do not reflect recent and upcoming changes to Medi-Cal eligibility policies. These changes include the elimination of the asset limit for non-Modified Adjusted Gross Income programs and the change in consideration of immigration status for adults age 50 and older, neither of which were in effect during the period covered by the Medi-Cal data in this report (2017–2021).[12]
- **Limited LTSS provider information.** Based on the data sources available for the analyses, Mathematica was able to obtain only a cross-section of current providers (from 2023), so it could not analyze how the set of LTSS providers has changed between 2017 and 2021. Counts of current providers may have some inaccuracies because it is likely records still exist that Mathematica was unable to de-duplicate; also, certain providers included in the analysis currently do not serve Medi-Cal enrollees and have a low likelihood of doing so in the future.
- **Limited data on LTSS provider capacity impacts the interpretation of maps.** Mathematica used user-to-provider ratio maps to assess potential gaps in access, where a high user-to-provider ratio suggests a possible shortage of providers at the organization level. However, because Mathematica lacked information on the staff within the organizations (such as the number of individuals who work for a personal care agency), these ratios provide only a crude indication of where supply may be

[11] The UCLA Center for Health Policy Research conducted a 2022 survey that examined the prevalence of need and unmet need for LTSS, but results were not broken out by current use of Medi-Cal LTSS. For additional details, see https://healthpolicy.ucla.edu/our-work/publications/unmet-needs-help-home-how-older-adults-and-adults-disabilities-are-faring-california.

[12] Elimination of asset tests for non-Modified Adjusted Gross Income (MAGI) Medi-Cal members became effective in January 2024: https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Asset-Limit-Changes-for-Non-MAGI-Medi-Cal.aspx. Adults age 50 and older became eligible for Medi-Cal regardless of immigration status as of May 1, 2022: https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/OlderAdultExpansion.aspx. Adults ages 26 through 49 became eligible for Medi-Cal regardless of immigration status as of January 1, 2024: https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Adult-Expansion.aspx

inadequate. Mathematica conducted a provider survey in fall 2023 to gather additional capacity information from HCBS providers, and findings were incorporated along with other qualitative information from providers.

- **Limited scope in assessing geographical access.** For these analyses, Mathematica defined access primarily as geographic proximity between member residence and provider, so it is limited in scope. Other important factors include language barriers in accessing culturally informed LTSS, wait times for scheduling appointments, and whether a provider is accepting new Medi-Cal clients.

3. Report organization

Following this chapter, Chapter II describes the LTSS Landscape in California, followed by four chapters detailing research findings. These findings are organized according to the following high-level themes:

- ***Chapter III:*** **Availability of programs and services to meet member needs for HCBS/MLTSS**
- ***Chapter IV:*** **Provider capacity to meet member needs and coordinate care**
- ***Chapter V:*** **Member ability to find and obtain high-quality person-centered care**
- ***Chapter VI:*** **Program administration and operations**

These categories align with similar categories in the Multi-year Roadmap to allow for easier cross-walking between gaps and recommendations presented across the two reports. Related initiatives and future directions are presented in Chapter VII. Appendices A to D.3 provide additional background information and details about the data and methods for each analysis.

II. The LTSS Landscape in California

A. Medi-Cal programs

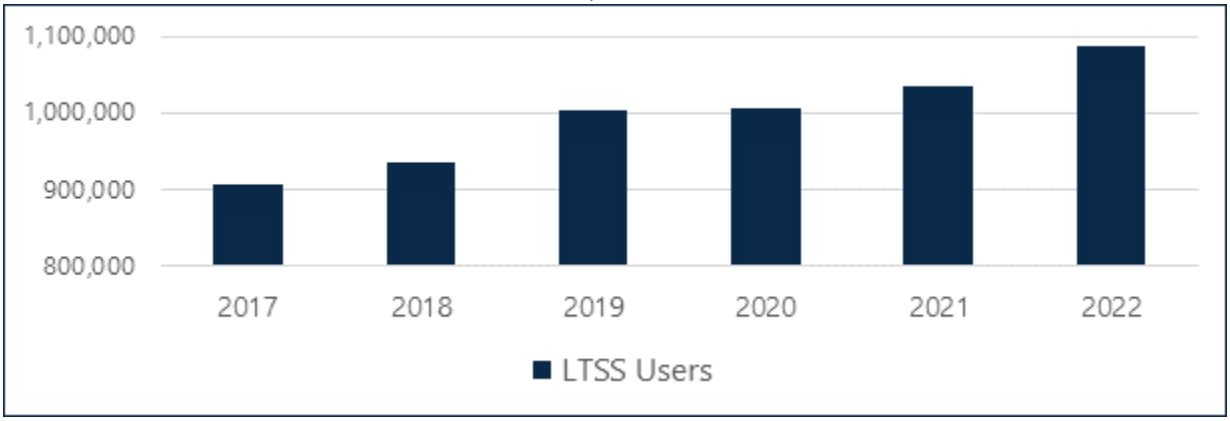
Older adults and people with disabilities often require assistance to perform ADL and instrumental activities of daily living (IADL) due to physical, intellectual, or cognitive limitations. The services providing such assistance are collectively referred to as LTSS (**Box II.1**).

Box II.1. Key definitions

- **LTSS** include the broad range of assistance that people with physical, cognitive, mental, intellectual, or developmental disabilities need to perform, including ADL (such as bathing, eating, and dressing) and IADL (such as housekeeping, laundry, grocery shopping, and medication management). LTSS can be provided in an institutional setting / long-term care facility (such as a nursing home) or an HCBS setting.
- **HCBS** are LTSS provided in an individual's own home or community-based settings, rather than institutions. HCBS encompasses a broad range of non-medical services and supports that help older adults and people with disabilities live independently, such as personal care assistance, transportation to medical appointments and community events, and home-delivered meals.
- **MLTSS** programs provide LTSS through contracts between the state Medicaid agency and MCPs, which are paid a fixed amount per enrollee per month to provide LTSS.

In California, the primary route to accessing LTSS affordably is through Medi-Cal, the state's Medicaid program. Between 2017 and 2022, the number of Medi-Cal members using some form of LTSS increased by almost 20 percent (**Exhibit II.1**), highlighting the program's crucial role in delivering these services. The number of Californians requiring LTSS is expected to continue growing over the coming decades as population demographics change and Medi-Cal eligibility criteria are expanded or revised.[13]

Exhibit II.1. Medi-Cal LTSS users in California, 2017–2022



Source: DHCS Medi-Cal LTSS Dashboard, https://www.dhcs.ca.gov/dataandstats/dashboards/Documents/LTSS-Dashboard/LTSS-Dashboard-Factsheet.pdf.

Over the last several decades, states have aimed to rebalance their LTSS systems by increasing the share of spending and use of HCBS (**Box II.1**) relative to institutional care (CMS n.d.). This shift broadly reflects

[13] For example, the 2024 Medi-Cal expansion, which allows all income-eligible Californians to qualify for Medi-Cal regardless of immigration status: https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Adult-Expansion.aspx.

state aims of supporting consumer preferences to live and receive LTSS in the community and enable more cost-effective services. California is ahead of the curve when it comes to rebalancing its LTSS system – shifting the proportion of its Medi-Cal spending and use of LTSS toward home and community-based settings and away from institutional settings (CMS 2020). In federal fiscal year 2020, the state spent almost $30 billion on LTSS, with just over 70 percent of that amount on HCBS, ranking 11th highest across all states (Murray et al. 2023). California is also high performing in the number of HCBS enrollees—in 2022, the share of HCBS enrollees relative to total LTSS users was 90.6 percent, an increase of 3.4 percentage points from 2017.[14] These trends reflect the state's significant investment in HCBS programs through various legislative authorities and funding opportunities that provide these services. **Exhibit II.2** describes the full set of programs through which Medi-Cal members can access HCBS.

In addition to HCBS, the Medi-Cal program also provides institutional LTC services:

- **Nursing facilities (SNFs or NFs):** settings where individuals may receive either short-term skilled nursing and rehabilitation after a hospitalization, subacute care, or long-term custodial care. Note that for individuals dually eligible for Medicare and Medi-Cal, Medicare may cover skilled nursing services; Medicare-covered SNF services are not included in this report.
- **Intermediate care facilities (ICFs):** residential facilities providing active, specialized treatment for individuals with intellectual or developmental disabilities who require constant supervision and continuous habilitation services.

[14] https://www.dhcs.ca.gov/dataandstats/dashboards/Documents/LTSS-Dashboard/LTSS-Dashboard-Factsheet.pdf.

Exhibit II.2. Key features of California programs providing HCBS as of January 2024

Program description	Program features
Section 1915(c) waiver programs	
HCBA waiver program	
Provides a range of services for individuals of **all ages**, including case management, respite, nursing and supportive services, and facility-to-community transition support services, that can be delivered in the home, a CLHF, or an ICF/DD-CN.[a]	**Qualifying condition** • Medically fragile • Technology dependent ☑ Institutional LOC ☐ < Institutional LOC **Most common services provided** Skilled nursing – HH aides; Environmental adaptation Personal care; Habilitation Case management; Caregiver support[b] **Delivery system** Fee-for-service[c] **Statewide**
ALW program	
Provides Medi-Cal members **age 21 and older** the option to live in assisted living settings in 15 counties, ***or*** public subsidized housing available in Los Angeles County only, as an alternative to nursing home placement.	**Qualifying condition** • Aging • Physical disability ☑ Institutional LOC ☐ < Institutional LOC **Most common services provided** Care coordination; Case management[d] Personal care; Homemaker – chore services Habilitation **Delivery system** Fee-for-service[c] **15 counties[e]**
MSSP	
Offers case management services for individuals **age 65 or older** to help them remain in the community. The program is designed to provide care management services to frail older adults as an alternative to nursing facility placement.	**Qualifying condition** • Aging • ADL and IADL limitation ☑ Institutional LOC ☐ < Institutional LOC **Most common services provided** Assessment; Personal care[f] Case management; Environmental adaptation Transportation; Meals[g] Homemaker – chore services[h]; Caregiver support[i] **Delivery system** Fee-for-service[c] **47 counties*** *Planned to be statewide (2024)
Self-determination program[h,j]	
Allows participants of **all ages** with an intellectual or developmental disability and their families the opportunity to have more freedom, control, and responsibility in developing their service plans and choosing services and supports to help them meet their objectives.	**Qualifying condition** • Intellectual/developmental disability (IDD) ☑ Institutional LOC ☐ < Institutional LOC **Most common services provided** Assessment; Habilitation Skilled nursing – HH aides; Environmental adaptation Rehabilitation[k]; Transportation Homemaker – chore services; Caregiver support Employment support **Delivery system** Fee-for-service **Statewide**

Program description	Program features

HCBS waiver for Californians with developmental disabilities (HCBS-DD)[j]

Authorizes HCBS and supports allowing people with intellectual or developmental disabilities of **all ages** to live at home or in the community rather than residing in licensed health facilities (ICFs/DD or State Developmental Centers).

Qualifying condition
- Intellectual/develop -mental disability (IDD)

☑ Institutional LOC
☐ < Institutional LOC

Most common services provided	
Assessment	Rehabilitation[k]
Homemaker – chore services	Skilled nursing – HH aides
Habilitation	Transportation[l]
Environmental adaptation	Caregiver support
Employment support	

Delivery system

● **Statewide**

Medi-Cal Waiver Program (MCWP)[j]

Aims to support participants of **all ages** in disease management, preventing HIV transmission, stabilizing overall health, and improving their quality of life. Formerly known as the HIV/AIDS waiver.

Qualifying condition
- HIV/AIDS

☑ Institutional LOC
☐ < Institutional LOC

Most common services provided	
Homemaker – chore services	Case management
Personal care	Meals[g]
Transportation[l]	
Professional nursing services	

Delivery system

◑ **26 counties[m]**

Section 1915(k), 1915(j), and 1915(i) state plan benefits

IHSS program

Covers in-home care expenses for people with disabilities of **all ages**, allowing them to continue residing safely in their homes. IHSS offers personal care services and supports, including help with household chores, ADL, paramedical services, and protective supervision. Beneficiaries or their support network are responsible for selecting and coordinating their IHSS workers.

Qualifying condition
- Any

☑ Institutional LOC for **CFCO program**
☑ < Institutional LOC for **IHSS-R, PCSP, and IP**

Most common services provided	
Assessment	Personal care
Caregiver support[n]	Homemaker – chore services

Delivery system

● **Statewide**

Counties conduct eligibility determinations and assessments. There are four separate sub-programs authorized by different authorities: (1) IHSS Residual (IHSS-R) Program; (2) Personal Care Services Program (PCSP); (3) IHSS Plus Option (IPO) Program; and (4) Community First Choice Option (CFCO) Program.

Program description	Program features

HCBS state plan benefit program[j]

Provides access to federal funding for community services for individuals with developmental disabilities **age 21 and older** who do not meet the eligibility requirements for the 1915(c) HCBS waivers.

Qualifying condition
- Intellectual/develop-mental disability (IDD)

☐ Institutional LOC
☑ < Institutional LOC

Most common services provided

Skilled nursing – HH aides	Employment support
Caregiver support	Homemaker – chore services
Rehabilitation[k]	Habilitation
Environmental adaptation	

Delivery system

● **Statewide**

Other HCBS programs

CBAS (Section 1115(a) authority)

A day health program providing health, rehabilitative, personal care, and social services to older adults or disabled adults **age 18 and older**, enabling them to restore or maintain capacity for self-care and delay or prevent institutionalization.

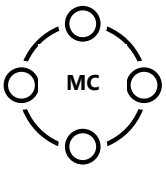
Qualifying condition
- Any

☑ Institutional LOC
☐ < Institutional LOC

Most common services provided

Assessment	Skilled nursing – HH aides
Personal care	Rehabilitation[k]
Transportation	Meals[g]

Delivery system



◔ **28 counties[o]**

CCT

The Money Follows the Person (MFP) demonstration offers transition services for people of **all ages** currently residing in institutions to transition back to the community. CCT also provides case management services for one year after transition to the community.

Qualifying condition
- Any

☑ Institutional LOC
☐ < Institutional LOC

Most common services provided

Assessment	Transition
Eligibility determination	Other services that vary by program

Delivery system

◔ **56 counties[p]**

PACE

PACE is a managed care program offering in-home care services, along with transportation to PACE adult day centers, where participants **age 55 and older** can receive medical care, meals, rehabilitative therapies, and social services.

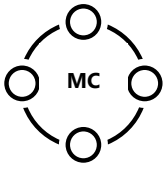
Qualifying condition
- Any

☑ Institutional LOC
☐ < Institutional LOC

Most common services provided

Assessment	Personal care
Skilled nursing – HH aides	Homemaker – chore services
Rehabilitation[k]	Habilitation
Transportation	Meals[g]
Case management	Caregiver support
Environmental adaptation	

Delivery system



◔ **27 counties[q]**

Program description	Program features
CalAIM Section 1115 demonstration	
Enhanced Care Management (ECM)	**Community Supports (CS)**
Statewide Medi-Cal benefit available to certain managed care members with complex needs. Services include access to a single lead case manager who provides comprehensive care management of all health and health-related care.	Medically appropriate and cost-effective substitute services to address members' health-related social needs, including support to secure and maintain housing and access to medically tailored meals to support short-term recovery.

[a] Restricted to ICF/DD CNs, or ICF-DD Continuous Nursing Care Homes, which are not subject to the Long Term Care Carve-In policy.

[b] Includes home respite and facility respite services.

[c] Currently delivered through fee-for-service but planned for managed care integration beginning in 2027.

[d] Includes plan-of-care development and follow-up.

[e] Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma counties.

[f] Most MSSP waiver program participants receive IHSS. MSSP can provide supplemental in-home chore and personal care services.

[g] Includes home-delivered meals and meals in congregate settings but does not constitute "room and board."

[h] Includes supplemental homemaker services.

[i] Includes respite care.

[j] Program is not included in the gap analysis due to data availability.

[k] Includes PT, OT, and ST.

[l] Includes non-medical transportation.

[m] Alameda, Butte, Colusa, Glenn, Shasta, Sutter, Tehama, Trinity, Yuba, Contra Costa, El Dorado, Nevada, Placer, Lake, Mendocino, Sonoma, Los Angeles, Orange, Riverside, San Bernardino, Sacramento, Yolo, San Luis Obispo, San Francisco, Santa Cruz, Ventura.

[n] IHSS provides several benefits to caregivers/providers, such as medical insurance, worker's compensation insurance, sick leave, and overtime pay. In addition, Career Pathways provides incentives for training, the Backup Provider System, CalSavers (a retirement saving account for IHSS providers), etc. For more information, see: https://www.cdss.ca.gov/inforesources/cdss-programs/ihss/ihss-career-pathways-program.

[o] Alameda, Butte, Contra Costa, Fresno, Humboldt, Imperial, Kern, Los Angeles, Marin, Merced, Monterey, Napa, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Stanislaus, Ventura, Yolo counties.

[p] All counties except: Napa and Marin.

[q] Alameda, Contra Costa, El Dorado, Fresno, Humboldt, Kern, Kings, Los Angeles, Madera, Marin, Merced, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, and Yuba counties.

ALW = Assisted Living Waiver; CalAIM = California Advancing and Innovating Medi-Cal; CBAS = community-based adult services; CCT = California Community Transitions; CFCO = Community First Choice Option; CLHF = congregate living health facility; CS = community supports; DD = developmentally disabled; ECM = Enhanced Care Management; HCBA = Home and Community-Based Alternatives Waiver; HH = home health; HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome; ICF/DD = intermediate care facilities for the developmentally disabled; ICF/DD-CN = intermediate care facilities for the developmentally disabled-continuous nursing care homes; IHSS = in-home supportive services; IHSS-R = IHSS Residual; IPO = IHSS Plus Option; LOC = level of care; MC = managed care; MFP = Money Follows the Person; MSSP = multipurpose senior services program; OT = occupational therapy; PACE = Program for All-Inclusive Care for the Elderly; PCSP = Personal Care Services Program; PT = physical therapy; ST = speech therapy.

As of July 2023, most Medi-Cal members (90.8 percent) are enrolled in managed care for their health benefits, whereas the remaining members receive care through the fee-for-service delivery system (California DHCS 2023d). However, most HCBS benefits remain carved out of (excluded from) managed care, except the CBAS program, which operates in 28 counties.

Beginning in 2022 through 2027, California plans to introduce new programs and make significant reforms to existing programs through the CalAIM program, a sweeping set of initiatives designed to

transform Medi-Cal.[15,16] Carving LTSS into managed care to establish an integrated MLTSS system is one of many CalAIM initiatives. This change aims to create incentives for MCPs to help their members remain in the community by placing the plans at financial risk for the cost of all LTSS; it is often less costly to provide LTSS in the community. CalAIM also intends to make benefits more uniform across the state to reduce service fragmentation across delivery systems and improve accountability (Chapman 2023).

The state has already made strides in this direction through several initiatives. For example, ECM is a new managed care benefit that coordinates clinical and non-clinical services to certain members with complex needs, although plans have discretion to choose which Community Supports are covered .[17] As of 2023, Medi-Cal MCPs can also offer personal care and caregiver respite services, among other services, as "in lieu of services" through the Community Supports option as long as such services complement rather than substitute for IHSS.[18] For LTSS in institutional settings, as of 2023, all Medi-Cal MCPs are responsible for covering SNF benefits, and as of 2024, long-term care in intermediate care facilities as well for Medi-Cal members with developmental disabilities.[19] Beginning in 2027, the state also plans to initiate the integration of HCBS services into managed care to broaden the number of programs, services, and Medi-Cal members covered by statewide MLTSS. Additional planning is underway – including the development of a roadmap – to assess and plan for the future of services currently available under the ALW, HCBA, MCWP, and MSSP 1915(c) waivers. DHCS has also expanded availability of Medi-Medi Plans – Medicare Advantage plans with an affiliated Medi-Cal managed care plan that enrolls dually eligible individuals and coordinates all benefits and services across Medicaid and Medicare. The state plans to make Medi-Medi Plans available statewide beginning in 2026.[20]

B. Medi-Cal LTSS users and use patterns

To examine demographic and enrollment characteristics of Medi-Cal LTSS users, Mathematica relied on Medi-Cal enrollment data to produce profiles for 2017 to 2021 by LTSS type (refer to Appendix B.1 for details on the methods used to create the descriptive profiles of current LTSS users). To examine use patterns over time by LTSS type, Mathematica relied on Medi-Cal claims and enrollment data (Appendix B.3). Mathematica also mapped the distribution of LTSS users overall and by type to understand where LTSS users live.

[15] https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM.aspx.

[16] "The goal of CalAIM is to improve health outcomes and advance equity for Medi-Cal beneficiaries and other low-income people in the state. It is a multifaceted initiative, and seeks to take a population health, person-centered approach to providing services. It seeks to expand California's whole-person care approach…statewide through California's Medi-Cal delivery system." For additional context on the CalAIM initiative, please see the Section 1115 Renewal application here: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Section-1115-Renewal-Application.pdf

[17] For more information on the Enhanced Care Management initiative, please see Enhanced Care Management and Community Supports.

[18] For more information about this option, please see DHCS-Community-Supports-Policy-Guide.pdf (ca.gov).

[19] https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx.

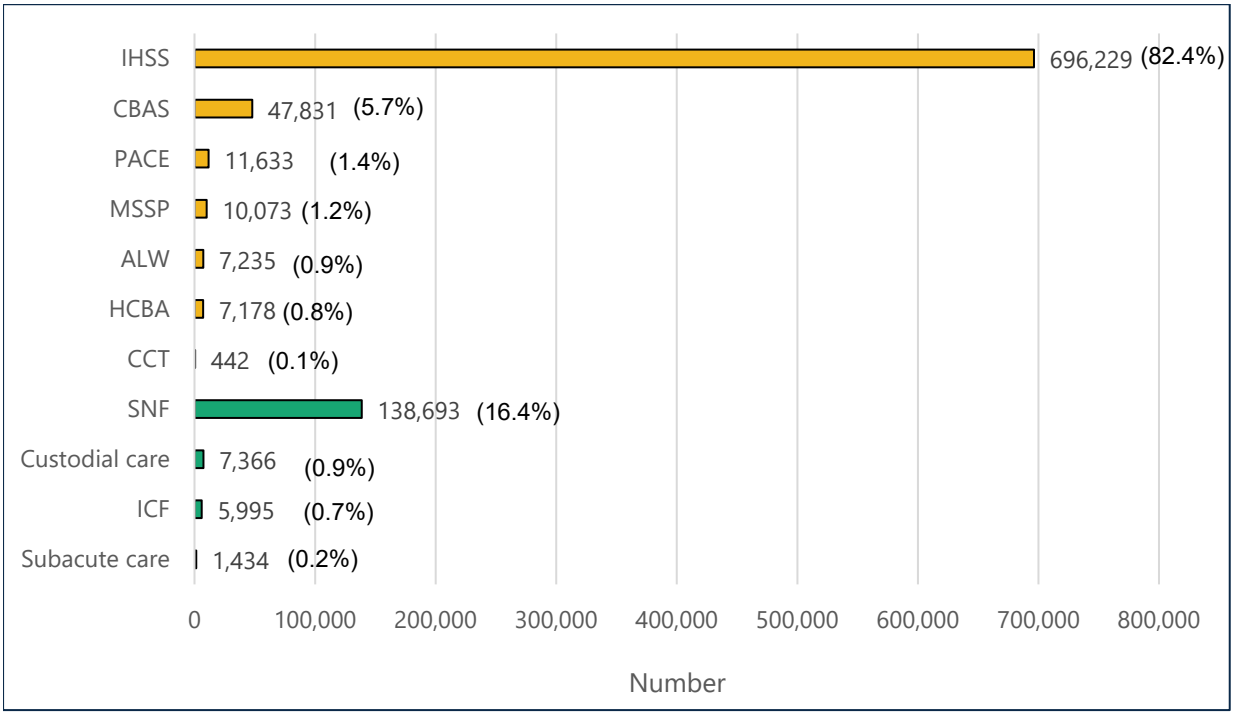
[20] https://www.dhcs.ca.gov/CalAIM/Pages/Article-Integrated-Care.aspx#:~:text=By%202026%2C%20eligible%20members%20will,fee%2Dfor%2Dservice).

1. LTSS user profiles for 2021

In 2021, 845,394 Medi-Cal members age 18 and older used any type of LTSS—5.5 percent of the 15.3 million Medi-Cal members that year.[21] About 86 percent of LTSS users were enrolled in an HCBS program during the year, 18 percent had at least one LTC stay (**Exhibit II.3**), and 6 percent had both an LTC stay and HCBS program enrollment (data not shown).

More than 80 percent of all LTSS users were enrolled in IHSS (**Exhibit II.3**). Six percent were enrolled in the CBAS program, and a small proportion (around 1 percent) were enrolled in each of the remaining five programs: ALW, CCT, HCBA, MSSP, and PACE. Among HCBS enrollees, 93 percent were enrolled in one HCBS program in the year and 7 percent were enrolled in two or more HCBS programs (data not shown).

Exhibit II.3. Distribution of LTSS users by program or service type, 2021



Source: Medi-Cal enrollment data and LTSS flags file from calendar year 2021.

Note: A member may have been enrolled in one or more HCBS program or had one or more types of LTC stays in the year. Thus, the individual percentages do not add up to 100.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; HCBS = home and community-based services; ICF = intermediate care facility; IHSS = in-home supportive services; LTC = long-term care; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care for the Elderly; SNF = skilled nursing facility

[21] Data retrieved from the Medi-Cal Long-Term Services and Support Dashboard, available at https://data.chhs.ca.gov/dataset/long-term-services-and-supports.

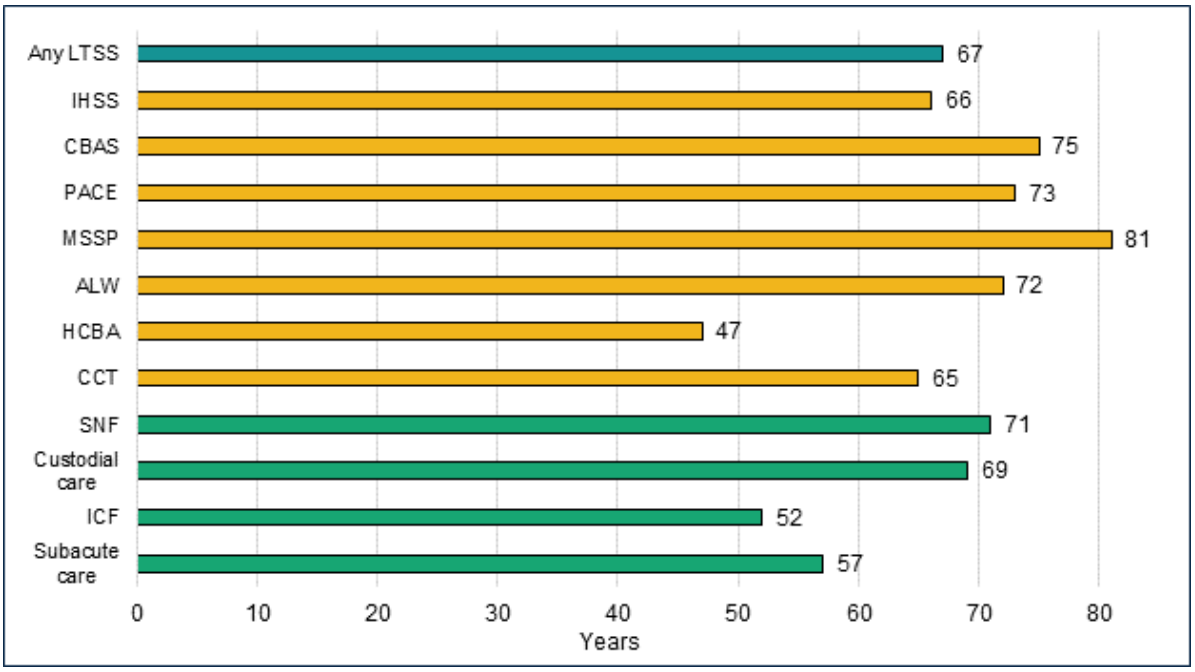
Nearly all members with an LTC stay used SNF services (95 percent, data not shown), and small proportions of members with LTC stays received custodial care in an institution (5 percent, data not shown), care in an ICF (4 percent, data not shown), or subacute care (1 percent, data not shown).[22]

a. Average age of LTSS users

Except for HCBA, the other HCBS programs in this analysis have age restrictions on enrollment. IHSS enrollees must be either 65 years and older, or blind or disabled (of any age); CBAS enrollees must be 18 years and older; MSSP enrollees must be 60 years and older; and ALW enrollees must be 21 years and older.

The average age of LTSS users in 2021 was 67 (**Exhibit II.4**). Enrollees in the HCBA program were the youngest, on average (47 years old), and those in MSSP were the oldest, on average (81 years old), which reflects the eligibility requirement for MSSP that enrollees be age 65 and older; HCBA has no age requirement for enrollment. People who received care in an ICF or subacute care were also younger (52 and 57 years old, respectively) than the populations who received SNF or custodial care (71 and 69 years old, respectively).

Exhibit II.4. Mean age of LTSS users by program or service type, 2021



Source: Medi-Cal enrollment data and LTSS flags file from calendar year 2021.

Note: Some HCBS programs have age restrictions for enrollment. IHSS enrollees must be 65 years or older, blind, or disabled; CBAS enrollees must be 18 or older; MSSP enrollees must be 65 or older; ALW enrollees must be 21 or older; and HCBA has no age limitation.

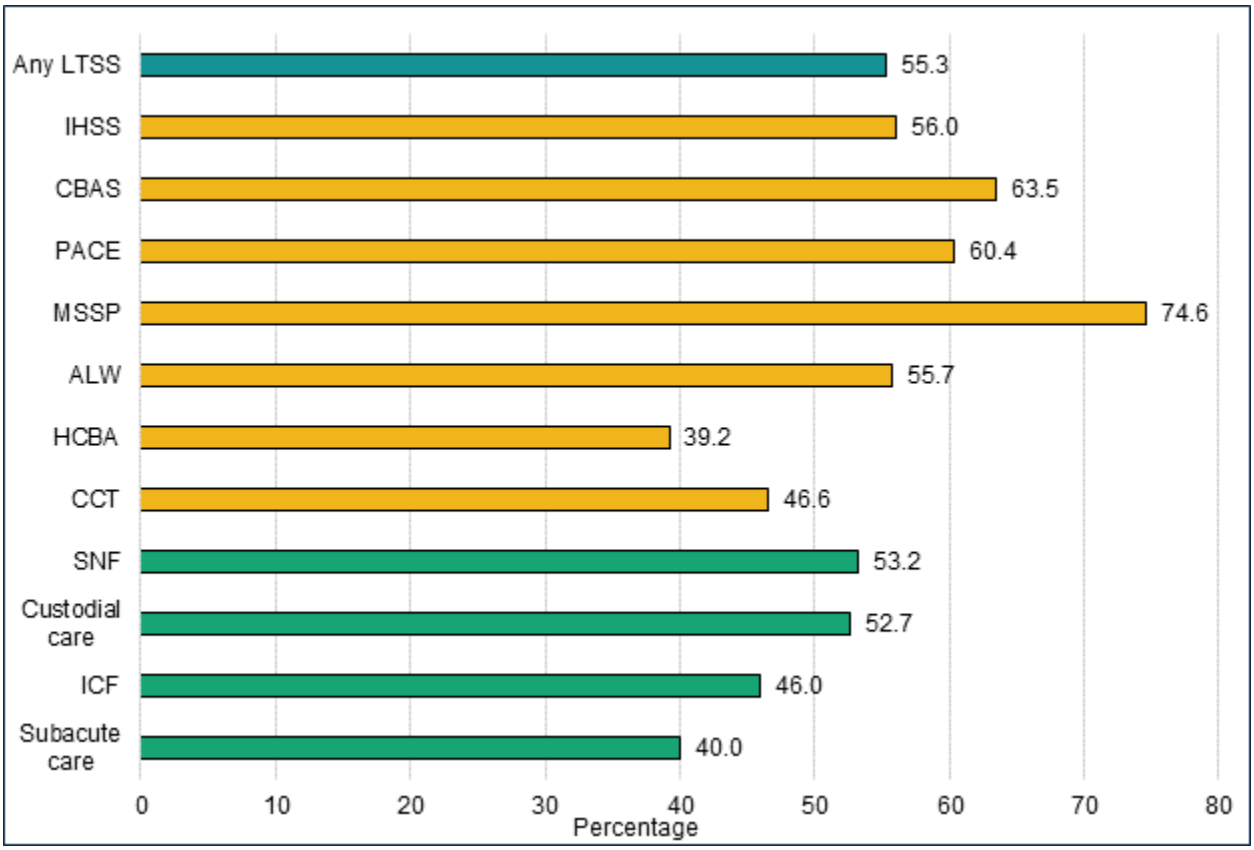
ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; ICF = intermediate care facility; IHSS = in-home supportive services; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care for the Elderly; SNF = skilled nursing facility.

[22] A member may have had more than one type of LTC stay in the year, so the individual percentages may not add up to 100.

b. Sex of LTSS users

Although slightly more than half of LTSS users in 2021 were female (55 percent), user categories show some variation (**Exhibit II.5**). For example, the HCBA program and subacute care had the lowest proportions of female users (around 40 percent), and MSSP had the highest (75 percent).

Exhibit II.5. Percentage of female LTSS users by program or service type, 2021



Source: Medi-Cal enrollment data and LTSS flags file from calendar year 2021.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; ICF = intermediate care facility; IHSS = in-home supportive services; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care for the Elderly; SNF = skilled nursing facility.

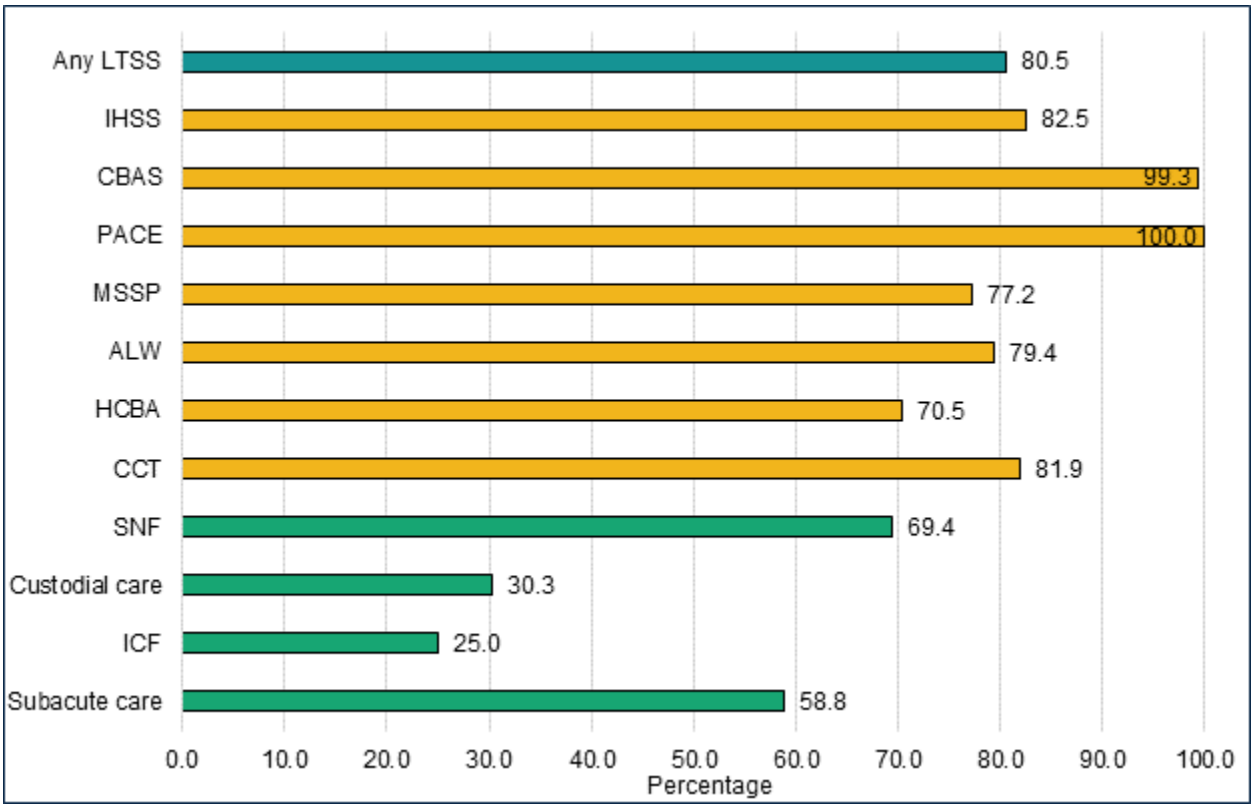
c. Enrollment of LTSS users in Medi-Cal MCPs

Most LTSS users (81 percent) were enrolled in a Medi-Cal MCP for their physical health benefits[23] in 2021 (**Exhibit II.6**). Among HCBS program enrollees, the highest proportion enrolled in a Medi-Cal MCP were in the PACE and CBAS programs (nearly 100 percent) because PACE is an integrated managed care delivery model and CBAS benefits were among the few categories of LTSS carved into the benefits package for Medi-Cal MCPs that year. The HCBA program had the lowest MCP enrollment (slightly over 70 percent). In

[23] Mathematica assigned each member to a managed care enrollment status based on the plan name that appeared on the plurality of their Medi-Cal-eligible months that year on the eligibility file (Appendix B.1), reflecting coverage in the MCP that encompasses physical health benefits.

general, members with LTC stays were enrolled in Medi-Cal MCPs at lower rates because these services were largely carved out of the managed care benefit package before January 2023 in 31 counties.[24]

Exhibit II.6. Percentage of LTSS users enrolled in an MCP by program or service type, 2021



Source: Medi-Cal enrollment data and LTSS flags file from calendar year 2021.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; ICF = intermediate care facility; IHSS = in-home supportive services; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care for the Elderly; SNF = skilled nursing facility.

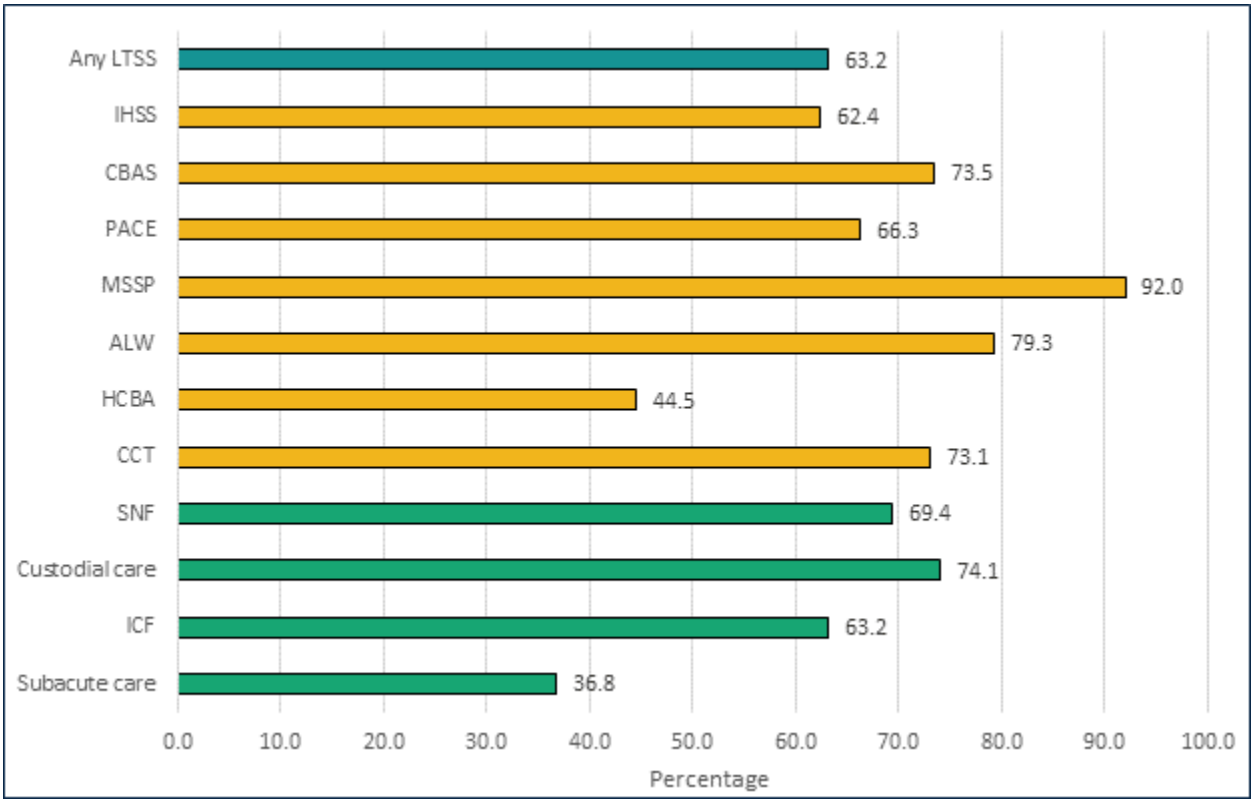
d. Dual eligibility status of LTSS users

Most LTSS users (63 percent) were dually eligible for Medi-Cal and Medicare in 2021 (**Exhibit II.7**). Among HCBS enrollees, the highest proportion who were dually eligible were in MSSP (92 percent); the lowest proportion were in the HCBA program (45 percent). Among those with an LTC stay, only about 37 percent

[24] More information about Medi-Cal LTSS managed care transition is in the CalAIM Long-Term Care Carve-In Transition, available at https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx. Before January 1, 2023, the Medi-Cal LTC benefit was provided through Medi-Cal MCPs in 27 counties. In the other 31 counties, institutional LTC coverage was limited to the first month of admission and the following month; Medi-Cal Members who received custodial care or care in an ICF represented the lowest proportion of enrollment in an MCP (30 and 25 percent, respectively); most subacute and ICF services were carved into managed care benefits starting in January 2024. MCP members were disenrolled from the MCP after the second continuous month of coverage in an SNF (https://www.dhcs.ca.gov/provgovpart/Documents/LTC-SNF-Carve-In-FAQ.pdf). As of January 1, 2023, MCPs in all counties are responsible for the full LTC benefit in SNFs; as of January 1, 2024, MCPs in all counties must cover LTSS provided in ICF/DDs.

of those who received subacute care were dually eligible, whereas 63 to 74 percent of those who received SNF services, care in an ICF, or custodial care were dually eligible.

Exhibit II.7. Percentage of LTSS users dually eligible for Medi-Cal and Medicare by program or service type, 2021



Source: Medi-Cal enrollment data and LTSS flags file from calendar year 2021.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; ICF = intermediate care facility; IHSS = in-home supportive services; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care for the Elderly; SNF = skilled nursing facility.

e. Race and ethnicity of LTSS users

Overall, about a quarter of LTSS users in 2021 were White and a quarter were Hispanic (**Exhibit II.8**). Those in other racial and ethnic groups comprised about a third of all LTSS users: Asian (16 percent), Black (12 percent), Native Hawaiian or Other Pacific Islander (2 percent), and American Indian and Alaska Native (0.4 percent). Race and ethnicity information was not available for 16 percent of LTSS users. This distribution points to potential barriers in access to LTSS for certain groups when compared to overall population demographics in California: 40 percent Latino, 34 percent White, 15 percent Asian/Pacific Islander, 5 percent Black, 5 percent multiracial, and 0.3 percent Native American.[25] For example, although the Latino population represents 40 percent of the overall population, just a quarter of LTSS users were Hispanic/Latino. However, this may reflect lower need for LTSS, since about 10 percent of Latinos are ages

[25] 2022 American Community Survey 1-Year Estimates, available here: https://www.ppic.org/publication/californias-population/#:~:text=No%20race%20or%20ethnic%20group,the%202022%20American%20Community%20Survey..

61 and over, compared to 18 percent of the California population overall, so their lower share of Medi-Cal LTSS users could be explained, at least in part, by this difference.[26]

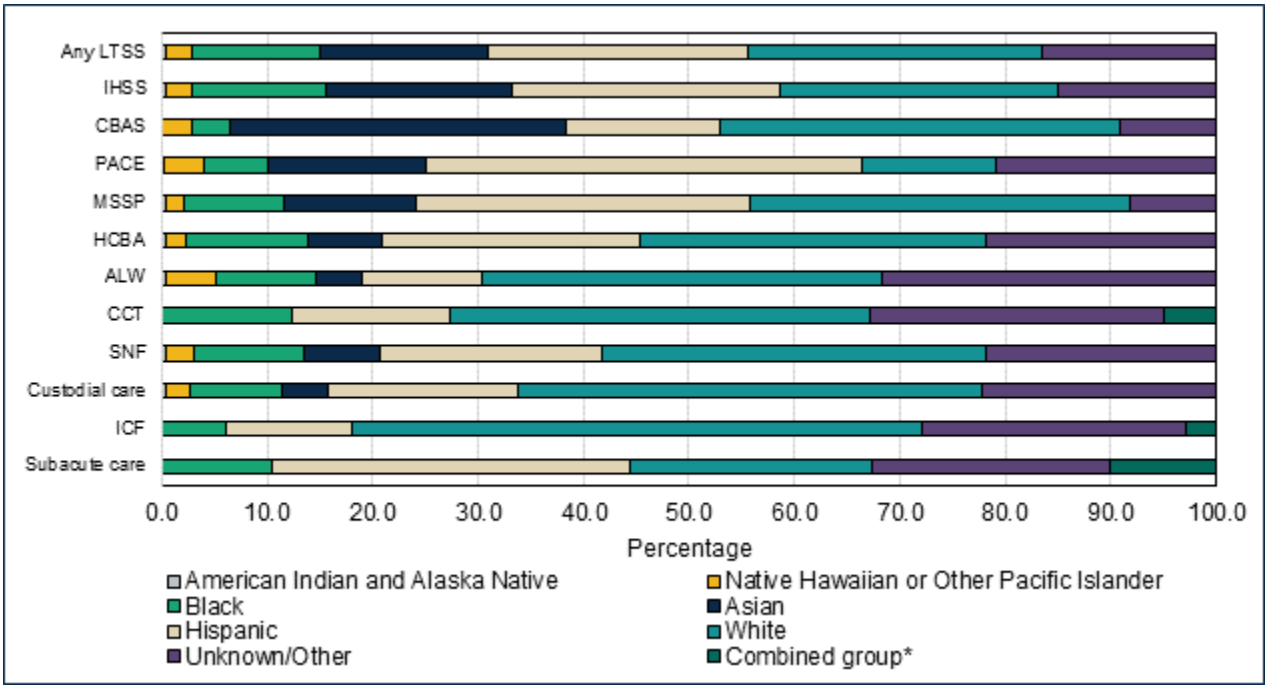
The distribution of self-reported race and ethnicity for participants in IHSS was similar to that of the overall LTSS population. The breakdown of race and ethnicity distributions varied in other HCBS enrollee categories. Relative to the racial and ethnic composition of the overall LTSS population, programs and service types showed the following breakdowns:

- The CBAS program had a higher proportion of White (38 percent) and Asian participants (32 percent).
- PACE had a higher proportion of Hispanic participants (41 percent).
- MSSP had a higher proportion of White (36 percent) and Hispanic participants (32 percent).
- The HCBA program had a higher proportion of White participants (33 percent) and a lower proportion of Asian participants (7 percent).
- The ALW program had a higher proportion of White (38 percent) and Native Hawaiian or Other Pacific Islander participants (5 percent); it also had the highest proportion of users with unknown race and ethnicity (32 percent).
- The CCT program had a higher proportion of White participants (40 percent) and a substantial proportion of participants with unknown race and ethnicity (28 percent).

Among institutional users, those receiving custodial care, ICF, or SNF services had a lower proportion of Asian and Hispanic users and higher proportions of White users. The highest proportion of White users (54 percent) was among those receiving care in an ICF.

[26] UCLA Latin Politics and Policy Institute, "15 Facts About Latino Well-Being in California", June 2022. https://latino.ucla.edu/research/15-facts-latinos-california/.

Exhibit II.8. Distribution of self-reported race and ethnicity of LTSS users by program or service type, 2021



Source: Medi-Cal enrollment data and LTSS flags file from calendar year 2021.

*The combined group aggregates the American Indian and Alaska Native, Native Hawaiian or Other Pacific Islander, and Asian racial and ethnic groups for select LTSS programs to protect confidentiality in accordance with the DHCS DDG v2.2.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; ICF = intermediate care facility; IHSS = in-home supportive services; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care for the Elderly; SNF = skilled nursing facility.

f. Primary language of LTSS users

Overall, about half of LTSS users in 2021 reported English as their primary spoken language, 16 percent primarily spoke Spanish, and 25 percent primarily spoke a language other than English or Spanish (**Exhibit II.9**). Information on primary language was not available for 8 percent of LTSS users.

Among HCBS enrollees, those in the CCT and ALW programs represented the highest proportion of LTSS users who primarily spoke English (89 and 81 percent, respectively); those in PACE represented the highest proportion who primarily spoke Spanish (38 percent); and those in the CBAS program represented the highest proportion who primarily spoke a language other than English or Spanish (65 percent).[27] LTC users were more likely to primarily speak English.

IHSS recipients spoke a mix of languages. Because a majority of the providers serving IHSS recipients are

> "I speak both [English and Spanish] but prefer everything in Spanish. The worker told me 'OK we are going to do everything in Spanish,' but then she gave me all the paperwork in English."
>
> –Consumer listening session participant

[27] The patterns for PACE may be related to the areas in which PACE organizations are located.

relatives, these providers might be more likely to provide culturally appropriate care and communicate in the language the participant prefers.[28]

Exhibit II.9. Distribution of self-reported primary spoken language of LTSS users by program or service type, 2021

Program or service type	Farsi	Korean	Vietnamese	Armenian	Cantonese, Mandarin, and other Chinese Languages	Spanish	English	Other	Unknown
Any LTSS	1.7%	1.7%	3.5%	4.8%	5.6%	16.0%	51.1%	7.6%	8.0%
IHSS	2.0%	1.8%	4.1%	5.6%	6.1%	16.7%	45.9%	8.7%	9.1%
CBAS	6.1%	11.6%	2.6%	16.0%	12.8%	12.0%	22.0%	15.6%	1.2%
PACE	S	0.7%	1.3%	S	11.5%	37.8%	40.4%	7.0%	1.1%
MSSP	1.6%	1.2%	2.3%	S	4.6%	25.9%	53.6%	10.1%	S
HCBA	0.6%	0.3%	1.7%	1.1%	0.8%	11.9%	65.6%	2.9%	15.1%
ALW	0.8%	3.1%	1.1%	0.6%	1.6%	5.3%	80.5%	1.0%	6.0%
CCT	S	S	S	S	S	6.6%	88.9%	S	S
SNF	0.6%	1.1%	1.5%	0.8%	2.1%	11.5%	78.5%	2.5%	1.5%
Custodial care	S	S	0.4%	S	1.8%	8.5%	84.5%	1.9%	2.6%
ICF	S	S	S	S	S	1.5%	84.5%	0.4%	14.4%
Subacute care	S	S	S	S	2.2%	19.5%	66.8%	1.8%	8.4%

Source: Medi-Cal enrollment data and LTSS flags file from calendar year 2021.

Note: Cells marked as "S" indicate that the data are not shown for counts less than 11 (1-10) to protect confidentiality in accordance with the DHCS DDG v2.2.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; ICF = intermediate care facility; IHSS = in-home supportive services; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care for the Elderly; SNF = skilled nursing facility.

g. LTSS users by Medi-Cal eligibility category

Most of the LTSS users in 2021 (85.3 percent) were enrolled in Medi-Cal through the Aged, Blind, or Disabled eligibility pathway (**Exhibit II.10**). A small proportion of LTSS users were enrolled in Medi-Cal through the Affordable Care Act (ACA) Expansion Adults pathway (5.5 percent) or low-income families pathway (1.5 percent). The eligibility pathway was unknown or missing for 7.6 percent of LTSS users. This distribution was similar across HCBS enrollees except for PACE, for which a higher proportion of users enrolled in Medi-Cal through the Expansion Adults eligibility pathway (10.0 percent) than all LTSS users, and MSSP, for which 100 percent of users enrolled in Medi-Cal through the Aged, Blind, or Disabled eligibility pathway (reflecting the eligibility criteria for MSSP). In contrast, a higher proportion of people

[28] More information about IHSS providers is available at https://www.cdss.ca.gov/inforesources/ihss/program-data and in Chapter IV of this report.

receiving SNF services were enrolled in Medi-Cal through the Expansion Adults pathway (12.4 percent) than all LTSS users.

Exhibit II.10. Distribution of Medi-Cal eligibility group of LTSS users by program or service type, 2021

Program or service type	Low-income families	ACA Expansion Adults	Aged/ Blind/Disabled	Other	Unknown
Any LTSS	1.5%	5.5%	85.3%	0.1%	7.6%
IHSS	1.5%	4.0%	85.5%	0.0%	9.1%
CBAS	0.7%	3.6%	95.7%	S	S
PACE	0.8%	10.0%	89.2%	0.0%	0.0%
MSSP	S	S	99.9%	0.0%	0.0%
HCBA	1.5%	5.1%	78.4%	0.2%	14.9%
ALW	S	2.3%	97.5%	S	0.0%
CCT	S	7.0%	91.4%	0.0%	S
SNF	1.4%	12.4%	85.5%	0.4%	0.3%
Custodial care	1.1%	9.0%	89.1%	0.5%	0.3%
ICF	S	3.6%	93.6%	S	2.3%
Subacute care	5.2%	27.4%	58.3%	1.5%	7.6%

Source: Medi-Cal enrollment data and LTSS flags file from calendar year 2021.

Note: Cells marked as "S" indicate the data are not shown for counts less than 11 (1-10) to protect confidentiality in accordance with the DHCS DDG v2.2.

ACA = Affordable Care Act; ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; ICF = intermediate care facility; IHSS = in-home supportive services; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care for the Elderly; SNF = skilled nursing facility.

2. Current IHSS recipients and authorized services in California

To examine demographic and enrollment characteristics of recipients of IHSS (the state's largest LTSS/HCBS program) covered by Medi-Cal, Mathematica relied on an extract of IHSS recipient data to produce a snapshot of recipients' demographic characteristics, functional status, and authorized services and hours.[29] Refer to Appendix B.2 for details on the methods used to create the snapshot of current IHSS recipients.

[29] DHCS supplied the IHSS recipient data extract.

a. Characteristics of IHSS recipients

Supplemental Security Income (SSI) recipients. Among the 636,684 IHSS recipients in the sample drawn from 2022–2023 data,[30] nearly two-thirds received SSI[31] (63 percent) and approximately one-third did not receive SSI[32] (37 percent) **(Exhibit II.11)**. Due to differences in the samples, values in this section may not align with the Monthly IHSS Program Data published by the California Department of Social Services.[33]

Subprogram enrollment among IHSS recipients. The largest number of IHSS recipients participated in the Personal Care Services Program (PCSP; 51 percent) and the Community First Choice Option (CFCO; 48 percent); a small proportion participated in the IHSS Plus Option (1.5 percent) **(Exhibit II.11)**. Two counties, Alpine and Sierra, have no IHSS Plus Option recipients.

Impairment level. Slightly more than one-third of IHSS recipients (37 percent) in the sample were considered severely impaired[34] and approximately two-thirds were considered non-severely impaired (63 percent) **(Exhibit II.11)**. Observed IHSS recipients in the sample who are severely impaired were enrolled in CFCO.[35] Most of the IHSS recipients observed in the sample who are considered non-severely impaired are enrolled in PCSP (80 percent).[36] Some of them are in CFCO (18 percent), and very few are in the IHSS Plus Option (2 percent). A slightly lower proportion of IHSS recipients observed in the sample who are severely impaired are Asian (17 percent, compared to 20 percent of all IHSS recipients) and a slightly higher proportion are Hispanic or Latino (32 percent, compared to 29 percent of all IHSS recipients).

[30] Recipients in the sample had active management records updated between December 2022 and May 2023, and were required to be age 18 and older; enrolled in one of the three programs covered by Medi-Cal (PCSP, CFCO, or IHSS Plus Option); and have a case status of Eligible, Presumptive Eligible, or Leave in the most updated record. The number in this file is different from the number of IHSS users presented in the 2021 LTSS User Profile presented above because of the difference in the time period of the files for the sample. See Appendix B.2 for more information on methods for identifying IHSS recipients and their characteristics.

[31] Recipients are eligible for Supplemental Security Income if they have a disability, blindness, or are age 65 or older, and meet income and resource criteria.

[32] People eligible for IHSS based on income do not receive Supplemental Security Income but get full Medi-Cal benefits with a qualifying Aid Code and meet all other eligibility criteria.

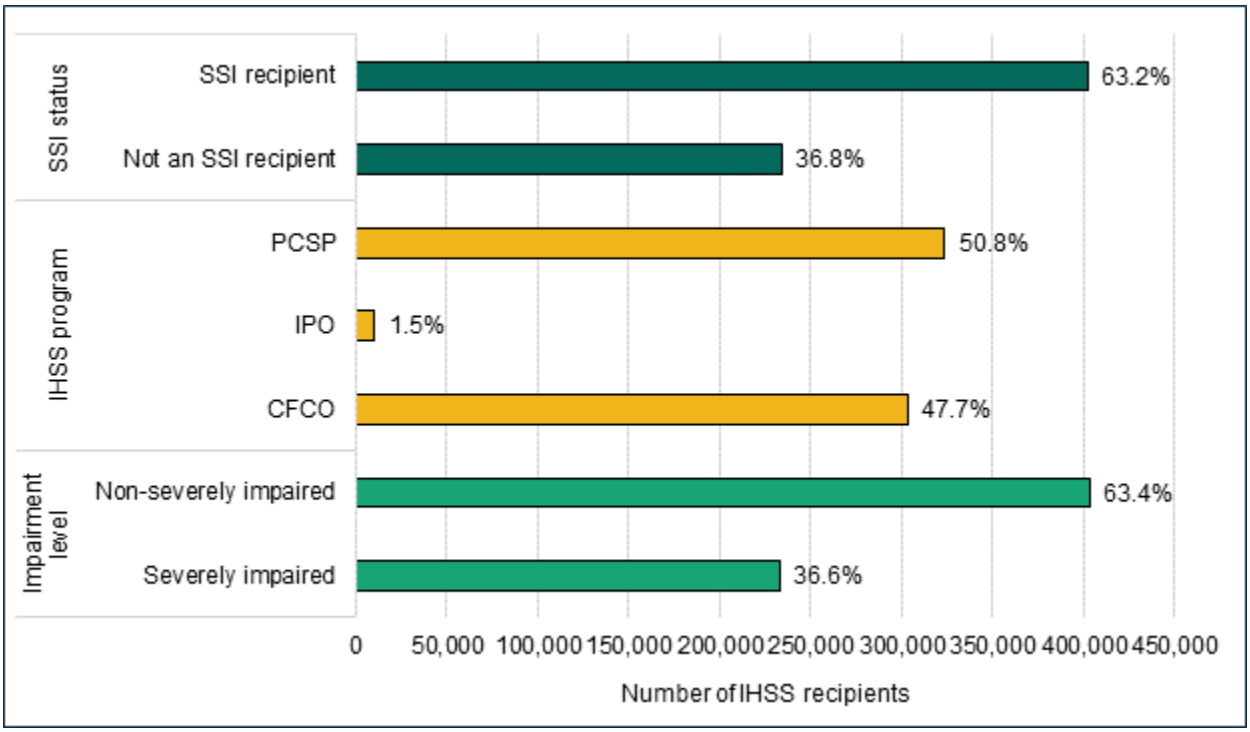
[33] The Monthly IHSS Program Data are available at https://www.cdss.ca.gov/inforesources/ihss/program-data.

[34] An IHSS recipient is considered "severely impaired" when they require at least 20 total hours per week of non-medical personal services, paramedical services, or meal preparation.

[35] Medi-Cal members who meet institutional level-of-care requirements are enrolled in the IHSS CFCO.

[36] Medi-Cal members who do not meet institutional level-of-care requirements can receive services through the IHSS PCSP if they are eligible for Medi-Cal based on age, blindness, or disability, or through the CFCO if they meet income requirements.

Exhibit II.11. Distribution of IHSS recipients by characteristic, December 2022–May 2023



Source: Active IHSS recipient management data records updated between December 2022 and May 2023.

Note: Due to differences in the samples, values may not match published figures from the California Department of Social Services. Different colors in the exhibit are used to distinguish the different characteristics that are displayed.

CFCO = Community First Choice Option; IHSS = in-home supportive services; IPO = IHSS Plus Option; PCSP = Personal Care Services Program; SSI = Supplemental security income.

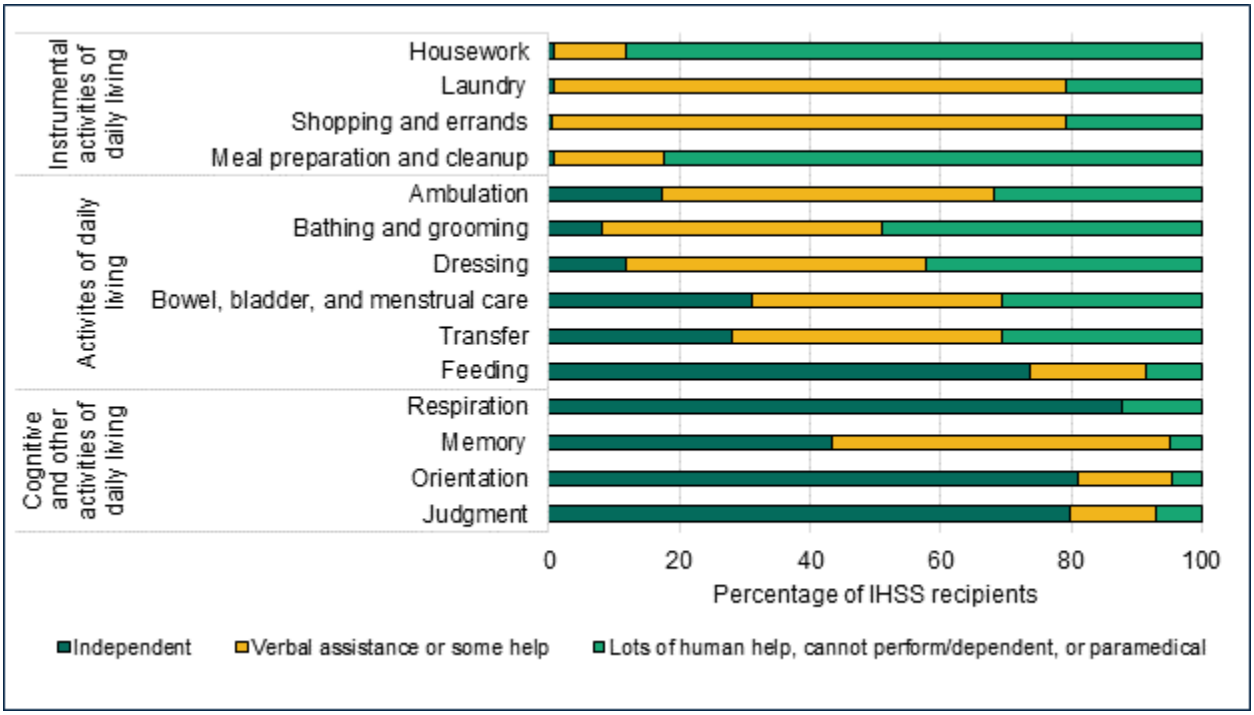
Gender identity. Because 45 percent of IHSS recipients have a missing value for gender identity, it is difficult to make inferences about differences across recipients who identify as male; female; or transgender, nonbinary, or another gender identity (hereafter referred to as "non-cisgender"). Among the 351,775 recipients for whom a gender identity was populated with a valid value, 39 percent identified as male, 61 percent as female, and 0.2 percent as non-cisgender. The proportions of recipients who identify as male or female (among those with non-missing values) align with those of the binary gender variable, which is fully populated and for which the choices are limited to male or female.

Sexual orientation. Similar to gender identity, 50 percent of IHSS recipients have a missing value for sexual orientation, limiting Mathematica's ability to make inferences about differences across recipients who identify as heterosexual, gay, lesbian, bisexual, queer, or another sexual orientation. Among the 317,910 recipients for whom a sexual orientation was populated with a valid value, 99 percent identified as heterosexual and 1 percent as gay, lesbian, bisexual, queer, or another sexual orientation.

Functional status. Among the 14 daily activities for which functional status was assessed, IHSS recipients are more likely to be dependent or require lots of human help for two IADLs—housework, and meal preparation and clean-up—and two ADLs—bathing and grooming, and dressing (shown in light green in **Exhibit II.12**). Most IHSS recipients are independent or need only verbal assistance or some help with feeding, respiration, memory, orientation, and judgment (shown in dark green in **Exhibit II.12**).

As expected, IHSS recipients who are severely impaired (and those in CFCO) are more likely to need lots of human help or are completely dependent for a broader set of functional areas. IHSS recipients who are Hispanic are slightly more likely than other IHSS recipients to be completely dependent or need lots of human help for ADLs, such as ambulation; bathing and grooming; dressing; and bowel, bladder, and menstrual care. A higher proportion of IHSS recipients who are American Indian or Alaskan Native or Black are dependent or require paramedical services for respiration (19 percent and 18 percent, respectively) than IHSS recipients in general (12 percent).

Exhibit II.12. Distribution of IHSS recipient functional status by activity, December 2022–May 2023



Source: Active IHSS recipient management data records updated between December 2022 and May 2023.

Note: Due to differences in the samples, values may not match published figures from the California Department of Social Services.

b. Authorized hours by service

The 636,684 IHSS recipients in our sample were authorized to receive 71.1 million hours per month, with an average of 112 hours per recipient per month. The maximum number of allowable hours per month ranges from 195 hours to 283 hours, depending on IHSS program and recipient functional status.[37] In the sample, more than 90 percent of IHSS recipients were authorized to purchase domestic services (including domestic services, meal preparation, meal clean-up, routine laundry, shopping for food, and other shopping and errands) and bathing, oral hygiene, and grooming (a non-medical personal care service) (**Exhibit II.13**). More than half of IHSS recipients were authorized to purchase services such as bowel and bladder care; dressing; ambulation and getting in and out of vehicles; transfer, care of, and assistance with prosthetics and medications; and accompaniment to medical services. Very few IHSS recipients (less than

[37] See https://www.cdss.ca.gov/agedblinddisabled/res/vptc2/1%20introduction%20to%20ihss/history_of_ihss.pdf.

10 percent) were authorized to purchase services such as routine bed baths, menstrual care, accompaniment to alternative services, protective supervision, or services for special circumstances (heavy cleaning, yard hazard abatement, removal of snow or ice, teaching, and demonstration). Meal preparation stands out as having a high number of authorized hours per recipient (average of 22.7 hours per recipient per month) and a high proportion of users (91.5 percent of users). The two other service categories with an average of more than 20 hours per recipient per month—protective supervision and heavy cleaning, with averages of 172.3 and 29.0 hours per recipient per month, respectively—had low proportions of users (6.7 percent and less than 1 percent of IHSS recipients, respectively).

Exhibit II.13. Authorized services and hours for IHSS recipients, December 2022–May 2023

Service	Total authorized hours per month	Total recipients authorized for service	% of recipients authorized for service	Average authorized hours per recipient per month
IHSS total	**71,111,058**	**636,684**	**100.0**	**111.7**
Domestic services				
Domestic services	1,834,897	584,879	91.9	3.1
Meal preparation	13,213,172	582,610	91.5	22.7
Meal clean-up	5,412,439	578,794	90.9	9.4
Routine laundry	2,888,533	586,280	92.1	4.9
Shopping for food	1,663,782	581,323	91.3	2.9
Other shopping and errands	1,191,792	582,505	91.5	2.0
Non-medical personal care services				
Respiration assistance	414,786	72,674	11.4	5.7
Bowel and bladder care	6,551,770	433,778	68.1	15.1
Feeding	2,279,064	161,117	25.3	14.1
Routine bed baths	607,605	58,250	9.1	10.4
Dressing	4,625,729	561,297	88.2	8.2
Menstrual care	69,880	26,613	4.2	2.6
Ambulation and getting in and out of vehicles	4,500,185	524,436	82.4	8.6
Transfer (moving in and out of beds, on and off seats)	3,063,647	457,976	71.9	6.7
Bathing, oral hygiene, and grooming	7,662,185	582,978	91.6	13.1
Repositioning and rubbing skin	2,791,521	314,702	49.4	8.9
Care of and assistance with prosthetic devices and help setting up medications	1,826,860	527,770	82.9	3.5
Accompaniment to medical services	1,520,910	525,089	82.5	2.9
Accompaniment to alternative services	30,814	4,836	0.8	6.4

Service	Total authorized hours per month	Total recipients authorized for service	% of recipients authorized for service	Average authorized hours per recipient per month
Paramedical services	1,626,639	64,959	10.2	25.0
Protective supervision	7,359,493	42,724	6.7	172.3
Special circumstances				
Heavy cleaning	493	17	0.0	29.0
Yard hazard abatement	0	S	0.0	0.0
Removal of snow or ice	395	96	0.0	4.1
Teaching and demonstration	0	S	0.0	0.0

Source: Active IHSS recipient management data records updated between December 2022 and May 2023.

Note: Due to differences in the samples, values may not match published figures from the California Department of Social Services.

Note: Cells marked as "S" indicate that the data are not shown for counts less than 11 (1-10) to protect confidentiality in accordance with the DHCS DDG v2.2.

c. Authorized hours by IHSS recipient characteristic

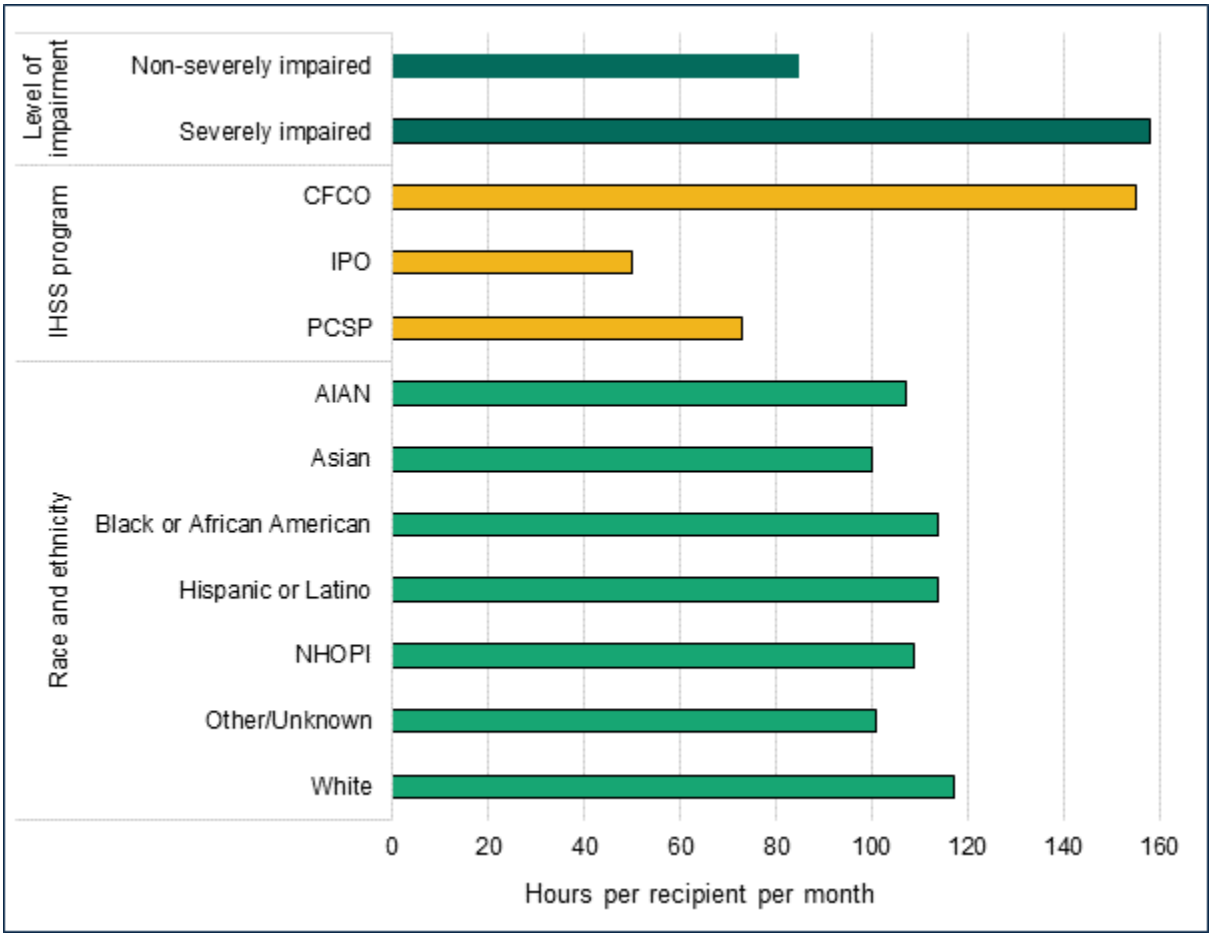
As expected, IHSS recipients who are severely impaired or enrolled in CFCO had higher per-person authorized hours (158 and 155 hours per recipient per month, respectively) than IHSS recipients enrolled in PCSP (73 hours per recipient per month) and the IHSS Plus Option (50 hours per recipient per month) (**Exhibit II.14**). IHSS recipients who are White had the highest average authorized hours per recipient per month (117 hours), and people who are Asian had the lowest (100 hours).

Authorized hours per recipient per month by county ranged from a low of 86 hours to a high of 138 hours compared to the state average of 112 hours per recipient per month. Counties with the highest average authorized hours per recipient include Del Norte, El Dorado, Inyo, Mono, and Placer (between 122 and 138 hours per recipient per month). Counties with the lowest average authorized hours per recipient include San Joaquin, Imperial, Lassen, Siskiyou, and Trinity (between 86 and 97 hours per recipient per month).

The share of authorized hours actually received is an important measure of access to needed services. However, Medi-Cal claims data available for this analysis did not have the details needed to calculate this metric.[38] In a similar analysis, the California Legislative Analyst Office found the average share of authorized cases *paid* every month was about 89 percent between August 2022 through January 2023, with the shortfall due to such factors as recipients not yet hiring an IHSS provider or a temporary hospital or facility admission during the month. Among paid authorized cases, about 97 percent of authorized hours were claimed as of January 2023 (CA LAO 2023). These findings suggest IHSS recipients, with some exceptions, are able to find providers and are receiving the services they are authorized to receive.

[38] While data included in the IHSS payment file would allow a calculation of authorized hours actually received, these data were not available to the project team as of the time of the report.

Exhibit II.14. Authorized hours per recipient by recipient characteristic, December 2022–May 2023



Source: Active IHSS recipient management data records updated between December 2022 and May 2023.

Note: Due to differences in the samples, values may not match published figures from the California Department of Social Services. Different colors in the exhibit are used to distinguish the different characteristics that are displayed.

AIAN = American Indian and Alaska Native; CFCO = Community First Choice Option; IPO = IHSS Plus Option; NHOPI = Native Hawaiian and Other Pacific Islander; PCSP = Personal Care Services Program.

3. Changes in LTSS user characteristics over time (2017–2021)

The number of Medi-Cal members age 18 and older with any LTSS use increased by 11 percent from 2017 to 2021, from 763,391 to 845,394.[39] During this time, the total number of Medi-Cal members decreased by 1.5 percent (from 15.5 million to 15.3 million).[40] As a result, the proportion of all Medi-Cal members who used any LTSS increased from 4.9 percent in 2017 to 5.5 percent in 2021.

[39] This analysis focused on users age 18 and older for the programs for which Medi-Cal data were provided, so the total users and growth over the period might be lower than those reported on the LTSS Dashboard, which includes other recipients.

[40] Data retrieved from the Medi-Cal Long-Term Services and Support Dashboard, available at https://data.chhs.ca.gov/dataset/d395c7fc-bad7-4869-a024-0d10a7107edb/resource/7c88bdae-4731-442e-9513-7db9f7e2931b/download/medi_cal_ltss_measures_annual_data.csv.

From 2017 to 2021, the proportion of LTSS users who received HCBS increased slightly (from 83.6 to 85.8 percent), and all HCBS enrollee categories experienced similar growth except for MSSP (for which enrollment decreased slightly). During the same period, the number of LTSS users with at least one LTC stay decreased by 4 percent, and the number of users in each LTC category also fell. As a result, the overall proportion of LTSS users with an LTC stay declined, from 20.1 percent in 2017 to 17.5 percent in 2021, a positive indicator of LTSS system rebalancing toward greater use of HCBS.

Changes in the characteristics of LTSS users between 2017 and 2021 varied by LTSS type.

Age. The average age of LTSS users stayed roughly the same overall (67 years old) from 2017 to 2021, but large changes occurred in three categories during this time frame: (1) the average age of people receiving subacute care decreased from 62 to 57 years old; (2) the average age of enrollees in the HCBA program increased from 42 to 47 years old; and (3) the average age of enrollees in the ALW program decreased from 75 to 72 years old.

Sex. The proportion of female LTSS users decreased slightly, from 57 to 55 percent; the ALW program had the steepest decrease (from 64 to 56 percent).

Managed care enrollment. The proportion of LTSS users enrolled in an MCP increased slightly, from 78 to 81 percent[41]; the steepest increases were among enrollees in the ALW program (from 73 to 79 percent) and people receiving custodial care (from 15 to 30 percent).

Dual eligibility. The proportion of LTSS users dually eligible for Medi-Cal and Medicare decreased slightly from 2017 to 2021 (from 65 to 63 percent).

Race and ethnicity. The proportion of LTSS users who were White, non-Hispanic decreased from 30 to 28 percent from 2017 to 2021. During the same period, the proportion who were Hispanic or Asian, non-Hispanic increased by about 1.5 percentage points each. The largest decrease in the proportion who were Hispanic over the five years was among PACE enrollees (46 to 41 percent).

Primary spoken language. The proportion of LTSS users whose primary spoken language was English decreased from 53 to 51 percent; the proportion with an unknown primary spoken language increased from 7 to 8 percent; and the proportion with any other primary spoken language did not substantively change. Among CBAS enrollees, the proportion who primarily spoke Armenian increased from 12 to 16 percent. Among PACE enrollees, the proportion who primarily spoke Spanish decreased from 43 to 38 percent.

Medi-Cal eligibility category. The proportion of LTSS users eligible for Medi-Cal through the Aged, Blind, or Disabled eligibility pathway decreased from 2017 to 2021, from 88 to 85 percent. During the same time, the proportions of LTSS users eligible through the ACA Expansion Adults or low-income families pathways increased slightly; this pattern was particularly pronounced among people with LTC stays.

[41] This percentage will increase in subsequent years as more LTSS benefits are carved into MCPs.

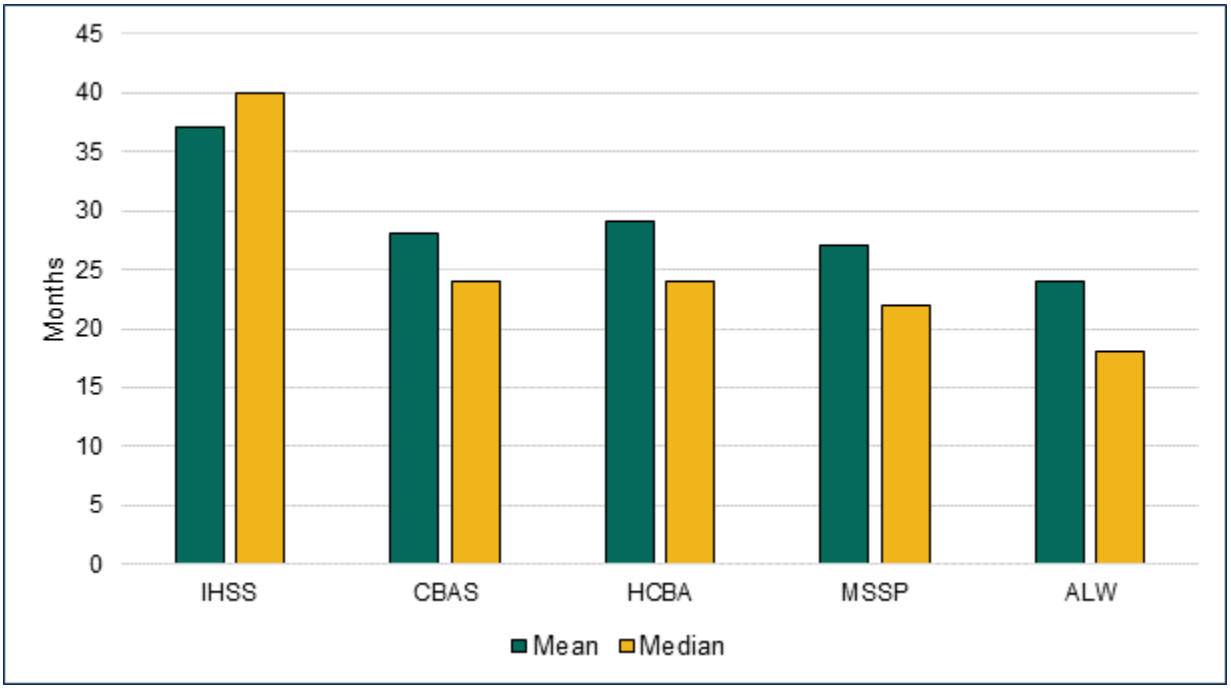
4. LTSS use over time (2017–2021)

The number of people in IHSS far exceeded that of any other LTSS type in every year from 2017 to 2021. IHSS served between nine and 11 times the number of participants in each of the four other HCBS programs included in the analysis between 2017 and 2021. The number of people who used institutional care and MSSP declined during that period, whereas the number of people who used other HCBS (IHSS, CBAS, HCBA, and ALW programs) grew.[42] The programs with the largest percentage of growth over the period were HCBA and ALW, reflecting increases in the number of approved slots in both programs over that period.

The average length of LTSS use within each year was around 10 months for each HCBS program, which remained relatively steady from 2017 to 2021. Looking across 2017 to 2021 for HCBS programs in the analysis, IHSS participants had the longest mean and median service use, at 37 and 40 months, respectively (out of a total of 60 months over the five-year period) (**Exhibit II.15**). IHSS was followed by HCBA participants (mean 29 and median 24 months of service use), CBAS participants (mean 28 and median 24 months), MSSP participants (mean 27 and median 22 months), and ALW participants (mean 24 and median 18 months).

[42] MSSP slots have fluctuated over time. As of fiscal year 2021–2022, the California Legislature restored MSSP slots that were removed in previous years. See https://www.aging.ca.gov/download.ashx?lE0rcNUV0zZxo4aRpx1QUw%3D%3D.

Exhibit II.15. Mean and median number of months of use for 2017 to 2021 across HCBS programs



Source: Medi-Cal claims data and data on LTSS flags from calendar years 2017–2021.

Note: Appendix B.3 includes methods for identifying relevant LTSS claims. This analysis was limited to participants with both the relevant program flag and claims representing service use for the program. Data on service use was not available for PACE or CCT users.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; HCBS = home and community-based services; IHSS = in-home supportive services; MSSP = Multipurpose Senior Services Program; PACE = Program for All-Inclusive Care for the Elderly.

III. Availability of Programs and Services to Meet Member Needs for HCBS/MLTSS

This section presents findings on the characteristics and geographic locations of current and future LTSS users and use patterns over time.

Box III.1. Key takeaways on the availability of programs and services to meet member needs for HCBS/MLTSS

- Current rates of all Medi-Cal LTSS and HCBS use vary substantially by county. Gaps in HCBS program coverage—whether programs are available at all or those with long waiting lists to enroll or receive services—appear to explain lower numbers of Medi-Cal LTSS and HCBS enrollees relative to 100,000 Medi-Cal members in some counties, particularly in rural regions.
- When examining changes in Medi-Cal LTSS user characteristics geographically and over time, between 2017 and 2021, rural counties experienced sizable increases in the proportion of the Medi-Cal LTSS user population who were age 65 and older (an increase from 51 to 55 percent of the total Medi-Cal LTSS user population over age 18).
- Looking ahead, Mathematica's forecasting model shows counties in the central Sierra region will have the highest rates of growth in LTSS users over the next 15 years.
- Together, these trends point to rapid demographic shifts in rural areas, where access to LTSS and specific HCBS programs may be more limited compared to urban and suburban areas.
- In many of the rural counties expected to experience the highest rates of growth in LTSS needs, a lower-than-average proportion of Medi-Cal HCBS enrollees exists compared to all Medi-Cal LTSS users (called the "rebalancing percentage"), coupled with limited HCBS program availability. Consequently, challenges in access to HCBS in these regions may continue to grow over time without intervention.
- Urban Medi-Cal LTSS users had higher proportions of users who were age 65 and older, had limited English proficiency, and were non-White. Mathematica forecasting shows populations of LTSS users who are Hispanic, older, and female are expected to grow the most in the future, and counties with the largest absolute growth in LTSS users will be the most populated urban counties in the state. These trends indicate the need for a more diverse workforce that can provide accessible, high-quality, and culturally competent care.◢

A. Geographic distribution of LTSS users

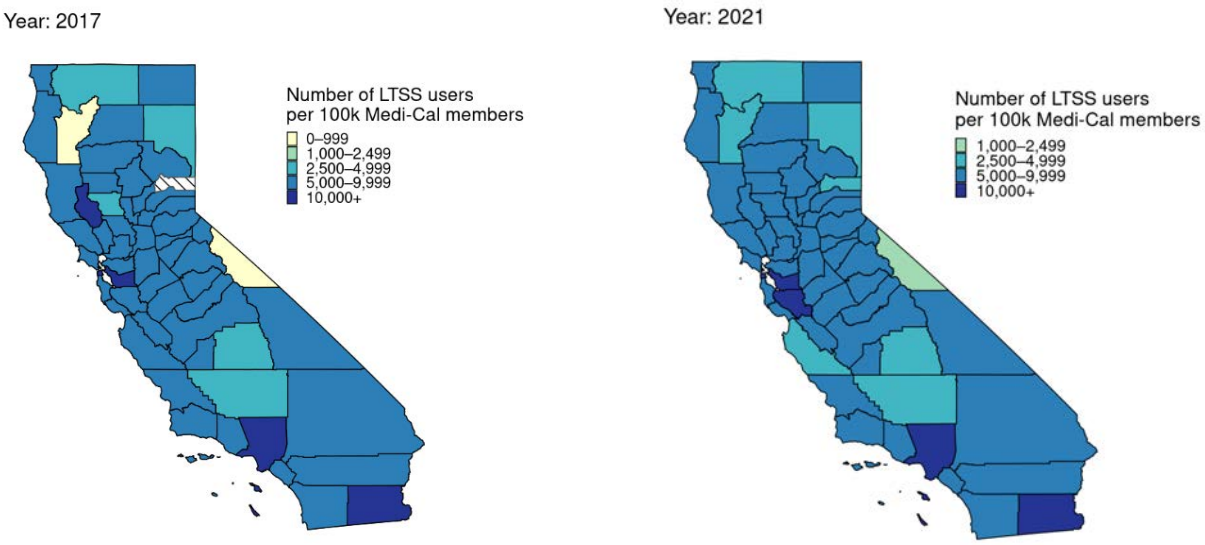
To compare LTSS use across counties, Mathematica normalized the number of LTSS users by the number of Medi-Cal members age 19 and older[43] in each county to highlight the proportion of Medi-Cal members who used LTSS (including PACE and CCT). Calculating the rate of LTSS users per 100,000 Medi-Cal members age 19 and older in each county accounts for population density and helps interpret differences between counties. However, it does not take into account the percentage of Medi-Cal members age 19 and older in each county who are disabled and may need LTSS.

[43] Ideally, Mathematica would normalize by the Medi-Cal population who were age 18 and older. However, Mathematica is limited by the publicly available data on the DHCS website (https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-with-demographics-by-month), which report Medi-Cal enrollment by certain age groups (0–18, 19–44, 45–64, and 65+), so Mathematica used age 19 and older rather than age 18 and older.

The rate of LTSS use varies substantially by county. The percentage of the Medi-Cal-enrolled population age 19 and older that used LTSS varied substantially by county (**Exhibit III.1**). In 2021, San Francisco County had 16,358 LTSS users per 100,000 Medi-Cal members (age 19 and older), the most of any county. Imperial, Santa Clara, Los Angeles, and Alameda counties also had more than 10,000 LTSS users per 100,000 Medi-Cal members (age 19 and older), although Imperial may appear to have inflated LTSS use rates due to the small number of Medi-Cal enrollees age 19 and older overall. Mono County had the lowest number of LTSS users per 100,000 Medi-Cal members (age 19 and older). Mono County is one of three counties in California where only IHSS, HCBA, and Home and Community-Based Services Waiver for Californians with Developmental Disabilities (HCBS-DD) programs are available, so limited HCBS program availability may explain the low number of LTSS users.

Seven other counties (Monterey, Sierra, Kern, Lassen, Siskiyou, Tulare, and Trinity) had fewer than 5,000 LTSS users per 100,000 Medi-Cal members (age 19 and older).

Exhibit III.1. Number of LTSS users per 100,000 Medi-Cal members (age 19 and older) by county, for 2017 and 2021



Source: Medi-Cal claims data and data on LTSS flags from calendar years 2017 and 2021. Medi-Cal certified eligible totals by county and demographic characteristics from the California Health and Human Services (CalHHS) website.

Note: The numerator of this metric is the number of LTSS users with any LTSS flags by county from calendar years 2017 and 2021. The denominator is the total number of Medi-Cal-eligible population age 19 and older by county from calendar years 2017 and 2021.

Counties with a white background and dashes indicate that the data are not shown for counts less than 11 (1-10) to protect confidentiality in accordance with the DHCS DDG v2.2.

LTSS = long-term services and supports.

According to demographic data from the CalHHS website, LTSS users are generally similar to the Medi-Cal population as a whole with respect to sex (55–56 percent female) and race (24–28 percent White).

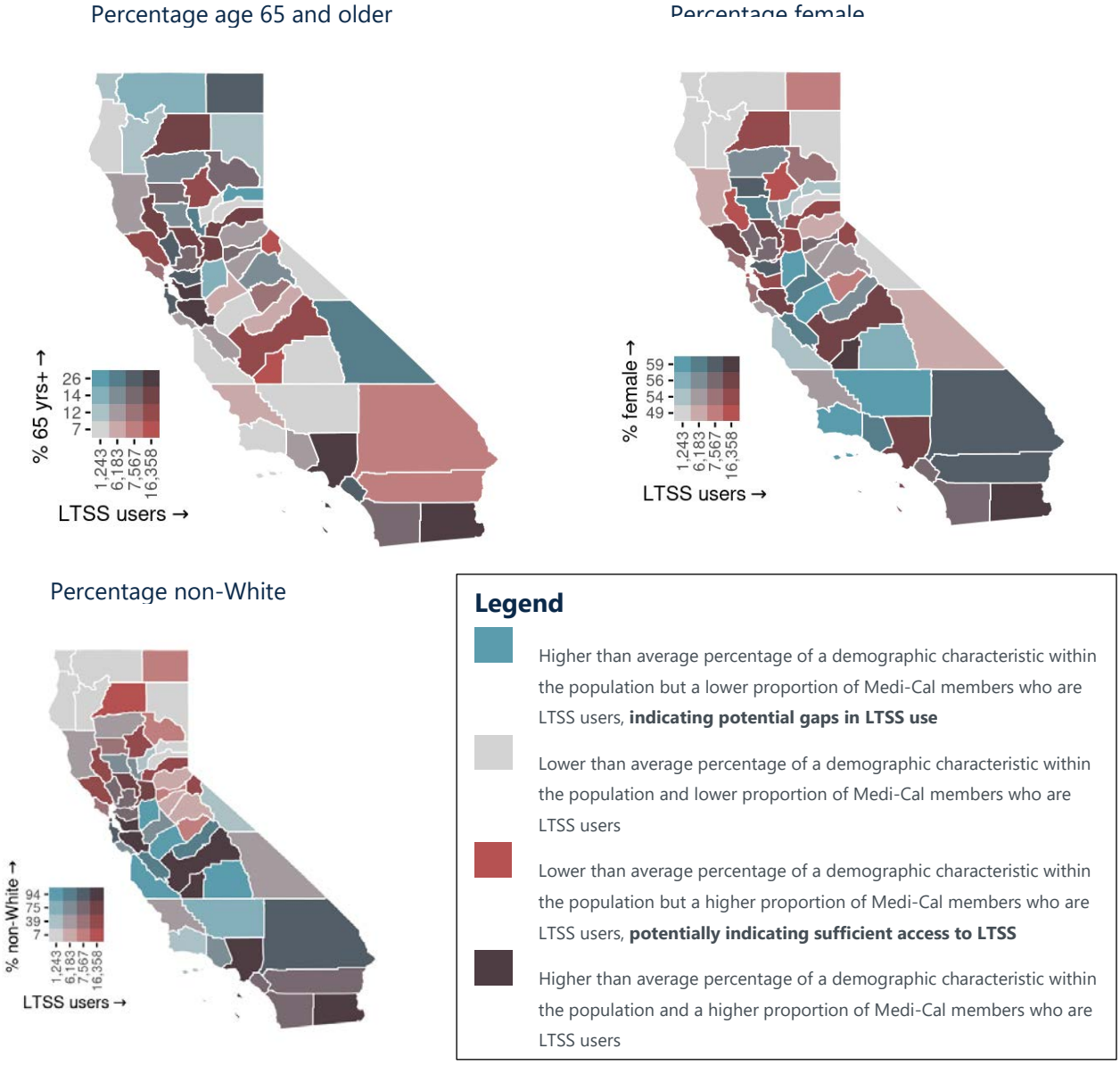
However, nearly four times as many LTSS users are adults age 65 and older (56 percent) than the Medi-Cal population as a whole (15 percent) due to the higher prevalence of disabilities among older adults.[44]

To identify potential gaps in access to LTSS by county, Mathematica compared the age, sex, and race of Medi-Cal members age 19 and older with the normalized LTSS user count (**Exhibit III.2**). Counties in the top quartile for these demographic characteristics but in the bottom quartile for the number of LTSS users per 100,000 Medi-Cal members (age 19 and older)—lower than expected—are shown in blue in the map below (**Exhibit III.2**), indicating a potential gap in access to LTSS.[45] For example, Sierra County has a much higher than average percentage of the population age 65 and older but a much lower than average proportion of Medi-Cal members (age 19 and older) who are LTSS users, which may suggest a gap in access to LTSS. Kern, Monterey, and Tulare counties have a much higher than average percentage of the population that is non-White but a much lower than average proportion of Medi-Cal members (age 19 and older) who are LTSS users, which may suggest a gap. However, because the rate of LTSS users per Medi-Cal population age 19 and older does not account for county variation in rates of disability and chronic conditions, these results provide an incomplete picture of potential gaps in LTSS access and availability.

[44] Medi-Cal Certified Eligibles Tables, by County, from 2010 to Most Recent Reportable Month. https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-with-demographics-by-month.

[45] Top quartile for sex indicates greater proportion of females in a county.

Exhibit III.2. Bivariate maps contrasting the normalized LTSS user counts and Medi-Cal population demographic characteristics by county, 2021



calendar year 2021. Medi-Cal certified eligible totals by county and demographic characteristics from the CalHHS website.

Note: LTSS users comprise the number of LTSS users per 100,000 Medi-Cal members.

CalHHS = California Health and Human Services; LTSS = long-term services and supports.

B. Change in characteristics of LTSS user population, by county geography

Although the number of LTSS users was far higher in urban counties, the characteristics of LTSS users in such counties remained relatively stable, whereas those in rural counties showed more changes over time. Across all years (2017–2021), significantly more LTSS users resided in urban counties than in suburban and rural counties (Exhibit III.3). Between 2017 and 2021, approximately 96–97 percent of LTSS users resided in

urban counties. Similarly, 96 percent of Medi-Cal members lived in urban counties. Qualitative information supports these findings as well, with several interviewees noting the significant difference in access to HCBS across urban, suburban, and rural areas. These qualitative findings are discussed in further detail in subsequent chapters.

> "The regional differences and availability of services is huge. We have one of the largest cities in the nation and we have some of the most rural counties you'll find as well. And so, the gaps between urban, suburban, and rural resources vary greatly."
>
> –Managed Care Quality and Monitoring Division

To compare the proportion of Medi-Cal members who are LTSS users across counties, Mathematica divided the number of LTSS users by the number of Medi-Cal members age 19 and older in each county. Urban and suburban counties had similar proportions of Medi-Cal members (age 19 and older) who were LTSS users—8,549 LTSS users per 100,000 Medi-Cal members age 19 and older in 2021—compared to rural counties, which had 5,742 LTSS users per 100,000 Medi-Cal members age 19 and older in 2021.

Compared to Medi-Cal LTSS users residing in suburban and rural counties, urban LTSS users had higher proportions of users who were age 65 and older, had limited English proficiency, and were non-White. Across all years, the percentage of the LTSS user population who were age 65 and older was highest in urban counties and lowest in rural counties; that percentage has held relatively constant between 2017 and 2021. However, rural counties experienced a sizable increase in the percentage of the LTSS user population who were age 65 and older, from 51 percent in 2017 to 55 percent in 2021. Across all years, urban counties had the highest percentage of LTSS users with limited English proficiency,[46] but this percentage has been increasing over time for rural counties (from 6 percent in 2017 to 9 percent in 2021) while staying stable for urban and suburban counties. In 2017, the percentage of the population that was non-White was 23 percent in rural counties; the percentage was more than double that in suburban counties (48 percent), and almost triple that in urban counties (69 percent). For all rurality types, the percentage of non-White LTSS users increased over time, and in 2021 was 26 percent for rural counties, 50 percent for suburban counties, and 71 percent for urban counties. Together, these trends point to rapid demographic shifts in rural areas where access to LTSS may be more limited compared to urban and suburban areas. Section D of this chapter builds on these trends to make projections into the future and finds that many rural counties will continue to experience demographic shifts.

[46] Limited English proficiency is defined as the person self-reporting that their primary spoken language is not English.

Exhibit III.3. Characteristics of LTSS users by year and rurality, calendar years 2017–2021

Year	Number of LTSS users	LTSS users per 100k Medi-Cal members	% Non-White	% Limited English	% Hispanic	% Female	% 65+
Urban							
2017	679,311	8,592	69	45	24	61	61
2018	700,535	9,002	69	45	25	61	61
2019	721,367	9,518	70	45	26	61	61
2020	722,664	9,307	70	46	26	60	61
2021	745,162	8,549	71	46	27	60	61
Suburban							
2017	21,611	8,270	48	29	34	61	54
2018	22,369	8,574	49	29	35	60	54
2019	23,146	9,063	50	29	36	60	55
2020	22,795	8,787	50	30	37	60	55
2021	22,934	8,041	50	29	37	60	55
Rural							
2017	3,290	5,136	23	6	7	64	51
2018	3,394	5,341	25	7	9	63	52
2019	3,729	5,977	25	7	9	62	51
2020	3,885	6,045	25	8	10	62	53
2021	4,078	5,742	26	9	11	61	55

Source: Medi-Cal claims data and data on LTSS flags from calendar years 2017–2021. Medi-Cal certified eligible totals by county and demographic characteristics from the CalHHS website.

Note: Mathematica normalized the count of LTSS users by measuring the number of LTSS users per 100,000 Medi-Cal members who were age 19 and older. The percentage of limited English proficiency is defined as those who self-reported that their primary spoken language is not English.

CalHHS = California Health and Human Services; LTSS = long-term services and support

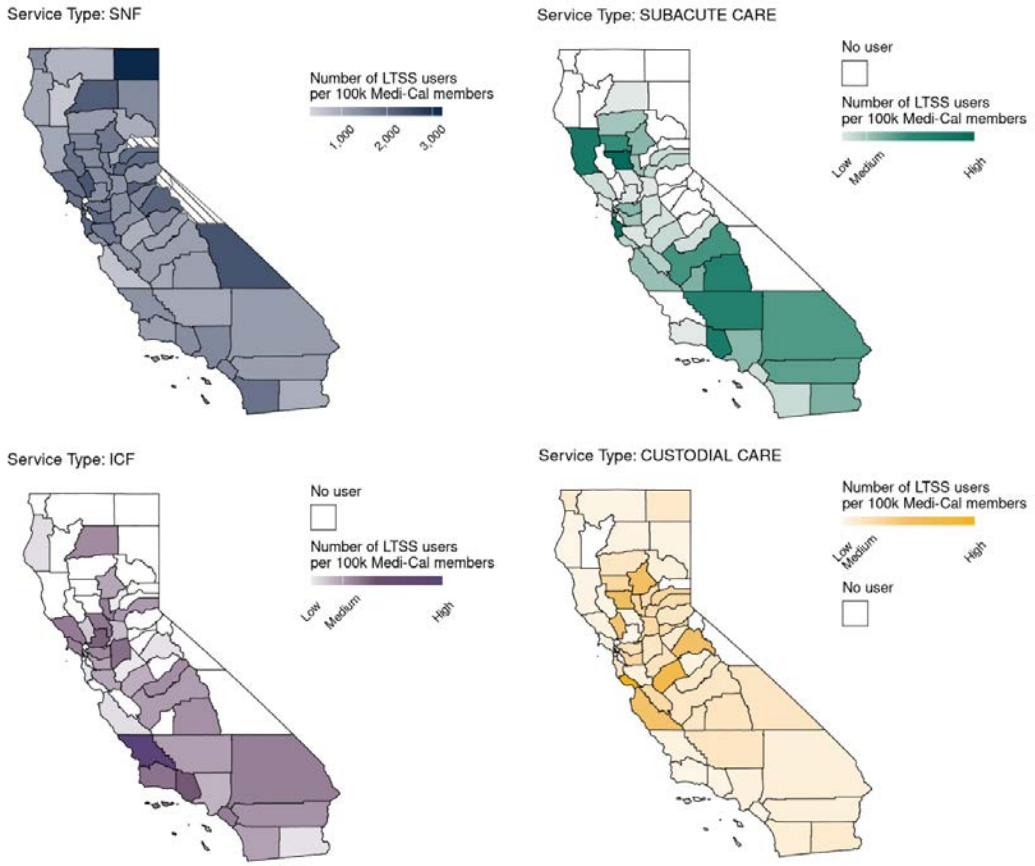
C. Variation in LTSS use, by type of service

To assess potential gaps in HCBS availability, Mathematica examined geographic variability in the use of LTSS by type of service and the use of HCBS relative to institutional LTSS in each count.

1. Geographic variability in institutional use

Among institutional LTSS users, SNF use was the most common, but counties with the highest rates of institutional use varied by institutional type. Rates of SNF stays per 100,000 Medi-Cal members, which range from 5,000 or more in the counties with the highest rates to less than 1,000 in counties with the lowest rates, are many times greater than rates for other types of institutional care (subacute care, ICF, and custodial care) (Exhibit III.4). In addition, counties with the highest rates of institutional use varied by institution type. The three counties with the highest rate of LTSS users per 100,000 Medi-Cal members (age 19 and older) are as follows for each type of institution: SNF (Modoc, Inyo, and Napa); subacute care (Colusa, San Mateo, and Mendocino); ICF (San Luis Obispo, Ventura, and Solano); and custodial care (Santa Cruz, Merced, and Colusa). Importantly, Modoc and Inyo have limited HCBS program availability and use, but the highest rates of SNF use (the dominant institutional type in these analyses).

Exhibit III.4. Number of members with LTC stays per 100,000 Medi-Cal members (age 19 and older), by county in 2021



Source: Medi-Cal claims data and data on LTSS flags from calendar year 2021. Medi-Cal certified eligible totals by county and demographic characteristics from the CalHHS website.

Note: Mathematica normalized the count of LTSS users by measuring the number of LTSS users per 100K Medi-Cal members who were age 19 and older. Counties without shading represent regions with no LTSS users for a given type of service.

Note: Counties with a white background and dashes indicate that the data are not shown for counts less than 11 (1-10) to protect confidentiality in accordance with the DHCS DDG v2.2.

CalHHS = California Health and Human Services; ICF = intermediate care facility; LTSS = long-term services and supports; SNF = skilled nursing facility.

2. Geographic variability in HCBS use

a. Geographic distribution of HCBS enrollees

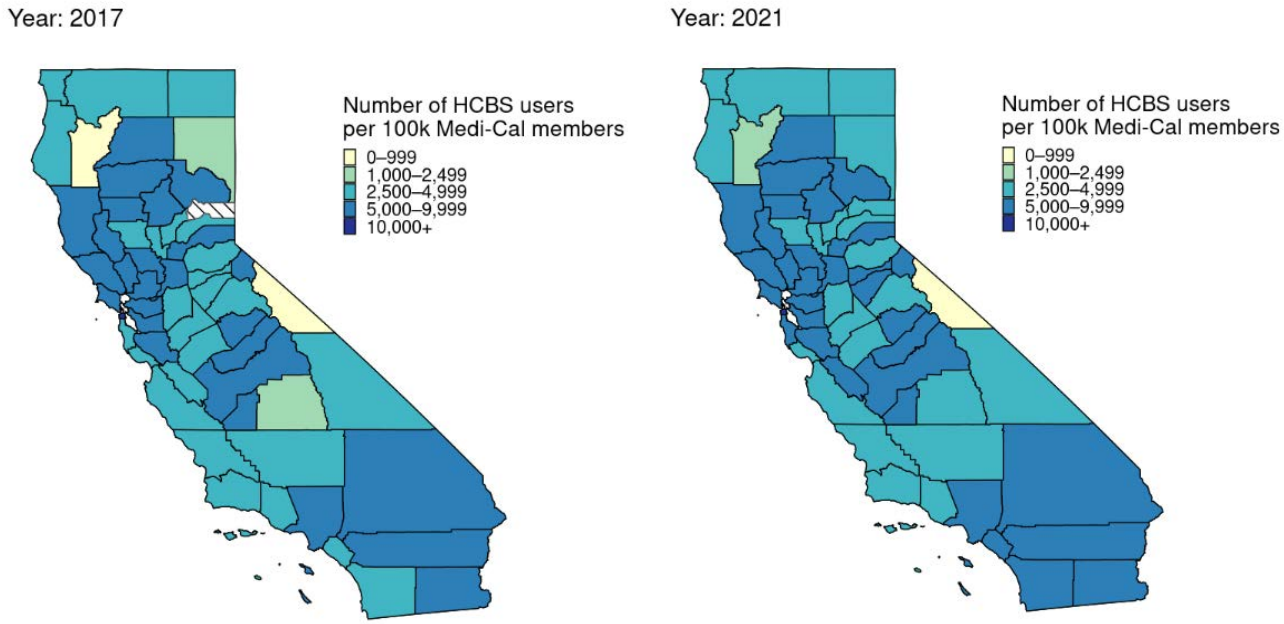
To compare HCBS use across counties, Mathematica normalized the number of HCBS enrollees by the number of Medi-Cal members who were age 19 and older[47] in each county to highlight the proportion of Medi-Cal members who used HCBS (including PACE and CCT). Calculating the rate of HCBS enrollees per

[47] Ideally, Mathematica would normalize by the Medi-Cal population who were age 18 and older. However, it was limited by the publicly available data on the DHCS website (https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-with-demographics-by-month), which reports Medi-Cal enrollment by certain age groups (0–18, 19–44, 45–64, and 65+), so Mathematica used age 19 and older rather than age 18 and older.

100,000 Medi-Cal members age 19 and older in each county controls for population density and helps interpret differences by county, although it does not account for the share of Medi-Cal members age 19 and older in each county who are disabled and may need LTSS.

The rate of HCBS use varies substantially by county. The average number of HCBS enrollees per 100,000 Medi-Cal members (age 19 and older) statewide grew from 6,744 in 2017 to 7,495 in 2020 and then declined to 6,860 in 2021 (**Exhibit III.5**). In 2021, San Francisco County had 13,796 HCBS enrollees per 100,000 Medi-Cal members (age 19 and older)—the most of any county. The second and third highest counties were Imperial and Santa Clara; however, the ratio for Imperial may be inflated due to the small number of Medi-Cal enrollees age 19 and older overall. Mono, Trinity, and Lassen counties had the lowest number of HCBS enrollees per 100,000 Medi-Cal members (age 19 and older). Mono County is one of three counties in California where only IHSS, HCBA, and HCBS-DD programs are available, so limited HCBS program availability may explain the low number of HCBS enrollees there (discussed in the next section). In addition to these HCBS programs, Trinity and Lassen counties have MSSP and CCT program coverage; however, these programs operate waiting lists, which likely has an impact on access to HCBS in these areas.

Exhibit III.5. Number of HCBS enrollees per 100,000 Medi-Cal members (age 19 and older) by county, for 2017 and 2021



Source: Medi-Cal claims data and data on LTSS flags from calendar years 2017 and 2021. Medi-Cal certified eligible totals by county and demographic characteristics from the CalHHS website.

Note: The numerator of this metric is the number of HCBS enrollees with any LTSS flags by county from calendar years 2017 and 2021. The denominator is the total number of Medi-Cal eligible population age 19 and older by county from calendar years 2017 and 2021.

Note Counties with a white background and dashes indicate that the data are not shown for counts less than 11 (1-10) to protect confidentiality in accordance with the DHCS DDG v2.2.

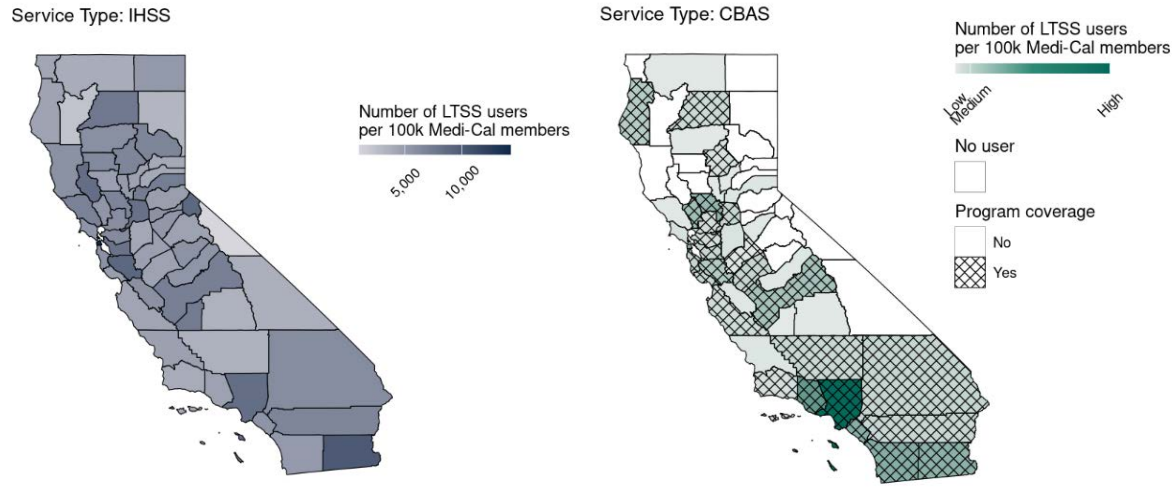
HCBS = home and community-based supports; LTSS = long-term services and supports.

Some HCBS programs are available in counties, yet residents make little or no use of them. In contrast, for programs that are not statewide, some members must travel across county lines to use these service programs. The maps in **Exhibit III.6** highlight this variability in HCBS program use. The counties with the highest rates of HCBS enrollees by HCBS programs tend to be the larger and more populated counties**.** Counties with hatched patterns represent regions where a service program is provided; for example, CBAS, ALW, MSSP, CCT, and PACE operate in 28, 15, 46, 56, and 26 counties, respectively, as shown in the figures below. Counties with shading colors represent those where Medi-Cal members used a service program in 2021.

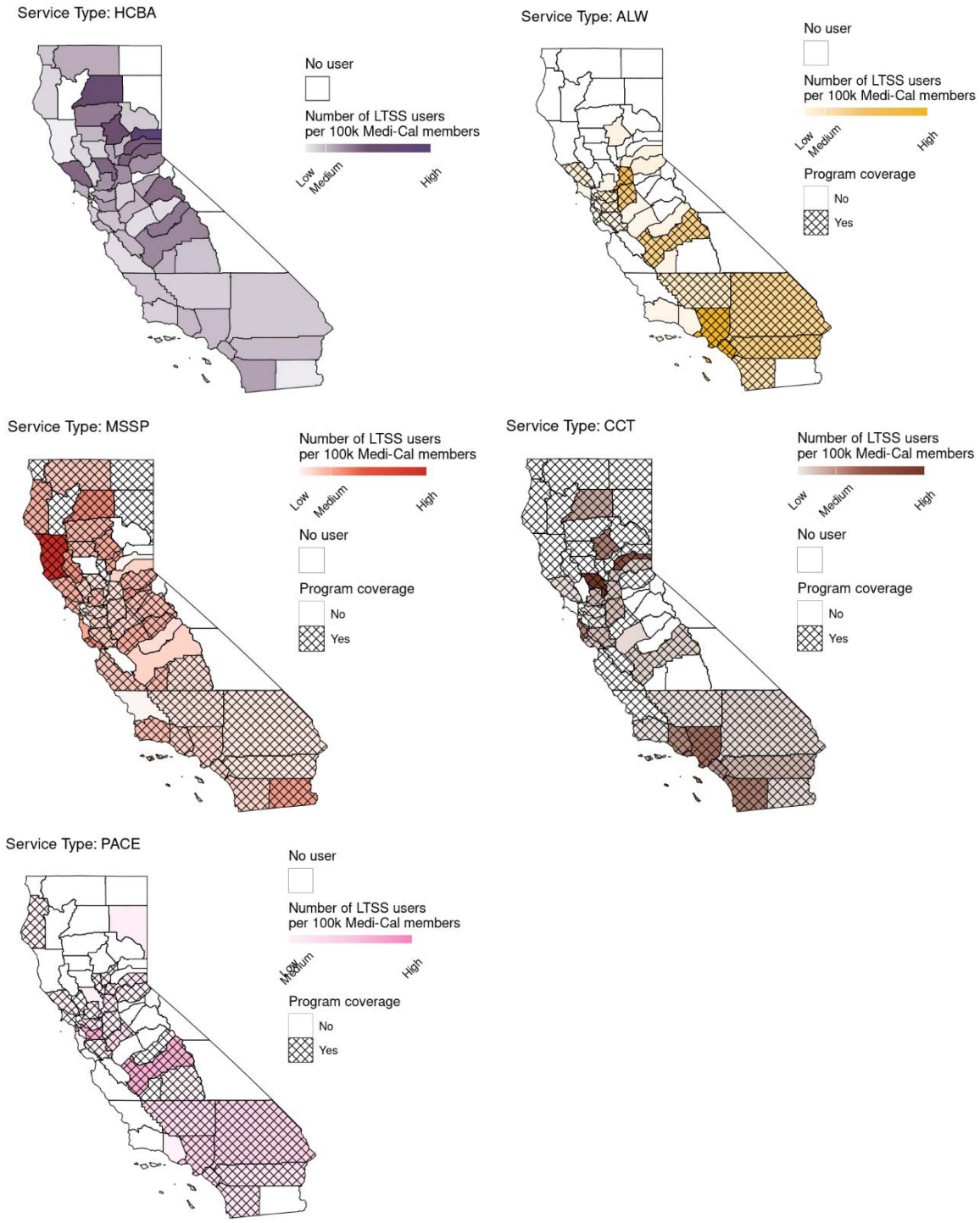
HCBS program locations and service utilization do not always overlap. For example, MSSP, CCT, and PACE are available in some counties in which no member who lives in those counties used the program (such counties in Northern California for the MSSP program, shown by hatching with no color shading). For programs that are not statewide, the maps show some counties that are shaded but not hatched, meaning that members travel across county lines to use these service programs (such as counties in the Northern San Joaquin Valley region for the ALW program).[48]

In general, **the counties with the highest rates of HCBS enrollees by HCBS programs tend to be the larger and more populated counties.** The counties with the highest rates of HCBS program users per 100,000 Medi-Cal members age 19 and older are often larger, more populated ones, with some exceptions. The three counties with the highest rates of users per 100,000 Medi-Cal members are as follows for each HCBS program: IHSS (San Francisco, Imperial, and Santa Clara); CBAS (Los Angeles, Ventura, and San Francisco); HCBA (Sierra, Shasta, and Butte); ALW (Orange, Los Angeles, and Sacramento); MSSP (Mendocino, Shasta, and Santa Cruz); CCT (Yolo, Nevada, and Los Angeles); and PACE (San Francisco, Alameda, and Fresno).

Exhibit III.6. Number of HCBS program enrollees per 100,000 Medi-Cal members (age 19 and older), by county in 2021



[48] These cases could also indicate that a member's address in the Medi-Cal data is a mailing address, not necessarily the address where the member resides. Mathematica was unable to distinguish whether the addresses for members in the Medi-Cal data are accurate and whether they reflect residence.



Source: Medi-Cal claims data and data on LTSS flags from calendar year 2021. Medi-Cal certified eligible totals by county and demographic characteristics from the CalHHS website.

Note: Mathematica normalized the count of LTSS users by measuring the number of LTSS users per 100K Medi-Cal members who were age 19 and older. Counties without shading represent regions with no LTSS users of that program in 2021. Counties with hatched shading represent regions where a program is available.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CalHHS = California Health and Human Services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; HCBS = home and community-based services; IHSS = in-home supportive services; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care for the Elderly.

b. Variation in HCBS rebalancing across counties

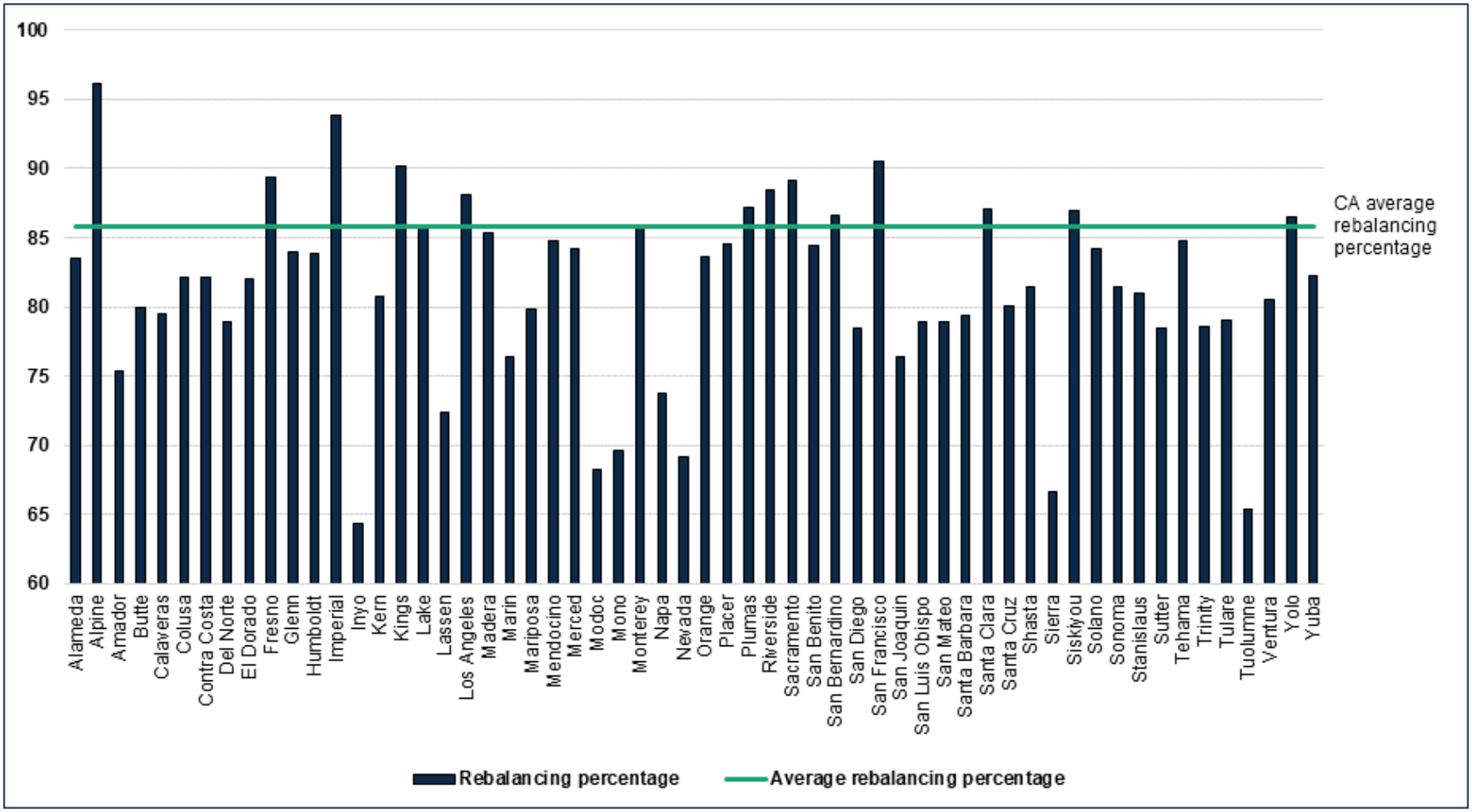
California is ahead of the curve when it comes to rebalancing its LTSS system relative to other states. California's spending rebalancing ratio – the share of Medi-Cal spending on HCBS relative to total LTSS expenditures – was 70 percent in 2020, compared to the national average of 62 percent (Murray et al., 2023). More recent data from 2022 indicates that 90.6 percent of California's LTSS users received services and supports delivered in home and community-based settings.[49]

To examine potential gaps in service use within the state, Mathematica assessed differences in the user rebalancing ratio across counties. In general, counties with more limited availability of various HCBS programs and in more rural areas had a lower rebalancing ratio – a lower share of LTSS users who received HCBS as opposed to institutional care – compared to urban counties with more HCBS programs. Compared to the weighted average (by the total number of LTSS users per county) across all counties of 86 percent (shown in green), five counties had the highest user rebalancing ratios: Imperial, San Francisco, Fresno, Kings, and Alpine (see **Exhibit III.7**).[50] Several counties fell below the state average for rebalancing, with the lowest counties (below 75 percent) including Inyo, Modoc, Mono, Napa, Nevada, Sierra, and Tuolumne. Although statewide HCBS programs (IHSS, HCBA, and HCBS-DD), are available in these rural counties, many of which are in the Northern or high Sierra regions, several others such as CBAS, MSSP, and CCT cover just a few of these counties, with no coverage from ALW or PACE at all.

[49] https://www.dhcs.ca.gov/dataandstats/dashboards/Documents/LTSS-Dashboard/LTSS-Dashboard-Factsheet.pdf.

[50] Alpine County, a frontier county in the northeastern area of California, did not have any institutional providers that met our definition so their residents could only use HCBS, explaining that county's high user rebalancing ratio.

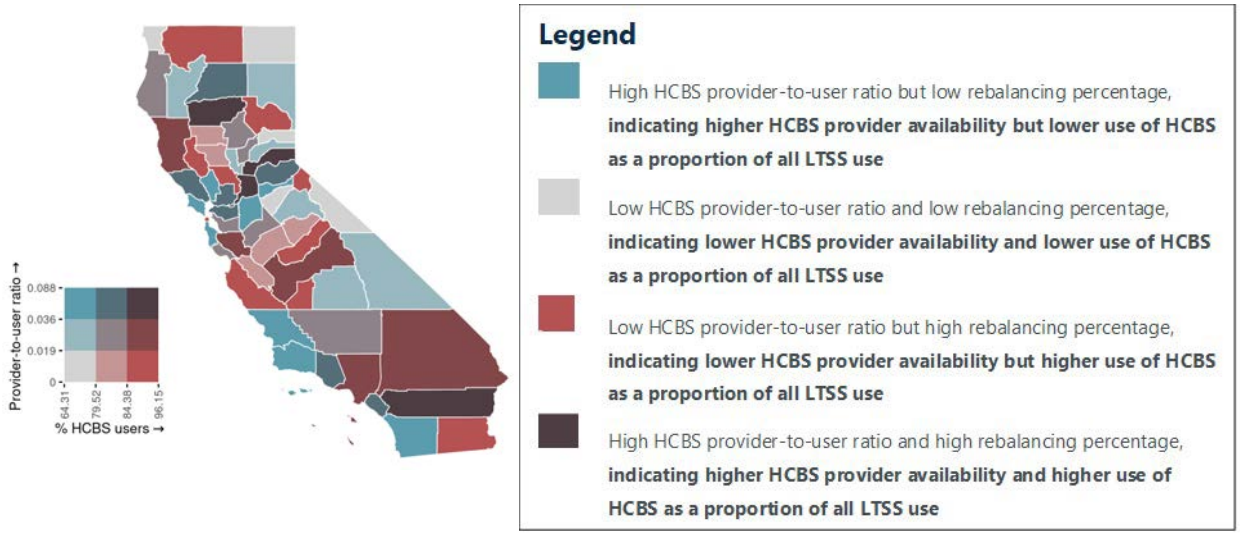
Exhibit III.7. HCBS enrollees as a share of all LTSS users by county, 2021



Source: Medi-Cal LTSS Dashboard. Phase 1 data from June 2023.

To examine the extent to which the availability of HCBS providers explains these findings, Mathematica compared the proportion of HCBS enrollees of total LTSS users to the availability of HCBS providers (measured as the provider-to-user ratio between HCBS providers and any LTSS users) (**Exhibit III.8**). In this exhibit, counties with higher values in the provider-to-user ratio, shown in blue and dark purple, indicate more provider availability. However, Mathematica did not find a statistically significant relationship between the rebalancing metric and the availability of HCBS providers.[51] For example, six counties fell in the lowest tertile for both the rebalancing metric and the provider-to-user ratio: Inyo, Modoc, Mono, Nevada, Sierra, and Tuolumne (similar to findings presented in **Exhibit III.7** above). That is, Mathematica saw a lower proportion of LTSS users accessing HCBS in those areas showing lower HCBS provider availability, which makes intuitive sense. However, there are several counties that show similar HCBS provider-to-user ratios but a much higher proportion of LTSS users accessing HCBS. These counties include Monterey, Siskiyou, Alpine, Santa Clara, Fresno, King, and San Francisco. These findings suggest factors other than the availability of HCBS providers likely are driving the variability in HCBS rebalancing. They could also reflect limitations in Mathematica's measure of providers, which largely reflect agency- or organizational-level providers but not the number of individuals who provide care.

Exhibit III.8. Bivariate map comparing the rebalancing metric to the availability of HCBS providers



A range of possible explanations exist for the discrepancies described above. For example, counties with the lowest rebalancing percentages tend to be rural counties in the Sierra Nevada or San Joaquin Valley regions, where HCBS services are less available. Awareness of services available in the community was also noted as a crucial barrier, with one interviewee stating Medi-Cal members in some areas of the state seem to have greater awareness of the HCBS available, which likely contributes significantly to greater use of HCBS programs as opposed to institutions. The number of HCBS providers does not include individual IHSS workers, so those counties in which a higher share of HCBS users rely on IHSS services, such as

[51] The Spearman's rank correlation coefficient—which measures the statistical dependence between the rankings of two variables—is -0.21 (p = 0.1), so Mathematica did not find a statistically significant relationship between the rebalancing metric and the availability of HCBS providers.

San Francisco, would have a low HCBS provider-to-user ratio but high rebalancing percentage. Without additional data, we were unable to identify the specific factors that explain these discrepancies.

For individuals seeking to transition from institutional to home and community-based settings, across Mathematica's interviews, the key issue raised was a severe lack of housing. Without affordable and accessible housing options, Medi-Cal members who could be served better in community-based settings may not have a choice about leaving their institutions. [52] Furthermore, even if individuals have housing to which they can return, interviewees noted difficulties in establishing home-based care to support them safely, an especially problematic issue for those with greater acuity needs. Representatives from MCPs and waiver agencies, as well as advocates, also all emphasized the need to address workforce shortages among community providers to allow more people to remain in or return to their homes with appropriate services in place.

Administrative delays in processing waiver or program applications can also raise barriers to receiving HCBS. An advocacy organization representative noted some people do have housing to which they can return, but waiver agencies can take a long time to assemble complete application packets and DHCS takes on average about 90 days to process waiver slots, which means individuals must retain their housing—sometimes for months. A key example noted was in the CCT program, where long wait times in areas across the state can prevent people from transitioning out of institutions. Similarly, for IHSS, if an individual receives an IHSS assessment but is not able to obtain timely housing, the IHSS case will close after six weeks and require a new assessment, creating inefficiencies and potentially preventing that individual from returning home. In general, interviewees pointed to challenges with coordination between different HCBS programs and community supports like housing. For example, for individuals transitioning out of institutions through the CCT program, additional supports often are required through the HCBA waiver program, and coordination between the programs is not always effective.

Several of these barriers to receiving HCBS are discussed in further detail in later chapters of this report.

D. Access to and future need for LTSS

1. Changes in California's population

To estimate future demand for LTSS in California, Mathematica developed a model to forecast change in three populations: (1) adults with any ADL limitation, (2) adults with any ADL limitation who report being enrolled in Medi-Cal, and (3) adults with Medi-Cal LTSS use.

To estimate the first two populations, Mathematica used American Community Survey (ACS) data from 2008 through 2019 to create a model that predicts having an ADL limitation and a model that predicts having an ADL limitation and reported Medi-Cal enrollment, based on demographic and geographic

[52] For more information on the impact of housing shortages on transitioning Medicaid beneficiaries back to their communities and potential strategies to better coordinate housing supports, please see https://www.medicaid.gov/sites/default/files/2024-03/mfp-best-practices-rtc-feb2024.pdf.

characteristics.[53] To estimate LTSS users, Mathematica created a model based on Medi-Cal data from 2017 to 2021 reflecting actual LTSS users (as reported above).[54] After creating models for the three populations, Mathematica used the California Department of Finance's projected[55] number of Californians by demographic group and county for 2025 to 2040 as inputs into the models Mathematica estimated in its first step. Mathematica then predicted what portion of these projected populations would have the outcome of interest (any ADL limitation, any ADL limitation and Medi-Cal enrollment, and Medi-Cal LTSS use). For more information on the data sources and methods used, see Appendix B.4.

Mathematica's analysis focused primarily on the population with any ADL limitation because it represents the people who might need LTSS in the future. Also, changes in Medi-Cal eligibility over time could affect the accuracy of Mathematica's projections for the latter two populations, even though models for these two populations are more specific for Medi-Cal access.

The number of future LTSS users is expected to grow substantially. The results indicate the likelihood of large increases in the potential population of future LTSS users, both in total and as a proportion of the California population (**Exhibit III.9**). Californians with any ADL limitation will grow from 2.6 million in 2020 to 4.0 million in 2040—or from 8.5 percent of the state population to 11.6 percent. Growth in the population with any ADL limitation and enrolled in Medi-Cal (from 4.2 to 5.5 percent of the total state population), and in the Medi-Cal LTSS user population (from 2.5 to 3.3 percent of the total state population) will be smaller than that for the general (non-Medi-Cal) population with any ADL limitation, but it still will be substantial, representing absolute increases of about 643,000 and 412,000 people, respectively. The growth in the *percentage* of the population with any ADL limitation is because of the aging California population and the higher predicted probability for older people to have any ADL limitation.

[53] Mathematica used ACS data from 2008 to 2019 because this period was stable period regarding how the ACS defined questions and collected data. The ACS changed its definition of ADL limitations beginning in 2008 and its measurement of race beginning in 2019. Mathematica chose to use ACS data for this forecast because the California-specific sample was larger than that available through the California Health Information Survey.

[54] Mathematica's populations of LTSS users included people with LTC stays (SNF, subacute care, ICF, and custodial care) or in select HCBS programs (IHSS, CBAS, HCBA, ALW, and MSSP). Mathematica did not include people in PACE or CCT in the projections due to the timing of receiving data about users in these programs.

[55] P-3: Complete State and County Projections Dataset available at https://dof.ca.gov/forecasting/demographics/projections/.

Exhibit III.9. Projections for future LTSS users as a percentage of the California population

Population	2020[a]	2025	2030	2040
Total adult California population	**30,777,294**	**32,092,990**	**33,406,351**	**35,145,224**
Population with any ADL limitation	2,626,345	2,938,772	3,299,821	4,061,071
Percentage of total population with any ADL limitation	8.5%	9.2%	9.9%	11.6%
Population with any ADL limitation plus Medi-Cal enrollment	1,293,985	1,433,751	1,594,561	1,936,925
Percentage of total population with any ADL limitation plus Medi-Cal enrollment	4.2%	4.5%	4.8%	5.5%
Population with LTSS use[b]	754,653	855,690	964,644	1,167,151
Percentage of total population with LTSS use[b]	2.5%	2.7%	2.9%	3.3%

Source: Mathematica used Medi-Cal enrollment and LTSS flags data from calendar years 2017–2021 and ACS data from calendar years 2008–2019 to create analytic models. Mathematica used California Department of Finance projections from 2020 to 2040 as inputs into the models to project populations.

Note: The sample is restricted to people age 18 and older.

[a] The numbers from 2020 are based on projections from the model, not actual counts.

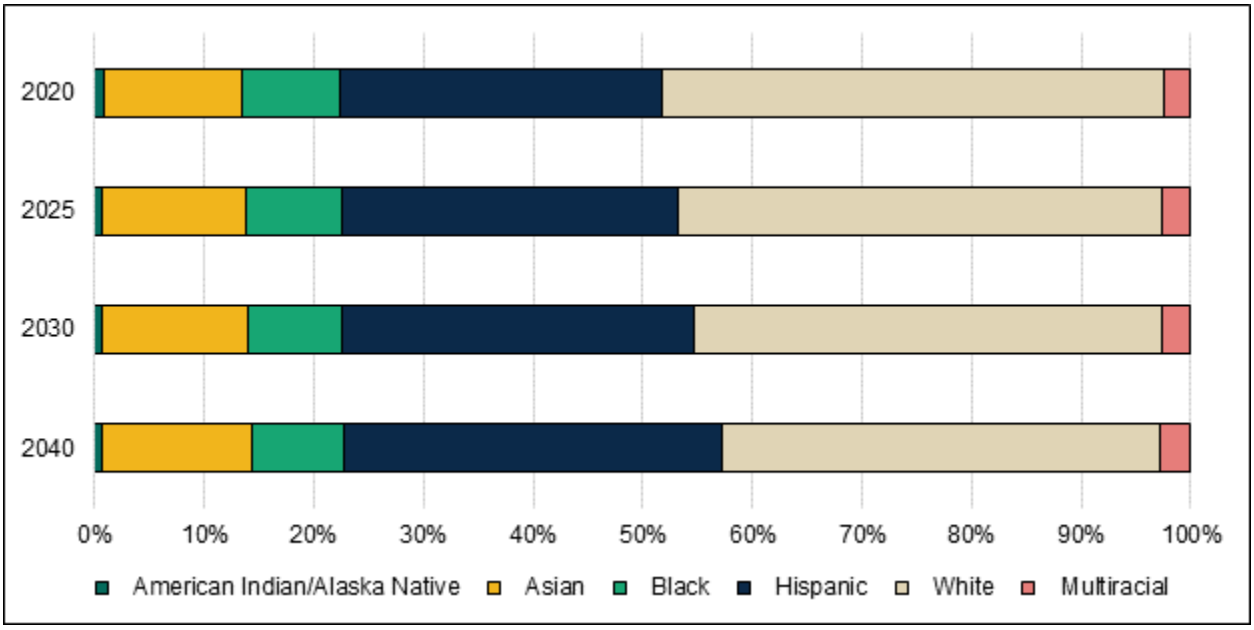
[b] The model Mathematica used to predict LTSS use is based on the population of LTSS users from other analyses; this population included people with LTC stays (SNF subacute care, ICF, and custodial care) or in select HCBS programs (IHSS, CBAS, HCBA, ALW, and MSSP).

ACS = American Community Survey; ADL = activity of daily living; ALW = Assisted Living Waiver; CBAS = community-based adult services; HCBA = Home and Community-Based Alternatives Waiver; HCBS = home and community-based services; ICF = intermediate care facility; IHSS = in-home supportive services; LTC = long-term care; LTSS = long-term services and supports; MSSP = Multipurpose Senior Services Program; SNF = skilled nursing facility.

2. Changes in population demographic characteristics

The population of future LTSS users is expected to include greater shares of people who are Hispanic, older, and female. As the population grows, the demographic characteristics of future LTSS users will also shift. Mathematica projects the population with any ADL limitation will become less White (declining from 46 percent of the population with any ADL limitation in 2020 to 40 percent in 2040) and more Hispanic (increasing from 29 percent in 2020 to 35 percent in 2040) (**Exhibit III.10**). Projections for other racial and ethnic groups as a proportion of the population with any ADL limitation will remain steady from 2020 to 2040.

Exhibit III.10. Distribution of race and ethnicity of the projected population with any ADL limitation in California, 2020 to 2040



Source: Mathematica used ACS data from calendar years 2008–2019 to create analytic models. The project team used California Department of Finance projections from 2020–2040 as inputs into models to project populations.

Note: The numbers from 2020 are based on projections from the model, not actual counts. The sample is restricted to people age 18 and older.

ACS = American Community Survey; ADL = activity of daily living.

The population with any ADL limitation will also become substantially older: people ages 75 to 84 will increase as a share of California's population with an ADL limitation, from 18 percent in 2020 to 24 percent in 2040, and people age 85 and older will increase from 16 percent to 28 percent (**Exhibit III.11**).

In addition, a slightly larger share of the population with any ADL limitation will be female, growing from 56 percent in 2020 to 58 percent in 2040 (**Exhibit III.12**).

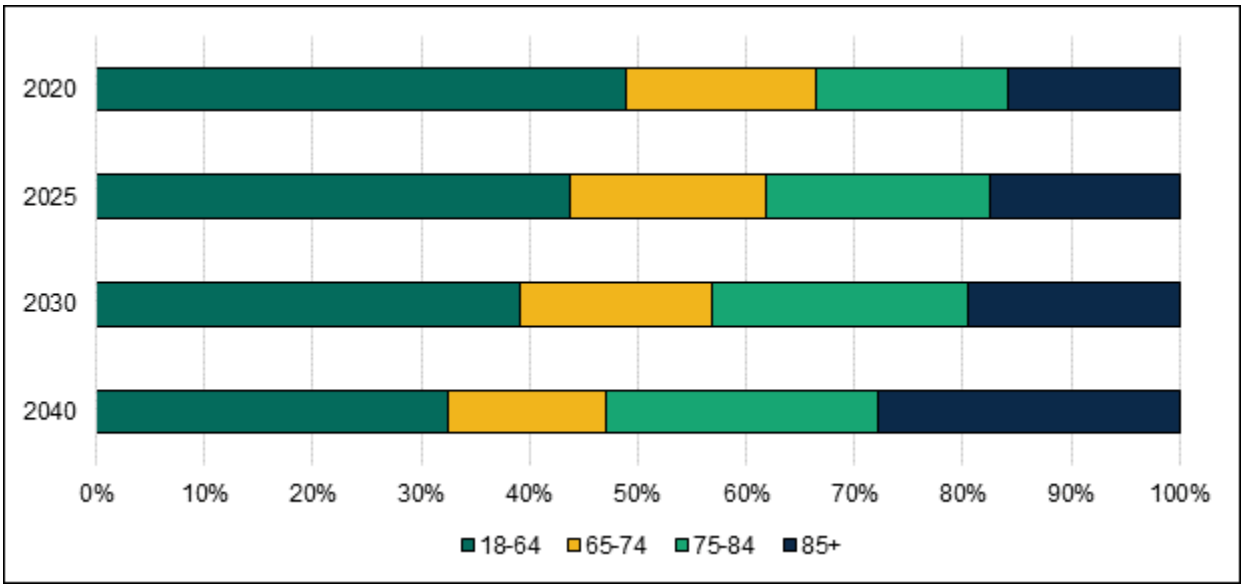
The entire population in California is expected to have greater shares of people who are Hispanic, older, and female. The projected patterns for people with any ADL limitation in the future reflect the overall projected demographic changes in California (among the entire population with and without an ADL limitation). Based on Mathematica's projections, the share of all Californians who are Hispanic will increase from 37 percent in 2020 to 41 percent in 2040, those who are female will increase from 50 to 51 percent, and adults age 75 and older will increase from 8.5 percent in 2020 to 16.7 percent in 2040. Mathematica found similar demographic changes

> "People are having [fewer] children or no children at all, and they are having children later. So, their children are in the prime of their professional capacity and are not wanting to leave the workforce. And so there is this shifting demographic in the availability of family providers. I think we will likely see a reduction from [current levels of] family providers. And when that happens, who is left?"
>
> –Representative from a direct workforce advocacy organization

for the population with any ADL limitation plus Medi-Cal enrollment (see Appendix Exhibit B.4.1).

Qualitative interviews echoed concerns on shifting demographics to higher-acuity participants and highlighted the juxtaposition to fewer active family caregivers available.

Exhibit III.11. Distribution of age of the projected population with any ADL limitation in California, 2020 to 2040



Source: Mathematica used ACS data from calendar years 2008–2019 to create analytic models. The project team used California Department of Finance projections from 2020–2040 as inputs into models to project populations.

Note: The numbers from 2020 are based on projections from the model, not actual counts. The sample is restricted to people age 18 and older.

ACS = American Community Survey; ADL = activity of daily living.

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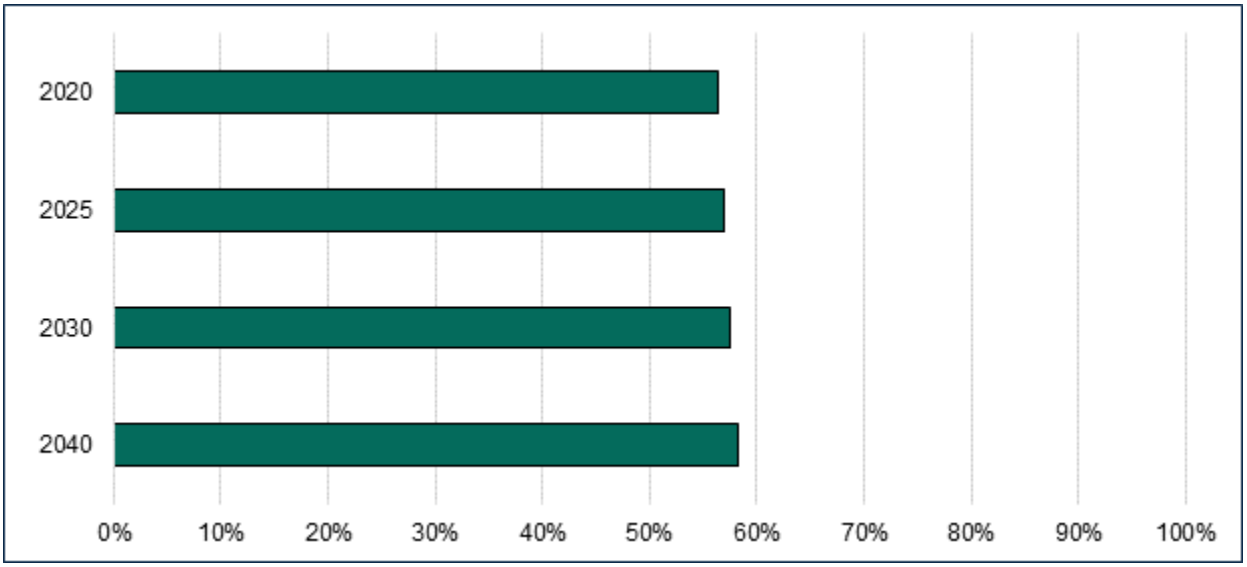
The entire population in California is expected to have greater shares of people who are Hispanic, older, and female. The projected patterns for people with any ADL limitation in the future reflect the overall projected demographic changes in California (among the entire population with and without an ADL limitation). Based on Mathematica's projections, the share of all Californians who are Hispanic will increase from 37 percent in 2020 to 41 percent in 2040, those who are female will increase from 50 to 51 percent, and adults age 75 and older will increase from 8.5 percent in 2020 to 16.7 percent in 2040. Mathematica found similar demographic changes for the population with any ADL limitation plus Medi-Cal enrollment (see Appendix Exhibit B.4.1).

"People are having [fewer] children or no children at all, and they are having children later. So, their children are in the prime of their professional capacity and are not wanting to leave the workforce. And so there is this shifting demographic in the availability of family providers. I think we will likely see a reduction from [current levels of] family providers. And when that happens, who is left?"

–Representative from a direct workforce advocacy organization

Qualitative interviews echoed concerns on shifting demographics to higher-acuity participants and highlighted the juxtaposition to fewer active family caregivers available.

Exhibit III.12. Percentage of the projected population with any ADL limitation in California who are female, 2020 to 2040



Source: Mathematica used ACS data from calendar years 2008–2019 to create analytic models. The project team used California Department of Finance projections from 2020–2040 as inputs into models to project populations.

Note: The numbers from 2020 are based on projections from the model, not actual counts. The sample is restricted to people age 18 and older.

ACS = American Community Survey; ADL = activity of daily living.

3. Changes in geographic distribution of the population

Counties in the central Sierra region are expected to have the highest rates of growth in LTSS users, whereas the most populated counties in the southern region of the state are expected to have the largest absolute growth in LTSS users. Counties in Northern California had the highest rates of people with ADL limitations in 2020 (see Appendix Exhibits B.4.2 and B.4.3), but counties in the central Sierra region (shown in dark purple in **Exhibit III.13**) had the highest *rates of growth* in the percentage of people with ADL limitations from 2020 to 2040. Specifically, the five counties expected to have the largest percentage growth in the population with any ADL limitation by 2040 are Mono, Calaveras, Alpine, Mariposa, and Inyo. The five counties with the largest growth in the absolute number of people with any ADL limitation are largely those in highly populated areas: Los Angeles, Riverside, San Diego, Orange, and San Bernardino.

Exhibit III.13. Percentage change of county population with any ADL limitation, 2020 to 2040

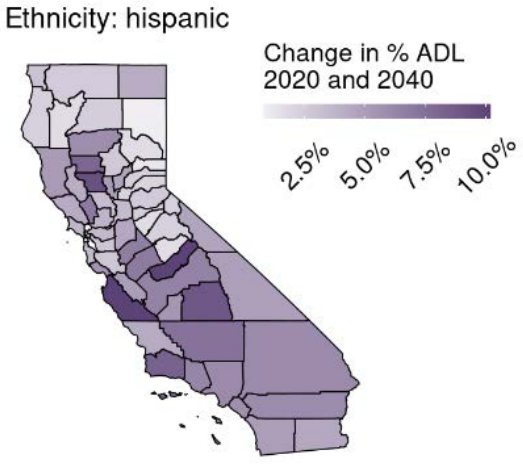
Source: Mathematica used ACS data from calendar years 2008–2019 to create analytic models. The project team used California Department of Finance projections from 2020 and 2040 as inputs into models to project populations.

Note: The numbers from 2020 are based on projections from the model, not actual counts. The sample is restricted to people age 18 and older.

ACS = American Community Survey; ADL = activity of daily living.

Several counties throughout California will have large increases in the share of the population who are Hispanic. Across California, the population with an ADL limitation will become more Hispanic (**Exhibit III.14**), and these changes will be particularly large in Monterey, Madera, Colusa, Tulare, and Santa Barbara counties.

Exhibit III.14. Percentage change from 2020 to 2040 in the population with an ADL limitation who are Hispanic



Source: Mathematica used ACS data from calendar years 2008–2019 to create analytic models. The project team used California Department of Finance projections from 2020 and 2040 as inputs into models to project populations.

Note: The numbers from 2020 are based on projections from the model, not actual counts. The sample is restricted to people age 18 and older.

ACS = American Community Survey; ADL = activity of daily living.

IV. Provider Capacity to Meet Member Needs and Coordinate Care

This section presents findings about the current availability and distribution of HCBS providers across the state, provider supply relative to the number of people who need HCBS, and their capacity to serve Medi-Cal members.

Box IV.1. Key takeaways on provider capacity to meet member needs and coordinate care

- Certain areas of the state have a shortage of, or in some cases completely lack, HCBS providers of certain types in addition to limited Medi-Cal HCBS program availability. They typically are Northern rural counties where the availability of Medi-Cal HCBS waivers is limited.
- Across HCBS programs, providers report limited capacity to serve individuals who need HCBS, indicating significant unmet need. However, quantifying its magnitude is difficult due to a lack of data on whether: (1) current Medi-Cal HCBS enrollees are receiving all of the services authorized in their service plans, or (2) people with LTSS needs are eligible for but not enrolled in Medi-Cal, or (3) people are enrolled in Medi-Cal but not receiving Medi-Cal LTSS even though they might need these services. California plans to collect more data to monitor unmet need as part of its obligation to report the HCBS access and quality measures required by the recent final federal rule, *Ensuring Access to Medicaid Services (CMS-2442-F).*
- The key challenges related to provider capacity to serve individuals with HCBS need include the following:
  - **Low provider participation in some HCBS programs:** Even in some areas where HCBS waiver programs are available, lower rates of provider participation (particularly for the ALW and CBAS programs) in Medi-Cal occur, contributing to barriers in access to HCBS. At least for the ALW and CBAS programs, access to these services could be increased for Medi-Cal members if more RCFE-ARFs and ADHCs participated in Medi-Cal, because a low proportion of existing RCFE-ARFs (for ALW) and ADHCs (for CBAS) currently participate.
  - **Workforce shortages:** Significant staffing vacancies and shortages create challenges for Medi-Cal-participating providers of HCBS. Providers say that low reimbursement rates make it difficult to offer competitive wage rates, which are the biggest hurdles to staff recruitment and retention. **Long waiting lists:** The state maintains HCBS waiver waitlists for several waivers, such as HCBA, ALW, and MSSP; also, at the local level, many providers maintain their own waitlists to manage their caseloads or because they have no available assisted living beds.

A. Current LTSS providers in California and distribution relative to Medi-Cal LTSS users

To identify counties with potential shortages of LTSS providers relative to LTSS users, Mathematica first obtained information about relevant LTSS providers from several data sources. Mathematica then took steps to merge and de-duplicate the data and determine provider locations (see the methodology described in Appendix B.5). Although many providers operate and serve clients in more than one county, the data available indicate only the county of the providers' physical address location. Consequently, this analysis is limited in that it does not reflect all counties where providers might be actively serving Medi-Cal members.

After identifying individual relevant LTSS provider types, Mathematica analyzed provider availability for each LTSS program based on the types of providers eligible to bill each program (**Exhibit IV.1**) and

mapped their availability by county.[56] IHSS non-relatives reflect the largest number of providers in Exhibit IV.1 because each provider delivers one-on-one care to recipients; Mathematica also did not have individual-level staff information for other agency- or organizational-level providers so the number of providers in Exhibit IV.1 reflects organizational-level providers. Regarding organizational-level providers, the largest number are RCFE-ARFs, followed by home health agencies (HHAs) and ADHCs.

Exhibit IV.1. Provider types and analytic approach for provider availability by LTSS program

Program	Provider types allowed to bill and available in data	Number of providers	Analytic approach
IHSS	• IHSS non-relative providers (individuals)	• Total non-relative providers: 255,784	Limited geospatial analyses to non-relative providers because they represent a potential pool of workers, who may be more likely than relatives to continue working as IHSS providers following program exit or death of the person for whom they cared. In addition, because non-relative personal care assistants are already enrolled as IHSS workers, the public authorities that screen and approve people for the registry to serve IHSS clients can identify which of these IHSS workers are available to serve other IHSS clients who do not have relatives who can serve them.[a]
CBAS	• ADHC – ADHCs participating in CBAS – ADHCs not participating in CBAS	• Total relevant providers, including all ADHCs (those that did and did not participate in CBAS): 1,703 • Total relevant providers, including only ADHCs participating in CBAS: 285	Examined subsets of providers: **1.** Total relevant providers, including all ADHCs (those that did and did not participate in CBAS) **2.** Total relevant providers, including only ADHCs participating in CBAS
ALW	• CCA • RCFE-ARF – RCFE-ARFs participating in ALW – RCFE-ARFs not participating in ALW • HHA[b] – HHAs that had any Medi-Cal billing in 2021 – HHAs that had no Med-Cal billing in 2021	• Total relevant providers, including CCAs, all RCFE-ARFs (those that did and did not participate in ALW), and actively billing HHAs: 18,747 • Total relevant providers, including CCAs, only RCFE-ARFs participating in ALW, and actively billing HHAs: 2,215 • Additional non-actively billing HAAs: 1,801	Examined subsets of providers: **1.** Total relevant providers, including CCAs, all RCFE-ARFs (those that did and did not participate in ALW), and actively billing HHAs **1.a**. Total relevant providers, including CCAs, all RCFE-ARFs (those that did and did not participate in ALW), and both actively and non-actively billing HHAs

[56] Mathematica did not have data on all provider types eligible to bill for every program. For example, for HCBA, Mathematica did not have data on HCBS waiver nurse providers (RN) or employment agencies, even though they are also provider types that can bill for HCBA-approved services.

Program	Provider types allowed to bill and available in data	Number of providers	Analytic approach
			2. Total relevant providers, including CCAs, only RCFE-ARFs participating in ALW, and actively billing HHAs **2.a.** Total relevant providers, including CCAs, only RCFE-ARFs participating in ALW, and both actively and non-actively billing HHAs
MSSP	• MSSP sites	• Total MSSP sites: 37	Grouped 2021 MSSP procedure codes into 11 categories and identified whether or not each site billed for each category in 2021 Medi-Cal claims
HCBA	• Prof Corp • Non Prof • INP • PCA • Regional- or county-level waiver agencies • CLHF – CLHFs participating in HCBA – CLHFs not participating in HCBA • HHA – HHAs that had any Medi-Cal billing in 2021 – HHAs that had no Med-Cal billing in 2021	• Total relevant providers including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, all CLHFs (those that did and did not participate in HCBA), and actively billing HHAs: 2,711 • Total relevant providers including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, only CLHFs that participated in HCBA, and actively billing HHAs: 2,410 • Additional non-actively billing HHAs: 1,801	Examined subsets of providers: **1.** Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, all CLHFs (those that did and did not participate in HCBA), and actively billing HHAs **1.a**. Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, all CLHFs (those that did and did not participate in HCBA), and both actively and non-actively billing HHAs **2.** Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, only CLHFs that participated in HCBA, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, only CLHFs that participated in HCBA, and both actively and non-actively billing HHAs
PACE	• PACE organizations	• Total PACE organizations: 27	Examined ZIP code service areas for PACE organizations
Institutional	• SNF • ICF • ARFPSHN	• Total institutional: 2,311	Examined all LTSS institutional types

Note: CCT uses designated lead organizations that employ or contract with transition coordinators, who work directly with the members, support networks, and providers to facilitate and monitor members' transitions from facilities to the community settings of their choice. As of February 2024, 20 CCT lead organizations were serving across the state. See https://www.dhcs.ca.gov/services/ltc/Documents/CCT-LO-Website-List-Feb2024.pdf.

[a] https://www.capaihss.org/public-authorities/roles/.

[b] HHAs in publicly subsidized housing (PSH) settings can bill for assisted living services (homemaker, home health aide, and personal care) as well as residential habilitation, so HHAs are relevant providers to consider as part of the ALW provider pool because there may be an opportunity to expand the ALW PSH model. However, as of 2024, there is only one HHA that participates in the PSH model in LA County so the HHA counts for ALW should be interpreted carefully with this context of the current low participation.

ADHC = adult day health center; ALW = Assisted Living Waiver; ARFPSHN = adult residential facility for persons with special health care needs; CBAS = community-based adult services; CCA = care coordination agency; CCT = California Community Transitions; CLHF = congregate living health facility; HCBA = home and community-based alternatives; HHA = home health agency; ICF = intermediate care facility; IHSS = in-home supportive services; INP = individual nurse provider; MSSP = Multipurpose Senior Services Program; Non Prof = nonprofit organization; PACE = Program of All-Inclusive Care for the Elderly; PCA = personal care agency; Prof Corp = professional corporation; RCFE-ARF = residential care facility for the elderly-adult residential facility; SNF = skilled nursing facility.

To examine where the gaps in LTSS providers may exist, we identified counties in which fewer than two providers are available for each program. This metric is relevant because many states with MLTSS programs use this provider network standard to ensure that members have a choice of at least two providers (Lester et al. 2022). Mathematica identified the list of counties based on the physical locations of providers. The counties that did not meet this threshold are listed in **Exhibit IV.2**. Mathematica did not include any HCBS waiver agencies in this analysis. These agencies perform assessment, care planning, and service coordination functions; typically, only one per county or region is involved, and waiver agencies are prohibited from providing direct services to avoid any conflict of interest.

Based on the physical location of providers, several counties have fewer than two providers of certain types. Adult residential facilities for persons with special health care needs (ARFs-PSHNs), professional corporations (Prof Corps), and ICF provider types are widely distributed across counties; RCFE-ARFs participating in ALW are also widely distributed across counties where the program is available. Only one or two counties have fewer than two of each of these provider types. However, it is likely that not as many counties as shown here have fewer than two providers per provider type because several provider types, such as Prof Corps, personal care agencies (PCAs), and nonprofit organizations (Non Profs) offer services that may be delivered by other providers operating in those counties. Also, providers in a nearby county may serve those counties. For example, Prof Corps and Non Profs are general descriptions of entities that may provide services delivered by many other LTSS provider types. In addition, care coordination services are provided by many kinds of organizations.

Exhibit IV.2. Counties with fewer than two providers by provider type

Provider type	Counties with fewer than two providers per provider type
HCBS providers	
ADHC	Calaveras, Glenn, Mariposa, Modoc, Plumas, San Benito, Trinity
ADHCs participating in CBAS	Butte, Monterey, Napa, San Mateo, Santa Barbara, Santa Cruz, Shasta, Solano, Stanislaus
RCFE-ARFs participating in ALW	Sonoma
CLHF	Marin, Monterey, Nevada, San Luis Obispo, Siskiyou, Sonoma, Yolo
HHA	Calaveras, Colusa, Del Norte, Kings, Lassen, Mariposa, Siskiyou, Tehama, Trinity, Tuolumne, Yolo, Yuba
CLHFs participating in HCBA	San Diego, San Luis Obispo, Santa Barbara, Santa Clara, Sonoma, Tulare, Yolo
INP	Amador, Lake, Napa, Nevada, Siskiyou

Provider type	Counties with fewer than two providers per provider type
Non Prof	Fresno, Kern, Merced, Nevada, San Bernardino, San Joaquin, Santa Barbara, Santa Clara, Santa Cruz, Ventura
PACE	Contra Costa, El Dorado, Humboldt, Kern, Kings, Madera, Marin, Napa, Placer, Solano, Sutter, Yuba
PCA	Alameda, Merced, San Joaquin, Stanislaus, Tulare, Tuolumne, Yuba
Prof Corp	El Dorado, Los Angeles
RCFE-ARF	Colusa, Del Norte, Inyo, Plumas, Trinity
Institutional facilities	
ARFPSHN	San Bernardino
ICF	Placer, Stanislaus
SNF	Amador, Calaveras, Del Norte, Glenn, Lassen, Mariposa, Sierra, Siskiyou, Trinity, Yuba

ADHC = adult day health center; ALW = Assisted Living Waiver; ARFPSHN = adult residential facility for persons with special health care needs; CBAS = community-based adult services; CLHF = congregate living health facility; ICF = intermediate care facility; INP = individual nurse provider; Non Prof = nonprofit organization; PACE = Program of All-Inclusive Care for the Elderly; PCA = personal care agency; Prof Corp = professional corporation; RCFE-ARF = residential care facility for the elderly-adult residential facility; SNF = skilled nursing facility.

Several counties with fewer than two providers by provider type are rural counties, and qualitative findings underscored similar trends in these identified gaps. Interviewees noted that rural areas in Northern California in particular lack what many called "HCBS infrastructure," including programs and providers. A few waiver agency interviewees described a lack of incentives for HCBS direct care service providers to expand into rural areas. One agency referenced the financial risks associated with such an expansion in light of their concerns about the sustainability of the rate structure for some HCBS programs like PACE that serve relatively small numbers of clients. A few interviewees noted that MCPs have been working to build CBAS provider capacity through developing community health worker training programs or creating a satellite model of care but discussed struggles in successfully encouraging providers to expand into rural areas, given the small market for HCBS in these regions.

1. Distribution of LTSS providers by program

To examine the geographical distribution of LTSS providers relative to where users are located, Mathematica calculated a user-to-provider ratio—that is, the number of all Medi-Cal LTSS users in each county by program. A higher ratio indicates lower provider availability and may suggest geographic areas with less access to HCBS.

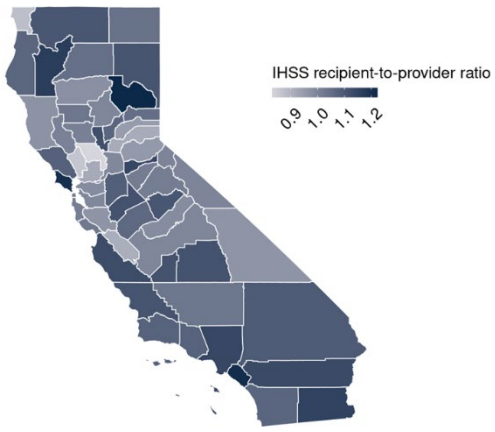
a. IHSS

IHSS provider analysis

Mathematica examined non-relative providers because they represent a potential pool of workers who may be more likely than relatives to continue working as IHSS providers following program exit or death of the person for whom they cared. In addition, because non-relative personal care assistants are already enrolled as IHSS workers, the public authorities that screen and approve people for the registry to serve IHSS clients[57] can identify which of these IHSS workers are available to serve other IHSS clients who do not have relatives who can serve them.

For IHSS, there were 255,784 non-relative providers in 2023 for Mathematica's analysis, which comprised around 37 percent of the total IHSS providers Mathematica identified. Among non-relative providers in 2023, the average number of recipients per provider was 1.3. Mathematica calculated the ratio of recipients to non-relative IHSS providers. This ratio ranges from 0.8 to 1.2 across the 58 counties, representing an overall balance of recipients and providers (that is, one-to-one). Orange County has 6,725 non-relative IHSS providers, but the high number of IHSS recipients (8,140) produces a high ratio (1.2 recipients per provider). In contrast, Yolo County has 0.8 IHSS recipients per provider, indicating a higher share of non-relative IHSS providers than in other counties (**Exhibit IV.3**).

Exhibit IV.3. Ratio of IHSS recipients to non-relative IHSS providers in 2021



IHSS = in-home supportive services.

Qualitative interviews revealed regional differences in wages, familial structures, and IHSS structures as the primary barriers to accessing IHSS. Many interview respondents reported that for individuals without family caregivers, it is harder to find people to serve as IHSS providers in Bay Area counties because of non-competitive wages. For example, they said that IHSS wages in Northern California are much lower than those in other local industries, so there is little incentive for workers to join the IHSS workforce.

[57] https://www.capaihss.org/public-authorities/roles/.

Others noted that for clients who cannot find a relative, friend, or neighbor to serve them, finding someone else to serve as an IHSS provider can be challenging. A representative from a consumer advocacy organization noted that for the subset of people who do not have a family member, friend, or neighbor willing to be their IHSS provider, the public authorities charged with referring consumers to independent care providers do not do enough to help them find and hire their providers. Public authorities also are charged with maintaining a provider registry—a referral list of people qualified to serve IHSS clients.[58] Interviewees also reported that often the IHSS referral lists maintained by the public authorities do not include enough actively engaged and available workers who can meet all of the needs of IHSS recipients looking for care. TA representative from a consumer advocacy organization explained that public authorities maintain two registries of potential IHSS workers—one for emergency backup and one for ongoing service delivery—and often these two lists are not maintained or disseminated in the same way, even within the same county. This finding was confirmed by research from Justice in Aging, which reported that only 118 IHSS users across all counties accessed their county's backup system in its first three months to find a provider. They thought it likely that users' lack of awareness of the backup program or a lack of providers enrolled in backup registries could be attributed to this outcome (Dickman 2023b).

> "Especially with my older clients, it's very hard for them to find a provider, hire a provider, train a provider, manage a provider, or fire a provider when they have no experience doing so. And if they have a cognitive impairment on top of that, it can be almost impossible to do so."
>
> –Representative from a legal support advocacy organization in Los Angeles

Justice in Aging reported that roughly 30 percent of IHSS users hire non-relative providers through IHSS registries maintained by regional public authorities (Dickman 2023b). Research in Los Angeles County found that one in six IHSS users who did not have a provider were still unable to find one eight months later. They noted that provider shortages and the inability to secure non-relative caregivers can directly be framed as an equity issue as well, disproportionately impacting LGBTQIA+ older adults and women. Although ultimately these challenges of unfilled caregiving are more related to network adequacy and provider availability, the provider registries and referral lists play an important role in the system that needs to be observed (Dickman 2023b).

> "Those [ongoing IHSS provider] registries in my opinion are somewhat non-existent in most counties and are just not easily accessible where they are available."
>
> –Representative from direct workforce advocacy organization

This complicated system is compounded by the potentially confusing and variable structure of IHSS enrollment for recipients. Interviewees reported that many county IHSS departments do not have an online application, and external reporting by Justice in Aging found significant barriers to the application process; for example, some counties, such as San Mateo and Kern, require a referral form to be completed before filling out an application and then require an affirmative contact with a county IHSS intake worker. In systems with limited county workers, this process can delay applicants receiving services,

[58] For additional details on the role of public authorities, see: https://www.capaihss.org/public-authorities/roles/.

and the additional steps can be especially challenging for individuals with cognitive impairments (Dickman 2023b).

Directly reaching IHSS workers can be challenging and untimely. Interviewees also reported some counties have changed how to access their helpline. For example, an advocacy organization highlighted how Los Angeles County has a central line consumers must call to reach a social worker or eligibility worker to ask questions. This central line often has long wait times and no option to leave a voicemail. Additionally, consumers no longer have direct contact information (phone number or email) for their assigned social workers under the Los Angeles County IHSS and must contact the helpline and then wait for a call back from a blocked number. Otherwise, IHSS users in the county are encouraged to use a "chat" feature online, with which many older adults or people with disabilities may struggle. The structural barriers to contact and develop direct relationships with IHSS social workers add significant burden and time for IHSS-enrolled individuals to change or flag issues with their IHSS services.

b. CBAS

CBAS provider analysis

Examined subsets of providers:

1. Total relevant providers, including all ADHCs (those that did and did not participate in CBAS)
2. Total relevant providers, including only ADHCs participating in CBAS

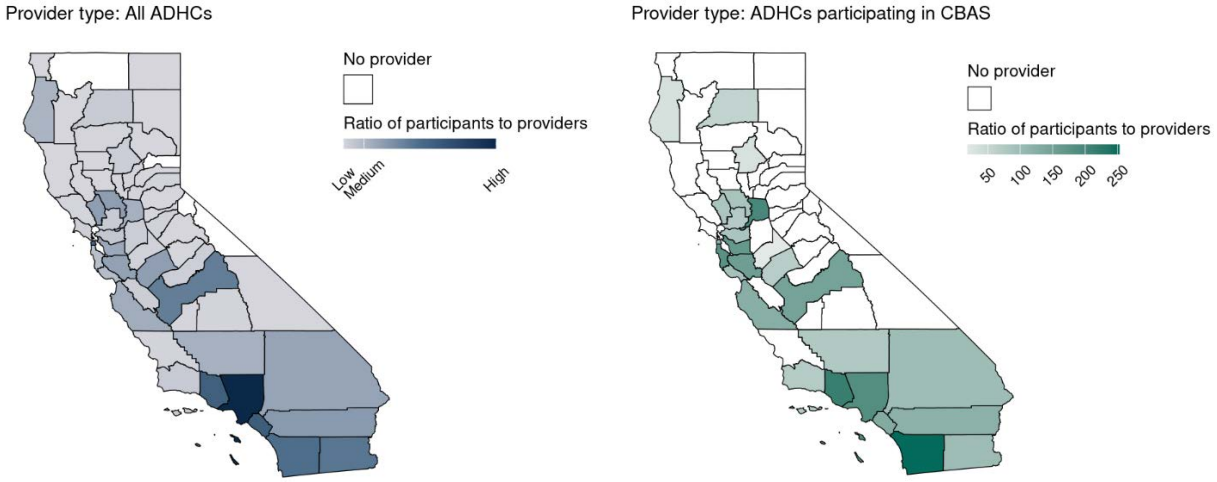
For CBAS, Mathematica examined the user-to-provider ratio for the overall pool of ADHCs, as well as the subset of ADHCs that participate in the CBAS program (**Exhibit IV.4**). Mathematica included 1,703 ADHCs and 285 ADHCs participating in CBAS in this analysis. The median user-to-provider ratio across the state is 2 for ADHCs and 99 for ADHCs participating in the CBAS program. A wide range of values exists for both metrics of the user-to-provider ratio for these subsets of providers. The ratio of users to ADHC providers ranges from the low end in Amador County to the high end in Los Angeles County. When Mathematica restricted the providers only to those who participate in the CBAS program, the user-to-provider ratio increased, and the distribution pattern also shifted. Stanislaus County had the lowest user-to-provider ratio, at 19, and San Diego County the highest, at 253. **This analysis suggests that to increase access to CBAS, it is important to encourage more ADHCs to enroll as CBAS providers.**

Interviews revealed a lack of awareness of CBAS programs, particularly among IHSS social workers, leading to gaps in CBAS referrals for IHSS recipients who could be eligible for and benefit from the services. Additionally, interviewees noted the economic barriers to open and maintain ADHCs participating in CBAS in Northern California, and the financial challenges associated with serving a smaller number of people spread out in rural counties. A representative from an ADHC participating in CBAS indicated facing significant challenges in maintaining a workforce in the Central Valley and Santa Clara area, which has especially low reimbursement rates.

A representative from an MCP noted that arranging reliable transportation from members' homes to ADHCs can be a deterrent to CBAS utilization, particularly for those located in less densely populated areas. They also noted that when HCBS enrollees do not have assistance in transportation access, they often are not able to attend ADHCs, thus deflating center attendance and ultimately limiting the centers' ability to remain open. Another MCP representative cited concern about new ADHCs seeking

to participate in the CBAS program in already saturated areas, such as in parts of Los Angeles County, and the impact it has on the sustainability of the existing ADHCs that participate in CBAS.

Exhibit IV.4. Ratio of users to providers for ADHCs and CBAS-specific ADHCs in 2021



ADHC = adult day health center; CBAS = community-based adult services.

Finally, a few interviewees noted that the COVID-19 pandemic significantly impacted the in-person community center-based model of CBAS, so some of them went out of business and thus were unable to reopen after the pandemic.

c. ALW

For ALW, we examined the user-to-provider ratio for the relevant ALW providers, which include care coordination agencies (CCAs), RCFE-ARFs, and HHAs (**Exhibit IV.5**). For both sets, we also included non-actively billing HHAs in the provider set as a sensitivity test to see how that addition would change the availability of providers. In ALW, HHAs in publicly subsidized housing (PSH) settings can bill for assisted living services (homemaker, home health aide, and personal care) as well as residential habilitation, so HHAs are relevant providers to consider as part of the ALW provider pool.[59]

RCFE-ARFs operate in 53 counties; RCFE-ARFs that participate in the ALW program operate in 15

ALW provider analysis

Mathematica examined the following subsets of providers:

1. Total relevant providers, including CCAs, all RCFE-ARFs (those that did and did not participate in ALW), and actively billing HHAs

1.a. Total relevant providers, including CCAs, all RCFE-ARFs (those that did and did not participate in ALW), and both actively and non-actively billing HHAs

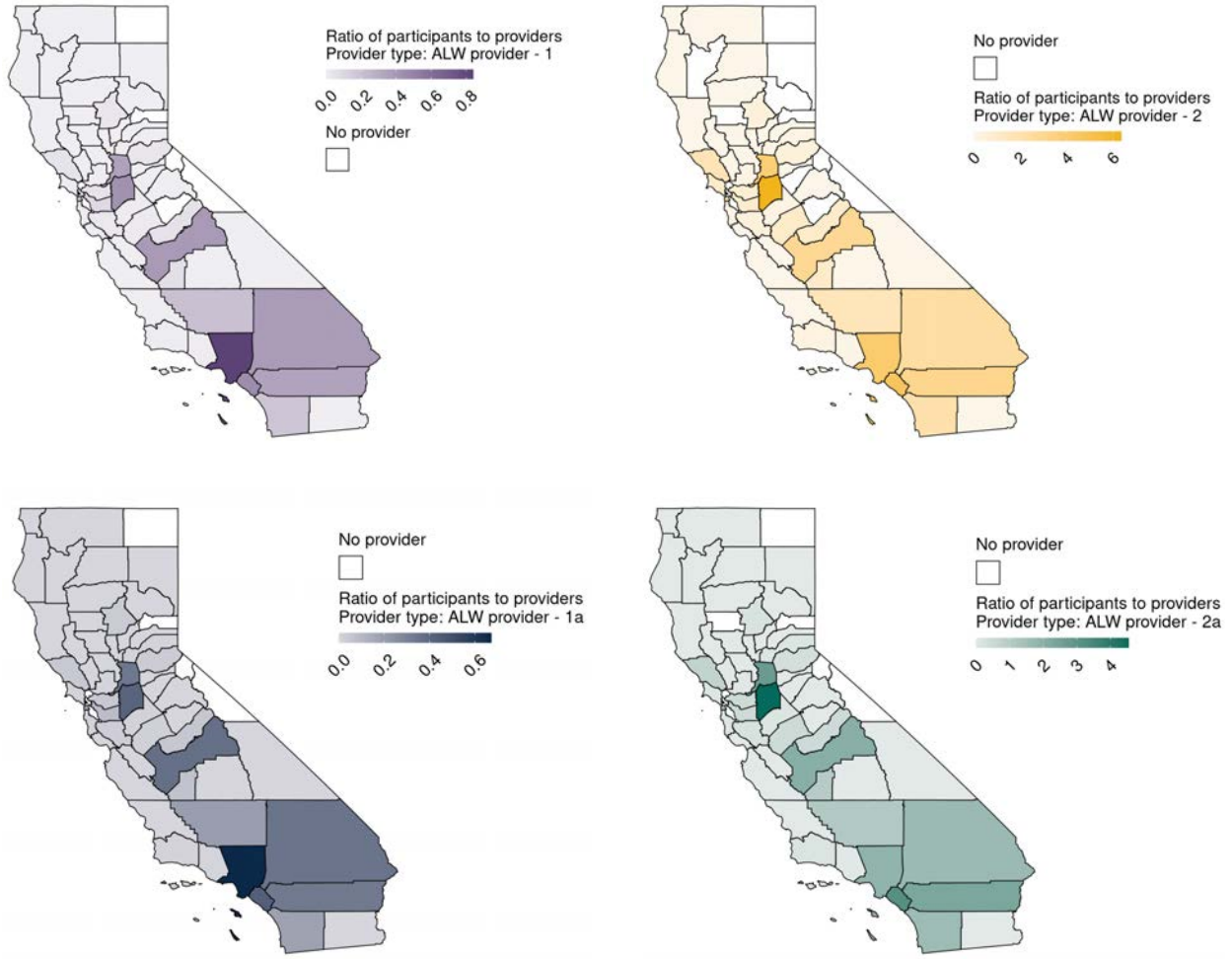
2. Total relevant providers, including CCAs, only RCFE-ARFs participating in ALW, and actively billing HHAs

2.a. Total relevant providers, including CCAs, only RCFE-ARFs participating in ALW, and both actively and non-actively billing HHAs◢

[59] Although there may be an opportunity to expand the ALW PSH model in the future, as of 2024, there is only one HHA that participates in the PSH model in LA County. Therefore, the HHA counts for ALW should be interpreted within this context of the current low participation in PSH model.

counties. Included in the Mathematica analyses were 16,532 total RCFE-ARFs and 917 RCFE-ARFs that participate in the ALW program. Due to the large number of available RCFE-ARFs, the median user-to-provider ratio across the state is 0, ranging from 0 in Amador County to 0.8 in Los Angeles County. When Mathematica restricted its analysis to the subset of RCFE-ARFs participating in ALW, this median user-to-provider ratio increased to 0.15, ranging from 0 in Amador County to 6.4 in San Joaquin County. Including non-actively billing HHAs in the provider pool had only a minimal impact on the availability of providers because the number of non-active billing HHAs is much smaller than the number of total RCFE-ARFs—the most dominant provider type relevant for the ALW program. The counties with the highest and lowest user-to-provider ratios did not change either.

Exhibit IV.5. Ratio of users to providers for ALW providers in 2021



ALW provider – 1: Total relevant providers, including CCAs, all RCFE-ARFs (those that did and did not participate in ALW), and actively billing HHAs

ALW provider – 1a: Total relevant providers, including CCAs, all RCFE-ARFs (those that did and did not participate in ALW), and both actively and non-actively billing HHAs

ALW provider – 2: Total relevant providers, including CCAs, only RCFE-ARFs participating in ALW, and actively billing HHAs

ALW provider – 2a: Total relevant providers, including CCAs, only RCFE-ARFs participating in ALW, and both actively and non-actively billing HHAs

ALW = = Assisted Living Waiver; CCA = care coordination agency; HHA = home health agency; RCFE-ARF = residential care facility for the elderly-adult residential facility.

Many interviewees mentioned that the low number of RCFE-ARFs participating as ALW providers in Northern California counties either forces people to relocate away from their community and family into a county that provides those services, or just live without needed care. This low number could also be placing additional burden on other HCBS programs to serve these Medi-Cal members when they would be better served through ALW.

In areas of higher concentrations of ALW-participating providers, interviewees noted it is often confusing to enroll in the program. Interviewees reported that many providers have their own waitlists for ALW beds in addition to the ALW waitlist for a waiver slot, and some reported variability in how those waitlists are maintained and how well services are provided. Many felt the opaqueness of the waitlist process could allow providers to prioritize different groups and as a result sometimes perpetuate potential bias. Other independent reports on ALW support the interviewee sentiments and have suggested racial and ethnic disparities in ALW waiver utilization (Dickman 2023a). Additionally, outside research indicates that how CCAs administer ALW waiver slots can lead to bias. Advocates cited the CCA policies that incentivize putting easier-to-place transitions first and encourage individuals to enter an institution to obtain a prioritized ALW waiver slot (Dickman 2023a). These reports also highlighted potential predatory behavior from assisted living facilities, encouraging individuals to secure a bed with private funds before they enroll in an ALW waiver slot with the promise of shifting to an ALW bed in the future, which then does not always occur (Buller 2023).

Some interviewees mentioned that the existence of waitlists at all can disincentivize people from initially applying. A few interviewees cautioned that counting the number of ALW-participating facilities inflates the true number of providers because many have only a few beds available for Medi-Cal ALW participants. They mentioned that no cap exists as to what the providers can charge for private pay beds, and thus little incentive to increase the number of Medi-Cal certified beds in assisted living facilities.

d. MSSP

MSSP provider analysis

Grouped 2021 MSSP procedure codes into 11 categories and identified whether or not each of the 37 MSSP sites billed for each category in 2021 Medi-Cal claims.

MSSP sites bill Medi-Cal directly, providing intensive care management and care coordination to participants. However, these sites contract out some other services provided to MSSP participants. Because of this approach, Mathematica could not accurately capture all of the providers who might participate in the MSSP program; instead, Mathematica analyzed MSSP service provision differently than other LTSS provider types in this chapter. Specifically, Mathematica grouped 2021 MSSP procedure codes into 11 categories and identified whether or not each of the 37 MSSP sites billed for each category in 2021 Medi-Cal claims. The categories of services included adult day care; other assistance; community transition services; supplemental personal care, chore, and protective services; consultative clinical services; respite; transportation; nutritional services; counseling and therapeutic services; communication; and care management.

The 37 MSSP sites in the state varied as to how many of them delivered different categories of services (**Exhibit IV.6**). The most common service categories were care management (36 sites), communication (36 sites), and other assistance (35 sites). The least common service categories were adult day care (0 sites), consultative clinical services (three sites), and community transition services (seven

sites). It is not known how many MSSP participants need these services and are approved to receive them as part of their care plan, but the low use of some services may be due to limited availability to deliver certain service types at the site level.

Exhibit IV.6. Counts of MSSP sites billing for MSSP service categories

Service category	Number of sites billing for service category (37 total)
Care management	36
Communication	36
Other assistance	35
Supplemental personal care, chore, and protective services	28
Nutritional services	27
Transportation	27
Counseling and therapeutic services	18
Respite	17
Community transition services	7
Consultative clinical services	3
Adult day care	0

Source: 2023 MSSP roster and 2021 Medi-Cal claims.

Note: Mathematica identified billing providers present on claims that contained one of the relevant procedure codes for MSSP-covered services and identified how many sites did not bill for that particular service category.

MSSP = Multipurpose Senior Services Program.

Qualitative interviews with waiver and provider agencies revealed some challenges in finding providers and establishing contracts to provide services. For example, agencies can find it difficult to identify appropriate vendors in rural areas to provide needed services with the proper licensures and insurance coverage.

> "Some of our counties, especially our more rural counties, the [MSSP] services that are available even for us to purchase are limited…anything that can't be delivered directly can be a challenge."
>
> –Representative from an MSSP Site

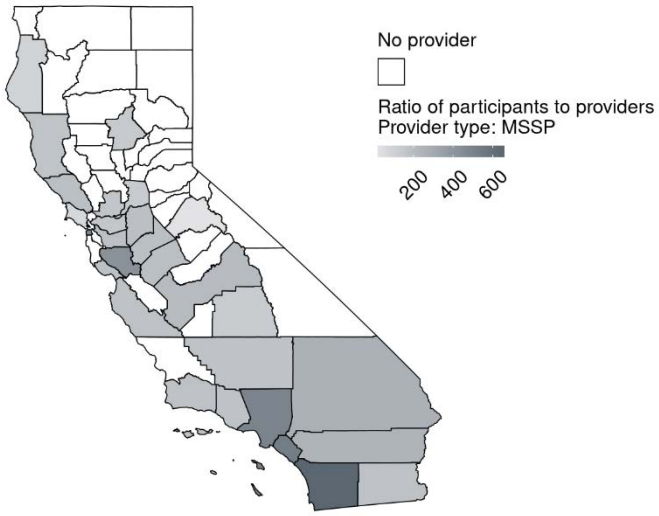
A waiver agency representative also noted significant difficulty in staffing, indicating that staff wages were too low to retain staff, and raising wages to keep case management staff means fewer funds available to spend on other services delivered to members. Representatives from waiver and provider agencies noted that nurses and social workers are particularly difficult to staff in MSSP. In addition to rates, waiver agencies noted significant documentation requirements, which reduce the time nurses and social workers can spend helping clients and can lead to rapid turnover. Workforce challenges can also make the care provided less person centered. For example, a representative from one waiver agency said that respite providers in MSSP often have only a few openings, and families have to work around what the contracted vendor has available, versus when the family really needs respite services.

Finally, poor communication was reported between stakeholders involved in providing MSSP services. A representative from an MCP said they have no idea how many of their members are enrolled or actively using MSSP, and often they do not find out until a significant problem arises (for example, an

individual is not able to fix a broken wheelchair) and the provider calls the plan instead of the MSSP agency to request authorization.

To examine where MSSP users reside, Mathematica calculated the ratio of recipients to MSSP sites, which ranges from 18 to 658 across the 28 counties, with the median value being 181. This finding means that most sites have a large number of users to serve. Except for Los Angeles County, with six MSSP sites, all other counties have only one or two such sites; this ratio is driven mainly by the variability in the number of users. San Diego County has one site and a high number of users (658), producing a high ratio (658 recipients per provider). In contrast, Tuolumne County also has one site but a low number of users (18), which produces a low ratio (18 recipients per provider) (**Exhibit IV.7**).

Exhibit IV.7. Ratio of MSSP users to providers in 2021



MSSP = Multipurpose Senior Services Program.

In interviews with waiver and provider agencies, many of them mentioned a significant lack of community knowledge of MSSP, which limits referrals to the program. However, a representative from one waiver agency felt that in some ways, limiting awareness of the program was intentional to maintain trust with the community, given the limited number of slots, which require maintaining waitlists both at state and individual site levels. Because of this mismatched demand, a consumer advocate interviewed felt that referral rates to MSSP agencies may be kept low so as not to promise a service that cannot be delivered, contributing to a lack of consumer awareness and knowledge about the MSSP program in general. A representative from another advocacy organization felt the MSSP waitlists were doubly

> "Our number of slots is always capped. And so a lot of times, you have more people that really should be in the [MSSP] program, but they can't because they're on a waiting list and they may be on a waiting list for a very long time…so, do you create this excitement in the community, and get all these referrals, and suddenly you have 1,000 people on the list that you are never going to be able to serve in people's lifetime?"
>
> –Representative from a regional waiver agency

punitive because waiver agencies maintain their own lists of people waiting for providers. This situation could result in a person still being on the agency's waitlist even after they come off of the state-maintained waiver waitlist.

The advocacy organization representatives also felt some MSSP programs were not forthright about all of the optional potential services they offer, so only individuals who know what to ask for are granted certain services, such as home modifications.

e. HCBA

For the HCBA waiver program, Mathematica examined the user-to-provider ratio for the relevant HCBA providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, congregate living health facilities (CLHFs), and HHAs (**Exhibit IV.8**). CLHFs are small group homes with an average of six beds and serve medically fragile or technology-dependent individuals. Because 180 CLHFs participate in the HCBA program—60 percent of all CLHFs in the state—and many other provider types are allowed to bill under HCBA, these two sets of maps in the exhibit appear rather similar. For both sets of maps, Mathematica has included non-actively billing HHAs in the provider set as a sensitivity test to see how this addition would change the availability of providers. For the overall pool of CLHFs, the user-to-provider ratio ranged from 0 in Amador County to 23 in Tehama County, with a median value of 3.2. Restricting the subset of CLHFs participating in HCBA increased the median value slightly, to 3.3, and the range of user-to-provider ratio ranged from 0 in Amador County to 24 in Marin County. Including non-actively billing HHAs in the provider pool brought down the median value to 2.5 (for all CLHFs) and 2.6 (for HCBA-specific CLHFs) but did not affect either end of the distribution. The county with the highest user-to-provider ratios is still Tehama County.

HCBA provider analysis

Examined subsets of providers are as follows:

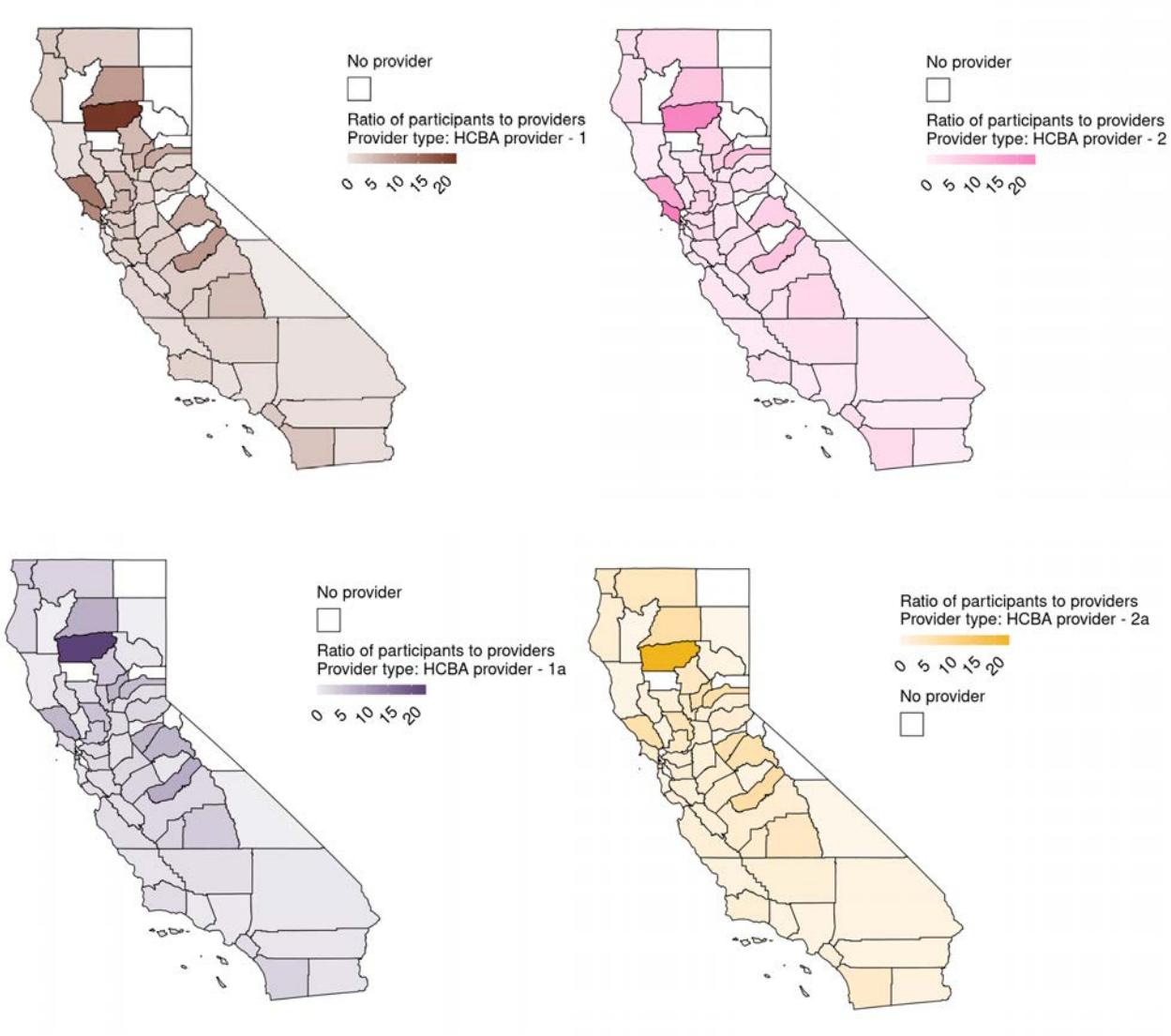
1. Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, all CLHFs (those that did and did not participate in HCBA), and actively billing HHAs

1.a. Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, all CLHFs (those that did and did not participate in HCBA), and both actively and non-actively billing HHAs

2. Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, only CLHFs that participated in HCBA, and actively billing HHAs

2.a. Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, only CLHFs that participated in HCBA, and both actively and non-actively billing HHAs◢

Exhibit IV.8. Ratio of users to providers for HCBA providers in 2021



HCBA provider – 1: Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, all CLHFs (those that did and did not participate in HCBA), and actively billing HHAs

HCBA provider – 1a: Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, all CLHFs (those that did and did not participate in HCBA), and both actively and non-actively billing HHAs

HCBA provider – 2: Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, only CLHFs that participated in HCBA, and actively billing HHAs

HCBA provider – 2a: Total relevant providers, including Prof Corps, Non Profs, INPs, PCAs, regional- or county-level waiver agencies, only CLHFs that participated in HCBA, and both actively and non-actively billing HHAs

CLHF = congregate living health facility; HCBA = home and community-based alternatives; HHA = home health agency; INP = individual nurse provider; Non Prof = nonprofit organization; PCA = personal care agency; Prof Corp = professional corporation.

Most of the qualitative interviewees pointed to gaps in accessing the HCBA program because of the limited number of slots and long waiting times. Enrollment in HCBA is a joint effort between waiver agencies that receive applications and conduct eligibility assessments, and DHCS, which reviews applications to make final eligibility and enrollment determinations. Interviewees raised concerns over the limited number of HCBA waiver slots and what was described as an opaque prioritization process from

DHCS regarding individuals not knowing where they are in the waiting list and what criteria are being used for prioritization. Despite DHCS regularly increasing the number of slots for the HCBA waiver since 2017, demand for the service continues to be higher than available slots, as well as a consistent statewide waitlist for waiver enrollment.[60] Additionally, many interviewees noted that even when a slot opens and is granted to an individual, significant wait times to access waiver services persist because of long processing times for application approvals at the state level. Even DHCS interviewees agreed that the HCBA approval process is predominantly manual, and limited data and staff make it significantly challenging to reduce wait times. Delays in waiver agencies completing all the necessary steps to submit applications may also lead to barriers in timely access. For example, how each waiver agency accepts HCBA applications has also been a significant barrier for equitable applications, particularly for agencies that may still rely on fax or mail to collect application information.

Many interviewees also noted a lack of community awareness of HCBA, with representatives of advocacy organizations pointing in particular to misunderstandings among Medi-Cal eligibility workers when it comes to identifying whether someone is eligible for HCBA. Other interviewees explained that in some counties, particularly rural ones, many Medi-Cal members speak languages other than English, but there are not enough of these members to compel Medi-Cal to provide materials in those languages. For example, a representative from an advocacy organization said Chico County has a large community of Hmong speakers, but Hmong is not one of the Medi-Cal threshold languages[61] in which the HCBA application is offered in the county.

A DHCS interviewee also explained that workforce challenges have made it challenging to maintain, let alone grow, the delivery of waiver personal care services under HCBA. A waiver interviewee shared similar sentiments about these challenges, saying "[waiver personal care services are] really the most tangible benefit…it's the hours that keep people safe at home for that level of functional need." Advocacy organizations highlighted a common transition for CCT participants into HCBA to access waiver personal care services, but there are challenges regarding which program has primary responsibility for coordinating care when an individual is making this transition.

f. CCT

CCT is the state's Money Follows the Person (MFP) demonstration program, which helps people residing in long-term care facilities transition to home and community-based settings. Twenty CCT lead organizations serve 56 counties (some serve one county, whereas others serve multiple counties).[62] Because CCT is a time-limited service focused on transitioning people from institutions to home and community-based settings, most CCT users enroll in other Medi-Cal HCBS programs to meet their needs within the community.

Many interviewees cited significant challenges in enrolling in CCT and coordinating across other HCBS programs. Enrollment barriers included the limited number of languages spoken by the lead

[60] https://www.dhcs.ca.gov/services/Documents/HCBA.pdf.

[61] Threshold language means a language identified as the primary language of 3,000 members or 5 percent of the member population, whichever is lower, by county. Resources are supposed to be provided in all threshold languages.

[62] https://www.dhcs.ca.gov/services/ltc/Documents/CCT-LO-Website-List-Feb2024.pdf.

organization staff in charge of coordinating enrollment and significant delays in DHCS approval of CCT applications. Several interviewees also noted fractured coordination, particularly between CCT lead organizations and HCBA waiver agencies, despite the common progression of persons transitioning to HCBS after their one year in CCT ends.

Qualitative interviewees underscored workforce challenges for CCT similar to the other HCBS programs (that is, low and stagnant wages contributing to workforce shortages, which in turn affects an individual's ability to find appropriate care). In addition, an advocacy organization representative highlighted that the process for securing housing through CCT support has changed; it is now difficult to secure housing for someone currently in an institution, so CCT is not transitioning as many individuals as it could. These challenges have limited California's ability to effectively transition Medi-Cal members out of institutions and into the community. In 2020, California transitioned 202 people through CCT, less than half the number transitioned in 2017 and 2018 according to monitoring data from the Centers for Medicare & Medicaid Services (Peebles and Dolle 2022). Low numbers may have been due to uncertainty in federal grant funding in 2018 and challenges related to the COVID pandemic in 2020.[63]

g. PACE

PACE provider analysis

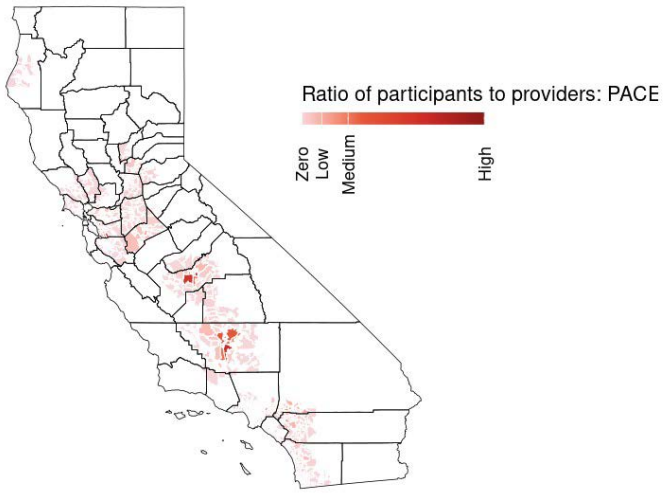
Examined ZIP code service areas for PACE organizations.

PACE organizations serve people age 55 and over with disabilities living in the community who require a nursing home level of care. PACE organizations are both health providers and MCPs; they deliver medical and LTSS to participants at home and in adult day health centers staffed by a multidisciplinary team, and contract with hospitals and other providers for other services. California currently has 27 PACE organizations, many of which operate programs in multiple counties. Each PACE organization serves an average of 430 participants (11,633/27 in 2021), although the average drops when taking account of multiple PACE programs operated by the same plan.

For PACE, Mathematica examined the availability of providers by ZIP codes because each PACE organization serves a distinct list of ZIP codes for service delivery (**Exhibit IV.9**). California has 1,235 ZIP codes that are in at least one PACE organization's service area. 970 of these ZIP codes include one or two PACE organizations, but a small number (46 ZIP codes) are served by four PACE organizations. The three ZIP codes with the highest user-to-provider ratios are 93702 (Fresno, CA), 93727 (Fresno, CA), and 94133 (San Francisco, CA).

[63] https://health.uconn.edu/aging/wp-content/uploads/sites/102/2021/11/MFP-Closed-Cases-report-2020.pdf

Exhibit IV.9. Ratio of users to providers for PACE in 2021



PACE = Program of All-Inclusive Care for the Elderly.

Several interviewees pointed to barriers to enrolling in PACE. Some noted that enrollment is slated only for the beginning of each month and does not align with immediate needs when an individual is discharged from an institution at a different time of the month. One representative from a PACE organization explained that for rural providers, challenges in transportation are a key problem for some people for getting the required multitude of different assessments in the first month. These challenges can be very burdensome for individuals used to living independently. The same interviewee also noted the difficulty in sustaining PACE programs with sufficient staff due to low reimbursement rates, and the need to limit certain services, such as no longer escorting an individual to a specialty appointment because of limited staffing capacity.

h. Institutional providers

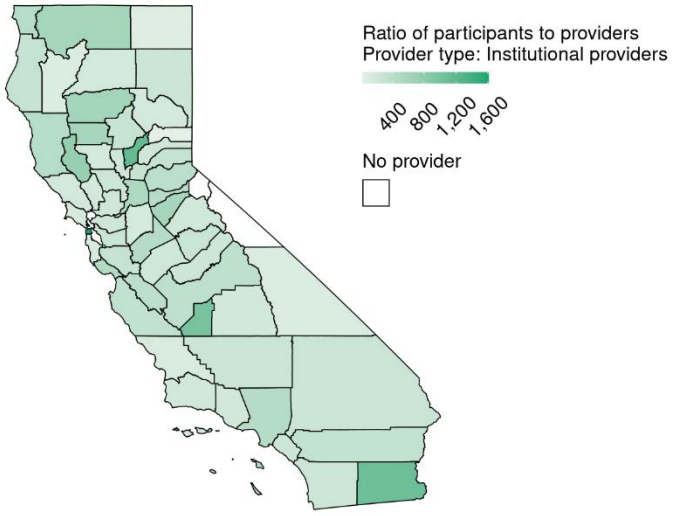
Institutional provider analysis

Examined all relevant LTSS institutional types, including SNF, ICF, and ARFPSHN.

For institutional providers, including SNF, ICF, and adult residential facility for persons with special health care needs (ARFPSHN), the ratio of recipients (characterized by all LTSS users) to providers ranges from 27 to 1,612 across the 56 counties with any institutional provider,[64] with a median value of 268. **This finding means that most institutional providers serve a large number of users.** The number of providers range from one to 10 in sparsely populated counties to 626 in Los Angeles County. San Francisco County has 18 providers and a high number of users (29,017), producing a high ratio (1,612 recipients per provider). In contrast, Sierra County has one provider but a low number of users (27), producing a low ratio (27 recipients per provider) (**Exhibit IV.10**).

[64] Two counties (Alpine and Mono) have zero institutional providers meeting the definition.

Exhibit IV.10. Ratio of users to providers for institutional groups in 2021



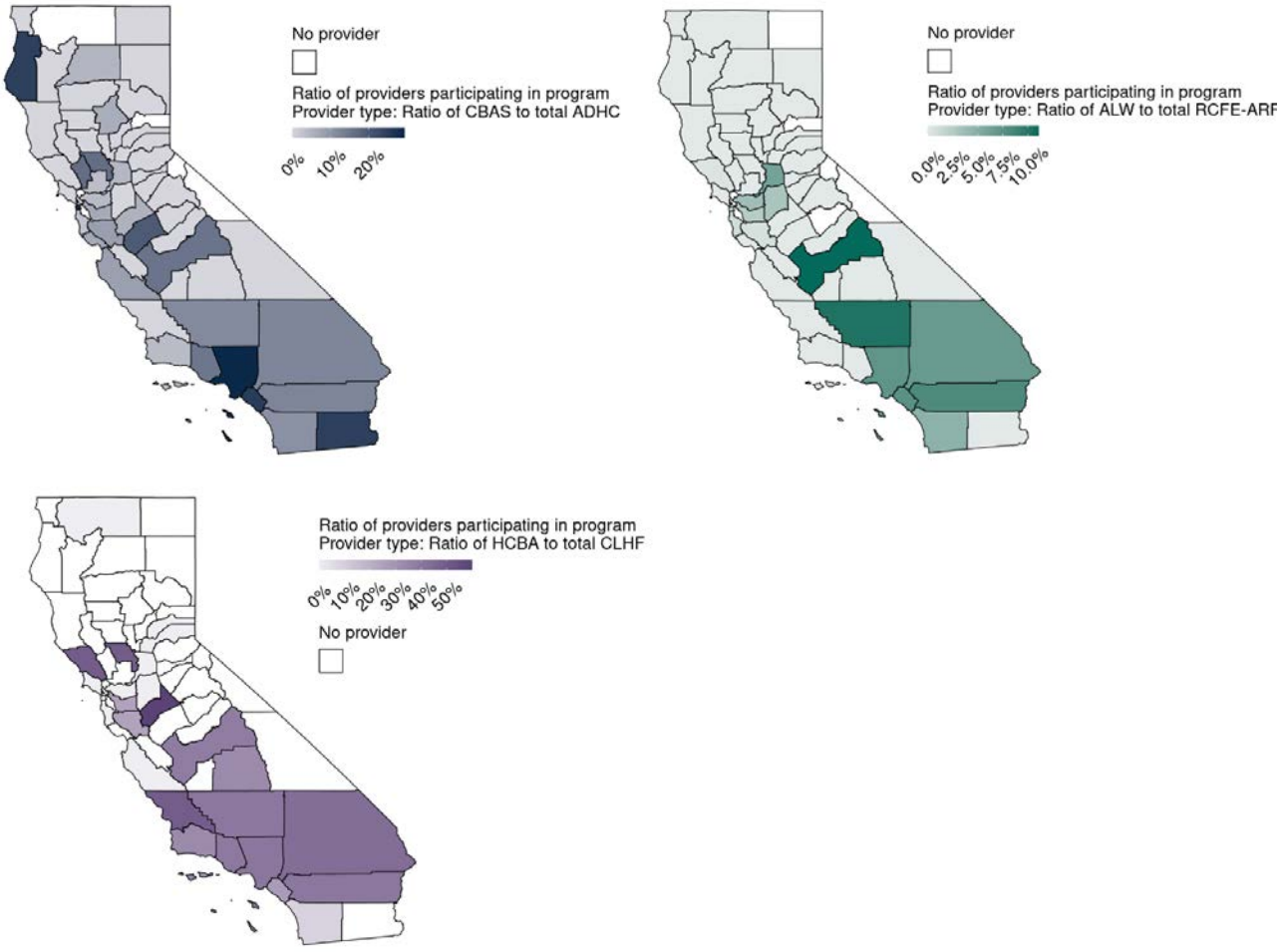
Note: Institutional providers included skilled nursing facility (SNF), intermediate care facility (ICF), and adult residential facility for persons with special health care needs (ARFPSHN).

2. Provider participation for CBAS, ALW, and HCBA

To examine provider participation in Medi-Cal HCBS programs, Mathematica calculated the following three metrics: (1) ratio of CBAS centers participating in Medi-Cal to total ADHCs; (2) ratio of Medi-Cal ALW-participating RCFE-ARFs to total RCFE-ARFs; and (3) ratio of Medi-Cal HCBA-participating CLHFs to total CLHFs (**Exhibit IV.11**).

HCBA operates in all 58 counties; Mathematica found an overall 60 percent participation rate in HCBA among CLHFs in the state. The median county participation rate for HCBA was 30 percent (range: 0–60 percent). CBAS currently operates in 28 counties, and Mathematica found an overall 17 percent participation rate in CBAS among ADHCs in the state. The median participation rate for CBAS was 0 (range: 0–29 percent), and the 75th percentile participation rate was 10 percent. ALW currently operates in 15 counties; Mathematica found an overall 6 percent participation rate in ALW among RCFE-ARFs in the state. The median participation rate in ALW was 0 (range: 0–11 percent). A few ALW interviewees noted that complexities in billing procedures between the state and RCFEs have deterred many of these organizations from enrolling as Medi-Cal-certified providers in ALW. **These findings suggest that the provider infrastructure to increase access to services through CBAS and ALW exists, and there may be opportunities to enroll more providers into the waivers by simplifying the billing process. HCBA still has room to improve access by enrolling more providers into the waiver, but DHCS could focus on increasing the capacity of enrolled providers to serve more Medi-Cal members.**

Exhibit IV.11. Provider participation in Medi-Cal CBAS, ALW, and HCBA programs in 2021



ADHC = adult day health center; ALW = Assisted Living Waiver; CBAS = community-based adult services; CLHF = congregate living health facility; HCBA = home and community-based alternatives; RCFE-ARF = residential care facility for the elderly-adult residential facility.

B. Provider capacity to serve Medi-Cal members

Key informant interviews and results from the provider survey analysis confirmed unequal distributions in the availability of HCBS providers by provider type within programs and waivers, and provided additional insights into the reasons for them. In particular, the challenges for individuals with highly complex care needs or in rural areas emphasized the significant gaps in HCBS provider capacity and availability. A primary source of these gaps is significant staffing vacancies and shortages, exacerbated by low wages. These workforce shortages are key barriers to individuals' access to HCBS and can often lead to unmet need.

1. Workforce vacancies and staffing challenges

Significant staffing vacancies and shortages create challenges for providers of HCBS. Based on the provider survey respondents, across all provider groups, direct care provider staff (that is, attendant care providers, home health assistants, homemaker providers, and personal care service workers) comprised the majority of HCBS staff, accounting for 67.4 percent of full-time and 71.7 percent of part-time staff in the state. Among respondents, direct care provider staff had the most open positions within each provider group, leading to an overall reported state vacancy rate of 65.9 percent. More than half of agencies that provided waiver management only[65] (57.7 percent) and direct care services only[66] (65.1 percent) experienced staff vacancies or shortages in the past six months, whereas only 36.4 percent of residential-settings-only providers (RCFEs or ARFs) reported staff vacancies or shortages. In the last six months, the average number of staff vacancies (either part- or full-time open positions) across provider groups was 7.35, with those who provide direct care services (either combined or exclusively) reporting the highest number of vacancies (10.0 for direct care services only, 9.28 for direct care services and waiver management,[67] and 12.0 for direct care services and residential settings).[68, 69] In addition, qualitative interviews cited a wide range of licensed specialist shortages for HCBS program providers, particularly in rural areas.

> "From a workforce perspective, I think we have to ask ourselves as a state, how do we make this a desirable workforce to enter into and to stay?"
>
> –Representative from a direct workforce advocacy organization

Across HCBS programs, providers noted several hurdles related to staff recruitment and onboarding. For example, fingerprinting and registering with the state as an HCBS worker, and even tuberculosis testing, can be "administrative nightmares," according to representatives from one provider agency. Smaller provider agencies are less able to dedicate time and resources to these administrative requirements. Providers also reported that these steps are time-consuming; sometimes, by the time the provider can assign a caregiver, the recipient has moved on to a different agency due to the long wait. The consequences are a frustrated caregiver who ultimately might leave for a different job and wasted investments from the provider agency to cover the fingerprinting and tuberculosis testing costs.

[65] Waiver management only: Survey respondent selected only one or more of the following waivers: CCT, CCA, MSSP, HCBA.

[66] Direct care services only: Survey respondent selected only one or more of the following services: CBAS, HHA, PCA.

[67] Direct care services and waiver management: Survey respondent selected at least one provider type from both direct care services (CBAS, HHA, PCA) and waiver management (CCT, CCA, MSSP, HCBA).

[68] Direct care services and residential setting: Survey respondent selected at least one provider type from both direct care services (CBAS, HHA, PCA) and residential setting (RCFE, ARF).

[69] The results of the provider survey are presented in further detail in Appendix B.6.

Providers also noted the significant time and cost required to train workers, as well as some resistance from workers to undergo training to provide care for people with more complex conditions. These providers emphasized the lack of clear incentives for workers to participate in additional training, saying that in most cases they are unable to pay a caregiver more as a result of such training. Many interviewees also mentioned that although IHSS training is mandatory, they perceived a significant a gap in training for all other programs.

> "I have not seen any training curriculum or even standard for people providing in-home care that are not IHSS providers…so, the training is going to look a thousand different ways across the state and it's really going to be on the home care agency for how invested they are in bringing that out."
>
> –Representative from a MSSP Site

Individuals who participated in consumer listening sessions echoed these sentiments, noting how challenging it can be to identify, train, maintain, and rely on HCBS providers, particularly for individuals with highly complex care needs or those residing in rural areas. In particular, participants reported challenges in finding specific providers who are a good fit for their needs.

> "We need a person who is consistently reliable and dependable. Some people from the agency would suddenly say they cannot come. For instance, a person promised to come on Monday, Wednesday, and Friday, but [all] of a sudden, a different person came. It's certainly an issue."
>
> –Consumer listening session participant

2. Staff wage rates

Low staff wage rates were the primary cause of these staffing vacancies, according to most interviewees. Interviewees often cited inflation as exacerbating the challenges caused by lower rates, particularly for IHSS and ALW programs. Lower wage rates mean the HCBS workforce is more vulnerable to competing labor markets. For example, many interviewees pointed to the cost-of-living adjustment increases for workers in SNFs as contributing to HCBS workforce retention issues (CANHR 2024). Several interviewees from provider agencies also referenced the fast food industry as a competitor for the HCBS workforce in both rural and urban regions, specifically citing the newly instated state minimum wage laws as an incentive for workers to choose jobs that have higher hourly wages, lower training requirements, and more predictable and stable hours (such as fast food restaurants). These jobs often pay a higher hourly wage, include more sick days or paid time off, and provide additional benefits such as retirement benefits. Other research has found that in 2023, the median hourly wages ranged from a low of $15.60 for home health and personal care aides to a high of $10.10 for certified nurse assistants (McConville et al. 2024). For IHSS in particular, representatives from the provider and waiver agencies Mathematica interviewed indicated that reimbursement rates significantly impeded IHSS services delivery, albeit with notable variations by county. Stakeholders and consumer listening session participants also raised similar concerns. Individuals in rural areas or those with complex health needs are aware that direct care workers can find jobs at a higher wage in other industries, leaving them constantly concerned about who will support and care for them in their homes. For IHSS in particular, the wage rate disparity from county to county may incentivize some IHSS workers to opt to deliver care in some counties over others, posing challenges to consumers in finding providers in their counties. In addition, the inability of providers to reimburse their workers for travel time to and from someone's home makes it challenging for provider agencies to serve members in remote areas.

3. Waitlists

As a result of staffing shortages, many provider agencies resort to waiting lists to manage their caseloads (separate from state-maintained 1915(c) waiver program waitlists).[70] Nearly all waiver management agencies (96.2 percent) reported maintaining a waitlist, compared to 34.5 percent of direct care service providers and 14.6 percent of residential settings providers. Waiver services (either combined or exclusively) reported the highest average number of clients on the waitlist (105.1 for waiver management only and 76.0 for direct care services and waiver management). For those providers that operate waitlists, the amount of time reported for an individual to move off the waitlist was 7.3 months on average, with waiver services taking the longest (8.3 months) and direct care services only being the shortest (5.5 months). Other providers reported during interviews that their waitlists were so long that they stopped maintaining them. For example, one representative of a CHLF with which Mathematica spoke said they decided to stop maintaining a waiting list, recognizing that demand was so high that if a bed opened up, it would not be difficult to fill.

4. Unmet needs

As a result of staffing shortages and waitlists, individuals in need of HCBS often experience significant unmet need. Provider survey findings showed that providers of direct care services reported having the highest number of clients they were unable to serve due to staff vacancies in the last six months. Although some provider and waiver agencies reported maintaining waitlists so that if their capacity changed, they could accept clients up to staff capacity. Interview respondents also mentioned other strategies to recruit and maintain their workforce. For example, a few providers Mathematica interviewed said they now institute "care minimums"—that is, they will not enroll or serve participants who need fewer than four hours of care at a time. One provider representative explained they now tell HCBS enrollees the available days and times during which they can provide care, instead of working within the participant's needs and preferences. They noted that asking a care provider to drive to only two locations a day is more attractive and palatable to the provider than switching locations multiple times per day. Although these strategies may help with workforce retention, they may also have an impact on the person-centered nature of high-quality care delivery.

Many interviewees, including advocacy organizations, expressed concern about the burdens on direct care workers that could negatively impact care delivery. A few of them explicitly cited large caseloads for social workers (examples ranged from 75 to 300 HCBS enrollees, depending on the program), and the provider survey pointed to similar outcomes on a larger scale.

One area of unmet need that emerged during consumer listening sessions was the need for respite and emergency respite care. Listening session participants noted challenges around the following: (1) receiving respite care at all, (2) receiving the minimum number of respite hours per month, and (3) receiving the full allotment of hours permitted by the waiver. These challenges seemed to be particularly serious for caregivers of individuals with the HCBS-DD waiver. Parents of adults with developmental disabilities receiving HCBS-DD waiver services noted particularly stressful experiences when attempting to secure

[70] These state-maintained 1915(c) waiver program waitlists are discussed in more detail in Chapter V.

emergency out-of-home respite care. It is important to note that emergency respite services are offered by regional centers, but the capacity of these centers to fulfill such requests can vary.

5. Reliance on contracting with outside providers

Providers sometimes contract with other providers to fill service gaps, but working through contracts can be challenging to manage and contracted providers are not always available, particularly in rural areas. As another strategy for addressing workforce challenges, waiver and provider agencies reported contracting out for needed services. However, waiver agencies also reported challenges in delivering contracted services in rural areas due to inadequate supply of available contracted providers. One waiver agency representative noted that respite, transportation, socialization programs, and in-home repairs as contracted services were particularly challenging to deliver. Both waiver and provider agency interviewees indicated the potential for a negative impact on the quality of care they deliver when relying heavily on contracted services. This challenge is especially difficult when considering that one waiver agency interviewee expressed the feeling that they were expected to provide services to support every activity in rural areas, even outside of their expected scope, such as an internal staff member doing yardwork for a client.

> "It's near impossible sometimes to find a vendor, one that also has the appropriate insurance, that has rates that we can afford. There's a lot of challenges to it. And the more rural the county, the more difficult."
>
> –Representative from a MSSP Site

6. Additional challenges for IHSS family caregivers

Challenges for family caregivers, particularly within IHSS, were common themes among stakeholder and consumer listening session participants. First, financial burden was a recurring theme. Although they had notable praise for IHSS, family caregivers noted confusion around the number of hours for which they could be paid. Some noted that because of their caregiving responsibilities, they were forced to reduce their hours dedicated to a different job, which had financial implications for their family. A few consumer listening session participants even noted that they had to use their personal income to supplement services that did not fully meet their needs, which exacerbated not receiving timely payments for IHSS providers. It was not clear from their comments whether the services referenced were authorized services eligible for payment through IHSS.

> "I understand that [payment] does take time, but…I'm behind on everything. I like to take my [care] recipient to the movies or to a park. Sometimes I can't even afford gas in my car because the payment is late."
>
> –Consumer listening session participant

V. Member Ability to Find and Obtain High-Quality Person-Centered Care

This section presents findings concerning barriers to HCBS access resulting from gaps in public awareness of Medi-Cal HCBS programs, confusing and uncoordinated eligibility and enrollment processes, and barriers for particular subgroups of Medi-Cal members that result in inequitable access and outcomes.

Box V.1. Key takeaways on member ability to find and obtain high-quality person-centered care

- The Medi-Cal HCBS system is fragmented, complex, and confusing for participants to navigate. Those in need of HCBS often do not know what programs are available to them in their community, and language and cultural differences can pose additional barriers to accessing HCBS.
- Complicated eligibility rules and criteria across HCBS programs sometimes lead Medi-Cal eligibility workers and health care providers to provide inaccurate information to members regarding HCBS programs with which they are less familiar.
- Inconsistent processes across HCBS programs—for example, different modes used for applications, waitlist procedures, and eligibility determination processes—can lead to differences in enrollment access for individuals seeking HCBS. In addition, even when they are determined eligible, individuals often experience delays between enrolling in an HCBS program and beginning to receive services. Interviewees said these challenges are particularly prevalent for people with cognitive impairment, behavioral health challenges, and high care needs.

A. Barriers in program awareness and confusing eligibility and enrollment processes

The HCBS system in California is fragmented, complex, and confusing for participants to navigate. Interviewees reported confusion on the part of those in need of HCBS, caused by nearly a dozen different HCBS programs in operation in California and no current universal assessment or "no wrong door" eligibility system for HCBS. Individuals may be referred to one program, but if they are not eligible, they may then be referred to another program, and the onus for navigating that system is on the Medi-Cal member. This piecemeal approach presents significant navigational challenges for consumers trying to apply to HCBS programs, thus hindering access to these services.[71] Separate applications on different websites for distinct programs act as a major barrier to enrolling in these programs. Furthermore, advocates also noted that the separation of eligibility processes for Medi-Cal and HCBS programs creates additional hurdles for individuals seeking assistance.

> "The people who are going to be harmed the most by these sort of siloed and disparate programs are going to be the people who are currently under resourced and underserved."
>
> –Representative from a legal advocacy organization

[71] One advocacy organization representative noted that even the use of different terminologies for these agencies (that is, care coordination agencies, lead organizations, waiver agencies, and others) further complicates individuals' ability to navigate this complex system.

"You have to have stamina, to be told to call one place and have that place tell you, you didn't call the right place, you need to call this place."

–Representative from a disability rights advocacy organization

Individuals often assume that staff members focused on one HCBS program, such as IHSS, will understand the eligibility requirements and services offered by another HCBS program, such as the HCBA waiver, which often is not the case.

The result of these siloes is a system that is complex for participants to navigate. Separate points of entry exist for each service, and each program is administered by different state and county agencies and has different application requirements. Interviewees were unaware of a centralized state resource that Medi-Cal members or their caretakers can call. A few counties and regions of the state have Aging and Disability Resource Connection (ADRC) agencies, which provide information about HCBS options and programs, as well as referrals, to all consumers, including Medi-Cal members or those who may be eligible for Medi-Cal. Although ADRCs are in development in several counties, many counties lack them. ADRCs must fulfill several requirements to achieve full ADRC designation, one of which is the ability to provide personalized assistance in completing Medi-Cal eligibility applications, but few ADRCs have met all of the requirements to become fully designated.[72]

Multiple program names and acronyms can also be confusing for participants, especially those with low incomes or low educational attainment, which might be especially true for IHSS enrollees with complex needs, as noted by a representative from one advocacy organization. The representative also noted that IHSS participants might be unaware they could apply or qualify for services such as waiver personal care services through the HCBA waiver, or meals on wheels. Additionally, many HCBS programs are not available in rural areas of the state.

"I need these services, but I have no idea where I can find them. Apart from references or recommendations from friends, I don't know whether there is an organization or resource place, which is more centralized, that you may be able to find such resources."

–Consumer listening session participant

Those in need of HCBS often do not know what programs are available to them in their community. Many interviewees said that individuals are often unaware of what HCBS programs are available. Some individuals may know of specific HCBS programs but not understand the full breadth of services or the differences between programs. For example, some people may know only about the more well-known HCBS programs, such as IHSS and the HCBA waiver, even if those programs are not best suited to meet a particular individual's needs. Without a

"We hear about barriers in terms of like, where to find the information? Where do I go to even see if I'm eligible for Medi-Cal? Once I'm eligible, how do I navigate the system or know which program is right for me?"

–Representative from a direct workforce advocacy organization

[72] See ADRC designation criteria here: https://aging.ca.gov/download.ashx?lE0rcNUV0zZnb2y%2bi4EbJw%3d%3d.

centralized assessment and eligibility system for HCBS access, individuals are often confused about how to access programs, navigate eligibility requirements, and enroll.

Many factors may be contributing to a lack of awareness of available services. A representative from one MSSP Site noted that they did a great deal of outreach for the MSSP program in their community; however, the individuals they can serve through MSSP often do not come to their events. Interviewees from several advocacy organizations noted that providers often do not tell individuals about the breadth of HCBS options—or that HCBS is even an option—when the individuals enroll in Medi-Cal. Other interviewees noted that individuals may be aware of services but do not believe they are eligible for them due to their income or living situation. A representative from a regional waiver agency noted that individuals are much more likely to be enrolled in HCBS programs if they have multiple touchpoints with health care or social service providers, particularly through Medi-Cal.

> "You know how they say, no wrong door [?] I feel like it's all wrong doors. Our Medi-Cal system is all wrong doors."
>
> –Representative from a legal support advocacy organization

> "I had different offices tell me, 'You can't have food stamps because you have IHSS. You can't have both of them.' It doesn't seem like anyone's on the same page, so it's hard to find out what's real and what's not."
>
> –Consumer listening session participant

Complicated eligibility rules and criteria across HCBS programs can lead Medi-Cal eligibility workers and health care providers to provide inaccurate information to consumers on programs with which they are less familiar. Successful enrollment in an HCBS program relies on accurate staff knowledge of nuanced eligibility criteria. Yet there is no centralized state system for confirming program eligibility criteria, leading to an overreliance on county social workers and local staff grasping the nuances of every HCBS program. Because of this fragmentation, DHCS staff noted that individuals often have a difficult time knowing whether one waiver program meets their needs better than another. Interviewees also said that health care professionals, such as nursing home discharge planners, community social workers, case managers, insurance companies, MCPs, and others, may be less knowledgeable about or lack detailed information on HCBS programs available in the community. As a result, Medi-Cal members who could benefit from HCBS may not be referred to these programs when they interact with or are discharged from hospitals and nursing homes. Interviewees stressed a strong need to raise awareness about these programs among health care providers in hospitals and SNFs. Additionally, a representative from one MSSP Site noted that health care providers who do know about HCBS programs may not have complete or up-to-date information on the differences between programs or services offered. This individual explained they often receive referrals for MSSP that should instead be for IHSS due to the participant's need for full-time care.

> "The fact that there isn't any clearly written, straightforward guidance that's broadly shared makes it difficult for professionals to give the right advice and to know what the facts are."
>
> –Representative from a long-term care advocacy organization

Many interviewees also said information on Medi-Cal eligibility from county social service departments who support Medi-Cal enrollment can be confusing and may lead individuals to believe incorrectly that they are not eligible for HCBS programs. A representative from one long-term care advocacy organization noted that often no "consumer-friendly" information exists about eligibility processes or criteria for HCBS programs, leading individuals to be confused about whether they qualify for programs. When consumers reach out to county social service departments or other help lines for support with Medi-Cal enrollment, they may receive inaccurate or incomplete information from staff who may lack training or be unfamiliar with all HCBS program options. One interviewee from an advocacy organization noted that Medi-Cal and IHSS workers may provide incomplete information to individuals about Medi-Cal eligibility—for example, by saying that an individual will bear a high share of the costs or be responsible for a monthly deductible—without considering circumstances that may reduce their share of costs, such as spousal impoverishment protections that allow individuals who are married or in registered domestic partnerships to receive Medi-Cal while protecting some of the income of their spouse or partner (see **Exhibit V.1**).

> "And I think maybe because there just aren't that many resources out [there], there's a lot of misinformation. People don't know what's good information and bad information. So they're just scared. So they don't apply."
>
> –Representative from a legal support advocacy organization

Interviewees often reported that consumers are deterred from applying for Medi-Cal due to incomplete or inaccurate information. For example, representatives from several advocacy organizations noted that individuals are afraid that Medi-Cal will take their home away if they enroll and subsequently die. This policy, known as "estate recovery," requires state Medicaid agencies to seek repayment for certain types of Medi-Cal services from the estates of some Medi-Cal members after they die. However, estate recovery is prohibited from the estate of a deceased Medi-Cal member who is survived by a spouse or registered domestic partner, and other limitations and exemptions also apply (see **Exhibit V.1**). Some individuals assume they will be contacted automatically about HCBS options after enrolling in Medi-Cal if they check the box asking about HCBS on the Medi-Cal application. Others do not realize they can access certain HCBS programs, such as IHSS, only after they enroll in Medi-Cal, which can delay eligibility determination. In addition, interviewees shared other misperceptions they had encountered, including about the length of waiting lists or the time it takes to receive services. Interviewees from several advocacy organizations explained that they have to prepare their clients with questions so they can receive accurate information, and encourage them to go to two or three information sources.

Language and cultural differences can pose barriers to accessing HCBS. Most eligibility and program information is offered in only a few languages. Many interviewees noted that this issue can be especially challenging for individuals who are monolingual in another language, or whose first language is not English; this point was corroborated during consumer listening sessions. At the time of this report, for example, the application for the HCBA waiver on the DHCS website[73] was available only in English, which a representative from one long-term care advocacy organization noted could dissuade individuals from applying because they do not think there will be a provider that can provide services in their language.

[73] https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-%28HCB%29-Alternatives-Waiver.aspx. Accessed June 14, 2024.

IHSS information is required to be in certain threshold languages only for the consumer, not the provider, who often completes enrollment for the client if the client has cognitive disabilities. Some counties, such as Los Angeles County, offer information in additional languages than the standard IHSS threshold languages, but not all do so; those decisions are up to each county's waiver agency or IHSS office. Other interviewees noted that waiver agencies might not have interpreters available—an additional barrier to receiving information about services.

Other cultural differences may dissuade individuals from seeking government assistance or accessing HCBS. Interviewees from two waiver agencies noted that many of their clients do not trust government programs, and mistrust can disincentivize them from seeking assistance for which they may be eligible. Other interviewees cited cultural differences that may prevent an individual from seeking services. For example, Medi-Cal members from some cultures may be reluctant to have a non-family member enter their home and provide care. Others may have had upsetting encounters with previous providers and thus be reluctant to re-engage with services. Individuals may also be unwilling to give up their current providers to join programs such as PACE.

Individuals often experience delays between enrolling in an HCBS program and beginning to receive services. These delays are largely driven by the eligibility determination process, which varies by program. Lengthy wait times before beginning to receive HCBS may impact the receipt of other supportive services, such as housing. Participants in consumer listening sessions also noted these delays and the frustration they felt while waiting for a decision to be made, as well as the many hoops through which they had to jump to get the services they needed. Many interviewees cited especially long delays in processing the HCBA waiver application and noted the lengthy backlogs. Interviewees reported that in their experience, the period for HCBA approval was typically 90 days or longer—double that of the Medi-Cal eligibility determination, which averages 30 to 45 days for approval. DHCS has only six nurses to process eligibility determinations for HCBA, which contributes to these delays. Additionally, HCBA waiver providers cannot provide services while waiting for the final eligibility determination, an especially challenging situation for individuals in crisis situations and needing emergency care planning.

> "The time it takes between identification and referral to actually participating in the HCBS program, that I would classify as one of the biggest barriers."
>
> –Representative from an MCP serving central California

Other waivers and programs experience similar delays in eligibility determination. For ALW, interviewees reported that it can take an average of two months for an individual to receive approval to receive services. Similarly, an interviewee noted that the CBAS program can have delays in the eligibility determination process of up to a month due to delays in scheduling face-to-face determinations or because of other factors, such as missing utilization information. Interviewees from advocacy organizations reported that the transition of CBAS into managed care has exacerbated this issue; as more individuals enroll in managed care, the MCPs need time to evaluate members' needs and connect them to services. One interviewee

> "For people with significant and emerging needs, that can be quite difficult, like the lag times and how long it takes for people to get services."
>
> –Representative from a legal advocacy organization

noted that MCPs sometimes deny CBAS referrals, which leads to individuals being removed from the program if they are unfamiliar with the grievance process (however, the interviewee did not indicate whether individuals in this scenario meet eligibility requirements). Interviewees reported similar issues among IHSS participants, with assessments often needing to be extended due to delays in an individual getting a nursing determination or housing, which are needed to determine eligibility. Additionally, though IHSS has a retroactivity requirement, which means that individuals are eligible to start services the day they apply, the provider does not get paid for up to four months while the eligibility determination and enrollment are being finalized. As a result, individuals can wait months to receive services until their IHSS providers will begin to be reimbursed by Medi-Cal, unless the individual is able to pay for services out of pocket during the window. Interviewees noted that the MSSP waiver currently has few delays regarding eligibility determination; however, many interviewees were concerned that transitioning the level-of-care determination to the state would add delays in the future.

Inconsistent processes across programs and geographic areas can also lead to differences in access for individuals seeking HCBS. Several key examples of this concern were discussed in the qualitative interviews:

- Waiver agencies that have waiting lists may not refer an individual to a different agency that does not have a waitlist—so when an individual reaches out to a specific agency with a waiting list, it may result in a dead end for that individual if the agency does not refer them to another agency.
- Counties charged with IHSS administration have different modes of application (for example, some county offices allow for IHSS applications online or by fax, whereas others require a phone call). In addition, county social workers may or may not also refer individuals to waiver agencies, and these county differences may lead to inequities in HCBS access.
- Misinformation about waitlist length for various waiver programs is rampant in some areas of the state, which can prevent individuals from even applying to these programs.
- Requirements for the provision of program information in threshold languages are not well enforced, which means that providers in areas with a significant representation of certain linguistic groups may not provide adequate information to those individuals.

These administrative complexities mean that individuals who can best navigate the system and successfully enroll in an HCBS waiver program are likely to be higher income, more educated, and English speaking, leaving other groups vulnerable to inequities in access, as discussed previously.

Interviewees discussed broader challenges with enrolling in Medi-Cal, which can impact older adults and people with disabilities who may become newly eligible for Medi-Cal around the same time they need to access HCBS. Interviewees noted that it can be unclear where to find accurate information about Medi-Cal financial eligibility, and many eligibility workers lack a complete understanding of how financial eligibility requirements for Medi-Cal may be different for older

> "People with disabilities want to be included and part of life like anyone else would want. The system of care is not set up in a way that allows for easy access to find out what's available to help us live independently. It's sad."
>
> –Consumer listening session participant

adults and people with disabilities, as well as how they differ across different HCBS programs. Participants in consumer listening sessions fundamentally understood that Medi-Cal eligibility is based on income but struggled to understand how just a small amount of income over the threshold would mean an individual who needs services would be unable to receive them. Interviewees shared that significant confusion and misinformation exists about share-of-cost rules, spousal impoverishment protections, institutional deeming, and estate recovery. All of these terms are defined in **Exhibit V.1**.

Exhibit V.1. Definitions for key Medi-Cal financial eligibility policies and processes

Financial eligibility policy or process	Description
Share of cost	Share of cost is a monthly deductible that some Medi-Cal members must pay toward the cost of their services for that month. It is required for people who make above the income limit for free Medi-Cal and is calculated based on an individual's income above the monthly "maintenance need" for their household size.[74]
Spousal impoverishment protections	Spousal impoverishment protections are Medi-Cal rules that allow individuals who are married or in registered domestic partnerships to receive Medi-Cal while protecting some of the income of their spouse or partner. These protections allow the spouse or partner who does not need Medi-Cal-funded HCBS (the "well spouse") to keep additional income without having to contribute all of it to share of cost.
Institutional deeming	Institutional deeming is a way of assessing someone's financial eligibility by considering only their personal income and resources while ignoring the income and resources of their parents (for children under 18) or their spouse (for married individuals). It allows a person to enroll in an HCBS program (such as HCBA and HCBS-DD) if they would otherwise be found ineligible due to their parents' or spouse's income.
Estate recovery	Estate recovery refers to the policy under which the Medi-Cal program may seek repayment for certain types of Medi-Cal services from the estates of some Medi-Cal members after they die. Estate recovery is prohibited for the estate of a deceased Medi-Cal member survived by a spouse or registered domestic partner; other limitations and exemptions also apply.[75]

Interviewees shared several examples of confusion around—or misapplication of—these financial eligibility policies and processes, which creates barriers to enrollment in HCBS programs:

- Some interviewees noted that IHSS eligibility workers sometimes overstated share-of-cost payments for prospective enrollees because enrollees did not ask about specific financial eligibility policies that could lower or eliminate their share of cost. As a result, individuals may be dissuaded from enrolling in Medi-Cal because they believe they will have unaffordable monthly payments. Inaccurate share-of-cost calculations have additional implications for ALW, which excludes individuals from enrollment if they are responsible for a share of cost. Interviewees described a lack of knowledge among some IHSS eligibility workers about spousal impoverishment rules, noting that requests for spousal impoverishment protection were often processed incorrectly and denied inappropriately.

[74] DHCS recently increased the maintenance need amount for medically needy individuals. This change will go into effect on January 1, 2025: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/23-31.pdf. However, this change will not affect how share of cost is calculated for long-term care Medi-Cal.

[75] Medi-Cal's Estate Recovery policy is described here: https://www.dhcs.ca.gov/services/Pages/TPLRD_ER_cont.aspx.

- Interviewees described inconsistent application of institutional deeming as another barrier. One staff member at DHCS noted that waiver agencies often assess income differently. Also, waiver agencies, Medi-Cal county offices, and MCPs often have little coordination on eligibility determinations, thus leaving prospective enrollees confused as to whether they meet financial eligibility criteria for a program under institutional deeming rules. This interviewee noted that incorrect denials based on institutional deeming rules by Medi-Cal county offices can prevent eligible individuals from enrolling in waivers and accessing needed services.
- Interviewees noted that many prospective enrollees are hesitant to enroll in or even apply for Medi-Cal due to fears about Medi-Cal estate recovery. Although this concern is valid, it does not apply to everyone, so it is important that Medi-Cal and HCBS eligibility workers explain it fully and accurately. One waiver agency noted they often encountered estate recovery hesitancy around their MSSP program and explained that although they want to help individuals understand the rules better, they themselves felt they did not understand all of the nuances and were not comfortable counseling potential enrollees on the topic. Overall, a lack of oversight and adequate training leads many individuals to receive faulty information about Medi-Cal eligibility.

> "And people literally think Medi-Cal will take their home if they apply, or once their family member dies Medi-Cal will take their home. So that's a big barrier."
>
> –Representative from a legal advocacy organization

In addition to confusion about financial eligibility criteria, the Medi-Cal redetermination process has emerged as an additional barrier that can impact enrollees' eligibility for HCBS programs because they lose access to HCBS if they are removed from the Medi-Cal program. This problem became a particular challenge when Medi-Cal redeterminations began again at the end of the public health emergency. In addition, individuals often miss the notification for their eligibility redetermination. A staff member from DHCS's Managed Care Quality and Monitoring Division also noted that it can sometimes be difficult to find accurate contact information so individuals can complete the redetermination process.

B. Barriers to receiving timely services

Many HCBS waivers have state-maintained waitlists to receive services, including HCBA, ALW, and MSSP, which can lead to delays between enrollment and receipt of services. Because few people remove themselves from waitlists, they can be lengthy, with many individuals waiting to enroll in these programs for months or years. Interviewees noted a lack of transparency as to where someone falls on the waitlist. Interviewees also noted that these criteria may not prioritize those who would most benefit from services. For example, the HCBA waitlist—which recently reached its limit—prioritizes the enrollment of children, who can otherwise access needed services and supports via the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit under Medi-Cal.[76] As a result, many adults with disabilities cannot access needed services—like waiver personal care services—available to them only under the HCBA waiver. One interviewee noted that one of the drivers for the long HCBA waitlist may be a lack of awareness among applicants that their needs can be met by the services offered under other HCBS

[76] EPSDT is a federal mandate that requires states to provide all medically necessary services to their Medicaid enrollees under age 21.

programs, such as MSSP. Although additional waiver spots recently were added to both ALW and HCBA, individuals still move off the waitlist slowly because of limited provider availability and capacity to serve enrollees.

Once individuals enroll in HCBS programs, they experience additional barriers to accessing services. The providers Mathematica interviewed and surveyed indicated that the high demand for services has resulted in providers maintaining their own waitlists. One interviewee noted, for example, that each MSSP site may have its own waitlist. As a result, once an individual is determined eligible for MSSP and receives a slot on the waiver, they may still have to wait before they can access the services they need. Another interviewee noted that many HHAs have difficulty finding nurses and as a result will not authorize services for eligible individuals.

For individuals residing in institutional settings, several administrative timelines often must align so they can successfully enroll in and receive services through HCBS programs that allow them to transition back to the community. For example, individuals seeking to transition from nursing facility settings back to the community can wait several months for a CCT application approval, during which time they may lose access to community housing. Individuals trying to enroll in IHSS may also encounter issues; even if they have housing to which they can relocate, delays in IHSS assessment can last several months and affect the individual's ability to return home safely. In general, interviewees commented that unpredictability and the lack of alignment of anticipated timelines and workflows of the various components of the application and assessment processes affects individuals' ability to access HCBS.

Upon final eligibility and enrollment determination, many interviewees cited additional barriers to participants receiving adequate services, particularly in IHSS. Interviewees noted that IHSS workers often do not share the breadth of services available when completing their assessments, which may lead participants to understate their needs. Additionally, although IHSS workers use the same assessment tools, some subjectivity exists in interpreting the results and needed hours, which can lead to variability in the participant experience in IHSS. Interviewees noted that some counties have advocates who work with IHSS participants to receive more hours; however, other counties do not have these advocate resources.

Individuals noted another barrier to IHSS—that the IHSS program cannot provide services to individuals who are homeless or unsheltered, often the group with some of the greatest needs for personal care services. One interviewee also noted that some IHSS workers may be hesitant or refuse to do IHSS assessments in shelter settings.

Some Medi-Cal members eligible for IHSS experience challenges in identifying and managing personal care attendants. IHSS was designed to allow participants to self-direct their personal care assistance to give them control over who provides these services. However, several interviewees cited challenges for a small proportion of participants to find and manage their providers. One interviewee stated that the inability to manage

> "It doesn't work for everybody. And I see especially with my older clients, it's very hard for them to find a provider, hire a provider, train a provider, manage a provider, fire a provider, when they have no experience doing so. And if they have a cognitive impairment on top of that, it can be almost impossible to do. People are very vulnerable to abuse in that situation."
>
> -- Representative from a legal support advocacy organization in Los Angeles

the responsibilities associated with self-direction can act as a disincentive to attempting to enroll in IHSS at all. Another interviewee suggested that county social service agencies and public authorities could provide more support to individuals who cannot manage the recruitment and hiring process by themselves. Interviewees also described challenges in contacting the local IHSS agency staff, who often provide only the agency phone number, leaving clients waiting on the line for hours, and doing an in-person visit only once a year. This situation is difficult for clients attempting to communicate with their IHSS social worker about a reassessment or request for increased levels of care.

Environmental and physical safety concerns can affect the ability of Medi-Cal members to receive HCBS. Natural disasters, such as snowstorms, mudslides, earthquakes, and wildfires impede service delivery in all areas of the state but have a particularly adverse effect in rural areas (see accompanying quotation). Although providers sometimes provide overnight hotel accommodations in emergency situations, the HCBS workforce experiences a significant time commitment and burden when using this tactic. In urban areas with higher crime rates, a few providers noted that providers are concerned about their personal safety, as well as the security of their personal belongings—such as their car—while providing services in these areas. One provider noted she was actively working with the city to try to secure safe parking for her staff so they would feel comfortable delivering services in a housing complex where a large number of people needing care reside.

> "The geographical location can be a challenge. I'm just thinking how rural some of our clients live…[We have] a client that's on MSSP that lives in a rural location and then lives a mile out on a dirt road. And that dirt road is a precarious travel. It's a steep hill and it's not necessarily even safe for cars. So, he's lucky he has a caregiver, but that's a very precarious relationship. Where would he ever find a second caregiver? It would just be really bad news [if he lost that caregiver].
>
> –Representative from a regional waiver agency

Finally, lack of accessible transportation can be a significant barrier to accessing services. When members must travel for services—for example, to an adult day center or a rehabilitation facility to receive the services they need—waiver agency interviewees described distance and lack of transportation as a significant barrier to accessing these services. Poor road conditions contribute to making transportation of an hour or more to a center or facility quite difficult for individuals with high care needs.

Quantitative data also suggest barriers to accessing services in certain HCBS programs, including MSSP and HCBA. Using 2017 to 2021 Medi-Cal claims and enrollment data, Mathematica examined the number of members who had (1) both claims for services and the corresponding HCBS enrollment flag for each program, (2) HCBS enrollment flags but no corresponding claim for services, and (3) claims for services but no corresponding HCBS enrollment flag. Large discrepancies between program-specific service claims and enrollment flags might indicate either missing data or data anomalies, that some members experience a lag between program enrollment and receiving services, or members enrolled in a program are unable to access services.[77]

[77] In some cases in which a member has a claim but no corresponding HCBS enrollment flag, certain procedure codes allowed under the program can be used for other Medi-Cal members, so those procedure codes may not uniquely

Based on the analysis, about half of the people who had MSSP enrollment flags in 2017 to 2021 did not have claims for MSSP services, and between 10 to 26 percent of people who had HCBA enrollment flags in 2017 to 2021 did not have claims for HCBA services (**Exhibits V.2** and **V.3**). These findings suggest either missing data, which limits the ability to monitor service use patterns, or access issues for MSSP and HCBA participants. A small proportion of members enrolled in IHSS, CBAS, and ALW did not have claims for the respective programs, suggesting fewer issues with access to services for these programs relative to MSSP and HCBA.[78]

Exhibit V.2. Number of unique HCBS enrollees by year and program, calendar years 2017–2021

Program	2017	2018	2019	2020	2021	Percentage change (2017–2021)
Members who had claims and the corresponding HCBS enrollment flag						
IHSS	616,641	639,887	663,701	673,196	696,229	13%
CBAS	35,730	38,103	38,228	40,841	45,220	27%
HCBA	2,147	2,112	2,237	2,403	2,517	17%
ALW	4,314	4,270	5,232	6,122	7,117	65%
MSSP	5,298	5,196	5,280	5,050	5,000	-6%
Members who had HCBS enrollment flags but no corresponding claims						
IHSS	0	0	0	0	0	0%
CBAS	1,471	868	1,453	2,517	2,611	78%
HCBA	1,434	1,474	2,368	3,649	4,661	225%
ALW	243	42	38	60	118	-51%
MSSP	5,300	5,286	5,353	5,246	5,073	-4%
Members who had claims but no corresponding HCBS enrollment flag[a]						
IHSS	33,382	30,362	25,670	21,643	14,773	-56%
CBAS	5,139	4,618	5,383	1,435	1,442	-72%
HCBA	10,223	9,491	11,669	10,578	10,990	8%
ALW	1,520	1,388	1,729	2,023	2,391	57%
MSSP	258	256	229	268	353	37%

Source: Medi-Cal claims data and data on LTSS flags from calendar years 2017–2021.

Note: Appendix B.3 includes methods for identifying relevant LTSS claims. Data on service use were not available for PACE or CCT users.

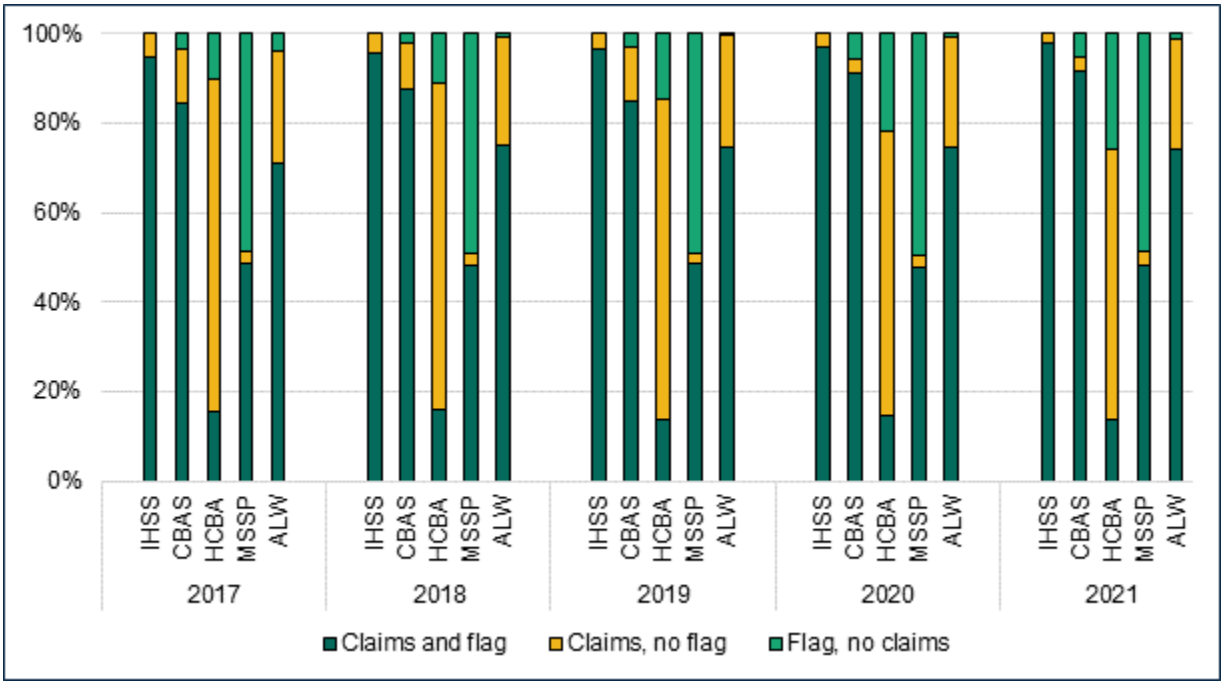
[a] This group could reflect use of procedure codes for programs other than the HCBS program for which the list of procedure codes was identified. For example, HCBA includes a procedure code for case management services; this procedure code might be used for programs other than HCBA, but Mathematica was unable to distinguish this situation using the claim.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; HCBS = home and community-based services; IHSS = in-home supportive services; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care.

distinguish respective HCBS program use. For example, the HCBA waiver includes a case management procedure code that may also be used for non-HCBA waiver enrollees.

[78] Data on service use were not available for PACE or CCT users.

Exhibit V.3. Percentage of Medi-Cal members with and without HCBS claims and corresponding enrollment flags



Source: Medi-Cal claims data and data on LTSS flags from calendar years 2017–2021.

Note: Appendix B.3 includes methods for identifying relevant HCBS claims. Data on service use were not available for PACE or CCT users. The group with claims but no program flag could reflect use of procedure codes for programs other than the HCBS program for which the list of procedure codes was identified. For example, HCBA includes a procedure code for case management services; this procedure code might be used for programs other than HCBA, but Mathematica was unable to distinguish this situation from the claim.

ALW = Assisted Living Waiver; CBAS = community-based adult services; CCT = California Community Transitions; HCBA = Home and Community-Based Alternatives Waiver; HCBS = home and community-based services; IHSS = in-home supportive services; MSSP = Multipurpose Senior Services Program; PACE = Program of All-Inclusive Care.

C. Barriers among subgroups

People with cognitive impairment, behavioral health needs, and high care needs face additional barriers finding and navigating services. Multiple interviewees noted that people with significant cognitive impairments or behavioral health needs experience unique barriers accessing and receiving services. A few interviewees partially attributed this challenge to the fact that some providers do not want to work with clients who have behavioral health needs because of the additional time required to serve them, which can exacerbate their workforce shortage. Interviewees reported that challenges accessing services are particularly salient for individuals with cognitive impairments, including but not limited to dementia, who do not have a family caregiver or other caregiving supports. An advocacy organization interviewee reported that the maximum amount of care provided under the IHSS waiver is still too low to meet the care needs of an aging person with dementia, requiring them to look for additional care through other avenues, such as the HCBA waiver. Additionally, challenges exist in trying to apply a "one size fits all" approach when it comes to providing HCBS for this unique population.

> "One of the biggest gaps [in services] is that we do serve a large number of high-functioning individuals, but we [also] serve individuals across the spectrum—from low functioning to high functioning. It is very difficult to apply the same kind of standards of services to the entire spectrum of people."
>
> –Consumer listening session participant (regional center provider for the HCBS-DD waiver)

A significant number of interviewees touched on the challenges that individuals with mental health needs or substance use disorders face when accessing and receiving services. A waiver agency and an advocacy organization interviewee both noted that they see increasing numbers of HCBS clients with significant or chronic mental health conditions. Additionally, individuals with significant mental health conditions may experience barriers accessing services in person at an office or center.

> "I think the other big driver is mental health issues, that we're seeing more and more clients with pretty significant mental health needs. And I don't know why that is, but we have seen that over the last 10 years or so. That's really changed."

A few interviewees also observed that individuals with high care needs in general experience additional challenges finding a provider and receiving services, with the long delays being especially harmful due to their high care needs. One representative from a waiver organization reported seeing increasing numbers of clients with higher acuity and higher care needs in the MSSP waiver over the last 10 years.

> "It's people who have maxed out their IHSS hours and need additional care hours…that [the] waiver should be serving…individuals who are meeting that level of care, who are experiencing homelessness, and people who don't have family caregivers and have dementia….Those two groups are at very high risk of…institutional placement or really negative health outcomes…they tend to be a higher proportion of individuals of color, particularly Black and Latino individuals. So, I think if you're going to look at like a racial disparity, that's where I would start."
>
> –Representative from a legal advocacy organization

One representative from an advocacy organization explained that gaps in care for individuals with complex needs in IHSS also overlapped with specific racial and ethnic populations.

People with limited family support lack the resources to successfully navigate the system. Interviewees reported more barriers to access faced by individuals who live alone or do not have someone to help them navigate the system. Many individuals engaging with the system need someone to advocate for them with Medi-Cal and HCBS program eligibility systems and providers. A few interviewees specifically referenced a lack of support for individuals experiencing transitions when their family caregiver or proxy dies without establishing a care plan or designating a new proxy. One provider described an individual whose parent and caretaker passed away, leaving their Social Security benefits to them. However, because of the extra income, the client lost Medi-Cal eligibility; with no available proxy to navigate re-enrollment or the complex eligibility criteria, the provider was no longer able to provide necessary services for the individual.

> "If they have high care needs…that requires skilled, you know, some type of skilled care and they're largely isolated, like if they don't have family members or friends, like a good circle of support, that's going to be the toughest person to serve."
>
> –Staff at DHCS

Housing issues and instability can further complicate the experience of accessing services. Multiple interviewees outlined the significant barriers they face providing services for clients experiencing housing instability due to a lack of affordable and accessible housing. In California, adults age 50 and older make up the fastest growing group of newly homeless individuals (CHCF 2023). Multiple programs, such as PACE, have eligibility criteria requiring clients to have stable housing, making it difficult to provide services for some people who often have significant levels of need. One waiver agency staff person noted that although they are unable to enroll and begin providing services for people who apply while experiencing homelessness, they are at times able to continue serving individuals who become homeless after enrolling. This interviewee also highlighted the difficulty of finding affordable, accessible housing for people transitioning out of facilities, which leads to delays in transitioning to HCBS.

For older adults and people with disabilities trying to age in place and maintain their housing, an advocacy organization described how a few years ago, some HCBA waiver agencies partnered with housing-related providers to educate people about the HCBA program to mitigate the risk of maintaining current housing without existing adequate supportive services. Although this effort was successful, it created the new challenge of a higher number of organizations referring people to the HCBA waiver, leading to its quickly hitting its enrollment cap.

Language and cultural differences between participants and providers create barriers to receiving services and culturally competent care. Nearly every interviewee emphasized language as a crucial barrier to enrollment and service delivery, especially due to a lack of translated application or outreach materials. Interviewees noted less awareness of and more misinformation in multicultural or immigrant communities surrounding what services

> "And it's in some cultures, it's not acceptable to get help from someone that you don't know or someone that's not a family member."
>
> –Representative from MCP serving central California

individuals are eligible for, with a few specifically mentioning Spanish-speaking communities in California. Part of this issue may stem from views of different cultures toward receiving in-home support, with some seeing it as more an individual responsibility and thus discouraging access to HCBS or LTSS programs. One interviewee from an advocacy organization even described reports they had heard in rural areas indicating that the IHSS social workers shamed and discouraged people from accessing services to support their aging family members.

Although interviewees from waiver agencies are responsible for providing interpreters, they noted that increasing costs for such services make it impossible to pay for interpreters at all hours of care. Rather, waiver and provider agencies often resort to having family members act as translators, as well as emphasizing diversity in hiring their staff members to potentially assist in translation. Although a few interviewees from advocacy organizations described being willing to translate documents for individuals enrolling in services, they mentioned restrictions on unofficial translations of state documents, limiting their ability to support clients who reach out to them for additional language support. Barriers related to language access are especially common for individuals who speak languages not designated by DHCS as threshold languages; few translated materials are available in these other languages.

> "But I mean, it's hard because if somebody's providing care for four hours, you can't provide an interpreter. It's just cost prohibiting. And so, sometimes it's just the language can't be accommodated and sometimes it's the family [that] has to step in because the family may speak English and then the family becomes the go-between, between the provider and the client."
>
> –Representative from a regional waiver agency

> "A lot of times there's a mismatch between languages spoken. Let's say we'll have a Mandarin-only-speaking client. We can't find a Mandarin-speaking respite provider, let's say. Or we'll have, for personal care, an elderly woman that only wants a female caregiver of the same race. That may not be possible. It's just the labor pool that we have with a particular vendor. We can't always accommodate people's choice of who provides the care for them."
>
> –Representative from a regional waiver agency

Language barriers also exist for agencies and providers. Interviewees from provider organizations reported difficulty understanding the needs of their clients without adequate interpreters, as well as what services they may be receiving. A few interviewees noted that a lack of translated materials also presents barriers for providers who may not speak English well, limiting their ability to provide services and navigate the legal and administrative systems required to provide care.

Clients often prefer that their provider or caregiver be of a specific race, ethnicity, or gender to align with their own background. Although providers and waiver agencies would like to accommodate such requests, they say it is often difficult to do so when providers already are struggling with recruiting and maintaining a sufficient workforce. This lack of accommodation may discourage individuals from accessing services if their preferences cannot be met.

Other subgroups experience various difficulties with the system. A few interviewees also reported challenges that individuals and families with lower educational attainment, lower literacy levels, or lower income face while enrolling in HCBS programs, navigating the system, and coordinating services. This

challenge is due in part to the complexity of navigating the system and the time required to do so. One interviewee from an advocacy organization noted that most of their clients have enough education to know how and when to reach out for additional support, whereas families with less education may not be aware they can request additional support from legal aid or other advocacy organizations.

A few interviewees also specifically mentioned challenges they face providing services for individuals experiencing significant transitions in care. They include foster youth aging out of services they may have been receiving for a long time, as well as the justice-involved population transitioning in and out of the justice system. One MCP interviewee described how justice-involved clients are often less willing to participate in services, either pre- or post-release. An advocacy organization representative reported that a new justice-involved initiative aimed at providing people with Medi-Cal services 90 days pre-release largely excluded HCBS, potentially contributing to the lack of access to services for justice-involved individuals.[79]

> "While it's relatively new to us, the justice-involved population is already proving to be a challenge. And I say that because in at least a very few instances that I, worked on in Stanislaus County or in LA county, the new member is certainly eligible for services, but they're unwilling to participate in either pre-release or post-release services."
>
> –Representative from a legal advocacy organization

[79] For more information on the Justice-Involved initiative, see https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/home.aspx.

VI. Program Administration and Operations

This section presents findings related to policy and program administrative challenges that inhibit access to HCBS, including the following: (1) barriers in data and information sharing between state agencies and among HCBS providers in the system, and (2) key operational challenges in conducting care assessments and billing infrastructure and processes.

Box VI.1. Key takeaways on program administration and operations

- DHCS delegates primary administrative responsibility to other CalHHS departments for several HCBS programs, which limits DHCS's ability to effectively oversee the Medi-Cal LTSS system as a whole. The decentralized administration of these programs creates challenges in tracking service use and outcomes across the continuum of services and programs at the individual level.
- Sharing of data and information between provider and HCBS waiver agencies and MCPs operating in the HCBS system is also limited at present, but the planned integration of certain HCBS programs into a managed care delivery system could alleviate some of these challenges.
- Beyond data and information sharing, additional operational challenges exist in administering HCBS programs:
  - The processes for conducting level-of-care assessments vary across HCBS programs, which creates inefficiencies and inequities in HCBS access.
  - Several challenges exist in the Medi-Cal billing infrastructure and processes, particularly for smaller providers, stemming from different guidance for billing across programs that are left to the provider to reconcile.

A. Intricacies of data and information sharing

1. Challenges in interagency coordination and data sharing at CalHHS

For many of California's Medi-Cal HCBS programs, DHCS delegates primary administrative responsibility to another department within CalHHS, with DHCS providing supporting functions. Although DHCS is ultimately accountable for all of the services delivered under Medi-Cal, federal rules allow state Medicaid agencies to delegate administrative authority to other agencies for HCBS program administration and oversight. In California, IHSS is administered by the California Department of Social Services; CBAS includes a partnership between DHCS, the Department of Public Health, and the Department of Aging; and MSSP is administered by the Department of Aging. Data on participants, services, and assessments are often collected and stored by the primary operating state agency, not DHCS.

> "We need the full data sets… the hard part about that is that it requires a whole bunch of teams and silos working in concert from the vision to the execution of getting that data in place, but we're able to do it if we have a map."
>
> –Staff at DHCS

This arrangement, in which sister agencies lead implementation and data collection for various HCBS programs, hinders DHCS' ability to effectively oversee the Medi-Cal LTSS system as a whole. Specifically, it has created silos for enrollment, service delivery, and data collection, making it difficult and time consuming to monitor service use, quality, and outcomes. Interviews with DHCS staff with roles related to data access,

systems, and linkages indicated that data quality and availability vary by operating agency and data source. Further, DHCS must execute data-sharing agreements with sister agencies to access data, a process that can take many months and must be repeated for each new data source or file.

For example, DHCS does not currently have access to case management data for HCBS waivers administered by sister agencies, and the administrative requirements for obtaining such access would be time intensive. The tools and systems used for collecting and storing case management data vary between HCBS waivers, with some using electronic systems and others using paper records. These differences in data collection and storage processes across state agencies also create variation in data quality and comparability for quality improvement purposes.

The decentralized administration of Medi-Cal HCBS programs at the state level makes it difficult for DHCS to track service use and outcomes across the continuum of services and programs at the individual level. When data about care plans and needs assessments sit across at least four different CalHHS agencies, it is difficult to conduct oversight of Medi-Cal LTSS as a whole, particularly as Medi-Cal members make transitions between institutional and community-based settings or move between different HCBS programs as their needs evolve. Particularly burdensome are gathering and linking data for all people served by Medi-Cal HCBS programs and analyzing service use for benefits covered by Medicare for the nearly two-thirds of Medi-Cal HCBS enrollees dually eligible for Medi-Cal and Medicare, subjecting these processes to delays and missing information when data files are pulled by different agencies. This process is further complicated by certain services like nursing facility services being delivered by MCPs and relying on encounter data submitted by those plans.

The transition of several HCBS programs into a managed care delivery system may also be an opportunity to address some of these design issues that could allow DHCS to better oversee the full range of acute care and LTSS used by HCBS enrollees. However, DHCS staff noted during interviews that they would experience challenges obtaining needed data from MCPs and providers to calculate quality measures—including those in the HCBS Quality Measure Set that California will be required to report to the Centers for Medicare & Medicaid Services in future years—given the lack of uniform data collection among plans and providers.

2. Data and information sharing among providers, waiver agencies, and MCPs

According to representatives from provider and waiver agencies and MCPs operating in the HCBS system, sharing of data and information between these parties is often limited. Representatives from MCPs suggested that inadequate provider infrastructure was the main barrier to information exchange; to share data securely with the plans, provider agencies would need to build more robust IT systems, hire staff to maintain these systems, and have ongoing capacity to use these systems correctly—investments providers are not always able to make. One representative for an MCP felt that provider agencies were not willing to share information with the plan because DHCS currently did not mandate it. Instead, if an issue arose with specific members, providers

> "Sharing information is challenging and building the IT infrastructure to share data securely is challenging, and dedicating resources to collect and share data…it's hard."
>
> –Representative from MCP serving central CA

would reach out to that plan to share the information needed to resolve the issue, but such exchanges were rarely proactive.

Because data and information sharing does not occur regularly across most providers and MCPs and there is no centralized data system, providers and waiver agencies reported that they are not always aware of the other programs in which an individual may be enrolled. Representatives from MCPs corroborated this challenge, stating it is hard to know what services people are receiving or which HCBS programs they are enrolled in without access to a common information system or health information exchange, or a closed-loop referral system.[80]

> "There are different systems at different stages of people's lives in the Medi-Cal program and those systems aren't always talking to each other, and we don't really have robust policies in place to force those systems to talk to each other."
>
> –Staff at DHCS

For example, when an MCP refers someone for services, it is rare for the plan to receive an update that the member did in fact receive those services; doing so would require providers to acknowledge the referral and record the result, which then would be communicated back to the plan in a closed-loop referral system. "Systems are so compartmentalized, one system does not know what the other system is doing," one advocate noted. Moving more HCBS programs into a managed care delivery system may help to reduce gaps in information about all of the services and programs a Medi-Cal member is receiving, but the MCP will still need to facilitate coordination across providers to ensure the member is receiving services that meet their needs.

For the few providers and MCPs that have implemented some form of data exchange, the process is often quite labor intensive. Electronic portals that providers can access to facilitate this process are rare, which results in manual forms of data exchange. For example, interviewees from one plan related a case in which they had to call a provider agency and ask them to plug in their fax machine so the plan could send over the needed information. However, one MCP representative noted the MCP is making efforts to improve the timeliness and quality of data and information it exchanges with providers.

A key issue that one interviewee highlighted was the lack of a comprehensive resource directory, provider registry, or database that could be used by provider agencies, consumers, social workers, health plans, and medical providers. Such a registry would allow everyone to review a full list of licensed provider agencies by program in each county or region, which would facilitate information sharing and referral. Closed-loop referral systems like those being used in Arizona, Tennessee, and other states depend on creating and maintaining accurate resource directories.

Finally, representatives from many providers and waiver agencies believe that DHCS does not consistently share information on updated rules or programs. For example, interviewees felt the MSSP

[80] A closed-loop referral system is an information platform that allows plans and providers to identify community resources, make electronic referrals, and track outcomes. As part of CalAIM's Population Health Management program, starting in 2025, Medi-Cal MCPs will be required to refer their members to community resources and follow up to ensure the services are delivered (that is, close the referral loop). The community organizations include county social service agencies and waiver agencies for IHSS and other HCBS. For more information, please see: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide-August-Update081723.pdf.

and ALW procedure manuals included confusing guidance on topics like eligibility and contracting with other outside providers. Other providers expressed feeling overwhelmed by the number of notifications of programmatic changes and updates, as each group within DHCS releases a different set of policy letters, which are not easily searchable on the DHCS website.[81] Interviewees felt this system of updates makes it difficult to fully understand policy and programmatic changes.

3. Integration of HCBS programs into managed care

In addition to improving state oversight mechanisms, the integration of several HCBS programs into a managed care delivery system may also enhance data and information sharing among HCBS providers and MCPs to address some of the concerns highlighted above. **Box VI.2** contains more detail on current provider and MCP care data and information-sharing capacities; opportunities for improvements and efficiencies under a managed care delivery system will be discussed in the Roadmap.

Box VI.2. Upcoming managed care transition

Although the current Medi-Cal HCBS programmatic design creates challenges for DHCS, providers, waiver agencies, MCPs, and HCBS enrollees, DHCS's plans to transition Medi-Cal HCBS programs into managed care allows for some opportunities to centralize oversight and more consistently exchange data.

Interviews with providers and MCPs on care coordination and integration indicated that there will be additional considerations regarding how to effectively carve HCBS programs into managed care:

- **Data sharing and platforms.** Provider and MCP representatives indicated variation and challenges in sharing data, including care management data, between providers, MCPs, and DHCS. Among these challenges is the fact that programs use different platforms to store and exchange data. Although DHCS is considering whether to transition more Medi-Cal HCBS programs to the MedCompass platform (currently used in the HCBA waiver), providers—especially smaller and lower-resourced ones—would need adequate training and support to adopt this system. Furthermore, the transition to managed care could result in providers being asked to use different care management platforms for each plan.
- **Agreements between providers and MCPs.** Some HCBS providers and managed care plans have entered into provider network agreements with one another as some providers have begun offering Enhanced Care Management or Community Supports. However, both providers and plans shared the challenges entering into these types of agreements, which will be a necessary component of carving HCBS programs into managed care. Providers emphasized the need for structured support from counties to assist rate negotiations between providers and MCPs, as the lack of this type of support has the potential to further weaken provider networks in areas where they lack the capacity, resources, or expertise to navigate lengthy rate negotiations. MCPs emphasized the need for capacity-building among providers, who may lack experience entering into provider network contracts. The Incentive Payment Program (IPP) provides a total of $1.5 billion in incentive funds to MCPs to improve member engagement and service delivery, build sustainable infrastructure and capacity, and foster equitable access.[82] Providing Access and Transforming Health (PATH) funding may also be used to build capacity among community-based organizations, public hospitals, and county agencies.[83] While these funds may be used to build capacity for MCPs to deliver ECM and CS, the funds can be used for all types of community-based organizations, not just HCBS providers.◢

[81] https://www.dhcs.ca.gov/formsandpubs/Pages/Letters.aspx.

[82] https://calaim.dhcs.ca.gov/pages/incentive-payment-plan

[83] https://www.ca-path.com/

- **Difficulty tracking members when they transition across settings.** Providers, plans, and DHCS staff all discussed the difficulty of tracking HCBS waiver participants who transition in and out of institutional settings. This inability to track—and lack of clarity about responsibilities to notify other entities when care transitions take place—can result in poorly coordinated care for these individuals. Though managed care creates opportunities for better tracking of individuals across settings, processes will need to be put into place to ensure that individuals are not lost.
- **Partnerships with community-based organizations and other organizations to address housing crises, limitations in resources and providers in rural areas, and equity-driven goals.** Providers and MCPs noted that they benefit from fostering partnerships with community-based and other local organizations to address challenges related to housing, limited resources in rural areas, and promoting equity. Upon transition to integrated MLTSS, DHCS may want to consider opportunities to allow—and potentially encourage—collaboration to support these initiatives. For example, the Housing and Homelessness Incentive Program (HHIP) offers Medi-Cal managed care plans the ability to receive incentive funding by establishing partnership with homeless systems of care, which may or may not be targeted towards HCBS providers.[84]

Providers and MCPs emphasized that they prioritize meeting DHCS's requirements to inform their direction to meet care coordination and integration capacities, suggesting the importance of establishing clear and concrete requirements for providers and plans as part of the transition to integrated managed care.

B. Key operational challenges

1. Conducting assessments to determine care needs

The tools and processes for conducting level-of care-assessments, and the data systems that store this information, also vary across HCBS programs, creating inefficiencies and inequities. Interviews with advocacy organizations and waiver agencies highlighted that the process of conducting level-of-care assessments, which are sent to the state for review and approval, is often duplicative and time consuming. Advocates believed the state review process is slow due to staffing shortages at the state level, which means that individuals eligible for HCBS remain on waiting lists for long periods of time. Once they enroll in HCBS programs, Medi-Cal members may undergo further comprehensive person-centered needs assessments that form the basis for person-centered care plans by multiple organizations. For example, an individual who is transferred to a nursing home after discharge from an acute hospital must be assessed on admission to the nursing facility. For those enrolled in managed care, the plan's transitional care team may conduct its own assessment. After discharge from the nursing home, the individual may be reassessed by the HCBS waiver or a provider to see whether their need for care at home has changed. Although each individual assessment may be required or justified, they can produce different findings and lead to delays in service provision.

2. Billing infrastructure and processes

Interviewees from provider organizations and waiver agencies also relayed several challenges with the Medi-Cal billing infrastructure and processes, particularly for smaller providers. After submission to DHCS, claims are sometimes returned to providers because of minor mistakes, which significantly delays payment and can threaten the financial solvency of smaller providers. Providers noted that in these

[84] https://www.chcf.org/resource-center/homelessness-health-care/medi-cal-and-homelessness/housing-and-homelessness-incentive-program/

cases, it was not always clear how to resolve the issue or whether there was a DHCS provider helpline to answer questions related to billing. In addition, audit processes can be incredibly burdensome to providers and affect their ability to operate their normal functions.

Mathematica also heard about program-specific challenges related to billing processes:

- **IHSS:** The retroactive billing feature—which allows individuals to begin receiving services the day they apply but requires them to pay out of pocket until their application is approved for retroactive reimbursement—can be a significant barrier to these individuals receiving HCBS.
- **ALW:** Due to the billing processes for ALW, DHCS is not always aware of what services providers are claiming, which prevents the state from paying those providers correctly in all cases. An example of this challenge is mismatched approval dates in the documentation of authorized services generated from DHCS, generating significant billing rejections for one ALW provider. Multiple interviewees also expressed delays in having billing cleared due to share-of-cost confusion. This issue has led to significant barriers in recruiting providers to the program because they are aware of the problems with payments from the state.
- **HCBA:** The program requires billing in one-hour increments for nursing, but 15-minute increments for supervision or oversight and habilitation visits, which can make it challenging for providers to plan their daily schedule and workflow for their staff.
- **CCT:** One provider explained that CCT also requires billing in one-hour increments, so if a provider spends a half hour arranging and facilitating a service for a CCT user, they feel they are not allowed to bill for that time.

Furthermore, DHCS officials noted that often complications occur with billing across programs and services (for example, there may be differences in the unit of service definition across programs: 15-minute increments versus an hour). Specifically, variation in billing procedure codes across HCBS programs may lead to confusion and pose challenges.[85] This billing issue especially affects providers who may be administering services across multiple HCBS programs and must remember different claiming requirements for different programs.

[85] For example, the ALW program has its own set of billing codes: https://www.dhcs.ca.gov/services/ltc/Documents/ALW-Reimbursement-Rates-2024.pdf.

VII. Related Initiatives and Future Directions

Although California is serving a substantial number of Medi-Cal members through various HCBS programs, the availability of programs across the state varies, leading to areas where access is limited, and members have difficulty navigating the system. Rural counties have particularly notable issues regarding access to programs and provider participation; as a result, Mathematica found higher levels of institutional LTSS use in these rural areas. The challenges with the Medi-Cal HCBS system stem from program complexities, such as lack of information and complicated enrollment processes; lack of provider capacity; and other design features, such as siloed operations across departments, which make it difficult to have consistent, streamlined, and accessible HCBS across the state.

There are several initiatives in California already underway designed to increase access to HCBS through a managed care delivery system, including, but not limited to:

- **Coverage of ECM and CS under CalAIM**.[86] These additional supports provide more comprehensive care management to certain managed care members with complex needs and help to address members' health-related social needs. MCPs that offer ECM/CS to those at risk of entering an institution or transitioning from an institution to the community may be able to help more people who need LTSS avoid or minimize their stay in an institution.
- **Managed care LTC carve in**. [87] As of January 2024, DHCS carved-in LTC to Medi-Cal managed care plan benefits, so all Medi-Cal MCPs must cover care that members receive in skilled nursing facilities (SNFs) and intermediate care facilities for people with intellectual and developmental disabilities (ICFs-IDD). This will make it easier for MCPs to coordinate medical services with post-acute and long-term care in SNFs and ICF-IDD.
- **Integration and coordination of Medicare and Medi-Cal services for dually eligible individuals.** Starting in 2023, dually eligible individuals not already enrolled in a Medi-Cal managed care plan were mandatorily enrolled in these plans to promote integrated care for these individuals receiving both Medicare and Medi-Cal services. In addition, starting in 2024, DHCS is launching a Default Enrollment Pilot[88] for a select group of Medicare Medi-Cal plans for full benefit dual eligible individuals. These Medicare Advantage plans combine Medicare and Medi-Cal benefits into one plan, creating incentives to prioritize HCBS over institutional care.
- **Use of enhanced federal funding to invest in HCBS initiatives.[89]** California has used $3 billion in enhanced federal funding to invest in a range of initiatives designed to enhance, expand, and strengthen Medi-Cal HCBS. These initiatives include strengthening the direct care workforce through supporting career ladders, providing additional trainings and stipends to direct care workers, and

[86] https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx

[87] https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx

[88] Default enrollment refers to an enrollment process that allows Medicare Medi-Cal plans to enroll a member of an affiliated Medi-Cal managed care plan into its Medicare Medi-Cal plan when that member becomes newly eligible for Medicare.

[89] https://www.dhcs.ca.gov/provgovpart/Documents/HCBS-Quarterly-Spending-Plan-Narrative-Q3.pdf.

providing funds to homeless and HCBS direct care providers. In addition, the state continues to prioritize modernizing information technology systems, including the development of a Long-Term Services and Supports dashboard to support data transparency. California has also used enhanced federal funding to add slots to the Assisted Living Waiver program to reduce the current waiting list.

In addition to these ongoing efforts, Mathematica will draft a Multi-year Roadmap that offers DHCS a set of specific policy options that hold promise for improving access to HCBS and better meeting the needs of older adults and people with disabilities enrolled in Medi-Cal now and in the future. The roadmap will be developed in collaboration with other CalHHS departments, including the Departments of Aging, Developmental Disabilities, Public Health, and Social Services which are the designated operational agencies for several HCBS programs.

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