September 22, 2025

Department of Health Care Services

HCBS Integration Team

HCBSIntegration@dhcs.ca.gov

Dear HCBS Integration Planning Team:

Thank you for convening the HCBS Integration Planning Workgroup and for giving a wide range of stakeholders the opportunity to provide input on integrating California's home and community-based 1915(c) programs into managed care delivery.

The undersigned 63 organizations are writing to provide feedback and express concern about the proposed plans presented to the HCBS Integration Advisory Workgroup. As detailed below, we strongly oppose moving forward with the planned integration at this time. **Instead, we urge the Department of Health Care Services ("DHCS" or "Department") to first adopt the recommendations outlined in this letter to address existing shortcomings and strengthen HCBS currently delivered through managed care before considering any expansion.**

To date, discussions with the Advisory Workgroup have centered on designing a new waiver that combines and streamlines four existing 1915(c) waivers into a single 1915(c) waiver.[1] DHCS has stated that moving to a single waiver and shifting delivery of these HCBS programs to managed care plans will address gaps identified in its 2025 HCBS Gap Analysis. But based on the Gap Analysis and other state data, managed care plans are not able and ready to address the gaps DHCS aims to address in this transition, nor are there adequate oversight and enforcement measures in place to ensure DHCS's delegation of these programs to managed care does not harm Medi-Cal's highest-needs populations.

California's 1915(c) waivers serve Medi-Cal's highest needs and highest cost members—including medically fragile or technology-dependent children, older adults with Alzheimer's or other dementias, and individuals with significant mental health conditions—who require nursing facility level of care and choose to receive that care at home and in their communities.

[1] DHCS communicated that the Department is considering creating a 1915(c) waiver for adults and a separate one for children. The recommendations in this letter apply to both.

Interruptions in care and reduced access puts 1915(c) recipients at risk of injury, costly hospitalization or institutionalization. Moving forward without addressing existing gaps would put older adults and people with disabilities—including children—who depend on these services to live in their homes and communities at serious risk of harm. **For this reason, we oppose the transition of California's 1915(c) waivers into managed care delivery at this time.**

Managed care delivery of long-term services and supports (MLTSS) is not new to California. The Community-Based Adult Services (CBAS) program was transitioned into Medi-Cal managed care in 2012.[2] Likewise, the launch of Community Supports under the CalAIM demonstration in 2022 has given managed care plans an option to deliver a menu of home and community-based services to their members.[3] And institutional long-term care was expanded as a managed care benefit in 31 counties 2023, and fully mandatory in all counties in 2024, intended to in part act as a financial incentive for plans to transition members to less costly HCBS.[4]

Notably, DHCS has on numerous occasions attempted to carve in the Multi-Purpose Senior Services Program (MSSP) into managed care but has abandoned those efforts due to lack of health plan readiness and the inability to assure that recipients of MSSP would retain the same extent of benefits and support.

Similarly, DHCS data, including data made available in the HCBS Gap Analysis and the Community Supports implementation dashboard, unequivocally show that managed care plans have not addressed the access, utilization, and provider gaps that are similar to those gaps the Department intends to address with the HCBS waiver transition. In fact, California's existing delivery of MLTSS reveals significant shortfalls in oversight, enforcement, and consumer protections. **Learnings from the current delivery of MLTSS as described below make clear that the Department must first address these known issues and ensure system readiness before transitioning additional HCBS into managed care.**

A. Managed Care Plan Delivery of LTSS has Failed to Close Gaps in HCBS Access

Counter to DHCS expectations from managed care delivery, quarterly Community Supports implementation reports, the Department's own Gap Analysis, state Medi-Cal data, and CBAS provider data indicate that managed care-delivered HCBS are characterized by underutilization, geographic and other inequities, and limited provider participation—the same inequities that managed care plans are expected to address through the proposed waiver integration.

1) **Community Supports: Community or Home Transition Services and Assisted Living Facility Transition Community Supports are Underutilized**

DHCS intended to improve rebalancing the provision of LTSS towards community settings by allowing plans to offer lower-cost alternative home and community-based services such as the

[2] CDA, "Community-Based Adult Services Program (CBAS)," (last visited 8/27/2025).
[3] DHCS, "Community Supports are Delivering on their Promise," (2025).
[4] DHCS, "CalAIM Long-Term Care Carve-in," (last visited Sept. 2, 2025).

Community or Home Transition Services and Assisted Living Facility Transitions Community Supports (AL Community Support) in lieu of more costly long-term care in institutional settings. Unfortunately, data showing low utilization of these Community Supports indicate that such rebalancing has not occurred.

For example, while 41,000 Medi-Cal managed care members received services in long-term care in 2024, only 414 members received the Community or Home Transitions Service in the same year.[5] The service was almost exclusively provided by only one plan—Health Plan of San Mateo.[6] It is the least used Community Supports of the 14 available HCBS-like services.[7]

After the Community or Home Transition Community Supports, AL Community Support has the second worst utilization rate of the 14 offered Community Supports, though not for lack of need. If successful, the AL Community Support could be used to effectively expand the current Assisted Living Waiver (ALW) statewide, eliminate a 13,000-person waiver waitlist, and offer support to high-needs adults in home-like settings. While the ALW is currently only available in 15 counties, the AL Community Support has no geographic restrictions and *can* be available statewide. And unlike the ALW, the corresponding managed care benefit does not have a participant cap. To date, however, the AL Community Support is significantly underutilized due in part to providers' reluctance to enroll as providers with the plans[8]:

- There are over 13,000 individuals on the ALW waitlist, yet only 1,182 members have accessed the AL Community Support in 2024.
- All but two of the plans—Partnership and SCAN Health—elected to add the AL Community Support to their menu of services, but members in only 11 of the state's 58 counties actually received the service.
- Plan members in just two non-ALW counties, Amador and El Dorado, have received the AL Community Support.

2) Managed Care Plan Delivery Failed to Close Gaps in CBAS and Worsened Geographic Inequities

When CBAS transitioned into managed care in 2012, it was available as a mandatory Medi-Cal benefit in 28 counties. In the 13 years since that transition, access to CBAS has not expanded. Instead, geographic inequities have worsened driven in large part by health plans' low reimbursement rates and complex billing processes, leading to center closures. [9] Currently, two

[5] DHCS, Total Number of Members Who Utilized Community Supports by Service in the Last 12 Months of the Reporting Period, (data for 2024); "Medi-Cal Monthly Eligible Fast Facts," (Dec. 2024).
[6] *Id*.
[7] *Id.*
[8] DHCS verbal remarks at DHCS Advocate Meeting on August 18, 2025; HCBS Integration Planning Workgroup Meetings, August 12th and 15, 2025;
[9] DHCS, "Home and Community-Based Services Gap Analysis," (Jan 1, 2025).

counties where CBAS was previously available now have no CBAS centers, and multiple other counties have experienced reduced capacity[10]:

- Only 17% of potential CBAS providers participate in CBAS. [11]
- The number of older adults and people with disabilities in Medi-Cal has grown 26% since the 2012 managed care carve-in, but the number of CBAS participants only increased by 12%, from 36,000 to 41,000, with three counties in Southern California accounting for almost all of the growth. [12]
- Geographic disparities in access have widened since 2012. Growth in capacity is mostly concentrated in Southern California, [13] many counties have seen little to no change in capacity even as their Medi-Cal populations grew, and four counties saw significant decreases. For example, Marin and Sonoma no longer have CBAS centers in spite of being mandatory CBAS counties per the *Darling v. Douglas* settlement. [14] In just the last three years, Stanislaus County saw an almost 60% average decrease in capacity. And since 2020, Alameda County and Contra Costa Counties both lost a center, reflecting an approximately 21% and 41% loss of capacity, respectively. [15]

B. DHCS Must Address Gaps in Current MLTSS Before Integrating HCBS Waivers

To prevent the same problems seen in the delivery of CBAS and Community Supports – such as inadequate and disparities in access and low provider participation – **the Department must address system and managed care plan readiness concerns prior to proceeding with transitioning additional HCBS to managed care delivery.**

Specifically, we urge DHCS to *first* close access gaps in the CBAS program and Community Supports by (1) implementing meaningful HCBS network adequacy measures to ensure increased provider participation, consumer choice, and timely, equitable access; (2) putting in

[10] *Id.*

[11] *Id.* at 13, 66 (finding that "provider infrastructure to increase access to services through CBAS and ALW exists," and access for CBAS could be increased for Medi-Cal members if more providers participated in the program). However, it is noteworthy that most of these providers are Adult Day Programs that would need to obtain an Adult Day Health Care license in order to become an authorized CBAS provider. See Appendix B.5.2. of the DHCS Gap Analysis, including Adult Day Programs in the total count of possible CBAS providers.

[12] Legislative Analyst's Office, "The 2012-13 Budget: Integrating Care for Older Adults and Persons with Disabilities,"(Feb 17, 2012); DHCS, "Medi-Cal Fast Facts: May 2024", (Aug. 2024). See also DHCS, LTSS Data Dashboard, (2017-2022) (While data on utilization by county is available only from 2017 to 2022, LA county CBAS utilization grew by 10,000 during that period—consistent with its growth in capacity from 2020 to 2025.)

[13] In 2012, 303 CBAS centers served approximately 36,000 individuals. In 2025, 317 centers were participating in the program. Nine of the 14 centers opened in LA County, which increased its capacity by 6,119 spots; Orange County increased capacity by 1,763 and San Bernadino increased its capacity by 856. CDA, Community-Based Adult Services (CBAS) (last visited 8/25/2025); CDA, "Center Overview," (Last visited 8/25/2025).

[14] Settlement Agreement, Attachment A, Darling v. Douglas, No. C-09-03798 SBA (N.D. Cal.), § XII(F)(3).

[15] CDA, Community-Based Adult Services (CBAS) (last visited 8/25/2025); CDA, "Center Overview," (Last visited 8/25/2025).

place data collection and other oversight, monitoring, and enforcement tools to track and ensure adequate due process; and (3) addressing gaps in consumer protections in managed care delivery to ensure access to due process rights and high quality community-based services for all Medi-Cal HCBS recipients.

1) Establish Meaningful MLTSS Network Adequacy Requirements with Enforcement

Network adequacy standards are a fundamental oversight and enforcement tool that DHCS uses to ensure that all managed care delivered services are available and accessible to Medi-Cal members.[16] Federal regulations require states with managed care contracts to establish network adequacy standards for LTSS.[17] Currently, the CBAS network adequacy standard only requires health plans to maintain the same number of centers as were available in 2012.[18] This standard does not account for growth in need as the population grows, and only acts to maintain an inequitable status quo, at best. There are no network adequacy standards for Community Supports, which are optional services.

The Department will not reach its goal of providing uniform LTSS access if network adequacy standards are not in place. The lack of LTSS network adequacy standards accounts for the poor availability of HCBS providers and the already apparent differences in utilization and access among geographic regions. We cannot have a system where only people living in Southern California, namely Los Angeles County, have access to LTSS.

Accordingly, prior to integration of additional HCBS into managed care, DHCS must put in place network adequacy standards for CBAS and other MLTSS. [19] DHCS should also enforce standards in the CBAS and AL Community Support programs to test robustness and ensure efficacy in improving access to HCBS programs already in managed care.

We recommend DHCS consider network adequacy strategies specifically tailored to HCBS[20] that:

- Are considerate of where services are provided – at home or at a provider's location;
- Include service fulfilment and provider ratio standards;
- Establish time, distance and choice standards, for agency and center-provided HCBS;
- Support consumer connection to family and community.
- **Expand the CBAS program statewide by making the program a state plan benefit that is subject to the future MLTSS network adequacy provisions to ensure access.**

[16] CHCF, "Network Adequacy Standards in California: How They Work and Why They Matter," (Dec 2021).
[17] 42 CFR §438.68 (b)(2)
[18] CMS, Approval Letter and CalAIM Standard Terms and Conditions, (Jan. 8, 2025) at page 22.
[19] *Id.*
[20] Community Living Policy Center, UCSF, "Managed Long-Term Services and Supports: Assessing Provider Network Adequacy," (Dec. 2018).

2) Implement Data Collection and Other Oversight, Monitoring and Enforcement Tools to Track Service Quality and Timely Equitable Access to MLTSS

To fulfill the Department's oversight and monitoring role as the state's Medi-Cal agency and ensure managed care plans are delivering necessary care to all their members, DHCS must collect and report on the below data points for CBAS and Community Supports, at a minimum, in order for the Department to comprehensively identify gaps, assess inequities, and act to address them. Setting up this data collection and reporting will allow the Department to put in place processes that can then be expanded to include other HCBS as they are integrated into managed care:

- The number of individuals referred to MLTSS through self, physician, and community pathways.
- The number of verbal and written requests for MLTSS, approval rates, and denial rates.
- Timely access data for all MLTSS services, including time elapsed between when a service was requested and when it was consistently received, up-to-date waitlist data including demographic information, time on waitlist, and number of individuals on waitlists.
- Number of individuals from ALW waitlists enrolled in the AL Community Support.

3) Additional Pre-Integration Considerations

Prior to transitioning additional HCBS programs into managed care, system changes are needed that address barriers to access identified in the DHCS HCBS Gap Analysis and ensure a smoother transition and minimize disruptions in care. We recommend DHCS:

(a) Expand Medi-Cal Managed Care Access to Members in the Medically Needy with Share of Cost Aid Code

All HCBS waivers, except for the Assisted Living Waiver, allow individuals with a share of cost to access services. CalAIM Medi-Cal managed care services are not open to individuals with a share of cost, except for those receiving institutional long-term care. To prevent disruption and ensure equitable access to all Medi-Cal services, DHCS must expand access to Medi-Cal managed care to individuals with a share of cost prior to managed care transition.

(b) Address Managed Care Delays in HCBS Assessment/Eligibility Determinations

The Department's Gap Analysis identified delays in CBAS eligibility determination processes **"**due to delays in scheduling face-to-face determinations or because of other factors, such as missing utilization information…." The report found that "the transition of CBAS into managed care has exacerbated this issue" and "as more individuals enroll in managed care, the MCPs need time to evaluate members' needs and connect them to

services."[21] To ensure prompt access to services, we urge DHCS to implement the following policies prior to the HCBS transition into managed care:

- Develop a streamlined universal assessment process that make clear the state's and the MCPs' roles with the goal of efficient and effective assessments and timely receipt of services.
- Implement presumptive Medi-Cal eligibility for HCBS members to eliminate administrative delays.
- Extend presumptive authorization to HCBS to ensure members receive prompt access to services when they need them. [22]
- Allow Medi-Cal members with a share of cost to project HCBS costs in order to facilitate timely HCBS access.

(c) Require participating Medi-Cal Managed Care Plans to provide an HCBS Liaison

Medi-Cal managed care plans are required to provide an LTSS liaison to assist long-term care providers but are not required to provide a liaison for HCBS providers. [23] To facilitate HCBS provider participation in MLTSS, DHCS should require plans to provide a dedicated HCBS liaison prior to waiver transition. DHCS should monitor the role of HCBS liaisons in improving CBAS provider participation and implement additional supports and interventions as needed.

(d) Settings Rule Compliance

DHCS should ensure managed care compliance with the Federal HCBS Settings Rule prior to integration, including:

- Issuing an All-Plan Letter instructing Managed Care Plans of their role and responsibilities in ensuring that CBAS and AL Community Support providers conform with the HCBS Settings Rule, even when the provider is working through a "hub," and not contracted directly with the managed care plan.
- Issue an All-Plan Letter instructing managed care plans of their obligation to ensure Medi-Cal members are afforded the opportunity to engage in the person-centered planning process.

Thank you for the opportunity to engage with the Department in the initial planning phases of the HCBS Integration to Managed Care Initiative. If you have any questions or would like to discuss the issues outlined above further, please feel free to contact Hagar Dickman Hdickman@justiceinaging.org.

[21] DHCS, "Home and Community-Based Services Gap Analysis," at 95.
[22] See policy for presumptive authorization for ECM, DHCS, "CalAIM Enhanced Care Management Policy Guide" at p108, (August, 2024).
[23] DHCS, APL 24-010 at 18, (Sep 16 2024

Thank you,

A Better Life Together, Inc.
AARP
Aging Services Collaborative of Santa Clara County
Alliance for Leadership and Education
Alzheimer's Los Angeles
Archstone Foundation
Bet Tzedek Legal Services
CA Foundation for Independent Living Centers
CA Senior Legislature
CALIF-ILC*
California Advocates for Nursing Home Reform (CANHR)*
California Alliance for Retired Americans
California Association for Adult Day Services (CAADS)
California Association of Area Agencies on Aging (C4A)
California Council of the Blind
California Health Advocates
California In-Home Supportive Services Consumer Alliance
California Long-Term Care Ombudsman Association (CLTCOA)
CalPACE
Cardea Health
Caring Across Generations
CDCAN (CA Disability-Aging Community Action Network)
Center for Elders' Independence (CEI)
Center for Healthy Living Inc
Choice in Aging*
Coalition of California Welfare Rights Organizations
Corporation for Supportive Housing
Disability Action Center
Disability Rights California
Disability Rights Education and Defense Fund (DREDF)
East Bay Innovations
Easterseals Southern California
Excel HealthCare Inc
Family Caregiver Alliance
Forever Young CBAS
Glenoaks ADHC
Grand Adult Day Health Care
Home Health Care Management, Inc.*
Hospital to Home Alliance of Ventura County
InSpirit
Jewish Family Service Los Angeles
Justice in Aging*
LeadingAge California
Libertana*
Little Lobbyists*
Loving Care ADHC Limited
Marin Center for Independent Living
MSSP Site Association*
My Place ADHC
Personal Assistance Services Council (PASC)
Real Care ADHC/CBAS
Senior and Disability Action
Senior Coastsiders
Serving Seniors
Shiraz ADHC
Silicon Valley Independent Living Center
Silver Wisdom Adult Day Health Care Center
St. Anthony's ADHC
St. Gregory ADHC
UDW/AFSCME Local 3930
United Way of Greater Los Angeles
Venus Adult Day Healthcare Center
Western Center on Law and Poverty
Consumer Advocates: Connie Arnold, Adrienne Lauby, Jessica Lehman, Michelle Rousey

* Indicates a member of the DHCS HCBS Integration Planning Workgroup

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Michelle Baass, Director, California Department of Health Care Services
Susan DeMarois, Director, California Department of Aging
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Senator Dr. Akilah Weber-Pierson, Chair, Senate Budget Subcommittee #3
Assemblymember Mia Bonta, Chair, Assembly Health Committee
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