MEDI-CAL LONG-TERM CARE AT HOME
BENEFIT DESIGN

BACKGROUND AND OVERVIEW

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

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

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

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

KEY GOALS

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

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

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

TARGET POPULATIONS

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

[1] 42 U.S.C. § 1396n(i).

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

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

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

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

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

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

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

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

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

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

Duplication of Services

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

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

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

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

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

Enrollment in Existing Home and Community-Based Services

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

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

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

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

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

Dual Eligible Beneficiaries

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

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

MODEL OF CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LONG-TERM CARE AT HOME PROVIDER NETWORK AND LICENSING

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

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

FINANCING AND COST

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

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

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

FEDERAL AUTHORITY

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

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

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

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

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

STAKEHOLDER ENGAGEMENT AND TIMELINE

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

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

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