

California's Home and Community-Based Services Spending Plan

California's proposed spending plan builds on the bold health and human services proposals included in [California's Comeback Plan](#) by expanding on or complementing the proposals to further achieve improved outcomes for individuals served by the programs. These proposals independently provide historic one-time investments to build capacity and transform critical safety net programs to support and empower Californians. Taken together, these investments advance the health and well-being of our entire state, promoting economic mobility and overall social stability.

Home- and Community-Based Services (HCBS) are types of person-centered care delivered in the home and community. A variety of health and human services can be provided in this way. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities. This includes individuals who may have a disability, including a serious behavioral health condition, and seniors.

These programs and services further California's commitment to community living for all, rooted in both the Olmstead Supreme Court decision of 1999 and in California's values of inclusion, access, and equity. This spending plan alongside the Governor's May Revision lays the foundation to make this commitment a reality, changing the life trajectory of children so they grow up to be healthier—both physically and mentally—and better educated with higher paying jobs and lower rates of justice involvement. It empowers older adults and people with disabilities to thrive in homes and communities of choice, and it includes proposals that lift homeless and formerly-incarcerated Californians to build back stronger and more resilient.

Enhanced Federal Funding Authorized by the American Rescue Plan Act

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARPA) (Pub. L. 117-2). Section 9817 of the ARPA provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS programs from April 1, 2021 through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021. In addition, states must use state funds equivalent to the amount of federal funds attributable to the

increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.

A state may claim the increased FMAP for the following expenditures:

- Home Health and Private Duty Nursing
- Personal Care
- Case Management
- Certain School-Based Services
- Behavioral Health Rehabilitative Services
- 1915c Waiver Services
- 1915(j) State Plan Services
- Program of All-inclusive Care for the Elderly (PACE)
- Managed Long-Term Services and Supports (MLTSS)

States will be permitted to use the equivalent to the amount of federal funds attributable to the increased FMAP through March 31, 2024, on activities aligned with the goals of section 9817 of the ARPA and as listed in [CMS's guidance](#). Under ARPA, states can implement a variety of activities, including enhancements to HCBS services, eligibility, infrastructure, and reimbursement methodologies, to enhance, expand, or strengthen Medicaid HCBS.

The time period allowed to expend funds attributable to the increased FMAP will provide states with sufficient time to design and implement short-term activities to strengthen the HCBS system in response to the COVID-19 Public Health Emergency (PHE), as well as longer term strategies to enhance and expand the HCBS system and to sustain promising and effective programs and services.

Examples of activities that states can initiate as part of this opportunity include, but are not limited to:

- New and/or additional HCBS
- Payment Rates
- HCBS workforce recruitment or training, expanding provider capacity
- Assistive technology, including access to additional equipment or devices
- Community transition and coordination costs
- Expanding HCBS capacity
- Support for individuals with HCBS needs and their caregivers
- Building No Wrong Door systems
- Quality Improvement activities
- Reducing or eliminating HCBS waitlists
- Institutional diversion
- Addressing social determinants of health (SDOH) and health disparities
- Enhancing care coordination

- Creating incentives for managed care plans or providers to develop partnerships with social service agencies, counties, housing agencies, public health agencies, and/or community-based organizations,
- Testing alternative payment methodologies or the delivery of new services that are designed to address SDOH that may include housing-related supports such as one-time transition costs, employment supports, and community integration, among others

CMS indicates that states are not limited to using state funds equivalent to the amount of the increased FMAP for services that are otherwise covered in Medicaid; however, Federal Financial Participation (FFP) is only available for covered services.

To demonstrate compliance with the prohibition on supplanting existing state funds expended for Medicaid HCBS, states must:

- Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021
- Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021
- Maintain HCBS provider payment at a rate no less than those in place as of April 1, 2021

CMS requires participating states to submit both an initial and quarterly HCBS spending plan and narrative to CMS on the activities that the state has implemented and/or intends to implement to enhance, expand, or strengthen HCBS under the Medicaid program to demonstrate that the state is supplementing, but not supplanting, existing state funds expended for Medicaid. States must submit the initial HCBS spending plan and narrative by June 12, 2021. CMS will review and approve the initial state spending plan and narrative within 30 days of a state's submission.

Home and Community-Based Services Spending Plan

The enhanced federal funding provides California with an opportunity to make substantial investments in the programs that serve our most vulnerable Californians, including populations that are aging, disabled, homeless, and those with severe behavioral health needs.

These investments further bolster the investments made in health and human services programs as part of the Governor's May Revision which are designed to begin addressing the health, economic, and racial inequities that were exacerbated by the pandemic. Collectively, these investments chart a path to a system where social services—such as housing supports, food and childcare—are

linked to the health and behavioral health services. Furthermore, these services are person-centered and address the social, cultural and linguistic needs of the individuals they serve. Finally, these proposals independently help bolster critical safety net programs that support and empower Californians. Taken together, these investments advance the health and wellbeing of all Californians, as well as their social and economic mobility. Furthermore, the investments made using these funds will help revamp and reimagine state programming and administrative practices, helping shuttle California into a more modern and forward leaning set of practices focused on outcomes and value.

This document serves as a multi-department proposed HCBS Spending Plan, including 35 initiatives, totaling approximately \$3B in enhanced federal funding for the following categories of services:

- Workforce: Retaining and Building Network of HCBS Direct Care Workers
- HCBS Navigation
- HCBS Transitions
- Services: Enhancing HCBS Capacity and Models of Care
- HCBS Infrastructure and Support

This HCBS Spending Plan will invest in a number of initiatives, across a range of state HCBS programs to build a modern, inclusive HCBS system that provides robust health and human services to California's most vulnerable residents, in their communities, in ways that ensure that California's HCBS workforce has the training and support necessary to provide the highest level of service to those in their care.

Workforce: Retaining and Building Network of Home and Community-Based Direct Care Workers

Critical to all endeavors to expand home- and community-based services is a robust direct care workforce. The state recognizes this workforce's cultural and linguistic strengths as valuable and finds it serves as a model as the state develops this network. Without an investment in the state's workforce the HCBS initiatives and services discussed later in this document are not viable.

In addition, turnover among the workforce who are directly involved with consumers prevents the development of trusting relationships and causes instability in services for the consumer. Targeted investments are needed to recruit, train, and retain a network of high-skilled workers to improve consumer experience and outcomes.

These proposals work to expand workforce supply and HCBS provider types, including homeless service workers; IDD providers; providers of HCBS wrap services to keep people in their homes and community; home-based clinical direct care. In addition, these proposals will increase training, ensuring a skilled and linguistically and culturally responsive workforce, while supporting a career ladder that allows HCBS workers to develop their skills and training.

Initiatives include:

- IHSS Specialized Upskilling Pilots
- Direct Care (Non-IHSS) Workforce - Training and Stipends
- IHSS HCBS Care Economy Payments
- Non-IHSS HCBS Care Economy Payments
- Increasing Home and Community-Based Clinical Workforce
- Providing Access and Transforming Health (PATH) funds for Homeless and HCBS Direct Care Providers
- Medicare Partnerships and Shared Savings on Supplemental HCBS Benefit Services
- Traumatic Brain Injury (TBI) Program
- Developmental Services Workforce Investment
- Community Navigator/Implicit Bias Training

IHSS Specialized Upskilling Pilots

Funding: \$68.4M enhanced federal funding (\$150M TF) One-time
Lead Department(s): DSS, with DHCS

In consultation with stakeholders, the State will expand upon existing training and identify additional opportunities to support the specialized training of IHSS providers to further support consumers with complex care needs and to be

utilized, when possible, in the proposed Community Based Residential Continuum Pilots for vulnerable, aging and disabled populations. More specifically:

- Building on the May Revisions proposal to make significant investments to transform California's behavioral health system and to address the housing needs of those that are currently unsheltered, IHSS providers will gain additional competencies in meeting the behavioral health needs of those they support through this effort.
- Pilot projects will also build capacity for IHSS providers to serve recipients with Alzheimer's or related dementia. The Master Plan on Aging indicates that by 2025, the number of Californians living with Alzheimer's disease will increase 25% from 670,000 today to 840,000 in 2025. Most persons with Alzheimer's or related dementia live at home, in the community, relying on a network of family caregivers and home care providers.
- Finally, pilot projects will focus on meeting the needs of IHSS recipients who are severely impaired.

This furthers the \$200 million one-time General Fund proposal that was included in the Governor's May Revision to incentivize, support and fund career pathways for IHSS providers, allowing these workers to build on their experience to obtain a higher-level job in the home care and/or health care industry.

The State will determine the process by which any required contracting and payment to identified training programs occurs. Efforts will also be made to ensure that specialized training is linked to existing career pathways, licensing, and certification to further expand the IHSS providers' ability for career advancement.

IHSS providers that complete a State-identified, with stakeholder input, pilot specialized training pathway will receive **a \$3.00/hour¹ pay differential** when enrolled to provide services to a recipient with the care need for which they completed specialized training.

This proposal includes funding to support county IHSS programs and/or IHSS Public Authorities, which will provide outreach to providers regarding training opportunities, assist interested providers to connect with training, track completion of training and issue stipend payments, as well as any other identified administrative activities. Additionally, Public Authority registries should be enhanced to capture completed training pathways for registry providers.

Finally, this proposal includes automation and state operations costs to support CDSS' implementation of the efforts described above, as well as the costs for a

¹ A \$3.00 pay differential is the maximum differential a provider can receive for providing IHSS. So, for example, a provider who serves multiple recipients with specialized needs would not receive a higher differential.

contractor to evaluate the effectiveness of the efforts (e.g. in terms of provider retention and recipient satisfaction).

Direct Care Workforce (non-IHSS) Training and Stipends

Funding: \$150M enhanced federal funding (\$150M TF) One-time

Lead Department(s): CDA, with DHCS, DSS, OSHPD

Direct care jobs are central to the economy: they are the largest (696,000) and fastest growing occupation in the State. Direct care is also essential to aging and disabled adults maintaining health and well-being while living at home – especially during the pandemic, direct care workers have provided critical care for adults staying home and staying safe from COVID-19. However, these care economy jobs often have limited training, compensation, and career paths and, as a result, inequitably burden the women, immigrants, and people of color who largely perform this work. These sector challenges also can lead to HCBS program providers and care recipients experiencing high turnover and staffing shortages. A new statewide Direct Care Workforce Training and Stipends Program – leveraging on-line learning innovations, rooted in adult learner principles, and delivered in multiple languages with cultural competency - will be provided to direct care workers caring for adults in HCBS (non-IHSS) programs. A statewide Training and Stipend program provides the foundation for and drives many positive outcomes in HCBS: for the care worker, these benefits include increased skills, satisfaction, and retention, as well as opportunities to advance on career and wage ladders; for the older and/or disabled adult, the benefits include increased health and well-being from high-quality care and the prevention of unnecessary institutionalization. This also furthers the Governor's May Revision to incentivize, support and fund career pathways for non-IHSS direct care HCBS providers, to build on their experience to obtain a higher-level job in the home care and/or health care industry.

IHSS HCBS Care Economy Payments

Funding: \$137M enhanced federal funding (\$275M TF) One-time

Lead Department(s): DSS

This funding would provide a one-time incentive payment of \$500 to each current IHSS provider that provided IHSS to program recipient(s) during a minimum of three months between March 2020 and December 2020 of the pandemic. The payment would be issued through the IHSS automated system, CMIPS and would focus on payment for retention, recognition, and workforce development.

Non-IHSS HCBS Care Economy Payments

Funding: \$6.25M enhanced federal funding (\$12.5M TF) One-time

Lead Department(s): DHCS, with CDA

This funding would provide a one-time incentive payment of \$500 to each current direct care, non-IHSS provider of Medi-Cal home and community-based services during a minimum of three months between March 2020 and December 2020. This amount would cover 25,000 direct care HCBS providers in MSSP, CBAS, HCBA, ALW, HIV/AIDS Waiver, PACE, and CCT and would focus on payment for retention, recognition, and workforce development.

Increasing Home and Community Based Clinical Workforce

Funding: \$100M enhanced federal funding (\$100M TF) One-time

Lead Department(s): OSHPD, with DHCS, CDPH, CDA

This proposal would increase the home and community-based clinical care workforce, including home health aide, CNA, LVN, RN workforce in Medi-Cal. The proposal focusses on increasing access and training for home based clinical care providers for children with complex medical condition, individuals with disabilities, and geriatric care for aging adults. Grants would be provided to clinics, physician offices, hospitals, private duty nursing providers, home health providers, or other clinical providers. To be eligible for funds, the provider would need to demonstrate significant Medi-Cal patient caseload. Grants can pay for loan repayment, sign-on bonuses, training and certification costs, etc.

Providing Access and Transforming Health (PATH) funds for Homeless and HCBS Direct Care Providers

Funding: \$50M enhanced federal funding (\$100M TF) One-time

Lead Department(s): DHCS, with DSS

PATH funds will support a multi-year effort to shift delivery systems and advance the coordination of delivery of quality care of services authorized under DHCS' Section 1115 and 1915(b) waivers. This complements the \$200 million (\$100 million General Fund) proposal in the Governor's May Revision to build capacity for effective pre-release care for justice-involved populations to enable coordination with justice agencies and Medi-Cal coverage of services 30 days prior to release.

California is proposing a significant expansion of the homeless system of care that will create over 2,000 direct service jobs for those providing services to homeless and formerly homeless individuals. Additionally, Medi-Cal is looking to expand enhanced care management and long-term services and supports statewide through CalAIM In Lieu of Services. To successfully implement these new investments, local governments and community based organizations will need to recruit, onboard, and train a new workforce. In particular, there is a need for a workforce with experience/expertise in working with the disabled and aging populations. Funding will support outreach efforts to publicize job opportunities, workforce development strategies to train staff in evidenced based practices, implement information technology for data sharing, and will support training stipends.

Medicare Partnerships and Shared Savings on Supplemental HCBS Benefit Services

Funding: \$100M enhanced federal funding (\$100M TF) One-time

Lead Department(s): DHCS, with CDA

In partnership with federal, state and local partners, DHCS' Office of Medicare Innovation and Integration will lead in planning for integrated, coordinated service delivery for dually eligible individuals (those with both Medicare and Medi-Cal eligibility), and in developing innovative approaches to integrated models of care and coordinated access to LTSS for Medicare-only beneficiaries. Current federal-state collaboration efforts for dually-eligible individuals do not provide the state with a portion of the Medicare savings from reduced inpatient or short-term nursing home stays. This reduces the state's ability to invest cost savings into services and supports that improve outcomes and reduce overall costs.

Through this proposal, DHCS would fund incentives to invest in models of care that reduce inpatient or short-term nursing home stays. DHCS would also pursue a Medicare and Medicaid Shared Saving program with the federal government, building on the success of Cal MediConnect and providing more incentives for Care Plan Options, leveraging the upcoming Dual-Special Needs Plan aligned enrollment model, and considering opportunities to improve care for dually-eligible populations in Medicare fee-for-service. Additionally, DHCS would provide incentives to Medicare Advantage plans to develop innovative approaches for integrated models of care, focused on partnerships with providers such as community based organizations that provide HCBS as supplemental benefits. DHCS will also consider partnerships and incentives to provide HCBS to Medicare fee-for-service beneficiaries.

Traumatic Brain Injury (TBI) Program

Funding: \$10M enhanced federal funding (\$10M TF) One-time

Lead Department(s): DOR

The Department of Rehabilitation's (DOR) Traumatic Brain Injury (TBI) Program provides five core services designed to increase independent living skills to maximize the ability of individuals with TBI to live independently in a community of their choice. These core services are also preventative as many TBI survivors who do not have access to a network of services and supports are at a higher risk of chronic homelessness, institutionalization, imprisonment, and placement in skilled nursing facilities due to an inability to perform activities of daily living and impaired emotional regulation. State law requires that 51% of the individuals served in the TBI program must be Medical recipients.

The Home and Community-Based Services (HCBS) Expanding TBI Provider Capacity Proposal will expand the capacity of existing TBI sites and stand up new

TBI sites in alignment with HCBS surrounding transition and diversion through community reintegration, personal care services through supported living services, and other supportive services to improve functional capabilities of individuals with TBI.

The proposal includes funding to expand capacity of six (6) existing TBI sites and to award up to six (6) additional TBI sites in unserved/underserved areas.

Developmental Services Workforce Investment

Funding: \$135M enhanced federal funding (\$215M TF) One-time

Lead Department(s): DDS

Recruitment and Retention for Direct Service Professionals (DSPs). This represents an investment of \$200M for the following:

- Recruitment – Even pre-pandemic, service providers had significant challenges hiring and retaining qualified staff. During the last year, DSPs worked above and beyond expectations to maintain consumer safety and continue providing necessary services and supports. To assist with retention, provide current DSPs \$500 and with recruitment offer \$500 to DSPs, upon hire.
- DSP Training - This training program provides DSPs an opportunity to receive a one-time training bonus upon completion of enhanced training. Additionally, this funding provides a bridge while DDS develops and implements the DSP training and certification program.

Employee Assistance for all DSP. This will provide an investment of \$15M for short-term counseling, support and resource referral service to assist DSPs and their families in managing difficult life events. Approximately \$5M annually and could be scalable for other systems.

Community Navigator/Implicit Bias Training

Funding: \$51M enhanced federal funding (\$75M TF) One-time with \$11M ongoing

Lead Department(s): DDS

COVID-19 highlighted the continued need to assist families of children who are regional center consumers from underserved communities to navigate systems to reduce service access and inequity and meet basic needs. The Budget proposes funding to establish one community navigator per regional center (21 total) to assist families in navigating regional center and generic resources. This additional investment will add 42 additional navigators, to the proposed 21, to double down on the effort to achieve meaningful change for regional center consumers and families who face challenges navigating regional center and generic resources.

The proposed Budget includes funding for implicit bias training for regional center staff who are involved in determining eligibility for regional center services. To further address structural inequities in the system this proposal accelerates implicit bias training and cultural and linguistic awareness and training for remaining regional center staff and expands to service providers.

Home and Community Based Services Navigation

To improve access to HCBS, these HCBS Navigation initiatives work to development a variety of statewide HCBS navigation systems, including screening and assessment tools, referral and navigation systems, coordination of services, and outreach campaigns.

HCBS Navigation Initiatives include:

- No Wrong Door System/Aging and Disability Resource Connections (ADRCs)
- Dementia Aware and Geriatric/Dementia Continuing Education
- Caregiver Resource Centers
- Individuals with developmental disabilities (IDD) Resource Navigation Portal
- Emergency Department HCBS Connections Toolkit
- Mental Health First Aid in Schools and Back-to-School Toolkit

No Wrong Door/Aging and Disability Resource Connections (ADRCs)

Funding: \$5M enhanced federal funding (\$5M TF) One-time

Lead Department(s): CDA, with DHCS, DOR

California is establishing a state-wide “No Wrong Door” system (or Aging and Disability Resource Connections), so the public can easily find information, person-centered planning, and care management for older adults and adults with disabilities across the range of home and community services provided by health plans (i.e., CalAIM “In Lieu of Services”) community-based organizations (CBOs), and counties. This investment supports the interoperability between the proposed ADRC technology and data systems with CBOs, health plans, and counties, in line with the CalAIM goals for statewide Managed Long-Term Services and Supports for all Californians participating in Medi-Cal and with the new Office of Medicare Innovation and Integration. This will further the various aging proposals included in the Governor’s May Revision and help to deliver on the vision of the Master Plan for Aging, which calls for California communities to build a California for All Ages where people of all ages and abilities are engaged, valued and afforded equitable opportunities to thrive as we age.

Dementia Aware and Geriatric/Dementia Continuing Education

Funding: \$25M enhanced federal funding (\$25M TF) One-time

Lead Department(s): DHCS, with OSHPD, CDPH

The Governor’s May Revision begins to deliver on the recommendations put forward by the Governor’s Task Force on Alzheimer’s Prevention and Preparedness. This spending plan makes additional investments to further this work by screening older adults for Alzheimer’s and related dementias to ensure early

detection and timely diagnosis, while also connecting individuals and families to community resources.

Dementia Aware: Develop an annual cognitive health assessment that identifies signs of Alzheimer's disease or other dementias in Medi-Cal beneficiaries. Develop provider training in culturally competent dementia care. Develop a referral protocol on cognitive health and dementia for Medi-Cal beneficiaries, consistent with the standards for detecting cognitive impairment under the federal Medicare Program and the recommendations by the American Academy of Neurology, the California Department of Public Health's Alzheimer's Disease Program, and its ten California Alzheimer's Disease Centers.

Geriatric/Dementia Continuing Education, for all Licensed Health/Primary Care Providers: Make continuing education in geriatrics/dementia available to all licensed health/primary care providers, in partnership with Department of Consumer Affairs and OSHPD, by 2024. This education of current providers complements the Administration's geriatric pipeline proposals for future providers; it is needed to close the gap between current health professionals with any geriatric-training and the rapidly growing and diversifying 60-plus population.

Caregiver Resource Centers

Funding: \$5M enhanced federal funding (\$5M TF) One-time
Lead Department(s): DHCS with CDA

Family caregivers are the largest group of providers of adult and disability care. This proposal would provide increased respite care, behavioral health services, and other supports to meet intensified needs due to pandemic pressures on families, through 11 Caregiver Resource Centers and 33 Area Agencies on Aging.

Individuals with Developmental Disabilities Resource Navigation Portal

Funding: \$5.6M enhanced federal funding (\$7M TF) One-time, \$500k GF Ongoing
Lead Department(s): DDS

This proposal would develop an online portal identifying resources for regional center consumers, families, and regional center staff. Information available in the navigation portal would include regional center intake information packets, resources on accessible housing options, and resource information from related safety net systems, such as In Home Support Services, CalFresh, Behavioral Health, etc. The proposed funding also includes an on-demand educational series for families.

Emergency Department HCBS Connections Toolkit

Funding: \$50M enhanced federal funding (\$50M TF) One-time
Lead Department(s): DHCS

This initiative is focused on improving the quality of care for older people, people with serious behavioral health needs, and homeless individuals in Emergency Departments, with the goal of improving health outcomes and connections to public and community based services. The funding will be used to create toolkits for Emergency Departments to provide pre-packaged resources, training, and information on local connections to services. Tools will be created with subject matter experts and leverage work such as the Geriatric Emergency Collaborative, CalBridge BH Navigator work, and homelessness resources.

Mental Health First Aid in Schools and Back-to-School Toolkit

Funding: \$75M enhanced federal funding (\$75M TF) One-time

Lead Department(s): DHCS, with CDPH

The Governor's May Revision makes a historic \$4 billion investment in transforming the children and youth behavioral health system in order to focus on prevention, increase the number of behavioral health professional, provide more crisis services, and add acute care services and beds. However, to provide immediate resources to schools and teachers, this investment will build on the bold proposals in the May Revision.

The Mental Health First Aid in Schools and Back-to-School toolkits will help address some of the immediate needs of children and youth for the much-anticipated return to school for the 2021-22 year. For the last year, students, teachers, and parents have had to adapt to distance learning and have missed out on the socialization and development opportunities that come with physically being on a school campus. The physical health of students has been well protected by the measures schools have taken to avoid the spread of COVID-19. The behavioral health needs of students and staff remain vulnerable and must be more fully addressed. Behavioral health needs are not as easily identified and the building of toxic stress and behavioral health challenges can be just as, if not more, debilitating for children and teens as COVID-19. By investing in up-front and early education, this proposal takes steps to address future more intensive needs that could result in institutional care.

This proposal presents strategies and tools to facilitate a successful return to schools by:

1. Implementing Mental Health First Aid for Schools: Youth Mental Health First Aid is an 8-hour public education program that introduces adults to the unique risk factors and warning signs of mental health problems in adolescents, builds understanding of the importance of early intervention, and teaches individuals how to help youth in crisis or experiencing a mental health challenge.

2. Implementing a media campaign, building off the existing CalHOPE media campaign, to destigmatize the stress and anxiety about returning to school. Messages will target students, parents and other caregivers, and school staff. The campaign will provide easy-to-access tips for how to talk to children and youth about returning to school. It will also identify social influencers that connect with the diverse populations of students, parents and caregivers, and teachers. It will utilize a wide range of mediums to reach audiences, including social media, digital, print, radio, television creative opportunities yet to be identified. The voice of youth will be used in developing and deploying messages for youth.
3. Building upon and connecting with the positive social and emotional learning environments, the existing networks of CalHOPE Communities of Practice are active in 57 counties. They provide a foundation to implement training and programs across California. The Communities of Practice are evolving toward Transformative social and emotional learning that helps address the causes of inequities and social justice.
4. Engaging youth as peer navigators/helpers with training on how to listen and support peers, including asking for more support when needed. Provide training through youth-serving organizations and support to engage youth as partners in the safe return to school.

This proposal will:

- a. Provide schools with a toolkit to support teachers, parents, and students
- b. Provide parents and caregivers tools for psychological first aid support.
- c. Provide training for teachers, parents, and caregivers.

Home and Community-Based Services Transitions

The HCBS Transition initiatives expand and enhance community transition programs to additional populations or settings and facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a homeless shelter) to a variety of community-based, independent, living arrangements. The proposals include transitions from skilled nursing facilities to home or assisted living environments, preventing long-term care placements, long-term housing placements for IDD consumers, transitions from homeless to housed, transitions from incarceration to home or residential programs, and diversion for those at risk of incarceration as a result of their health care (primarily behavioral health) needs.

These HCBS initiatives invest in reducing health disparities among older adults, people with disabilities, and homeless individuals. They include initiatives to test alternative payment methodologies or the delivery of new services that are designed to address social determinants of health and inequities. These new services may include housing-related supports, such as one-time transition costs, employment supports, and community integration as well as providing more intensive care coordination for individuals with significant socioeconomic needs.

HCBS Transition Initiatives include:

- Community Based Residential Continuum Pilots for Vulnerable, Aging and Disabled Populations
- Eliminating the Assisted Living Waiver Waitlist
- Expanding Capacity of Independent Living Centers
- Housing and Homelessness Incentive Program
- Affordable Housing for Individuals who have IDD

Community Based Residential Continuum Pilots for Vulnerable, Aging, and Disabled Populations

Funding: \$286M enhanced federal funding (\$774M TF) One-time

Lead Department(s): DHCS, with DSS

The Community Based Residential Continuum Pilots would provide medical and supportive services in home and community care settings (home, ARFs, RCFEs) in order to avoid unnecessary healthcare costs, including emergency services and future long-term care placement in a nursing home. This program would ensure individuals are able to live in the least restrictive setting possible by ensuring access to home-based health and other personal care services for vulnerable populations, including seniors and people with disabilities.

This further supports the investments made in the Governor's May Revision for community care expansion for the construction, acquisition and/or rehabilitation to further stabilize these facilities with physical upgrades and capital improvements.

Focus populations include individuals with serious mental illness; elderly homeless; individuals needing additional housing and supportive services but not meeting an institutional level of care; individuals in an institution who could be served at home or in a community care setting; individuals with disabilities; and individuals being diverted or released from prisons, jail, state hospitals, or juvenile justice systems.

These services would be provided to individuals who do and do not meet institutional level of care, and who require medical and/or behavioral health and supportive services to live successfully in the community. DHCS would determine the eligibility criteria for these pilots and managed care organizations would make individual eligibility determinations.

Pilot funding would be provided to managed care plans to provide these benefits to members. Managed care plans would contract with licensed providers to provide needed medical and/or behavioral health services to beneficiaries in their own home, in coordination with any authorized IHSS services or personal care/homemaker services. For individuals residing in or needing the support of a community care setting, managed care plans would contract either directly with the licensed community care setting to provide these services or with a licensed provider who would deliver services onsite.

This proposal creates new models of care for those who need personal care, medical, and/or behavioral health supports to live either in their own home or a community care setting. The proposal is well aligned with CalAIM and other DHCS, DDS, and DSS efforts to support individuals living in the least restrictive setting possible and maximizing their dignity, privacy, and independence.

For the Prison, Jail, and Juvenile Justice Re-entry and Diversion Populations, this proposal will establish residential or board and care settings where medical, behavioral and social services are available or on-site, as re-entry hubs for this population. Services provided will include peer supports, job-training preparation, employment services, and education linkage (trade schools or getting GED as examples). After a period of time (e.g., six months) and completing job training, housing search and rental assistance will be provided. After a further period of time (e.g., 2 years) if stably employed, participants will be provided with a housing acquisition package. This would include a \$1000/month stipend for up to 9-12 months to help stabilize someone after re-entry into the community.

This would build off the Center for Employment Opportunities, which provides subsidized employment and other services to individuals who have recently

returned home from incarceration, using the Returning Citizens Stimulus program in response to the COVID-19 pandemic. It provided three monthly cash transfers to people who were recently released from incarceration to ease their transition into society at a time of social distress and high unemployment. The program leveraged the Center for Employment Opportunities' existing pay card system to deliver three monthly "stimulus" payments totaling at least \$2,250 to individuals who participate in services designed to facilitate successful reentry. In August 2020, the Center for Employment Opportunities and local partner organizations expanded Returning Citizens Stimulus in California to provide three monthly payments totaling \$1,500 to an additional 1,000 citizens returning from incarceration under the Returning Home Well initiative, which provides housing, health care, treatment, transportation, direct assistance, and employment support for Californians returning home from prison.

Eliminating Assisted Living Waiver Waitlist

Funding: \$85M enhanced federal funding (\$255M TF), \$38M ongoing

Lead Department(s): DHCS

Add 7,000 slots to the Assisted Living Waiver in an effort to eliminate the current Assisted Living Waiver waitlist while furthering the vision of the Master Plan for Aging. The current Assisted Living Waiver capacity is 5,744 slots; of which 5,620 are filled as of May 1, 2021. There are approximately 4,900 beneficiaries on the waitlist as of May 1, 2021, and an additional 1,300 beneficiaries approved for enrollment in the Assisted Living Waiver but waiting for an available assisted living facility placement to complete enrollment. The proposed addition of 7,000 slots will enable DHCS to provide sufficient Assisted Living Waiver capacity to enroll all waitlisted beneficiaries and to clear pending enrollments while still providing a cushion for continued growth. The proposed commitment to Assisted Living Waiver growth will also likely encourage participation of residential care facility for the elderly (RCFE) and adult residential facility (ARF) providers in the Assisted Living Waiver program, as the waitlist has been previously cited as a barrier to provider participation.

Expanding Capacity of Independent Living Centers

Funding: \$10M enhanced federal funding (\$10M TF) One-time

Lead Department(s): DOR

Expanding Capacity of Independent Living Centers (ILCs) Proposal supports transition and diversion services for individuals with disabilities including transition and diversion through hospital discharge and by addressing the gaps that exist between California Community Transitions (CCT) and other applicable waivers. The proposal prevents institutionalization by establishing a Community Living Fund for one-time community transition costs to help persons with disabilities to transfer home from a congregate setting. This proposal anticipates CalAIM approval and models capacity to leverage the resulting flexibilities around transitions and

diversion. Under this proposal, DOR will partner closely with the Department of Health Care Services on the program model to ensure compliance with HCBS requirements.

The proposal includes the following:

1. Funding to the 28 ILCs dedicated staff to provide the services.
2. Funding for transition or diversion services to consumers up to \$5,000 per service, with an average of \$2,700 per transition service.
3. One DOR SSA to provide grant administration.

Funding will be provided to ILCs to hire Transition Coordinators, and to establish the Community Living Fund to use as a mechanism to provide grants to secure housing, housing modifications, assistive technology, in-home care, and other items necessary to enable persons with disabilities to transfer home from a congregate setting. HCBS Allowable Activities: Transition Support including Transition Coordination and One-Time Community Transition Costs.

Housing and Homelessness Incentive Program

Funding: \$1B enhanced federal funding (\$2B TF) One-time

Lead Department(s): DHCS

Medi-Cal managed care plans would be able to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. There would be a requirement that 85% of the funds go to beneficiaries, providers, and/or counties. Funds would be allocated by Point in Time counts of homeless individuals and other housing related metrics determined by DHCS. Managed care plans would have to meet specified metrics to draw down available funds.

The target populations for this program would be aging adults, individuals with disabilities, families, individuals reentering from incarceration, homeless adults, chronically homeless individuals, persons who have/had been deemed (felony) incompetent to stand trial, Lanterman-Petris Short Act designated individuals, and veterans. This furthers the proposals included in the Governor's May Revision on housing and homelessness.

Managed care plans, in partnership with local public health jurisdictions, county behavioral health, Public Hospitals, county social services, homeless Continuum(s) of Care, and local housing departments must submit a Homelessness Plan to DHCS. The homelessness plan must outline how Housing and Homelessness Incentive Program services and supports would be integrated into the homeless system. This would include a housing and services gaps/needs assessment and how these funds would prioritize aging and disabled (including those with a behavioral health disability) homeless Californians. Plans should build off of existing local HUD or other homeless plans and be designed to address unmet

need. In counties with more than one managed care plan, plans would need to work together to submit one plan per county.

The Homelessness Plans must include mapping the continuum of services with focus on homelessness prevention (particularly for the aging and/or disabled population), rapid re-housing (families and youth), felony incompetent to stand trial and Lanterman-Petris-Short Act patients and permanent supportive housing.

The Homelessness Plans must identify what services will be offered, how referrals will be made, how other local, state, and federal funding streams will be leveraged, and how progress will be tracked towards goals including numbers served and other incentive performance measures. The Plans should build on existing homelessness plans and articulate how CalAIM services are integrated into the homeless system of care.

The following are some examples of Administrative or Delivery System incentives:

- Hire Homelessness lead/liaison at managed care plans
- Implement closed loop referral system for connecting homeless individuals to service bundles, housing, rental subsidies, etc.
- Sign contracts with local entities such as the county, Continuum of Care, and/or housing CBOs.
- Investing in the creation or expansion of a flexible housing subsidy pool
- Investing in the creation or expansion of a training academy for homeless services workers (bonus for specialized community health workers training)
- Partnering with local health care providers for the homeless program
- Creating a housing voucher program
- Partnering with existing housing capital and acquisition programs including Homekey, Community Care Expansion, and Behavioral Care Continuum Infrastructure Program

Examples of Performance Measures

- Incentive for every person housed
- Tiered bonus payments for % of county homeless housed
- Reduction in chronic homelessness (x% within the next X years OR Decrease X% over prior year)
- Incentive for keeping someone housed; paid on 6 month increments
- Reduced recidivism (x% within the next X years OR Decrease X% over prior year)
- Reduction in first time homeless (prevention) OR number of households who receive homeless prevention services
- Reductions in street homelessness
- Reduction of repeat occurrences of homelessness

- % maximizing other entitlements (SSI, Food, Medi-Cal, CalWorks, IHSS, in-home support, etc.)
- Reduction in people experiencing homelessness in local jails
- Addressing racial disparities (by monitoring demographics in PIT count and HMIS)

Affordable Housing for Individuals who have IDD

Funding: \$150M enhanced federal funding (\$150M TF) One-time

Lead Department(s): DDS

- Develop affordable housing with a requirement for restricted use for individuals with IDD. Funds to match existing funding sources and used to secure carve out or set-asides.
- Provide rental assistance to IDD consumers. COVID-19 had a direct impact on individuals being able to secure safe, affordable housing in the community of their choosing. To support individuals living in their own home, apartment, etc., this proposal helps establish housing and rental assistance for individuals with IDD and will be supported in future years through non-state or federal funds.

Services: Enhancing Home and Community-Based Services Capacity and Models of Care

By innovating and improving HCBS models of care to meet the needs of the individuals it serves, the state can increase capacity in the HCBS system, allowing more individuals, particularly those in the aging and disabled communities, to access services.

Initiatives include:

- Nursing Home Recovery & Innovation
- Alzheimer's Day Care and Resource Centers
- Adult Family Homes for Older Adults
- Family Home Agency
- Coordinated Family Support Service
- Reimagine Work Activity Programs
- Enhanced Community Integration for Children and Adolescents
- Capacity Expansion for Deaf Community
- Contingency Management

Nursing Home Recovery & Innovation

Funding: \$50M enhanced federal funding (\$50M TF) One-time
Lead Department(s): CDPH, with OSHPD, DHCS, and CDA

The critical lessons and losses from COVID for skilled nursing home residents, families, and staff must accelerate innovations for nursing home facilities that drive quality care for residents. California's priorities include revisiting and expanding the pilot for Small Home facilities, for both quality of care and quality of jobs; facilitating in-room broadband access for residents; and disaster readiness improvements for facilities and systems, to respond to wildfires, earthquakes, and other emergencies where residents are especially vulnerable, among other innovations.

Alzheimer's Day Care and Resource Centers

Funding: \$10M enhanced federal funding (\$10M TF) One-time
Lead Department(s): CDA, with DSS, CDPH, DHCS

The COVID-19 pandemic has masked and accelerated cognitive decline in older adults and increased the isolation and stress of older adults and caregivers living with dementia. More than 690,000 older adults and 1.62 million family caregivers in California are living with dementia, with women and people of color disproportionately susceptible to the disease and overwhelmingly providing the care. Dementia-capable services at licensed Adult Day and Adult Day Health centers provide services in the community vital to the health and well-being of

diverse older adults and families, prevent institutionalization, and advance health equity. This furthers the recommendations for the Governor's Task Force on Alzheimer's Prevention and Preparedness.

Adult Family Homes for Older Adults

Funding: \$9.1M enhanced federal funding (\$9.1M TF), \$2.6M Ongoing

Lead Department(s): CDA, with DDS

Adult Family Homes offer the opportunity for up to two adult individuals to reside with a family and share in the interaction and responsibilities of being part of a family unit, while the family receives a stipend and support from a local Family Home Agency (FHA) for caregiving for the adult individual(s). California will pilot Adult Family Homes for older adults in one county, with the Department of Developmental Services (DDS) assisting the Department of Aging (CDA) in developing and operating the program. This pilot is based on the successful program serving adults with developmental disabilities currently run by the DDS. Interested family homes are assessed and receive background clearances from a non-profit FHA under contract with a Regional Center. DDS performs oversight over the Regional Center and the FHA. CDA will mirror this model with Area Agencies on Aging and the existing non-profit FHAs. Moreover, this furthers the vision and recommendations of the Master Plan for Aging.

Family Home Agency

Funding: \$37M enhanced federal funding (\$61.7M TF) One-time

Lead Department(s): DDS

The benefits and outcomes of Family Home Agency (FHAs) include, reduced reliance on new housing options, direct service professionals, reduced isolation, and increased continuum of service options for all Californians in need of services and supports. Under the current funding structure, limited financial assistance is available to participating families and likely hinders the expansion of this service. FHAs offer the opportunity for up to two adults with developmental disabilities per home to reside with a family and share in the interaction and responsibilities of being part of a family and building connected relationships. This proposal would provide pass through funds to family home providers and include a differential for multi-cultural/multi-lingual families.

Coordinated Family Support Service

Funding: \$75M enhanced federal funding (\$125M TF); One-time, \$25M GF ongoing

Lead Department(s): DDS

Currently, adults living outside the family home have more coordinated supports than individuals living with their family. DDS data shows a significantly higher percentage of adults who identify as non-white (75%) live with their family as

compared to adults who are white (52%). To improve service equity for adults who live with their family, and improve individual supports at home, this proposal would pilot a new service for families similar to supported living services provided outside the family home. The pilot would assist families in coordinating the receipt/delivery of multiple services.

Reimagine Work Activity Programs

Funding: \$9M enhanced federal funding (\$15M TF) One-time
Lead Department(s): DDS

Existing work activity programs largely support sub-minimum wage employment in segregated settings. Funding would support the transition out of services provided in sheltered work settings to a new model of service that is time-limited, person-centered and focused on a “Pathway Forward” to employment connecting to Paid Internship Programs or Competitive Integrated Employment and measuring outcomes.

Enhanced Community Integration for Children and Adolescents

Funding: \$50M enhanced federal funding (\$50M TF) One-time
Lead Department(s): DDS

Children with IDD are frequently left out from participation in community programs, but both the child with IDD and children without greatly benefit from opportunities to develop friendships. This proposal would support community social recreational connections for children through a multi-year grant program. The grant program will be for regional centers to work with CBOs and local park and recreation departments to leverage existing resources and develop integrated and collaborative social recreational activities.

Capacity Expansion for Deaf Community

Funding: \$10M enhanced federal funding (\$15M TF) One-time
Lead Department(s): DDS

This proposal works to improve services for individuals with intellectual and developmental disabilities who are deaf. Due to the uniqueness of the deaf culture and their communication needs, funding will provide regional centers the ability to contract for communication assessments that will be used in developing Individual Program Plans. DDS will also contract with an individual or entity with the experience and qualifications to advise DDS in the most appropriate assessment tools, qualifications of assessors, and the necessary services or service adaptations to meet the needs of individuals who are deaf. Funding will also be used for statewide training.

Contingency Management

Funding: \$31.7M enhanced federal funding (\$58.5M TF) One-time

Lead Department(s): DHCS

Unlike alcohol and opioid addiction, there are no medications that work for stimulant use disorder. Overdose deaths from stimulants equal deaths from fentanyl in California, and rates continue to rise, causing high social costs (in terms of criminal justice involvement and foster care placement) and high medical costs (stimulant use disorder leads to high ED and hospital costs for infections, lung and heart disease). The lack of effective community-based treatments for stimulant use results in increased utilization of residential treatment services, particularly in the Medi-Cal program.

DHCS proposes to offer contingency management via a pilot, as it is the only treatment repeatedly shown in studies to work for stimulant use disorder. Contingency management uses small motivational incentives combined with behavioral treatment as an effective treatment for stimulant use disorder. The Department proposes to implement the motivational incentives through a mobile application that will be accessible to patients through smart phones, tablets or computers.

The Department proposes to start the pilot in January 2022 and continue the pilot through March 2024. DHCS would conduct a robust evaluation, and if the program is demonstrated to be effective, then submit a proposal through the budget process to allow contingency management to be an ongoing Medi-Cal benefit, as part of the Drug Medi-Cal Organized Delivery System.

By increasing the availability of community-based treatment, this proposal will reduce demand for residential treatment services, reducing costs and allowing individuals with substance use disorders to recover in the community and further builds on the behavioral health delivery system reforms in California Advancing and Innovating Medi-Cal (CalAIM).

Home and Community-Based Services Infrastructure and Support

The following infrastructure investments will support the growth of HCBS services, to allow existing HCBS programs to serve existing clients better as well as expand to serve more individuals who meet eligibility criteria.

Initiatives include:

- Long-Term Services and Supports Data Transparency
- Addressing Digital Divide for Adults with HCBS
- System Improvements
- Ombudsperson Office and Restructure

Long-Term Services and Supports Data Transparency

Funding: \$20M enhanced federal funding (\$20M TF) One-time
Lead Department(s): DHCS, with CDPH, DSS, CDA, OSHPD

This is a multi-department initiative to improve long-term services and supports (LTSS) data transparency, including utilization, quality, and cost data. This will be accomplished by creating a LTSS Dashboard linked with statewide nursing home, long-term care, and HCBS utilization and cost data, CDPH licensing data, LTC Ombudsman data, and other quality and demographic data. The goal of increased transparency is to make it possible for regulators, policymakers, and the public to be informed while we continue to expand, enhance and improve the quality of home and community-based services.

Addressing Digital Divide for Adults with HCBS

Funding: \$4.7M enhanced federal funding (\$9.5M TF) One-time
Lead Department(s): CDA

Telehealth services accelerated during the pandemic have the potential to improve access to health care from home and with family. Older adults, however, are less connected to the internet than younger populations and need devices, broadband, and tech support to equitably access tele-health, especially in rural and low-income communities. Older adults and adults with disabilities eligible for Medi-Cal tele-health services and participating in HCBS will be provided tablets or other appropriate devices for telehealth, along with broadband and tech support (including expanded language access for tech support). This initiative leverages a new CDA digital divide initiative with Older American Act providers to increase the number of older adults and adults with disabilities receiving HCBS who are connected to tele-health and to other digital services and supports that prevent isolation and support well-being, while furthering the goals of the Master Plan for Aging.

System Improvement

Funding: \$181.8M enhanced federal funding (\$256M TF) One-time

Lead Department(s): DDS, with DHCS participation Outcome-Based System

The proposed immediate investments will improve and stabilize the services directly impacting consumers, build the infrastructure to support consumers and their families through person-centered practices and supports. Additionally, a prevailing need and challenge within the developmental service system is moving from a compliance-based system to an outcome-based system. To accomplish this conversion, DDS will need to build infrastructure and modernize methods for collecting and analyzing information about consumer services and outcomes.

1. Accelerate Service Coordinator Recruitment and Hiring - An investment of \$45M TF one-time is proposed, and ongoing funds are included in the proposed Budget. The proposed Budget also includes a Performance Incentive Program focused on reducing caseload ratios beginning in 2022-23, while DDS works with stakeholders to design the program. Providing this funding in 2021-22 would provide more immediate support to reduce service coordinator ratios and focus on consumer and family outcomes and improved experiences. This proposal would improve coordination and consumer experiences by reduce caseload ratios through hiring approximately 400 service coordinators in 2021/22.
2. Outcomes-Based System – A one-time investment of \$15M over multiple years. - The May Revise proposed designing a Performance Incentive Program tied to outcomes for Regional Center operations. This proposal would go beyond regional center operations to fund the evaluation of the purchase of service structure which utilizes vendorized providers. Purchase of service currently funds services and supports based on consumer needs, but payments are not linked to consumer outcomes. A successful contractor would work with the Department to design a system that establishes an alternative payment system driven by consumer outcomes. This funding would support a request for proposals to develop and implement an outcomes-based system for purchase of services.
3. Modernize Regional Center Information Technology Systems – Update the regional center fiscal system and implement statewide Consumer Electronic Records Management System. An investment of \$120M one-time, multi-year to support the scope of work, request for proposal process, procurement, and initial implementation. Ongoing costs are anticipated to be supported with current resources.

- a. Uniform Fiscal System (\$70M) – The current information technology systems for billing and case management are disjointed and unable to quickly adapt to changing needs given the age of the systems and lack of standardization. Changes require DDS and regional centers to create and apply patches and result in significant data lags which can delay identification of problems and hinder decision-making given outdated information. The existing fiscal system was implemented in 1984. Replacement of the RC fiscal system, which processes provider payments, will improve efficiencies as the system is modernized and provide more detailed expenditure data consistent with CMS payment system expectations.
 - b. Consumer Electronic Records Management System (\$50M) – The Regional Centers do not have a statewide standardized client case management system. Securing timely and accurate data is extremely challenging due to system differences. Additionally, there is not an outward facing option for self-advocates and families to access their information; such as, IPPs, current authorizations, appointments, outcomes data, etc., instead that information is delivered by mail or email. This proposal will increase the availability and standardization of information; to include, measures/outcomes, demographics, service needs, special incident reports, etc. Lastly, the system will allow consumers, via the web or app, to access their records. This investment will also support the efforts to develop an outcomes-based system for purchase of services.
4. Organizational Change Management (RCs and DDS) – A \$20M multi-year one-time investment to prepare regional center and department staff and develop and implement numerous changes in fiscal system, consumer electronic record system, implementation of statewide policy and performance incentive's driven by outcomes, and service delivery post-COVID.
5. Person Centered Planning – A \$26M multi-year one-time investment for comprehensive person-centered plans (PCP). Investment supports compliance with HCBS and is foundational for implementation of an outcome-based service delivery system. Investment is anticipated to support person-centered planning for approximately 15,000 individuals each year.
6. Support Development of New Community Services and Supports - \$30M one-time, multi-year. *Background:* The DDS budget includes approximately \$27M for startup annually in the area of community resource development called Community Placement Plans (CPP/CRDP), which only partially funds qualified proposals. The funds are allocated to regional centers, after

community engagement to contract the development of new resources to support current needs based on consumer growth (residential, employment, etc.). *Proposal:* Increase the funds available for 3 years at \$10M each year. The additional funds would be earmarked for new and innovative pilot development to move the system forward with the following priorities: first-responder training, resources for underserved populations, services that are culturally and linguistically sensitive, enhance pathways for employment (College to Career) and services that promote independence (employment).

Ombudsperson Office and Restructure

Funding: \$10M enhanced federal funding (\$20M TF), \$1.5M GF ongoing
Lead Department(s): DDS

This initiative works to improve dispute resolution and due process activities – Self-advocates and families (primarily the Lantinx community) have shared they don't believe there is a "safe" place for them to go to assist with conflicts with regional centers and have long asked for the Department to have an Ombudsperson office. Additionally, the current fair hearing process/dispute resolution process is cumbersome, difficult to navigate and intimidating for communities where questioning "authority" is difficult or not acceptable. Families share that they believe they don't feel they have enough representation as compared to the regional centers. For example, regional centers have highly educated staff defending their decisions and families in the lower socio-economic threshold don't have the financial means to "fight the system". This proposal would establish an Ombudsperson's Office at DDS and redesign the appeal and Fair Hearing process.

###