CHAPTER 3: Program Components

Policy: Standards of casework will be provided to all sites to ensure compliance with the federal Home and Community-Based Services Waiver.

Purpose: This chapter provides information on the components of the Multipurpose Senior Services Program (MSSP) care management process from outreach and initial screening to termination of program participation. Program standards reflect the following assurances made to the Centers for Medicare & Medicaid Services (CMS).

1. MSSP sites must certify and report to the California Department of Aging (CDA) that all care management staff meet prescribed qualifications as specified in Chapter 2 of this manual and training requirements specified in the CDA Standard Agreement, Exhibit A, Article II. MSSP Program Operations, Sections A, G and H, and Exhibit D, Article XIX. Information Integrity and Security, Section D.

2. At the time of enrollment, the participant is informed of their rights to:

    1. Freedom of choice between waiver services and institutional care.
    2. Freedom of choice among services, service providers, sites and care management staff.

3. The initial Level of Care (LOC) determination must be completed within 60 days of MSSP application (Section 3.410, Requirements for Enrollment). The CDA-finalized LOC is a requirement for enrollment.

4. The LOC predetermination must be written by a qualified Nurse Care Manager (NCM) (as defined in Chapter 2) on the LOC Predetermination form (Appendix 19 or 20), consistent with the need for institutionalization per the California Code of Regulations, Title 22, Sections 51118, 51124, 51334 and 51335 (Appendix 18). The final LOC determination will be made by a CDA MSSP Nurse, using assessment(s) and the LOC form completed at the site level.

5. Care plans are based on MSSP approved assessment tools (Appendix 37) and include services that fully address the MSSP participant's needs and goals.

6. Participants must be involved in the care plan process and indicate their agreement by signing the care plan.

7. Care plans must be revised at least annually and as participant needs change.

8. Services/interventions delivered to the participant must match the care plan, service code and be paid appropriately.

9. Only vendors who meet qualifications, licensure, and training requirements (CDA Standard Agreement, Exhibit D, Article II. Assurances, Section A, and Article XIX. Information Integrity and Security, Section D) can provide services for participants.

10. Care management staff monitor participants by monthly contact, quarterly home/telehealth visits and annual reassessments, at a minimum.

11. As mandated reporters, MSSP site staff must report all critical incidents of participant abuse, exploitation, neglect, including self-neglect, to the appropriate local agency, immediately or as soon as possible. Information regarding any incident and participant-reported outcome that the care manager is aware of must be documented in the progress notes and reported on the Critical Incident Report, as part of the Quarterly Report submitted to CDA.

12. CDA MSSP Section will conduct utilization reviews of MSSP sites.

13. CDA Audits and Risk Management Branch will conduct financial audits on MSSP sites.

14. Assurances to CMS provide that each participant is Medi-Cal eligible at enrollment and throughout program participation and that all waiver and care management services are appropriate and necessary.

References:

- Home-and Community-Based Services Waiver #0141.R07.00
- Interagency Agreement between DHCS and CDA
- CDA Standard Agreement (Site Contract)
- California Code of Regulations, Title 22, Sections 51118, 51124, 51334 and 51335

3.000 Outreach

Outreach efforts should be specific to each site's situation. A new MSSP site conducts outreach to inform the community of its existence and services; sources of referrals to the program are identified; and working relationships are initiated. As the site becomes established, outreach activities continue, but their nature evolves and changes. Changes in State MSSP policies and the site's own host agency require that the MSSP site continually redefine itself within its community.

Each MSSP site will engage in ongoing outreach efforts. Outreach may require ongoing interaction with a variety of community entities.
Ongoing outreach efforts may be necessary to ensure sites maintain a monthly active participant count equal to 100 percent of their budgeted waiver slots (CDA Standard

Agreement, Exhibit A, Article II. MSSP Program Operations, Section F and Chapter 9, Section 9.040, Slot Allocations and Enrollment Levels).

3.020 Wait List

Enrollment in the MSSP Waiver is limited to the maximum number of funded slots authorized for each MSSP site. MSSP Waiver slots are available when a site has unused waiver capacity. MSSP sites may not defer enrollment when there is unused waiver capacity (an open slot) unless an applicant has chosen to defer. Each MSSP site must maintain a wait list of individuals eligible for potential enrollment.

Enrollment into MSSP is based on the "imminent need" for services determined through a standardized process to provide fair and equitable access. Sites must develop and implement a wait list policy and procedure that incorporates sufficient screening information to assign the applicant to a Low, Medium, or High-Risk Level on the wait list and provides for ongoing monitoring to review and reassign priority as the applicant's needs change.

Priority enrollment is given to those applicants that are assigned to the "High Risk Level", participants transferring from another MSSP site, and to former MSSP participants who continue to meet LOC and other eligibility criteria.

3.020.1 Wait List Data

Wait list data regarding the number of individuals on the list and the average length of time on the list will be maintained by the site and reported to CDA monthly and on the Quarterly Report.

3.030 Standards

The CDA MSSP policy for required face-to-face home visits is as follows:

- All new MSSP participants must receive initial face-to-face home visit assessments by both the Social Work Care Manager (SWCM) and the Nurse Care Manager (NCM) (Section 3.620, Initial Health Assessment/Initial Psychosocial Assessment).

- All participants must be monitored monthly by a member of the care management team. Monitoring entails review of each care plan participant need statement and evaluating the effectiveness of the care plan through face-to-face or telephone contact (Section 3.1520, Monitoring Activities).

- A home or telehealth visit with each participant by a member of the care management team must be conducted quarterly (at 3-month intervals) in the participant's residence (Section 3.1520, Monitoring Activities). While sites have the flexibility to conduct these contacts via the telehealth service delivery option, quarterly contacts conducted as an in-person visit should be the default/preferred method of conducting quarterly contact, with telehealth provided as an option considering the participant's choice and circumstances (Section 3.1530.1, Telehealth as an Option for Quarterly Contact).

- A face-to-face home visit with each participant by either the SWCM or NCM is required for the annual reassessment (Section 3.630, Reassessment).

- A face-to-face home visit conducted by the alternate discipline is required each year. The alternate discipline visit should occur within 12-month intervals and may be linked to monthly contact, a quarterly contact or the Reassessment (Section 3.1520, Monitoring Activities).

3.040 Sequence of Enrollment Processes

The sequence of events is as follows:

1. Pre-Screening (Section 3.200).

2. Screening Process (Section 3.220).

3. Application (Section 3.330). Prior to or concurrent with enrollment.

4. Initial Assessment (Section 3.620). Either of the assessments must be completed within two weeks of the Application, with the second assessment occurring within the next two weeks.

5. Level of Care Predetermination (Section 3.110). Completed by the NCM prior to or upon enrollment to MSSP confirming program eligibility.

6. Level of Care Submission to CDA for Final Determination of Initial LOC (Section 3.110.5). Sites must submit a completed LOC packet to CDA within 60 days of Application.

7. Enrollment (Section 3.400). Enrollment occurs after the participant has completed and signed the Application, the NCM has completed the initial LOC, and the packet is submitted to CDA for approval. The enrollment effective date is the date that the completed LOC packet is submitted to CDA.

8. Participant Enrollment/Termination Information Form (Chapter 7, Section 7.210).

9. Care Plan (Section 3.640). Completed within two weeks of the most recent assessment.

These activities may occur on the same date.

3.100 Eligibility

There are certain eligibility criteria that must be met in order to receive services as a participant of MSSP. Eligibility for the program is addressed initially at pre-screening and/or screening and confirmed throughout participation in the program.

The MSSP eligibility criteria include all of the following:

- Certifiable for placement in a nursing facility (NF) (Section 3.110, Certifiable for Placement in a Nursing Facility) also known as “level of care”, per California Code of Regulations, Title 22, Sections 51118, 51124, 51334 and 51335 (Appendix 18).

- Age 60 or older (Section 3.120, Age 60 and Older).

- Receiving Medi-Cal under an appropriate aid code (Section 3.130, Receiving Medi-Cal under an Appropriate Aid Code).

- Able to be served within MSSP’s cost limitations (Section 3.150, Able to Be Served Within MSSP’s Cost Limitations).

- Appropriate for care management services (Section 3.160, Appropriate for Care Management Services).

- Will not enroll in or receive duplicative care management services from another program (Section 3.1110, Non-Duplication of Care Management Services).

3.110 Certifiable for Placement in a Nursing Facility (or Level of Care Determination)

General Criteria:
An individual evaluation for the required LOC per California Code of Regulations, Title 22, Sections 51118, 51124, 51334 and 51335 must be made by the NCM and finalized by a CDA MSSP Nurse for each eligible applicant. General criteria include:

- LOC determinations must be documented on the Level of Care Predetermination form (Appendix 19) or the Level of Care Predetermination form with FNAG (Appendix 20) which are available electronically. All certifications, including initial and re-certifications, must be recorded on this form by a Nurse Care Manager (NCM).

- LOC forms must include the NCM name, title, signature and date (Chapter 5, Section 5.810, Staff Signatures and Signature Requirements).

- The participant’s case record must contain supporting information (assessment information, physician, or other consultant information) that substantiates the LOC determination.

- The LOC form, assessment(s), and Functional Needs Assessment Grid (FNAG) must be submitted to CDA for final approval by a CDA MSSP nurse (Section 3.110.5, Submission to CDA for Final Determination of Initial LOC and Section 3.110.11, Submission to CDA for Final Determination of Recertification LOC).

3.110.1 Clinical Judgment and Level of Care

LOC determination is a clinical judgment made by the NCM and CDA MSSP nurse in accordance with the California Code of Regulations, Title 22, Sections 51118, 51124,

51334 and 51335. The submission of the initial LOC predetermination must be completed within 60 days of MSSP application (Section 3.410, Requirements for Enrollment). The CDA finalized LOC is a requirement for enrollment.

LOC predeterminations are based on the nurse's professional assessment and observations and/or information gathered through the screening tool and other sources such as care management staff, the participant, the attending physician and others involved in caring for the participant. The information required for this analysis must be obtained by conducting a home visit.

Sites should use their clinical judgment to determine if an applicant meets level of care. If a site is unsure if an individual meets level of care criteria, sites can email MSSPLOC@aging.ca.gov to request a consultation, but do not include any participant Protected Health Information (PHI). A CDA nurse will contact the site via phone to discuss details.

3.110.2 Use of the California Code of Regulations (CCR), Title 22, to Determine Eligibility

The applicant must be certified as functionally impaired or have a medical condition requiring the LOC provided in a nursing facility (NF).

The LOC standards for NF are set forth in the California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 3, Article 2, Sections 51118, 51120, and 51124 and Article 4, Sections 51334 and 51335. The regulations are located in Appendix 18.

3.110.3 Application of Title 22 Criteria

The Title 22 criteria (Appendix 18) were developed specifically for NF eligibility, thus, applying these criteria to determine LOC for individuals living in the community can be challenging. To make this translation from facility or “patient-focused” to community-based or “participant-focused” care, the NCM must focus their analyses and judgment on the elements described below. The functional status of all four areas need to be addressed and recorded on the LOC form as follows:

- Cognitive and sensory
- Diagnoses
- Activities of Daily Living (ADLs)
- Instrumental Activities of Daily Living (IADLs)

- Cognitive and Sensory: The participant’s mental status must be described - whether the participant is alert and oriented to person, place, time (X3), oriented to person only, or has specific cognitive deficits. It is helpful to describe any cognitive deficits related to attention, working memory, judgment, reasoning, problem solving, decision making, and comprehension, the production of language and/or hearing, vision, or other sensory loss. It is useful to incorporate information from the cognitive screening tool. When reporting the SPMSQ score on the LOC, sites should include the number of errors. It is helpful to include the description of mental functioning. For example, if an individual has four errors the

LOC should state “Applicant/participant had four errors on the SPMSQ indicating mild cognitive impairment.”

- Diagnoses: The evaluation process for eligibility requires the inclusion of participant diagnoses to better determine their LOC. Diagnoses provide critical insight into an individual’s functional abilities, health conditions, and care needs, which are essential for aligning with the standards outlined in Title 22 Criteria (Appendix 18). These include diseases, injuries, or chronic conditions which have been identified by the participant’s health care provider (PHCP). While official diagnoses from the PHCP are preferred, receiving diagnoses from the participant, family member or caregiver is acceptable.

- Activities of Daily Living (ADLs): Activities of daily living are those personal functional activities which are essential for health and safety. ADLs, as defined by CMS, are bathing, dressing, transferring, toileting, mobility, and eating.

- Instrumental Activities of Daily Living (IADLs): Instrumental activities of daily living, as defined by CMS, are activities related to independent living including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication. IADLs may also include medication management and stair climbing.

3.110.4 Completion of LOC Predetermination Forms

The LOC Predetermination form (Appendix 19) or LOC Predetermination with FNAG form (Appendix 20) must be completed to certify the **LOC requirement**. This validates that the participant has functional deficits that meet the eligibility criteria “certifiable for placement in a nursing facility.” All certifications must be recorded on this form. Forms must be fully signed and dated by the NCM. (Chapter 5, Section 5.810, Staff Signatures and Signature Requirements). CDA does not require any specific format or style when completing the LOC form (Appendix 19 or 20) but has samples available for reference (Appendix 19A and 20A).

The rationale and justification for the LOC determination must be summarized by the NCM in the space provided. Documentation on the form must identify functional status and limitations. Although medical diagnoses provide clarifying details, alone they are not sufficient to describe a participant’s functional status. When official diagnoses are not available, signs and symptoms may be described. Describing signs and symptoms experienced by diagnoses assists in providing a comprehensive depiction of the participant's level of care related to their functional ability during evaluation for eligibility of services. The level of assistance required for the completion of ADLS and IADLs is critical to provide a comprehensive description of the participant’s functional deficits. It is helpful to include explanations or reasons for the level of assistance required with ADLs/IADLs when documenting functional status. For example: “The participant is dependent in housework, laundry, and shopping/errands due to shortness of breath related to COPD, poor balance, unsteady gait, generalized weakness, and arthritis in the hands and knees.” The participant’s case record must contain supporting documentation or evidence that substantiates the LOC.

3.110.5 Submission to CDA for Final Determination of Initial LOC

Federal interpretation of 42 CFR Section 431.10 requires that MSSP program eligibility be determined by the State. Therefore, all LOC determinations must be submitted to CDA for final approval.

LOC packages will be uploaded to Unfoxer, the software system used to house/transfer all LOC related documents and correspondence. To protect participant Protected Health Information (PHI), CDA requires that all communications about LOC determinations be made within the Unfoxer system.

Prior to submitting a case to CDA, the MSSP site must prepare the LOC package which requires the following in Unfoxer:

- LOC form (Appendix 19 or 20) with all required information: cognition, functional status of ADLs/IADLs, diagnoses and nurse name, title, and signature
- Initial Health Assessment (IHA) (Appendix 25) OR Initial Psychosocial Assessment (IPSA) (Appendix 26)
- Functional Needs Assessment Grid (FNAG) (Appendix 30)

The FNAG must be completed by the discipline completing the in-home assessment used for LOC submission. If the NCM is completing the assessment, the NCM may complete the LOC with FNAG form (Appendix 20) in lieu of needing to complete an LOC and separate FNAG (Appendix 30). If the FNAG and LOC differ because the SWCM completed the FNAG and the NCM completed the LOC, a journal entry should be added to the Unfoxer case to explain the reason for any significant differences. The NCM should use their clinical judgment when completing the LOC. If any required items are incorporated into larger documents, multiple attachment types may need to be identified for the larger document to satisfy the validation requirement in Unfoxer.

The following documentation is optional depending on the initial assessment submitted:

- Medications list (Appendix 32)
- Psychological Functioning Assessment (included with Appendix 26)
- Any additional supporting documentation the site feels is necessary. Examples include, but are not limited to pre-screening forms, fall risk assessment, nutritional assessment, etc.

The site should ensure all relevant documentation for case review is provided. Cases with incomplete information are subject to processing delays. The enrollment date is the date that the completed LOC packet is submitted to CDA.

LOC submissions will be reviewed by CDA on a first-come, first-served basis, within 30 days of submission. The maximum duration for review and final response will be 60 days from case submission. Cases older than 60 days of submission are subject to denial if all requested information has not been provided. If additional information is required, CDA will contact the site via a journal entry within Unfoxer with the request for additional information. The site will receive an automated email to notify them of a new journal entry with the Unfoxer ID to reference.

3.110.6 Consultation with CDA for Urgent/High-need Cases

In the event MSSP staff identifies a situation or need of such a critical nature that must be dealt with immediately rather than waiting for the standard LOC review and approval process, the site can request an emergency review of the LOC. The site should enter a "Journal Entry" within Unfoxer with journal topic "Case Review" which includes any pertinent information describing the need for an emergency review. After the case has been submitted to Unfoxer, the site should email CDA at MSSPLOC@aging.ca.gov to request an emergency LOC review. Within the email include the following information: Emergency LOC review request, site number and Unfoxer ID. Do not include any participant PHI in the email request.

3.110.7 Initial LOC Submission Timing Consideration

Sites are encouraged to complete care management activities in the same month as initial LOC submission to CDA. Since care management services are billed using a monthly rate, all enrollment activity that took place in the same month as the LOC package submission date would be reimbursed for all approved LOC cases. Any site workload prior to LOC case upload is at risk of not being reimbursed if done in the month(s) prior to LOC submission and approval. For example, if the site begins the assessment process at the end of the month and does not submit their LOC package until the beginning of the next month, they would not be reimbursed for completing the assessments in the month prior to case submission.

3.110.8 Unfoxer Case Status Updates and Notifications

Sites may check Unfoxer for the current status of all cases. Cases will be organized in different tabs by their status. MSSP sites will be notified of the following case status updates via automated email:

- Under Review: CDA has received the case and started the review process.
- More Information Needed: More information is needed to complete the review process. The case will return to the "In Progress" status tab for site edits.
- Approved: LOC is approved. The site will download the final approved LOC for their records and will proceed with care management and waiver service delivery and billing. Participant ID is not required for approval; however, Participant ID must be entered in order to download the final LOC certification.
- Denied, Participant Does Not Meet Eligibility: Participant does not meet eligibility criteria. The site can ask CDA to reconsider the denial decision if they disagree. If the site agrees, they will proceed with the denial/termination process that includes sending and maintaining a copy of the Notice of Action (NOA).
- Denied, Insufficient Information to Approve: After multiple attempts to gather information, the case does not contain sufficient information to approve. The site can ask CDA to reconsider the denial decision. The site will have to comply and submit the requested information. The enrollment date may be altered based on delay of information.

3.110.9 Retention of Finalized LOC

Unfoxer will retain LOC information after a final determination is made. For approved cases, CDA will retain a copy of the finalized LOC for ten years after finalization. Sites are expected to download a copy of the finalized LOC and maintain copies of all submitted supporting documentation for as long as the case is open and active, then for seven years following case termination, as required by the CDA Standard Agreement (Exhibit E, Additional Provisions, Article II. Records Provisions Specific to this MSSP Agreement). Due to an amendment to Welfare and Institutions (W&I) Code Section 14124.1, effective Fiscal Year 2026-27, the retention period will be ten years from the date of termination.

3.110.10 Recertification (Reevaluation) for LOC

The purpose of the recertification review is to verify that the participant continues to meet the LOC requirements for MSSP participation.

Recertification is **required** annually, on the day of, or prior to the end date of the last LOC, or more frequently if the participant's status has changed. Completed recertification LOC packages must be submitted to CDA within 365 days of the previous LOC. A recertification LOC is considered late if it is submitted to CDA one year plus one day after the same date of the previous LOC. As an example, if the initial LOC is submitted to CDA on July 1, 2025, the recertification LOC would need to be submitted by July 1, 2026. On July 2, 2026, the recertification LOC would be considered late. Recertification LOC packages may be submitted up to 30 days prior to the 365th day and the annual due date will remain unchanged. The assessment and FNAG must be completed within 30 days prior to the 365th annual due date. The LOC must be written by the NCM no later than 14 days after the assessment.

Sites should begin planning in the weeks or month leading up to the 30-day timeframe to schedule the LOC assessment with the participant. Reasonable efforts must be made to complete the LOC recertification requirements within this 30-day period. If circumstances beyond the site's control prevent completion of the LOC by 365 days, the reason for delay must be documented in the progress notes. If a participant is hospitalized or in a SNF at the time of recertification, the assessment should be completed upon the participant's return home or as soon as possible.

The site must document all follow-up attempts to schedule the assessment and the reason for any delay must be clearly documented in the progress notes. For LOC cases submitted to CDA after 365 days, the LOC date will be the date of submission to CDA which will reset the LOC timeline, making future recertification LOCs due 365 days from that date. When LOCs are not submitted by the 365th day, services should not be billed between the 365th day and the day of LOC submission to CDA. If no care management services are provided during the month, care management should not be billed for that month. Failure to make reasonable efforts to complete the LOC package within the required timeframes may result in recovery of funds.

3.110.11 Submission to CDA for Final Determination of Recertification LOC

Recertification LOC packages will be uploaded to Unfoxer, a software system that will be used to house/transfer all LOC related documents and correspondence. To protect

participant Protected Health Information (PHI), CDA is requiring all communications about LOC determinations to be made within the Unfoxer system.

Before submitting a case to CDA, the MSSP site must prepare one of the following recertification LOC packages depending on whether the LOC is done at the Alternate Discipline Visit (ADV) or at the Reassessment (RA). The recertification LOC must be based on an in-home assessment within 30 days of the recertification LOC. If the SWCM or another NCM completes the in-home assessment (ADV or RA), another NCM may complete the recertification LOC based on the documented assessment. The NCM completing the recertification LOC and the discipline that completed the assessment should communicate regarding any changes in the participant's needs or condition, particularly as they relate to determining the appropriate LOC.

LOC Done at ADV	LOC Done at Reassessment
ADV Assessment form (SWCM or NCM)	Reassessment form (SWCM or NCM)
Previous LOC* (NCM)	Previous LOC* (NCM)
Current LOC or LOC with FNAG form (NCM)	Current LOC or LOC with FNAG form (NCM)
FNAG form** (SWCM or NCM)	FNAG form** (SWCM or NCM)

*Previous LOCs not already in Unfoxer will need to be uploaded with the recertification LOC packet. Finalized approved LOCs already in Unfoxer do not need to be attached. Unfoxer allows you to select participants already in the system which will automatically attach the previous LOC to the current recertification case. Beginning January 1, 2025, the date of the initial LOC is the date of LOC package submission to CDA.

**The FNAG must be completed by the discipline completing the in-home recertification assessment used for LOC submission. If the NCM is completing the recertification assessment, the NCM may complete the LOC with FNAG form (Appendix 20) in lieu of needing to complete an LOC and separate FNAG (Appendix 30) . The CDA-Approved Cognitive Screening Tool, FNAG form, and Medication List can be completed with either the ADV Assessment or Reassessment; however, they must be completed at least every 12 months. The Safety and Special Equipment Checklist (Appendix 31) will be required to be completed with the IPSA and at reassessment; it is not required to be submitted with the LOC case.

The site has the option to include additional supporting documentation as necessary. Examples include, but are not limited to: cognitive assessment screening tool, relevant progress notes, fall risk assessment, nutritional assessment, medication list, etc.

For all LOC packages, the site should ensure all relevant documentation for case review is provided. Incomplete packages will result in the LOC being dated based on the number of additional days it takes to receive the completed package.

LOC submissions will be reviewed by CDA on a first come, first served basis. CDA will review recertification LOC packages within 14 days of submission. If approved, Unfoxer will send notification to the site, who then must download the finalized LOC form from Unfoxer (Section 3.110.9, Retention of Finalized LOC).

3.110.12 Requests to Reset a LOC Due Date

Sites have the option to permanently reset the recertification LOC date when submitting a LOC case to CDA. The Unfoxer software system will prompt the site to specify the one-time LOC reset date, allowing it to submit as an exception earlier than the annual due date. Resetting an LOC date is intended to be a one-time, permanent change to reset the LOC date as the foundation for scheduling all future recertification LOCs. This will reset the LOC timeline, making subsequent recertification LOCs due 365 days from the new date. Resetting may occur for specific circumstances including, but not limited to the following:

- Change of assessment method (Section 3.110.13, Requests to Change Recertification LOC Assessment Method)
- Aligning with a companion case
- Resetting a care manager's caseload
- Reenrollment (Section 3.1720, Reenrollment)
- Restoration of annual due date after late submission

For all other situations, reset requests should be emailed to MSSPLOC@aging.ca.gov for consideration.

Requirements for resetting an LOC date:

- The reset date must be within 365 days of the previous LOC
- The recertification assessment must be completed within 30 days of the reset date
- The LOC package must be sent to CDA within 30 days after completing the recertification assessment and predetermination LOC (whichever comes first)
- The current predetermination LOC must be within 14 days of the recertification assessment
- The reset date must be on or after the recertification assessment or LOC date

Example recertification LOC dates when resetting recertification date:

- Initial LOC: July 10, 2025
- Original annual recertification LOC due date: July 10, 2026
- Reset LOC: January 15, 2026.
- New annual recertification LOC due date: January 15, 2027
- On January 16, 2027, the recertification LOC would be considered late.

3.110.13 Requests to Change Recertification LOC Assessment Method

Sites have the option to complete a recertification LOC using one of two assessment methods: ADV Assessment form or Reassessment. If a site elects to use a different assessment method than it is currently using, a written request must be submitted via email to CDA at MSSPLOC@aging.ca.gov at least 30 days prior to implementation. To maintain program consistency, the site must adhere to that chosen assessment method for all participants. The change in assessment method will allow for a one-time LOC date reset (3.110.12, Requests to Reset a LOC Due Date), which will reset the LOC timeline, making future recertification LOCs due 365 days from the new date.

When resetting the LOC date, the enrollment date and reassessment month will stay the same unless sites opt to reset the reassessment calendar to a different month than the initial enrollment as the foundation for scheduling future reassessments. If needed, the site may choose to reset the reassessment month at this time.

3.120 Age 60 or Older

Age is to be verified by checking the date of birth on the Medi-Cal card or on the Medi-Cal eligibility website. If an applicant presents conflicting documentation from any other source, information on Medi-Cal documents prevail.

3.130 Receiving Medi-Cal under an Appropriate Aid Code

In order to be eligible for MSSP, the applicant must have a qualifying primary Medi-Cal aid code. Qualifying primary Medi-Cal aid codes are defined in Appendix 10.

Applicants for MSSP who appear eligible for Medi-Cal but are not receiving benefits should be referred to the county welfare department for Medi-Cal eligibility determination, utilizing institutional deeming, if appropriate (Section 3.130.1, Institutional Deeming [MSSP Aid Codes 1X and 1Y]).

MSSP sites are required to service participants with aid codes 1Y, 17, 27, 37, 4V, 6R, 65, 67, 81, or 87 or those subsequently redetermined into one of these aid codes if the participant has means (In-Home Supportive Services [IHSS], medical expenses, etc.) of meeting their share of cost. If the participant cannot meet their share of cost within a reasonable time frame, the site may initiate termination procedures. A reasonable time frame is a minimum of 30 days.

Verification of initial and continuing participant eligibility for Medi-Cal is each site's responsibility. Sites should verify Medi-Cal eligibility monthly. Batch eligibility verification is available through the Medi-Cal website. Sites that do not verify each participant's Medi-Cal eligibility could be at risk for non-payment.

Sites may use the aid code as a prompt to ask the applicant/participant questions about their particular situation, but it would not change how the NCMs determine LOC using Title 22 standards (Section 3.110.3, Application of Title 22 Criteria).

3.130.1 Institutional Deeming (MSSP Aid Codes 1X and 1Y)

According to the California Department of Social Services Manual of Policies and Procedures, Chapter 30-701 (d) (1), "Deeming means procedures by which the income

and resources of certain relatives, living in the same household as the recipient, are determined to be available to the recipient for the purposes of establishing eligibility and share of cost."

In determining Medi-Cal eligibility for someone living in an institution (institutional deeming), under spousal impoverishment provisions, the income or resources of a parent or spouse are not considered as being available to that individual. Instead, the institutionalized person is considered to be an isolated unit in terms of budgeting, even though they may be someone's minor child or spouse. The income and assets available to the institutionalized person are "deemed" to belong to the other family members, up to certain limits.

Since MSSP participants meet nursing facility (NF) level of care requirements, Medi-Cal eligibility rules for institutionalized individuals (institutional deeming) can be applied. The result may be that by deeming assets and resources to a spouse (resulting in those assets not being considered in a person's Medi-Cal application), some individuals may then be eligible for Medi-Cal benefits, including the MSSP Waiver.

While Medi-Cal eligibility is a requirement for MSSP, institutional deeming is not necessarily the answer for all potential MSSP candidates because of the impact on their eligibility for the Personal Care Services Program (PCSP), Community First Choice Option (CFCO), or IHSS provided under the State Plan (formerly IHSS Plus Waiver). One important difference is that under PCSP, the participant's spouse cannot be paid as the provider of personal care services (Welfare and Institutions Code, Section 14132.95 [f]), nor may services be provided under advance pay status. Some potential MSSP waiver participants who have their spouse as their provider or who receive advance pay may be unable or unwilling to change these arrangements.

Referrals for institutional deeming will be made by sending the CDA Waiver Referral form (MC 364) (Appendix 11) directly from the site to the local county welfare office. This form is available online through two sites:

1. By Medi-Cal program form number (MC 364)

2. By Medi-Cal program form name

Each MSSP site will designate one person (and a back-up) to coordinate referrals and act as liaison with designated staff at the county.

The spousal impoverishment provisions must be applied upon the applicant's request to participate in MSSP, rather than once enrolled into the program (All County Welfare Director Letter [ACDWL] 17-25). During the initial screening, MSSP staff must determine that an applicant meets all waiver eligibility criteria (with the exception of Medi-Cal eligibility) **before** referring the individual to the local county welfare office to have their application for Medi-Cal processed. This eligibility determination includes an initial LOC predetermination completed by the site NCM. Submission to CDA is not required at the time of the deeming process; however, it will need to be submitted prior to enrollment (Section 3.110.5, Submission to CDA for Final Determination of Initial

LOC). If it is not possible for the site to complete a LOC, the county may ask for a Doctor's Verification form to be completed in order to establish that nursing facility level of care criteria is met (ACDWLs 17-25 and 18-19).

Applicants should be informed that they will be receiving an application packet for Medi-Cal from the county and that these forms be completed and returned to the county in a timely manner. Once the Medi-Cal application has been processed and eligibility confirmed and finalized by CDA, the applicant may be enrolled in MSSP. Two Medi-Cal aid codes have been established for those applicants who qualify under this institutional deeming provision: 1X (those with no share of cost), and 1Y (those with a share of cost). If a wait list exists, an applicant may remain under these aid codes regardless of the length of wait time.

It is important that participants who become eligible for Medi-Cal via institutional deeming understand that continuing eligibility for Medi-Cal is conditional upon continuing eligibility for the MSSP Waiver. Therefore, if they are terminated from MSSP, they also lose their other Medi-Cal benefits within 30 days. A special application form containing this information (Appendix 13) will be used to enroll these individuals. There is also a specific section on the termination and denial letters (Appendix 2 or 3) that addresses the linkage between MSSP and Medi-Cal for these participants.

Institutionally deemed MSSP participants are limited to five percent (5%) of a site's total caseload. It is important to track the information regarding the number of participants utilizing institutional deeming to ensure that this limitation is not exceeded.

3.140 Residence Requirements

The ZIP Code for a participant's residence should be within the geographic boundaries defined in the site's contract with consideration given to a participant's right to freedom of choice (Section 3.320, Freedom of Choice).

Under Medi-Cal residency requirements, participants must be residents of California with the intent to remain permanently or indefinitely. When a participant leaves the state of California (but remains within the United States, Canada or Mexico) for a period of less than 30 days, they may receive monthly or quarterly contact care management services via telehealth. Sites would only be able to bill for care management provided while a participant is in these countries, otherwise it would not be allowable in other countries.

3.150 Able to Be Served Within MSSP's Cost Limitations

Each MSSP site's average monthly cost for all Title XIX services cannot exceed 95% of the average monthly cost of institutional care. During the screening process, if ongoing costs are projected to exceed the cost of institutional care (100% of the benchmark), the applicant is ineligible for MSSP. However, if there is a plan to bring these costs down to the benchmark within three months, the applicant may be enrolled (Section 3.920, The Benchmark and Calculation of Costs, and Section 3.930, Authorization and Utilization of Services).

3.160 Appropriate for Care Management Services

This criteria addresses the applicant's *need* for and *ability/willingness to participate* in the care management process. Both elements must be present.

- "Need for care management" is indicated when an applicant requires assistance to: gain access to community services; maintain or effectively utilize available services; and/or manage serious health conditions.

- "Ability/willingness to participate" is indicated by the applicant's cooperation in formulating and then carrying out the care plan. Participants must also be willing to participate in monthly care management calls, Quarterly Contacts, Reassessments, and all required home visits. Required in-person home visits include the completion of the application/enrollment forms, Initial Health and Psychosocial Assessments, Alternate Discipline Visit, and Reassessment (Section 3.1530, Telehealth as a Service Delivery Method).

In the event the applicant/participant is cognitively unable to participate independently, a personal representative may fulfill this requirement (Section 3.520, Authorization for Use and Disclosure of Protected Health Information Form).

3.200 Pre-Screening

Potential applicants are pre-screened to determine eligibility and appropriateness for participation in MSSP.

3.210 Screening Forms

Screening forms or tools may vary from site to site; however, each site must be consistent in the form and process it employs. The screening form must be completed for every referral. If an applicant is deemed ineligible, the screening form must be retained in a separate file for ten (10) years from the date of the decision. (Section 3.230, Referrals Not Accepted for MSSP Participation).

3.220 The Screening Process

The initial screening can be performed by telephone or in person, at a community agency, at the person's place of residence, or in an acute care hospital or nursing facility. If the screening is conducted in an institution, the person may not be enrolled in the program and no services can be provided until s/he is discharged from the facility and residing in the community, except as permitted under Deinstitutional Care Management (Section 3.1300, Deinstitutional Care Management).

Written notice is **not** required if someone chooses not to participate, or does **not** meet the criteria for age, Medi-Cal eligibility, residence, or is enrolled in a duplicative program they do not intend to withdraw from. The staff member conducting the screen should inform them they may contact the program at a later date should their situation change. Site staff should attempt to link ineligible applicants to other community resources.

For those participants enrolled in MSSP, the screening form must be completed and retained in the participant record.

3.230 Referrals Not Accepted for MSSP Participation

Medi-Cal beneficiaries who live in the site's contracted service area who are age 60, but do not meet other MSSP requirements but still wish to participate, must receive a written notice regarding their right to a State Fair Hearing (Appendix 5 and 6) in accordance with Welfare and Institutions Code, Sections 10950-67 (Appendix 1). Disqualified applicants must receive a written notice (Notice of Action, NOA) stating the reason for this decision (Appendix 3), including instructions for requesting a State Fair Hearing (Appendix 5 and 6).

All records of applicants not accepted for MSSP participation must be retained by the site for State and federal review for a period of seven years from the date of the decision. Due to an amendment to Welfare and Institutions (W&I) Code Section 14124.1, effective Fiscal Year 2026-27, the retention period will be ten years from the date of the decision.

3.300 Application for MSSP Services

3.310 Non-enrolled Applicants

Persons who are not accepted for MSSP participation are given a written notice (Appendix 3) by the site and have the right to a State Fair Hearing (Appendix 5 and 6) in accordance with Welfare and Institutions Code, Sections 10950-67 (Appendix 1).

All records of persons not accepted for MSSP participation must be retained by the site for State and federal review for a period of seven years from the date of application. Due to an amendment to Welfare and Institutions (W&I) Code Section 14124.1, effective Fiscal Year 2026-27, the retention period will be ten years from the date of the application.

3.320 Freedom of Choice

Persons deemed eligible for participation in MSSP will be informed of their right to choose whether they will participate in MSSP. MSSP sites must have a process to inform and respond to participants for the following:

- The right to refuse services.
- The right to choose institutional care (NF).
- The right to choose a specific care management provider (site) and/or care manager.
- The right to choose services and/or a specific service vendor for each service in their care plan.
    - Participants may request that a MSSP site contract with a willing and qualified vendor that meets all requirements.
- The right to choose the location, time (within business hours) and method of how their **monthly** contact is conducted.
- The right to choose whether **quarterly** contact is in-person or via telehealth, if there are no health or safety issues that would necessitate an in-home visit (Section 3.1530.3, When Telehealth is Not Appropriate).

3.330 Application

The Application (Appendix 12) summarizes what the participant can expect from the program, alternatives regarding services, and the rights of program participants.

The application must be completed for all persons enrolling in MSSP. A copy of the form must be provided to the participant. The original signed and dated application must be retained in the participant's record.

If the participant is unable to sign for themselves, the following individuals may sign and date for them:

1. *Conservator.* This is a person appointed by a court.

2. *Agent.* This is a person named in the participant's power of attorney for health care or other legal document.

3. *Personal representative.* Is an adult designated by the participant in the presence of the MSSP staff member.

Documentation of the above must be in the participant record either on the Application form or in the re/assessment or progress notes.

If the applicant/participant is not able to fully sign their name, an "X" is acceptable.

3.400 Enrollment

3.410 Requirements for Enrollment

Within 60 days of the application for participation in MSSP, the LOC determination must be submitted to CDA. Enrollment occurs after the applicant has completed and signed the Application, the site has submitted the initial LOC package to CDA, and a CDA MSSP nurse has finalized the LOC (Section 3.110.5, Submission to CDA for Final Determination of Initial LOC).

3.420 Notification of Rights

The participant must be notified of his/her rights by receiving copies of:

1. Participant Rights in MSSP (Appendix 15); and
2. Your Rights Under California Public Benefits Programs (Appendix 16).

The purpose is to provide information regarding participant rights. The forms cover both the informal grievance process and the formal State Fair Hearings.

MSSP participants must also be informed of the following:

- Circumstances which may cause loss of services.

- Termination procedures, including an explanation of the participant's right to refuse or discontinue services.

- The local MSSP site's informal grievance process, including the name, address, and telephone number of the person(s) responsible for resolving complaints or initiating the grievance procedure.

- Any other information determined to be essential for the proper delivery of services.

3.500 Release of Participant Information

3.510 Confidentiality

Participant information is strictly confidential (Chapter 5, Participant Records and Information, and Chapter 7, Section 7.100, Confidentiality and Information Systems).

The Application informs the participant that personal information will be shared among MSSP staff, governmental agencies, managed care health plans, consultants and service vendors in order to facilitate service. According to 45 CFR 164.506(c)(4)(passim) conducting case management and care coordination (including care planning) falls under the subset of health care operations activities that can be disclosed without needing patient consent or authorization. Beyond those parameters, sharing and obtaining information requires the specific consent of the participant. In all cases (including family members and caregivers) the participant must sign a written consent to obtain or release such information (Authorization for Use and Disclosure of Protected Health Information form, Appendix 17).

3.520 Authorization for Use and Disclosure of Protected Health Information Form (AUDPHI)

All pertinent data will be entered on the form (Appendix 17) *before* the participant is asked to sign. Staff will not have participants sign blank forms.

Each AUDPHI must specifically state the agency or individual who is to provide or receive the information, and the type of information to be exchanged. The AUDPHI may be used for a specific agency or individual or it may address an individual/entity when specifics are unknown "Attending Physician at Redwood Clinic" or "Saint Mary's Hospital".

The expiration date on the AUDPHI cannot exceed two years from the date of the participant's signature.

If the participant is unable to sign for themselves, the following individuals may sign for them:

1. *Conservator.* This is a person appointed by a court.

2. *Agent.* This is a person named in the participant's power of attorney for health care or other legal document.

3. *Authorized representative.* This is an adult designated by the participant, either in writing or orally, in the presence of the MSSP staff member.

Documentation must be included in the participant record reflecting this permission. The documentation may be handwritten on the AUDPHI or included in the re/assessment or progress notes.

Participants must be offered copies of all signed AUDPHIs. If the participant declines to receive copies, that information must be documented in the record.

3.530 Requests for Participant Information

A request for information about a participant requires written consent from the participant or authorized representative. Information regarding the release of PHI during an emergency can be located here.

3.600 Care Management

3.610 General Guidelines

The MSSP care management process involves:

- Understanding the Waiver and other resources (community, Medicare, Medi-Cal State Plan, Title III, etc.).
- Conducting and documenting timely and comprehensive assessments and reassessments.
- Creating a participant needs list from specific issues identified in assessment/reassessment.
- Developing and updating a care plan and tracking outcomes.
- Coordinating services and/or purchases using waiver funds only for approved expenditures after other resources have been exhausted or are not available.
- Monitoring interventions and the impact on the waiver participant's functional abilities and goals.
- Interdisciplinary collaboration and crisis intervention as needed.
- Documenting and record keeping.
- Terminating participation in the program.

The participant's primary point of contact for the duration of their participation in the program is their care manager. Care management is a collaboration between participant and care manager. When a participant is unwilling or unable to continue care management as evidenced by the participant's lack of cooperation, the services of MSSP will be terminated following established termination guidelines (Section 3.1700, Termination).

Assessments, reassessments, participant needs lists, care plans, progress notes, and Service Plan and Utilization Summary (SPUS) are the tangible elements of the care management process. The goals and outcomes of care management must be clear. The participant's preferences and functional needs must be reflected and incorporated in the documentation.

Assessments, reassessments, and alternate discipline visits must be conducted at the participant's residence. In the event that extenuating circumstances exist and the visit cannot be conducted in the participant's home, the reason must be documented in the progress notes. The only other exception to performing an assessment in an alternate location is under Deinstitutional Care Management (Section 3.1300, Deinstitutional Care Management).

Quarterly home/telehealth visits should also be conducted at the participant's residence, with telehealth provided as an option considering the participant's choice and circumstances (Section 3.1530.1, Telehealth as an Option for Quarterly Contact).

3.620 Initial Health Assessment / Initial Psychosocial Assessment

Each person determined to be eligible through the MSSP intake screening process will receive face-to-face comprehensive initial health and psychosocial assessments to identify specific issues, resources, needs, and preferences.

Initial assessments are conducted by the NCM (Initial Health Assessment or IHA, Appendix 25) and the SWCM (Initial Psychosocial Assessment or IPSA, Appendix 26.) They do not have to be completed in any particular order; however, the first one must be completed within two weeks of the date of the application, and the second one must be completed within two weeks of the first one. If this timeframe cannot be met, the reason for the delay must be documented in the progress notes. Shortage of staff is not an acceptable reason for delay.

An initial assessment requires a face-to-face interview with the participant. Additional information may be obtained through contact with the family and other informal supports; contact with the participant's physician and other health providers; as well as a review of the participant's health, medical, and psychosocial history. These contacts are made with the knowledge and consent of the participant, or the participant's significant support person who participates in the assessment and care planning process.

Initial assessments must be conducted in the participant's place of residence. It is important to have a clear understanding of the home environment and the impact on the participant's functioning since it is the goal of the MSSP to support the participant's ability to live safely at home. The care manager should gather information on the home environment during the home visit. If a participant is unable to complete the assessment (due to fatigue or other reasons), the rest of the assessment may be conducted via telehealth. The reason for not completing the assessment in its entirety in the home must be documented.

Initial assessments will be reviewed for completeness of information and pertinent medical and social information relating to present conditions, function, and environment. All sections of the assessment must be completed. If information is unobtainable, the reason must be noted. On occasion, completion of a component may be deferred. If completion of a section is deferred, the reason must be noted and a timeframe for obtaining the information should be included in the narrative or progress note.

All applicable checkboxes of the assessments must be completed or addressed in the written comments. If a checkbox requires additional information, the comment section must be used to describe. If a section is not applicable, write “no”, “none” or “N/A”. As part of each initial assessment process, a participant description and needs list must be included within the record (e.g., within the assessment, LOC, or progress notes).

The participant’s involvement in the process should be clear by documenting their input regarding services or other information.

The Initial Health Assessment and Initial Psychosocial Assessment shall contain information to identify the following elements that will be used to formulate a current Level of Care certification/recertification, care plan, and determine participant goals/outcomes:

- Date of assessment
- Name and title of the staff member completing the assessment
- Participant needs list
- Participant’s strengths and resources
- Participant’s functional levels and capacity to live independently
- Participant’s preferences and choices
- Care manager’s assessment of the participant’s service needs and additional supports that are necessary to sustain the participant with as much self-determination as possible
- Signature – the assessment must be signed by the qualified staff member completing the assessment (Chapter 5, Section 5.810, Staff Signatures and Signature Requirements)

Each initial assessment must contain a participant needs list of issues/concerns that will be formulated into participant need statements on the care plan. A care plan participant need statement may include one or more related items from the participant needs list.

CDA required documents for assessments are available electronically. The assessment packet consists of the assessments with supporting forms as detailed below.

The documents required by CDA consist of:

Initial Health Assessment (IHA) (Appendix 25)

- Cover Sheet (Optional, Appendix 23)
- Initial Health Assessment
- Participant’s Medications List (Appendix 32)
- Participant Needs List

Initial Psychosocial Assessment (IPSA) (Appendix 26)

- Cover Sheet (Optional, Appendix 23)

- Initial Psychosocial Assessment
- Psychological Functioning (included in Appendix 26)
- Safety and Special Equipment Checklist (Appendix 31)
- Participant Needs List

The CDA-Approved Cognitive Screening Tool (Appendix 33) and Functional Needs Assessment Grid (FNAG) (Appendix 30) are also required, however, can be completed with either the IHA or the IPSA. The comment fields are optional; however, comments are encouraged to help provide a clear picture of the participants' needs. The cognitive screening tool and FNAG can be typed or handwritten, then completed as an individual form or incorporated into the larger assessment. Either the SWCM or the NCM can complete the cognitive screening tool and FNAG.

3.620.1 Vital Signs

It is highly recommended and considered a best practice for nurses to obtain vital signs during a home visit whenever possible. This helps support clinical judgment and provides a more complete picture of the participant's current health status, which can be especially valuable in cases where recent vital signs have not been obtained otherwise (such as when an individual has been unable to visit their primary care physician).

Obtaining vital signs is particularly important when participants have medical conditions or circumstances such as:

- A history of hypo/hypertension
- Diabetes (to monitor for signs of hypo/hyperglycemia)
- Use of medications that can impact cardiovascular or respiratory status (e.g. beta-blockers, diuretics)
- Complaints of feeling unwell, fatigued, dizzy or lightheaded
- Recent changes in health status or hospitalization
- Signs of infection (e.g. fever, chills)
- Unexplained weight changes or concerns of fluid retention
- Concerns related to falls, especially in the context of blood pressure variability

The NCM should use their clinical judgment to identify abnormal or concerning values to help guide appropriate interventions, recommendations, education, or activating emergency services, if needed.

3.620.2 Cognitive Assessment Tools

CDA has approved the use of four screening tools: Folstein Mini Mental State Examination (MMSE); Montreal Cognitive Assessment (MoCA); Saint Louis University Mental Status Examination (SLUMS); and the Short Portable Mental Status Questionnaire (SPMSQ). See Appendix 33.

If a site elects to use a different cognitive assessment tool, a written request with a copy of the tool must be submitted to CDA for approval prior to adoption. To maintain program consistency, the site must use the selected cognitive screening tool with all MSSP participants. Sites are responsible for obtaining the cognitive tool of choice.

A cognitive screening tool must be attempted for each assessment. If a participant is unable to complete due to a diagnosis of Alzheimer's Disease, dementia or neurodegenerative disease, the site should complete the Functional Assessment Staging Tool for Dementia (FAST) or the Dementia Severity Rating Scale (DSRS). If the participant is unable to complete either tool, the reason must be documented on the assessment or in the progress notes.

3.630 Reassessment

The reassessment is a formalized method of documenting and analyzing changes during the period since the previous assessment. It is **not acceptable** to report "no change" without additional comment or to copy the prior re/assessment.

Reassessments must be completed annually by either the NCM or SWCM. They require an interview with the participant and must be conducted in the participant's place of residence, whenever possible. In-home visits are the default and preferred method for completing assessments. However, to ensure compliance with required timeframes, there may be limited circumstances in which a telehealth assessment may be used on an interim basis (Section 3.1530, Telehealth as a Service Delivery Method). As with the initial assessments, it is important to have a clear understanding of the home environment and its impact on the participant's functioning. The reassessment should reference the interventions provided by MSSP during the prior year and whether the anticipated outcome was achieved.

The reassessment shall contain information to identify the elements that will be used to determine participant goals and formulate a new care plan. The information should align with and support the LOC certification. Information that should be included:

- Date of assessment
- Name and title of staff person completing the assessment
- Participant needs list
- Current status of and any changes to participant need statements on the care plan
- Participant's strengths and resources
- Participant's functional levels and capacity to live independently
- Participant's preferences and choices
- Care manager's assessment of the participant's service needs and additional supports that are needed to sustain the participant with as much self-determination as possible
- Signature – the assessment must be signed by the care manager completing the assessment (Chapter 5, Section 5.810, Staff Signatures and Signature Requirements)

The format of the reassessment document is the same regardless of the professional discipline of the care manager conducting the reassessment.
The reassessment consists of:

- Cover Sheet (Optional, Appendix 23)
- Reassessment (Appendix 27)
- Functional Needs Assessment Grid (FNAG) (Appendix 30)*
- Safety and Special Equipment Checklist (Appendix 31)
- CDA-Approved Cognitive Screening Tool (Appendix 33)*
- Participant's Medications List (Appendix 32)*
- Participant Needs List

*The CDA-Approved Cognitive Screening Tool, FNAG form, and Medications List can be completed with either the ADV form or Reassessment; however, they must be completed at least every 12 months.

Care managers are encouraged to use collateral sources of information as reference points for the reassessment. Sites may also use additional documents, including interview guides or check lists, to collect the information for the reassessment. Information collected in this manner must be incorporated into permanent case documents. Informal notes should not be included in the participant's file.

Timeframe for reassessment:

- The month of initial enrollment is the foundation for future reassessments.

- A grace period of one month on either side of the anniversary month is acceptable. For example, if the participant is enrolled in September, reassessments would always be due in September; however, they could be done in August or October and still meet the required timeframe. The grace period does not change the requirement that a participant be contacted quarterly. The grace period does not apply to reassessments linked to LOC redetermination.

Sites have the option to reset the reassessment calendar to a month different from the month of initial enrollment as the foundation for scheduling future reassessments. To reset the reassessment calendar, the reassessment must be completed in **less than** 12 months and the progress notes must document both the change as being permanent and identify the new reassessment due date.

No participant shall go more than 12 months without a reassessment to convert to the new schedule. Quarterly home/telehealth visits would then be adjusted to align with the new schedule maintaining compliance for quarterly contact at three-month intervals.

3.630.1 Alternate Discipline Visits

Sites must maintain a multi-disciplinary staffing model and ensure that each participant is seen by both the NCM and the SWCM at least every 12 months for the alternate discipline visit (ADV).

The ADV must be face-to-face with the participant and may be completed as a monthly contact, quarterly contact (conducted as a home visit), reassessment, or an additional home visit. ADV documentation must meet the requirements for the type of visit

(Monthly, QC, RA) and provide review of the participant's status incorporating the expertise of the opposite discipline (Section 3.820, What Progress Notes Include).

For sites that combine the ADV with the reassessment, it is acceptable to take advantage of the one-month grace period for the reassessment. This does **not** apply to ADVs linked to LOC redetermination. If a home visit cannot be completed for the ADV due to unforeseen circumstances, a telehealth visit may be conducted. All attempts to schedule and complete the visit as a home visit must be documented in the progress notes. Shortage of staff is not an acceptable reason to defer the home visit requirement. The home visit must be completed as soon as possible, but no later than 30 days of the telehealth contact (Section 3.1530, Telehealth as a Service Delivery Method).

The ADV Assessment form (Appendix 28 or 29) is completed by the alternate discipline during the ADV to identify clinical and functional changes in the participant. This form must be fully completed when the ADV Assessment form is submitted instead of the reassessment for LOC recertification (Section 3.110.11, Submission to CDA for Final Determination of Recertification LOC). If the ADV is the site's method of assessment for LOC recertification, the discipline completing the ADV assessment must complete that discipline's form. This form is not required for ADVs that are not being submitted for LOC evaluation.

Examples of incorporating nursing expertise may include, but are not limited to:

- Performing a brief head-to-toe assessment to identify changes in the patient's condition, such as new swelling, shortness of breath, or skin breakdown.
- Reviewing updates in medications for potential interactions and side effects, as well as addressing changes in diagnoses for their impact on functional status and the patient's ability to perform ADLs/IADLs.
- Evaluating chronic wounds for signs of infection and monitoring healing progress.
- Tracking trends in vital signs such as blood pressure, blood glucose or weight.

Examples of incorporating social work expertise may include, but are not limited to:

- Reviewing changes to cognitive and psychological functioning, such as mental health diagnoses or challenges (i.e.; depression, anxiety, suicidal ideation, response to losses, memory problems, wandering, etc.).
- Monitoring any changes to formal services received (i.e.; Social Security, IHSS, CalFresh, Medi-Cal, etc.).
- Assessing any changes to living situation or environmental safety issues.
- Discussing any changes to social support, including threats of social isolation or withdrawal.

3.640 Care Planning

Care planning is the process of developing an agreement between the participant and care manager regarding identified needs, resources, outcomes to be achieved, and services arranged in support of goal achievement. These are detailed on a care plan (Appendix 37).

The care plan provides a focus for the needs identified in the assessments, organizes the service delivery system to the participant, and helps to assure that the service being delivered is appropriate to address the participant's needs. The care plan reflects services and resources necessary to support the participant's ability to live in their community.

The MSSP interdisciplinary care management team must develop a comprehensive care plan for each participant (Section 3.640.3, Care Plan Components; Section 3.640.4, Care Plan Activation: Signatures and Review Process, Appendix 37: Care Plan Form, and Appendix 37A: Care Plan Instructions).

The care plan must be written, reviewed at the care plan conference, and signed by the primary care manager and SCM within two weeks of the completed initial assessment or reassessment. As an example:

- If the Initial Health Assessment is conducted on June 1 and the Initial Psychosocial Assessment on June 7, the care plan must be completed and signed by MSSP staff by June 21.

- If the assessments are completed concurrently on June 1, the care plan must be completed and signed by MSSP staff by June 15.

The care plan must:

- Be participant centered,
- Be based on information in the health and psychosocial assessment or reassessment and participant needs lists,
- Address all appropriate participant needs, and
- Encompass both formal and informal services.

The MSSP Care Plan (Appendix 37) includes:

- Participant need statements derived from the participant needs list based on needs identified during the assessment process. Participant need statements are individualized to capture the participant's needs which provide a clear picture of how the issues impact the participant's ability to live independently. Similar issues from the participant needs list may be grouped into one participant need statement.

- Measurable goals that are based upon the need, the time frame, the resources available, and the desires/motivation of the participant/family.

- Interventions to address the needs.

- Service provider type (informal, referred, purchased) and name of provider/vendor (if known at time of care plan development).

The care plan process also includes the Service Plan and Utilization Summary (Chapter 7, Section 7.220, Service Planning and Utilization Summary SPUS; Appendix 39).

The SPUS must list all Care Management, Care Management Support, and Purchased Waiver Services. The SPUS details the fund code, service provider, services authorized and delivered (unit, type, rate, and cost). This component is not generated at the onset of the care plan process but is tied by the historical tracking of all services provided to each participant on a monthly basis.

3.640.1 General Guidelines

The MSSP Care Plan (Appendix 37) consists of several elements that are interdependent. They must support each other and combined, validate the necessity and appropriateness of program services.

- **Assessment:** Comprehensive detailed information regarding the participant's situation detailed in the Health/Psychosocial Assessment and Reassessments.

- **Care Plan:** Identifies the needs, goals, services, and care management activities to be implemented, regardless of the resource or payor. Once a purchase is made using waiver funds, the name of the item/service purchased must be documented on the care plan.

- **Service Plan and Utilization Summary (SPUS):** Lists each Waiver Service, noting the vendor, units and cost of service - authorized and delivered. A description of the service is required in the notes section, unless the service code clearly indicates the service. For example, under Communication: Device (9.2) a monthly billing for ERS would not need to be clarified; however, under Specialized Non-medical Home Equipment (2.3) the purchase of a non-slip bathmat from Amazon would need to be listed in the notes, so the purchase is clear on the SPUS.

Care planning is a continuous process that is participant centered. It begins with the assessment of the participant's health and social needs followed by the development of a care plan, coordination of services, implementation, and ongoing monitoring and updating of the care plan.

The participant and as appropriate, informal caregiver, or authorized representative, will participate in the development of the care plan, and the participant's preferences will be considered. The participant must be given the freedom to choose:

1. Between Waiver Services and institutional care.

2. Waiver Services and providers, as available in the local community.

Participants have the right to refuse specific service(s); however, when a service is refused, the risks and consequences associated with refusing the service must be addressed and documented in the participant's record (Section 3.700-3.740, Assessing and Documenting Risk).

The care manager is responsible for drafting the care plan document, which is followed by the care plan conference involving at a minimum three parties including the NCM, SWCM, the SCM or Site Director. The purpose of this team conference is to review the information assembled during the assessment process and draft a care plan to address the participant's situation. The care planning process culminates with the signatures of the primary care manager and SCM which activate the care plan. The timeframe for this process is two weeks from the date of the last re/assessment to care plan signature. The participant is also required to sign the care plan but has additional time to do so as noted in Section 3.640.4, Care Plan Activation: Signatures and Review Process.

The care plan must be filed as part of the case record. If care plans are updated electronically when a participant need statement or intervention is added, the site must be able to produce a copy of the current document upon request. It is also helpful to provide the participant a copy of the signed care plan. When a site sends NOAs to reflect changes (including additions, when applicable) to the care plan, a copy of the NOAs must be in the case record.

Deferred interventions/services must have appropriate justification for the deferral documented in the participant record. The methods of addressing any risk associated with the deferral must be documented. A timeframe for addressing the needs or providing the service(s) must be included in the documentation.

If the care plan contains sensitive information (mental health issues; abuse or neglect), the content may be modified to avoid placing the participant's health or safety at risk. Details of the situation and the reason for modifying the content of the care plan or the participant's copy must be documented in the progress notes.

3.640.2 Emergency Care Plan

In the event MSSP staff identifies a situation or need of such a critical nature that it must be dealt with immediately rather than waiting for the regular care plan process, an emergency care plan may be crafted.

Prior to an emergency care plan being approved, the LOC must be determined, composed, dated, signed and finalized by the CDA MSSP Nurse. In these events, the site can request an emergency review of the LOC at the State level (3.110.6, Consultation with CDA for Urgent/High-need Cases). The need/issue and intervention must be included in the appropriate assessment and on the initial care plan.

In these situations, the written approval of the SCM can initiate a service or purchase in response to this emergency. The situation must be documented in the progress notes.

3.640.3 Care Plan Components

Sites may modify the care plan form (Appendix 37); however, the basic integrity and all components of the form must be maintained with space-allotted to record the required information.

Although there are similar health and safety issues for all participants, the participant need statements, goals, interventions and outcomes must be individualized to address

the participant's needs. The care plan is viewed as a living document and must be updated throughout the year when new needs and/or interventions are identified.

The care plan document must include the following components:

A. Date(s)

- Care plan conference date must be documented on the care plan form or in the monthly progress note.
- Duration of care plan.
- Date the need was originally identified/reconfirmed.

B. Participant Need Number

This column lists participant need statements in a sequential manner. As additional needs are identified, new numbers may be added. Care plan participant need statement numbers must be placed into sequential order each year.

C. Participant Need Statement

Participant need statements are derived from the participant needs lists identified in the assessment/reassessment process. Participant need statements can be added during the year as new issues arise.

1. Participant need statements must:
    - Be person centered
    - Address the participant's needs
    - Support the goals
    - Link to the interventions

    Statements such as "related to", "secondary to", "due to", "as evidenced by" are helpful to describe the participant's needs related to their ADL/IADLs, health/diagnoses, cognitive status, mental health, social needs, etc.
        - For example, "Participant is at risk for injury due to history of falls, poor vision, dizziness and weakness secondary to chronic back and leg pain."

    Care plans should not contain item-centered participant need statements or be based upon a singular intervention. Grouping of interventions should be based upon the focal objective of the participant need statement and corresponding goal. Prior to crafting a new participant need statement, the existing care plan should be reviewed to determine where an intervention might fit or if a new participant need statement is warranted.

2. The participant needs identified on the care plan must:

    - Justify the need for care management and substantiate the need for service delivery, including informal, referred, and purchased

services. Needs may include ADL/IADLs, health, mental health, cognitive, social, and other needs.

- Reflect the multi-disciplinary team collaboration on assessment findings.

If there are areas of participant need identified that will not be addressed in the care plan, an explanation must be documented in re/assessment or in the progress notes. These include areas that are sensitive in nature or needs the participant chooses not to address through the care management process (Section 3.640.1, General Guidelines).

D. Service Provider Name and Type

The Service Provider and Type section lists the service provider(s) for all services and the type of provider(s) (Informal, Referred, Purchased, Care Management). More than one vendor/provider and type may be entered for an individual service (Section 3.930, Authorization and Utilization of Services).

I = Informal: a service or support provided without cost to MSSP through the participant's network of family, friends, or other informal helpers. It may be helpful to also include the participant's strengths, abilities, and other supports. (Section 3.1410, Informal Support)

R = Referred: a service (e.g., Meals on Wheels, transportation funded by Title IIIB or health benefit) provided without cost to MSSP through referral to a formal organized program/agency (Section 3.1420, Referred Services).

P = Purchased: a service or item purchased with Waiver Service funds (Section 3.1430, Purchased Waiver Services).

C = Care Management: is the coordination of care and services provided to facilitate appropriate delivery of care and services (Section 3.1430, Purchased Waiver Services– Care Management 50 and 4.6).

The name and/or type of provider(s) for each service should be entered if known. A generic category of service may be used to define the service in lieu of a specific vendor.

E. Goal

This section lists participant goals for the identified needs or issues. The goal must be measurable and relate to the issues identified in the participant need statement while linking to the interventions. The goal should reflect the participant's input.

Goals specify the skills and behaviors to be developed, utilized, or enhanced, information to be provided, health and/or psychosocial conditions to be met.

Measurable goals must describe desired outcomes and/or achievements. It is helpful to include the participant's strengths, abilities, and other supports.

F. Plan/Intervention

The Plan/Intervention section outlines possible actions, solutions, or interventions that have been identified to address the need.

All interventions purchased with Waiver Service funds **must** be listed on the care plan. If an intervention is identified after the care plan was crafted, the intervention must be added to the care plan. Failure to record a purchased intervention on the care plan could result in recovery of funds. Handwritten entries are acceptable.

It is acceptable to enter a generic category of services/items as an intervention (e.g., safety equipment) at the onset. Once specific services/items are purchased (e.g., transfer pole, smoke alarms, etc.) a notation must be entered on the care plan defining all services and items purchased using Waiver Service funds. It is recommended that maximum quantities of items/services to be purchased be added to the care plan.

G. Date Resolved/Outcome/Comments

This section can be used to make notations regarding the name of the service provider, the date a service/item was provided, the outcome, and/or general comments. Handwritten entries are acceptable.

3.640.4 Care Plan Activation: Signatures and Review Process

The care plan is written based on the documentation and findings in the assessment. The care manager and SCM must sign the care plan within two weeks of the completion of the re/assessment. These signatures are required to activate the plan and to initiate purchases with waiver funds. Purchases made with Waiver Service funds prior to care plan activation are subject to recovery.

The participant must also sign and date the care plan at or before the first quarterly home/telehealth visit following the care plan activation. The participant's signature indicates their acceptance of the plan but is not required prior to the commencement of any services.

Pending receipt of the participant's signature on the initial care plan, documentation must demonstrate that the care plan has been reviewed and the participant is in agreement with the provisions. Care managers must discuss all elements of the care plan with the participant. This discussion and the participant's verbal acceptance of the initial care plan must be documented in the progress notes for the first monthly contact unless the participant has signed the care plan prior to the first monthly contact. If the participant's signature cannot be obtained within the required timeframe, the reason must be documented in the progress notes.

For renewal care plans that include changes to services, the participant's verbal acceptance should be documented if the signature is not obtained before the next monthly contact.

For participants that opt to have their quarterly contact be conducted via telehealth, sites should have a process established for obtaining the participant's signature on the care plan before or at the first quarterly home/telehealth visit (3.1530.1, Telehealth as an Option for Quarterly Contact). Documentation should be added to the progress notes that includes:

- When the signature was requested;
- What method (mail, in-person, or electronic signature) was used (Chapter 5, Section 5.820, Electronic Signatures for Participants); and
- Attempts to obtain the signature after the first quarterly home/telehealth visit due date has passed.

If the participant is unable to sign for themselves, the following individuals may sign for them:

1. *Conservator.* This is a person appointed by a court.

2. *Agent.* This is a person named in the participant's power of attorney for health care or other legal document.

3. *Authorized representative.* This is a person designated by the participant. The designation may be in the form a signed release form (Appendix 17, Authorization for Use and Disclosure of Personal Health Information) or verbal statement to the MSSP care manager. Oral designation must be documented in the progress notes.

The care plan must be rewritten annually following the reassessment. Timeframes for obtaining signatures are detailed above.

3.640.5 Care Plan Implementation

MSSP interdisciplinary care management teams must maximize the use of the participant's personal resources and other community resources before purchasing services/items using Waiver Service funds. In authorizing services for a participant, the care manager must use the following order of priorities:

1. Informal: All services available through the informal support of family, friends, etc., must be considered first, unless informal provision of services puts the participant at risk (ex: abuse, unskilled/unwilling family member providing care, etc.). Informal support shall only be considered for inclusion in the care plan and in determining the Waiver Services to be purchased when such support is provided voluntarily and at times that the individual providing such support is available.

2. Referred: After the informal support services have been exhausted, referred services funded from other resources (public or private) for which the participant

is eligible and which are available in the community, must be used. Medi-Cal/Health Plan, In-Home Supportive Services, Title III are some examples.

When a service is available through Medi-Cal, these resources must be utilized to the maximum extent prior to the purchase of services with waiver funds. Documentation must be included in the participant's record or available upon request.

3. Purchased: Identify the service/item to be purchased using Waiver Service funds. Waiver Services that are not included in the care plan are subject to recovery. The vendor or vendor type should be listed, if known, with preference given to the most cost-effective source.

3.640.6 Care Plan Monitoring

Sites must review, verify, and document the following information each month:

- All care management activities,
- The status of each care plan participant need statement,
- The effectiveness of interventions implemented during the month, and
- The status of each care plan goal. For example, if the goal is, "Participant will remain free of falls or injury", documentation will include whether the participant experienced any falls or injury during monthly contacts. If the goal is, "Participant will report all personal care and chore needs are met daily", documentation will include whether the participant's daily needs have been met.

The care manager is responsible for monitoring the health, safety, and welfare of the participant. The care manager is responsible for discussing with the participant or their representative, the participant's health status, care being provided, and any other significant changes. Each participant need statement must be addressed as they are the focal point of care plan monitoring. Care plan monitoring must be documented in the progress notes each month. During the month of reassessment, either the reassessment summary or progress note must ensure that all participant need statements, including any changes to the care plan, are addressed.

Any deferral of interventions/services must be justified in the participant record. Documentation must include a plan and timeframe when the issue will be addressed. The methods of addressing any risk associated with the deferral must be documented and followed up on a timely basis (Sections 3.700 – 3.740, Assessing and Documenting Risk).

The monthly SPUS is considered a component of the care plan and must be signed and dated by the care manager to verify that the services were delivered as stated in the care plan and progress notes. This signature indicates that any services purchased with MSSP funds are approved for payment. CDA requires that the final version of the SPUS that includes verified expenditures be signed and available for review (Chapter 7, Section 7.220, Service Planning and Utilization Summary [SPUS]). As participant costs increase, additional levels of approval may be required for the SPUS (Section 3.930, Authorization and Utilization of Services).

3.640.7 Changes to the Care Plan

Care plan documents must be updated/revised when warranted by changes in the participant's condition, goals, or service needs. Participants must be involved in any discussion or plans regarding any changes to their care plan. Documentation of any care plan changes occurring between assessment intervals must be recorded in the progress notes.

A Notice of Action (NOA) must be sent to participants for any adverse decision regarding waiver enrollment, or when a Waiver Service is reduced, suspended, terminated, or denied (Chapter 6, Section 6.230, Notice of Action). A ten-day notice period is required, unless the participant has requested the reduction, suspension, or termination of Waiver Services. Participants must be informed, in writing, of their right to request a State Fair Hearing (Appendix 5 and 6) regarding any adverse decision about enrollment, reduction, suspension, termination or denial of Waiver Services.

NOAs are not required for additions to the care plan, or changes in vendors if comparable services continue. If a site chooses to issue a NOA when making additions to the care plan, a copy of the NOA must be maintained in the record as an active component of the care plan.

3.700 Assessing and Documenting Risk

Risk assessment facilitates the systematic exploration of situations that have a high possibility for adverse outcome.

3.710 Goal of Risk Assessment

MSSP participants have the right to refuse suggested interventions or services. If a participant refuses an intervention/service, the site must have a process to verify that any risks associated with the refusal are addressed. In most cases, it is sufficient to document the situation, including that the participant was informed of the possible consequences of their decision.

If a care manager determines that the participant's action/behavior is detrimental to the participant's health and/or safety; or places others at risk, the care manager may need to evaluate the best course of action. Situations where there is a high possibility of an adverse outcome (e.g., smoking while using oxygen, heating a room using the oven, etc.) may require further action on the part of the care manager. Participants have the right to assume risk commensurate with their ability and willingness to understand and assume responsibility for the consequences of that risk. It is the responsibility of the care manager, however, to assess if the risk is limited to the participant or if the safety of others would be compromised as well.

3.720 Assessment of Ability to Assume Risk

In evaluating the participant's ability to assume risk an assessment must include the following:

- Can the participant make choices and communicate those choices?
- Can the participant give reasons why the choice was made?

- Does the participant understand the implications of the choice?
- Can the participant consider the consequences of the choice?

3.730 Risk Management

A negotiated risk agreement (Appendix 38) will be developed when a situation arises where the participant has chosen a course of action that may place them and/or others, including MSSP staff, at risk for a high possibility of an adverse outcome. The risk management plan will be developed by the care manager in collaboration with the participant.

The negotiated risk agreement (Appendix 38, 38A or 38B) will include at a minimum:

- A description of the situation.
- An explanation of the cause(s) of concern.
- The possible negative consequences to the participant and/or others.
- A description of the participant's preference.
- Possible alternatives/interventions and back-up plans to minimize the potential risk(s) associated with the participant's preference/action.
- A description of the services/interventions, if any, that will be provided to accommodate the participant's choice and minimize the risk.
- Frequency of reassessment of risk.
- The final agreement, if any, reached by all involved parties.
- The signatures of the participant and care manager. If the participant refuses to sign the negotiated risk agreement, the reason must be documented in the progress notes.

The participant's refusal to cooperate may be grounds to initiate the termination process under reason code 10– Unable/Unwilling to Utilize Care Management or Follow a Care Plan (Chapter 6, Section 6.400, Notice of Action for Terminations). The termination process must be documented in the progress notes.

3.740 Monitoring of Negotiated Risk Agreements

The status of the negotiated risk agreement must be monitored and documented in the progress notes at an appropriate interval. The negotiated risk agreement must be reassessed at intervals mutually agreeable to the participant and care manager. The interval will be determined by the nature of the individual situation.

3.750 Mandated Reporting

Care managers are mandated reporters under California's Adult Protective Services (APS) Program and must immediately report instances of abuse neglect, exploitation, or suspicious death, as required by California Law (California Welfare and Institutions Code Section 15630 (b)(1)) to the local county APS or law enforcement agency who investigate and resolve the reports. A written report (SOC 341) of any known or suspected instances of abuse, including physical, verbal, sexual, mental, financial, and neglect (including self-neglect) must be submitted to the appropriate local APS agency within two business days of learning of the incident, or as soon as possible.

Using county-specific reporting websites are acceptable; however, the SOC 341 form can also be used.

3.760 Critical Incident Reporting

A critical incident can be defined as an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a waiver participant.

Reportable critical incidents include:

- Abuse, including physical, emotional/verbal, psychological or sexual
- Neglect, including self-neglect, or abandonment
- Exploitation, including financial, coercion, or fraud
- Mismanagement of medications
- Use of restraints, overly restrictive interventions, or seclusion
- Falls or other incidents with serious injuries
- Environmental incidents, including a positive diagnosis during a pandemic, or natural disasters that directly impact the participant
- Housing issues, including evictions, pest infestations and/or hoarding/safety concerns that require APS intervention
- Legal issues, including criminal arrests or victimization
- Suicide attempts or threats
- Suspicious, unexplained or unanticipated death

Care managers are responsible for documenting critical incidents, including any applied interventions and education in the progress notes and care plan if applicable. If hospitalization occurs as a result of the above reportable critical incidents, then documentation and the Critical Incident Report should include that. Please note that hospitalizations for unrelated health reasons are not required to be reported on the Critical Incident Report; however, should be documented in the progress notes. Care managers should also include (to their knowledge) whether a critical incident has been reported to APS or law enforcement, regardless of who completed the report.

Care managers must continue to monitor the progress of participants' unresolved critical incidents, at a minimum monthly, until all risks to the participant's health, safety, and welfare are mitigated. It is not required that a report outcome be obtained from APS or law enforcement; however, the critical incident must be reported as resolved by the participant in order to cease regular monitoring of the critical incident. This process of

monthly and as needed collaboration and sharing of information (including any investigation results obtained) results in the coordinated agreement between the care manager and participant that the incident has been resolved and no health or safety threat remains.

Sites must include all reportable critical incidents and participant-reported resolutions to CDA on the Critical Incident Report, as part of the Quarterly Report process.

3.770 Fall Prevention Training for Care Management Staff

Falls are a common and serious health threat to older adults, with MSSP participants being among the highest at risk. Every year, more than one in four older adults fall, but more than half of those who fall don't tell their healthcare provider. MSSP care management creates an opportunity to provide education and intervention for those participants at highest risk for falls.

Falls Prevention Training is a mandatory annual training requirement for all site care management staff. The Stopping Elderly Accidents, Deaths, and Injuries (STEADI) initiative was developed in response to this growing health threat. STEADI offers free training and resources to help healthcare providers, such as MSSP care managers, put fall prevention strategies into practice. Continuing education credits are available for this free accredited course. As with other mandatory training requirements, MSSP care managers will be required to complete the STEADI training once per fiscal year (FY), with the completion verified by the MSSP Quarterly Report.

3.780 Restrictive Interventions, Restraints, and Seclusion

The MSSP sites are responsible for ongoing monitoring and ensuring the health, safety, and welfare of waiver participants, including ensuring that restrictive interventions, such as restraints and seclusion, are not utilized under any circumstances. Care managers will monitor the participant's health and safety at both the monthly contact call and the quarterly contacts, documenting any critical incidents, including use of restraints and seclusion, in the progress notes and care plan if applicable.

Definitions according to the CMS Final Rule:

- Restraints 42 CFR §482.13(e)(1)(i)(A), (B), and (C):
  A. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or
  B. A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
  C. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

For the purposes of reporting critical incidents to CDA, a restraint does not include devices, such as lap belts or safety belts for wheelchairs or furniture when the participant can safely remove or release the device independently, or when the device does not otherwise restrict the participant's freedom of movement.

- Seclusion 42 CFR §482.13(e)(1)(ii): defined as the "involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.".

According to the CMS Final Rule, a waiver participant should not be restricted within a setting, unless such restriction is documented in the participant centered care plan, all less restrictive interventions have been exhausted, and such restriction is reassessed over time.

3.800 Progress Notes

3.810 General Requirements

Progress notes must document all care management activity and must address each care plan participant need statement monthly. During the month of reassessment and/or alternate discipline visit, participant need statements may be addressed in the reassessment/ADV form, as an alternative to documenting in the progress notes. All entries must be legible, dated, signed and conform to record keeping practices as described in Chapter 5 (Chapter 5, Section 5.810, Staff Signatures and Signature Requirements). Lack of documentation of ongoing care management activities, including review of all active care plan participant need statements, can result in the recovery of care management fees.

3.820 What Progress Notes Include

Progress notes are the ongoing chronology of the participant's status and care management (Section 3.640.6, Care Plan Monitoring).

Monthly progress notes at a minimum must include the following:

- Health and safety issues, including all critical incidents, interventions provided, ongoing monitoring of the incident (if applicable), and the participant-reported resolution (Section 3.760, Critical Incident Reporting).

- The date and type (telephone, virtual or in-person) of MSSP staff contact with the participant.

- Documentation addressing the status of each participant need statement and goal listed in the care plan.

- The effectiveness of the interventions and purchases of services to address the needs described in the participant need statements and any actions taken when interventions do not produce the desired outcome.

Progress notes should document care management activity which may include the following:

- A record of all events that affect the participant (hospitalization, contact(s) with other agencies, physician appointments, etc.).

- Discussion or plans between the care manager and the participant regarding any changes to the care plan, including any new arising needs, and the participant's agreement to the change(s).

- Education provided to the participant and/or caregiver.

- Any significant information regarding the participant's relationship with family, community or any other information which could impact the established goals for the participant's independent living.

- If an LOC is unable to be completed by the annual due date, progress notes should include the following information:
    - Attempts made to complete the assessment in a timely manner
    - Reason why the LOC was not completed on time
    - Date of LOC submission to CDA

Progress Notes for the **Quarterly Contact** must include:

- The minimum requirements for a monthly progress note;

- A clear description of the participant's presentation, including physical appearance and cognition (if applicable), as well as any changes in functional status since the last home visit; and

- Observations by the care manager specific to the participant's home environment, particularly related to health and safety concerns.

If the participant chooses telehealth in lieu of the home visit, the care manager must attempt to obtain this information via the telehealth modality (3.1530.1, Telehealth as an Option for Quarterly Contact). If the care manager is unable to visually see the participant or the participant's home environment, the care manager should ask questions to attempt to gather the related information. For example:

- Are your personal care needs continuing to be met?
- Have you had any issues getting dressed and groomed each day?
- How is your home environment?

Documentation for a telehealth visit must also include that:

1. The participant was given the choice of having a home visit or doing telehealth, and

2. There are no health/safety issues or extenuating circumstances that would make an in-person home visit necessary (Section 3.1530.3, When Telehealth is Not Appropriate).

In addition, it is helpful to focus the quarterly contacts to be an enhanced version of a monthly contact. Some ways to enhance the contact include providing education and/or following up on any deferred services/items or needed durable medical equipment/needs.

Lack of documentation of ongoing care management activities, including review of all active care plan participant need statements, can lead to recovery of care management fees.

3.900 Managing Participant Services

3.910 Tracking Cost Effectiveness

In addition to care management services provided by the MSSP site staff, the program is authorized to purchase long term services and supports from the list of site's vendors (Section 3.1430, Purchased Waiver Services). MSSP care managers are required to follow service authorization procedures prior to the purchase of Waiver Services.

3.920 The Benchmark and Calculation of Costs

All Medicaid waivers, including MSSP, are required to be cost-effective. The cost-effectiveness of MSSP is reported to CMS through the Annual Report on Home and Community-Based Services Waivers (CMS-372). Each year the formula in this report is used to demonstrate whether the average annual cost per MSSP participant is less than the average annual cost per institutional care-based Medi-Cal recipient.

CDA designed the benchmark to ensure that MSSP continues to meet this mandate for cost-effectiveness. Sites are not to enroll applicants whose cost for all Medi-Cal services is projected to exceed 100% of the benchmark. After an individual has been enrolled and becomes a participant, if their costs are projected to exceed the benchmark, additional documentation is required (Section 3.150, Able to Be Served Within MSSP's Cost Limitations).

Care managers must be aware of the cost associated with maintaining a participant in MSSP. Case documentation must identify the costs and the plan for managing them within the program limits.

a. The care manager may not authorize costs that exceed 95% of the monthly benchmark without the approval of the SCM (Chapter 5, Section 5.810, Staff Signatures and Signature Requirements [SPUS]).

b. If the participant's cost is expected to exceed 120% of the monthly benchmark, the Site Director's approval is required (Chapter 5, Section 5.810, Staff Signatures and Signature Requirements [SPUS]).

c. If costs are expected to exceed 120% of the monthly benchmark *for more than three consecutive months*, the Site Director's approval is required, and case documentation should provide:

- A summary of the availability to the participant of family and friends including the number of hours they provide care, a description of the care provided and why they are unable to provide more care.
- An analysis for reducing costs by shifting to other sources of care.
- Description of the efforts the care manager has made to effect change and the results of these efforts.
- Identification of the expected outcomes for the participant should termination from MSSP occur.

d. In the event CDA reviews a record and finds insufficient documentation to support retaining the participant on high-cost status, the site will need to develop a plan to bring costs under the benchmark or terminate the participant from the program as ineligible.

3.930 Authorization and Utilization of Services

In authorizing services for a participant, the care manager will use the following prescribed order of priorities (Section 3.640.5, Care Plan Implementation):

1. Informal services available through support of family, friends, etc., must be used whenever available. Informal support shall only be considered for inclusion in the care plan and in determining the Waiver Services to be purchased when such support is provided voluntarily and at times when the individual providing such support is available.

2. Referred services may include:

- Medi-Cal/Health Plan for referrals for services including but not limited to DME, transportation, and specialty assessments (nutrition, occupational therapy).
- Healthcare providers.
- Title III Older Americans Act (Section 3.1420, Referred Services).
- Title XVIII Medicare.
- Title XIX Medi-Cal (TAR process).
- Title XX Social Services.
- Other publicly funded services.

3. Purchased Waiver Services.
After evaluating the availability of informal support, community resources and referred services and confirming lack thereof, the care manager may request the use of MSSP funds to purchase Waiver Services (Section 3.1430, Purchased

Waiver Services). For any services typically provided by Medi-Cal, evidence of Medi-Cal's denial must be verified and documented in the case record prior to the use of purchased Waiver Services funds. To document medical necessity for items typically provided by Medi-Cal/Medicare, a copy of the doctor's prescription should be obtained when possible (e.g., prescription eyeglasses, lift chairs, etc.). Purchased Waiver Services should consider the most cost-effective items/services that meet the participant's assessed needs and choices.

3.1100 Other Care Management Programs

3.1110 Non-Duplication of Care Management Services

MSSP sites must ensure that participants are not enrolled in a duplicative program that provides care management services that would preclude them from receiving MSSP. Participants should be asked as part of the screening, application, and enrollment process, and during initial assessments/reassessments of their involvement with other community agencies.

Below is a summary of how MSSP intersects with existing Medi-Cal programs that provide care management services, organized by two categories:

1) Participants must choose MSSP **OR** the other program:

   There are comprehensive care management programs that are duplicative of MSSP services. Many provide services to Medi-Cal beneficiaries who may also meet the eligibility criteria for MSSP. Participants who are receiving these programs have a choice of continuing with MSSP or another similar program.

   Individuals can only be enrolled in one of these programs at any time:

   - Program of All-Inclusive Care for the Elderly (PACE) (Appendix 48)
   - Senior Care Action Network (SCAN) Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) (Other SCAN Health Plans are allowable)
   - Enhanced Care Management (ECM) through the county or managed care plan
   - Targeted Case Management (TCM) (Mental Health excluded)
   - 1915(c) Home and Community-Based Services (HCBS) Waiver Programs:
     - Medi-Cal Waiver (formerly AIDS Waiver)
     - Assisted Living Waiver (ALW)
     - Home and Community-Based Services Waiver for the Developmentally Disabled (DD)
     - Home and Community-Based Alternatives (HCBA) Waiver
     - Self-Determination Program (SDP) Waiver

2) Participants can receive services through **BOTH** MSSP and another program:

   MSSP should not duplicate or supplant services provided by other programs. As long as there is no duplication of services provided, and they are not a program listed in 1) above, the MSSP waiver participant may receive services from multiple programs. The MSSP care plan must be updated to include the services provided by other programs. The MSSP care manager must ensure that they coordinate with all agencies and programs that provide services to the participant to ensure non-duplication of services. If the other program can offer a complete array of services and there is no longer a need for MSSP, the MSSP case should be closed.

   Examples include, but are not limited to:
   - Hospice
   - Veteran's Affairs (VA) Care Management Services
   - Community-Based Adult Services (CBAS)
   - Community Supports through the county or managed care plan

3.1120 Coordinating MSSP and Other Care Management Services

Other care management services, such as hospice services, may be appropriate and allowable for some MSSP participants (Section 3.1110, Non-Duplication of Care Management Services). In order to determine whether MSSP should continue to be involved with the participant after they enroll in another allowable care management program, the MSSP care manager must determine what specific services the other program will provide, and what needs (if any) remain.

MSSP should not duplicate or supplant services being provided by another care management program. Each case should be evaluated individually because other programs' services differ, and the availability of particular services may be contingent on their funding sources.

The MSSP care plan must be updated to include other care management services in cases where MSSP will continue to work with the participant. In other situations, where the other care management program can offer a complete array of services and there is no longer a need for MSSP, the MSSP case should be closed.

3.1200 Institutionalization

3.1210 No Waiver Services Provided During Institutionalization

No Waiver Services are to be initiated for a participant upon placement in a nursing facility or in a hospital with the following two exceptions:

1. The individual is being served under Deinstitutional Care Management (Section 3.1300, Deinstitutional Care Management, and Section 3.1430, Purchased Waiver Services; service code 4.6).

2. Supplemental Homemaker Services (service code 3.1) and Supplemental Personal Care (service code 3.2) may be provided for seven (7) calendar days (Section 3.1430, Purchased Waiver Services).

Immediately upon notification that a participant has been placed in a nursing facility or hospital, the care manager will attempt to determine the probable length of placement. Wherever possible, pending, or ongoing services will be immediately canceled, reduced, or suspended.

If it appears that the participant will be institutionalized or placed more than 30 days, termination procedures should be promptly initiated. A 10-day notification is required (Chapter 6, Section 6.400, Notice of Action for Terminations). If there is reasonable expectation that the participant will be institutionalized on a short-term basis (30 days or less), termination procedures are not necessary.

During institutionalization, contacts by the care manager to obtain participant status are appropriate. After 30 calendar days of institutionalization, unless definite plans for discharge are being made by the institution and are documented in the participant's record, the participant must be terminated from MSSP.

3.1300 Deinstitutional Care Management

3.1310 Background

Deinstitutional Care Management (DCM) services can be provided during the last six months of an institutional stay to facilitate the resident's successful discharge to community living.

The services available under DCM include all of the services currently offered under the Waiver:

- Care management - expanded to assist in the planning and preparation for discharge
- Purchase of some goods and services (e.g., installation of a ramp, provision of money management, etc.). These services must be billed separately from DCM.

3.1320 Waiver Status of Recipients of DCM Services

Although Waiver Services may be provided to an institutionalized resident, the individual cannot actually be enrolled into the MSSP Waiver. Sites cannot bill for services provided (Chapter 9, Section 9.110, Billing Process) while the participant is institutionalized; however, they can report the participant in their active caseload until the date of discharge from the institution. Individuals receiving services under DCM have the same rights as participants, including access to State Fair Hearings to resolve disputes.

3.1330 Screening for DCM Services

New referrals of individuals who may be appropriate for DCM services will be screened using the site's established screening tools and processes.

The screening tool used will be retained either in the case record (if the individual goes on to receive services) or in a separate file maintained for all referrals that are screened out (Section 3.230, Referrals not Accepted for MSSP Participation).

3.1340 Request for DCM Services

3.1340.1 Request for DCM Services Form

Persons screened for DCM services will complete a Request for Deinstitutional Services (Appendix 14) and be given a copy of the form. As noted in Section 3.1310, DCM services are limited to the final six months of an institutional stay. If the discharge decision has not been acted on during that six-month period, the DCM case must be closed. The individual can be referred for DCM services at a later date should their situation change.

3.1350 Denial of DCM Services

Persons screened for assessment of appropriateness of DCM services, but subsequently denied participation, are provided written explanation of the reason for denial in a Notice of Action (Appendix 3) and have the right to a State Fair Hearing in accordance with Welfare and Institutions Code, Sections 10959-67 (Appendix 1).

Persons who choose not to participate, or do not meet program criteria for age, Medi-Cal eligibility, or residence, will be informed they may contact the program at a later date should their situation change. A Notice of Action is **not** required.

3.1360 Deinstitutional Services Assessment

Following the completion of the Request for Services form, the Deinstitutional Services Assessment (Appendix 24) will be completed. The process of the DCM Assessment is the same as the standard MSSP assessment (Section 3.620, Assessment/Initial Assessments): gather pertinent information relative to the individual's needs regarding their ability to transition to and live in a non-institutional setting.

For individuals who were terminated from MSSP within three months of requesting DCM services, to rescind the termination an abbreviated assessment process may be conducted in lieu of completing the entire DCM Assessment form. At a minimum, this abbreviated assessment will consist of the functional needs assessment grid, a brief summary, and a participant needs list identifying areas that need to be addressed to facilitate a successful discharge back into a community living situation.

Should the care manager determine that additional information or sections of the DCM Assessment document are necessary to accurately assess the individual's situation and potential for discharge, they should expand the abbreviated assessment process to accommodate those needs.

3.1370 Plan for Deinstitutional Services

Beginning with the assessment and utilizing any other pertinent information, the care manager will work with the individual to develop a care plan (Appendix 37). Collaboration between the NCM and SWCM will be reflected in the case record including care plan development and conferencing. The care plan will reflect input from

both health and social work disciplines and must be signed by the care manager and SCM to authorize necessary expenditures. The individual will also sign to indicate their agreement with the proposed care plan.

The care plan must be developed within two weeks of the assessment and list services that will be provided prior to discharge, and an estimate of the MSSP Waiver Services that will be required upon enrollment into the Waiver. As noted in Section 3.1310, the services available under DCM include all services that are offered under the Waiver (Section 3.1430, Purchased Waiver Services).

Authorization of DCM services will follow the same order of priorities for all MSSP services (Sections 3.640.5, Care Plan Implementation and 3.930, Authorization and Utilization of Services): informal support from family and friends will be utilized first, followed by services available from other public and private resources including the participant's Medi-Cal health plan. Only when these first two resources have been exhausted can MSSP funds be used to purchase Waiver Services from the list of those defined under the Waiver. Sites will not be able to bill for Care Management, Care Management Support or Waiver Services provided under DCM, if the participant does not ultimately transition into the Waiver.

On-going communication with the nursing facility/institution staff is critical to ensure coordination of timeframes, activities, and services necessary to facilitate a successful discharge to the community.

Progress notes must document all care management activity including inter-disciplinary collaboration while the individual is receiving DCM services. Monthly entries are required and should meet all requirements for MSSP progress notes as described in Section 3.820.

3.1380 Conclusion of DCM Services

There are two outcomes for recipients of DCM services:

1. **Qualified and enrolled in MSSP.**
   These individuals successfully transition from the facility to the community and enroll in MSSP. The standard enrollment process including all required forms, and submission of the LOC to CDA, must be completed (Section 3.110.5, Submission to CDA for Final Determination of Initial LOC). The participant is counted in the site's caseload.

   Billing for DCM services occurs upon discharge (Chapter 9, Section 9.110, Billing Process). Sites can only bill once per month for Care Management and Care Management Support services. During the month of enrollment into MSSP, these services should be billed under the Waiver rather than included in the DCM billing.

2. **Not enrolled in MSSP.**
   These individuals do not transition to the MSSP Waiver (changed their mind; died; discharged but lack a qualifying Medi-Cal aid code).

Billing without enrollment is disallowed, as Federal Financial Participation (FFP) cannot be claimed for DCM services where the participant does not transition into the Waiver.

3.1380.1 (Section Retired)

3.1390 Out of Area Referrals

Each site's contract with CDA defines the area it serves. It is possible that a site could receive a referral for DCM services where either:

1. The nursing facility/institution where the individual currently resides is outside the site's service area, but the individual intends to be discharged to a residence within the site's boundaries; or

2. The facility is in the site's service area, but the individual intends to live in a residence outside those boundaries.

In addressing these issues, the primary considerations should be to minimize disruption and maximize continuity and quality of services for the individual.
If the nursing facility/institution and the individual's intended residence could reasonably be served by one site, that is the site that should receive the referral and begin work with the individual.

If it is necessary for one site to initiate DCM services and it is known that the individual will have to receive on-going services from another MSSP site, coordination between the initiating and receiving site must be maintained from the beginning (Section 3.1800, Transfer of Participants Between Sites).

3.1400 Description of Services

There are three major categories of services available to MSSP waiver participants. They are: Informal Support, Referred Services, and Waiver Services.

3.1410 Informal Support

These services are provided to the participant at no cost to MSSP. Examples of providers of services include, but are not limited to:

- Spouse
- Family members
- Friend/neighbor
- Religious/spiritual support
- Volunteers
- Charitable Organizations

3.1420 Referred Services

These services are available in the community and funded by sources other than the MSSP Waiver. The main sources of these services are:

Medicare (Title XVIII):

Title XVIII of the Social Security Act is the national health insurance program for frail older adults and people with disabilities. The Medicare program is divided into the following:

- The hospital insurance portion (Part A) covers in-patient acute care costs, short-term skilled nursing facility costs (based on medical necessity) and home health agency costs.

- The supplemental medical insurance program (Part B) covers out-patient costs.

- The Medicare Prescription Drug Program (Part D) provides prescription drugs to Medi-Cal recipients.

Medicaid Program (Title XIX):
Title XIX of the Social Security Act enables states to provide medical assistance to families with dependent children, aged, blind, permanently and totally disabled individuals who cannot afford such services. The program is called Medicaid nationally and "Medi-Cal" in California. It is administered at the State level by the Department of Health Care Services (DHCS), the Single State Agency for Medicaid.

The Centers for Medicare & Medicaid Services (CMS) has federal responsibility for monitoring program compliance and financial participation. Medi-Cal services available under the State Medicaid plan include: physician services, hospital services, medications, and other medical benefits (including Durable Medical Equipment).

➢ Most MSSP participants receive In-Home Supportive Services under the State Plan. Advocating for participants to receive the appropriate level of service from IHSS and intervening to assure that needs are addressed are regular activities for MSSP care managers. Recognizing the importance of coordinating services between MSSP and IHSS, CDA and CDSS have entered into a Memorandum of Understanding (Appendix 47). This agreement provides that county welfare offices (administrators of IHSS) will not count MSSP services as an "alternate resource" in assessments for IHSS. In turn, through its use of Waiver Services, **MSSP may supplement but not supplant IHSS.**

Medi-Cal and Medicare services may not be purchased with MSSP funds. Sites are not required to report Medi-Cal or Medicare service costs on the SPUS. Medi-Cal and Medicare services should be documented on the care plan if known.

➢ Title III, Older Americans Act: Title III services are provided by local agencies under contract with the Area Agency on Aging (AAA). The availability of these services differ across the State. Refer to CDA Service Categories and Data Dictionary for the range of services funded by Title III through AAA. Services received by a participant through Title III should be referenced on the care

plan although they are not reported in the MSSP automated services system (SPUS).

- Managed Care Plans: Sites may be coordinating service delivery with the respective health plans in their catchment areas. Services that are provided to a MSSP participant by the health plan and that are complementary to basic medical services should be referenced on the care plan although they are not reported in the MSSP automated services system (SPUS).

- Additional Community Resources: Services provided by any other source. These services, while available to participants and included in care plans, are not reported in the MSSP automated services system (SPUS).

3.1430 Purchased Waiver Services

To provide for the additional services needed by the program's frail older adult participant, MSSP requested and received waivers under Title XIX (Medi-Cal). The waivers added several services to those that may be provided using existing Title XIX funds.

Waiver Services funds cannot be used to purchase services or items until the preceding categories of services have been exhausted. Family members will **not** be reimbursed for the provision of any service provided under the Waiver.

The following criteria must be met and documented in the case record:

- The assessment identifies the need for the interventions (services and/or items) including how they are a necessary support for the participant to remain in the community, and the care plan specifies the service(s)/item(s). Later identified needs discovered through ongoing care management should be documented in the progress notes and added to the care plan as applicable.

- For DCM participants, the record documents the participant is receiving Deinstitutional Care Management services, and the proposed interventions (services/items) are required to facilitate discharge from the institution to a community residence, and the care plan specifies the services/items.

- The services/items are unobtainable through other resources.

- The services/items are necessary to preserve the participant's health and safety, improve functional ability, and assure maximum independence, thereby preventing elevation to a higher level of care and avoiding more costly institutionalization.

Licensing and certification requirements for specific Waiver Services are summarized in Appendix 40.

The services approved for purchase under the MSSP Waiver are:

Adult Day Care (1.1): Adult Day Care services may be provided when the participant's plan of care indicates that the service is necessary to reach a therapeutic goal or provide respite for the family.

Adult day care centers are community-based programs that provide non-medical care to persons 18 years of age or older in need of personal care services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual for less than a 24-hour basis. The California Department of Social Services (CDSS) licenses these centers as community care facilities.

Adult Day Care centers are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:

- Support access to the greater community;
- Be selected by the participant from among setting options;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices;
- Facilitate choice regarding services and who provides them; and
- Be physically accessible.

Vendor contracts with Adult Day Care centers must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4) (Appendix 49).

Minor Home Repairs and Maintenance (2.2): Minor home repairs do not involve major structural changes or major repairs to the dwelling. As specified in the waiver participant's care plan, services may include provision of physical adaptions including, but not limited to, the installation of ramps and grab bars, widening of doorways, modification of the bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Minor home repairs are limited to repairs that are necessary to ensure the health and safety of the participant. Services should address imminent needs and do not include ongoing subscriptions for household maintenance (e.g. pest control services to address an infestation are allowable versus an ongoing subscription for prevention would not be). Eligible participants are those whose health and/or safety or independence are jeopardized because of deficiencies in their place of residence.

This service is limited to participants who own and reside in their own home, or those in rental housing where the owner refuses to make needed repairs or otherwise alter the residence to adapt to specific participant needs. Written permission from the owner (including provision for removal of modifications, if necessary) is required before undertaking repairs or maintenance on rented/leased premises. All services shall be provided in accordance with applicable State or local building codes.

Specialized Non-medical Home Equipment (2.3): Includes equipment and supplies which address a waiver participant's functional limitation and/or condition, that are necessary to assure the participant's health, safety and independence, and are not otherwise provided through this Waiver or through the Medicaid State Plan.

Specialized non-medical home equipment include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; and (d) equipment not available under the State Plan or another waiver service that is necessary to address participant functional limitations.

Allowable categories of items:

- Small appliances
- Large appliances
- Furniture
- Home safety devices
- Clothing related items (Must stem from a medical or functional need)
- Paperwork related/ Organizing items
- Household items (Items that are not specifically designed for home safety, but are necessary to maintain independence and safety in the home)
- Kitchenware
- Bedding/Bath items
- Exercise equipment
- Social support/ Therapeutic activity supplies
- Personal care items (Items related to personal care and the prevention of skin breakdown)
- Health related supplies (Items that have a health component, but are not covered by the State Plan)
- Incontinence supplies (Specific items should be listed, i.e., gloves, wipes, washcloths, creams, etc.).

Please note that items previously billed to Non-medical Home Equipment 2.3 that are specifically designed to increase, maintain, or improve functional capabilities of participants should now be billed to Assistive Technology 2.6. Examples include, but are not limited to, a transfer pole, bed cane or rail, grabber/reacher, dressing aid or sock aid, etc.

The costs associated with delivery and repairs of the items allowable under this service are also included.

Experimental or prohibited treatments and Over the Counter (OTC) medications are excluded as well as those items and services solely for entertainment or recreation.

Community Transition Services (2.4): Are non-recurring moving and/or housing set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence in the community where the person is directly responsible for their own living expenses.

Allowable expenses are those necessary to enable a participant to establish a basic household that do not constitute room and board and may include:
(a) Security deposits that are required to obtain a lease on an apartment or home;
(b) Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
(c) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
(d) Services necessary for the participant's health and safety such as pest eradication and one-time cleaning prior to occupancy;
(e) Moving services, which may include materials and necessary labor;
(f) Activities to assess need, arrange for and procure needed resources.

Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Assistive Technology (2.6): Assistive technology means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:
(A) the evaluation of the assistive technology needs of a participant, which is performed and billed under the MSSP care management service. The evaluation includes a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; applying, maintaining, repairing, or replacing assistive technology devices;
(C) services consisting of selecting, designing, fitting, customizing, adapting;
(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the care plan.
(E) the costs associated with delivery and repairs of the items allowable under this service are also included.

Please note that items previously billed to Non-medical Home Equipment 2.3 that are specifically designed to increase, maintain, or improve functional capabilities of participants should now be billed to Assistive Technology 2.6. Examples include,

but are not limited to, a transfer pole, bed cane or rail, grabber/reacher, dressing aid or sock aid, etc.

Assistive Technology may be used to purchase a device and/or technical assistance (i.e., training, troubleshooting, repair, etc.) for a participant for the purposes of facilitating telehealth, if the following criteria are met:

1. The participant has an assessed need for the item. Documentation should include how it is a necessary support to increase, maintain, or improve the participant's functional capabilities (i.e. allowing the participant to continue their medical service appointments, therapies, and supports by telehealth).
2. Care management and/or waiver services will be delivered remotely through the device.
3. The participant has the cognitive and physical ability to be able to use the device with or without a caregiver's assistance.
4. The participant has, or is willing to obtain, ongoing internet service, with the ability to connect a device through Wi-Fi.
5. The participant does not currently have a device and has no other resources available to obtain or purchase one.
6. The site has the ability to assist the participant with set up of the device and provide or refer for education on how to operate the device.

Supplemental Services (3.1, 3.2, and 3.7): These services are for purposes of household support, personal care, and protective supervision for those services above and beyond those available through the In-Home Supportive Services (IHSS) Program or to participants that are not eligible for IHSS.

Examples include:

1. The MSSP participant has not yet been assessed for IHSS and needs services in the interim until IHSS can be arranged.

2. The regular IHSS provider is not available and IHSS cannot provide a substitute.

3. IHSS services are in place; however, MSSP has assessed a greater need. In these cases, MSSP will advocate with IHSS for increased time for those services before authorizing expenditure of waiver funds.

Services purchased can supplement but not supplant IHSS.

Supplemental Homemaker, Personal Care, and Protective Supervision services shall be subject to Electronic Visit Verification (EVV) requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 3.1, 3.2, and 3.7 services must contain language that addresses Electronic Visit Verification (EVV) requirements.

Supplemental Homemaker Services (3.1): Is for purposes of household support and applies to the performance of household tasks rather than to the care of the

participant. Homemaker activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance. Instruction in performing household tasks and meal preparation may also be provided to the participant under this category.

Homemaker service providers may be paid while the participant is institutionalized. This payment is made to retain the services of the care provider and/or prepare the home for the participant's discharge from the institution. Services are limited to seven (7) calendar days per institutionalization.

Services purchased using 3.1 can supplement but not supplant IHSS.

Supplemental Personal Care (3.2): Services under this category provide assistance to the participant to maintain bodily hygiene, personal safety, and activities of daily living (ADL) which are essential to the health and welfare of the recipient.

These tasks are limited to non-medical personal care services such as:

- Feeding.
- Bathing.
- Oral hygiene.
- Grooming.
- Dressing.
- Care of and assistance with prosthetic devices.
- Rubbing skin to promote circulation.
- Turning in bed and other types of repositioning.
- Assisting the individual with walking.
- Transferring.

Instruction in self-care may also be provided.

When a personal care service is to be performed by a caregiver, the duties will be limited to those allowed by the worker's employer, or permissible according to the Board of Registered Nursing policy on unlicensed assistive personnel, and as permitted by the worker's certification (if applicable).

Purchase of personal care supplies may be covered under Specialized Non-medical Home Equipment (2.3) where there are no other resources. These items include supplies not covered by Medi-Cal.

Services purchased using 3.2 can supplement but not supplant IHSS.

Supplemental Protective Supervision (3.7): Ensures provision of supervision in the absence of the usual care provider to persons in their own homes who are very frail or may suffer a medical emergency, to prevent immediate placement in an acute care hospital, nursing facility, or other 24-hour care facility. Such supervision does

not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency.

This service may also include checking on a participant through a visit to the participant's home to assess the situation during an emergency.

Waiver participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device; however, are not allowed to also receive an Emergency Response System (ERS) services paid for by Waiver Service funds.

Services purchased using 3.7 can supplement but not supplant IHSS.

Therapeutic Services (3.3): Addresses the unmet needs of waiver participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria:

- The assessment identifies need for this support and the care plan reflects the required service(s).
- MSSP must utilize all of the services available under Medicare, Medi-Cal/Health Plan, and other health coverage prior to purchasing these services using waiver funds.
- This service can augment non-covered benefits and/or supplement benefits provided by the existing Medicare and Medi-Cal programs including managed care, using providers who meet standards under Provider Qualifications: Licensure and Certification, Appendix 40.
- The service is provided by authorized individuals when such care is prescribed or approved by a physician.
- Services may include the following professionals/services:

    1. Foot Care.
    2. Massage Therapy.
    3. Swim Therapy.

Therapeutic services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 3.3 services must contain language that addresses EVV requirements.

Consultative Clinical Services (4.3): This service addresses the unmet needs of waiver participants when such care is not otherwise available under the State Plan. MSSP's waiver participants are extremely frail and, on occasion, in need of services

that cannot be provided under Medi-Cal. This service is especially critical for persons recently discharged from acute hospitals or who are otherwise recovering at home from an acute illness or injury. This MSSP service supplements, but does not supplant, benefits provided by the State Plan.

These services will be provided based on the following criteria:

- The waiver participant assessment identifies need for this support and the care plan reflects the required service(s).
- MSSP utilizes all of the services available under the State Plan prior to purchasing these services as Waiver Services.

In addition to the provision of care, waiver participants and their families/caregivers are trained in techniques which will enable them (or their caregivers) to carry out their own care whenever possible.

Allowable services are:
• Social services and legal/paralegal consultation to assist the individual with addressing critical incidents, public benefits, housing issues, and/or safety issues
• Dietitian/Nutrition consultation
• Pharmacy consultation
• Vital sign monitoring

Each component of this waiver service is separately authorized and the participant may exercise free choice of providers for each component. The participant may choose to receive consultative clinical services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described in the Waiver (Section 3.1530.2, Waiver Service Telehealth Requirements).

Care Management (50 and 4.6): Assists participants in gaining access to needed waiver and other services including medical, social, and other services, regardless of the funding source.

Care managers are responsible for ongoing monitoring of the provision of services included in the participant's plan of care. Additionally, care managers initiate and oversee the process of recertification of participant level of care, assessment, reassessment, and monthly review of care plans.

Care Management (50): MSSP Care Management includes:

- Assessment.
- Care plan development.
- Identification, coordination and authorization of services.

MSSP utilizes a care management team comprised of a nurse and social worker. The team is responsible for care management services including the assessment,

care plan development, service authorization/delivery, monitoring, and follow up components of the program.

The participant may choose to receive care management services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described in the Waiver (Section 3.1530, Telehealth as a Service Delivery Method and Section 3.1530.2, Waiver Service Telehealth Requirements).

Deinstitutional Care Management (DCM) (4.6): Is used ONLY with individuals who are institutionalized (Section 3.1300, Deinstitutional Care Management). It allows Care Management to begin up to 180 days prior to an individual's discharge from an institution. It may be used in two situations, as follows:

1. Where MSSP has gone into a facility (nursing facility or acute hospital) to begin working with a resident to facilitate their discharge into the community.

2. Where a prior MSSP participant is institutionalized and MSSP services are necessary for the person to be discharged back into the community.

All care management services (monthly Care Management Support and Care Management) provided during this period are combined into one unit of DCM and billed upon discharge. Any purchased Waiver Services would be billed separately at this time. For those individuals who do not successfully transition to the Waiver, billing is disallowed, as Federal Financial Participation (FFP) cannot be claimed for DCM services where the participant does not transition into the Waiver. (Chapter 9, Section 9.110, Billing Process).

Respite (5.1 [In-Home] and 5.2 [Out-of-Home]): Respite purchased with Waiver Service funds includes the supervision and care of a participant while the family or other individuals who normally provide unpaid informal care take short-term relief or respite. Respite may also be needed in order to cover emergencies and extended absences of the regular paid caregiver.

In situations where a caregiver provides both paid and unpaid care, it is important to distinguish between providing respite (for unpaid time) and substitution or augmenting paid hours. An example is when a family member is being paid by IHSS as the participant's caregiver for a certain number of hours and tasks, but this caregiver also puts in time that is not reimbursed by IHSS. If the IHSS hours are insufficient, the first recourse is to intercede with IHSS and advocate for a reassessment to incorporate the additional necessary care. If unmet needs remain and there is justification to expend waiver funds, appropriate services to consider include:

3.1 (Supplemental Homemaker Services)
3.2 (Supplemental Personal Care)
3.7 (Supplemental Protective Supervision)

It is not appropriate to use Waiver Service funds to purchase any hours for which a caregiver receives pay. If the caregiver needs a break or vacation, a substitute or temporary provider should be found to work the hours allocated by IHSS (the regular caregiver would not be paid for this time since they would not be working). Coverage of the unpaid hours could be considered for respite under the Waiver.

Services may be provided In-Home (5.1) or Out-of-Home (5.2).

Waiver Service funds will not be used for respite services provided beyond thirty consecutive days, or for any combination of direct care and protective supervision that exceeds 24 hours of care per day. Waiver Service funds will not be used for the cost of room and board. Individuals providing services in the participant's residence shall be trained and experienced in personal care, homemaker services, or home health services, depending on the requirements in the participant's care plan.

Respite care services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 5.1 services must contain language that addresses EVV requirements.

Transportation (6.3 [hour] and 6.4 [one-way trip]): These services provide access to the community (non-emergency medical transportation to health and social service providers) and special events for participants who do not have means for transportation or whose mobility is limited, or who have functional disabilities requiring specialized vehicles and/or an escort.

These services are different from the transportation service authorized by Medi-Cal or managed care plans which is limited to medical services or participants who have documentation from their physician that they are medically unable to use public or ordinary transportation.

Informal services such as family, neighbors, friends, or community agencies which can provide this service without charge must be utilized whenever possible.

Transportation services are usually provided under public paratransit or public social service programs (Title III of the Older Americans Act) and shall be obtained through these sources without the use of MSSP resources, except in situations where such services are unavailable or inadequate.

Service providers may be:

- Paratransit subsystems of public mass transit.
- Specialized transport for frail older adults and people with disabilities.
- Private taxicabs when they are subsidized by public programs or local government to serve the elderly and handicapped.

- Private taxicabs and ride-sharing services (such as Uber or Lyft), when no form of public mass transit or paratransit is available or accessible.

- Contracted vendors that offer transportation as one of the array of services.

Escort services may be authorized for those participants who cannot manage to travel alone and require assistance beyond what is normally offered by the transportation provider.

"OWT" (one way trip) is defined as travel from point A to point B and is recorded as one unit of transportation (1 OWT). A round trip, travel from point A to point B and back to A, is recorded as two one-way trips (2 OWT).

MSSP sites can use Waiver Service funds to purchase fuel cards after all other alternative transportation and transportation funding resources have been exhausted. If no alternative transportation resource is available, sites may purchase fuel cards valued at no more than $50.00. To ensure fuel cards are used only to purchase the fuel necessary to meet participant care plan objectives, each participant who receives a fuel card must keep a detailed log documenting how they used the fuel card to meet their needs.

MSSP sites must implement the following measures to substantiate the appropriate use of fuel cards purchased with Waiver Services funds.

- Record in the participant's care plan that the provision of the fixed-limit fuel card is based on a specific participant care need(s).

- Instruct the participant, their family member(s) and/or caregiver(s) that they can use the fuel card only to purchase the fuel necessary to provide the transportation to:

  ✓ Attend medical appointments.

  ✓ Attend legal and business appointments affecting the participant's health and safety.

  ✓ Perform shopping and other errands necessary to support the participant's safe and independent living at home.

- Instruct the participant to maintain a log for each fuel-card supported trip that provides the following information:

  ✓ Name of the driver

  ✓ Date vehicle used

  ✓ Starting and ending odometer readings

- ✓ Purpose of trip (e.g. medical appointments, shopping/errands, etc.)
- ✓ Name and location of destination (e.g., Dr. G Smith's Office, 123 Any Town Drive, Any Town, CA 99999)
- ✓ Participant number (name not necessary)

During monthly contacts, the participant's care manager must verify and document that scheduled appointments were attended and the reason for the fuel card purchase. It is not permissible to use the fuel card for non-approved purchases.

Misused fuel cards will be revoked. The fuel card is not for personal use by any member of the participant's household or other caregivers. Further, fuel cards cannot be used for any of the following vehicle services:

- Registration
- Oil changes
- Car washes
- Insurance

Nutritional Services (7.1, 7.2, and 7.3): These services may be provided daily but are not to constitute a full nutritional regimen (three meals a day) [42 CFR 441.310].

Congregate Meals (7.1): Meals served in congregate meal settings for participants who are able to leave their homes or require the social stimulation of a group environment in order to maintain a balanced diet. Congregate meals can be a preventive measure for the frail older person who has few (if any) informal supports, as well as a rehabilitative activity for people who have been physically ill or have suffered emotional stress due to losses associated with aging.

This service should be available to MSSP participants through Title III of the Older Americans Act. MSSP funds shall only be used to supplement congregate meals when funding is not available or is inadequate through Title III or other public or private sources.

Congregate Meal Sites are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:

- Support access to the greater community;
- Be selected by the participant from among setting options;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices;
- Facilitate choice regarding services and who provides them; and
- Be physically accessible.

Vendor contracts with Congregate Meal Sites must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4) (Appendix 49).

Home Delivered Meals (7.2): Prepared meals for participants who are homebound, unable to prepare their own meals and have no caregiver at home to prepare meals for them. The primary provider of this service is Title III of the Older Americans Act. Waiver Service funds shall only be used to supplement home-delivered meals when they are unavailable or inadequate through Title III or other public or private sources.

Oral Nutritional Supplements (ONS) (7.3):
As Medi-Cal may cover ONS, efforts must be made to obtain ONS through a Medi-Cal Treatment Authorization Request (TAR). The process must be documented in the monthly progress notes.

If ONS are to be purchased with Waiver Services funds, the following **must** be recorded in the participant record:

- A nutritional screen (Appendix 34 or comparable assessment) is conducted by the primary care manager in consultation with the NCM. The progress notes must reflect the collaboration between the SWCM and NCM.

- The use of home-prepared drinks/supplements (instant breakfast, pureed food) has been explored and found not to meet the participant's needs.

- All other options for payment of ONS have been exhausted.

If all three criteria have been satisfied, ONS may be purchased initially for a period of three months. Concurrently, the participant's physician must be notified and a physician order must be obtained.

Upon annual reassessment, if all criteria, including a new nutritional screen, are satisfied and the previous physician order has expired, another three months may be purchased. The physician's order must be renewed on an annual basis.

When the participant or family is purchasing ONS, the care manager should advise them to notify the participant's physician.

Counseling & Therapeutic Services (8.3, 8.4 and 8.5): These services include protection for participants who are isolated and homebound due to health conditions; who suffer from depression and other psychological problems; individuals who have been harmed, or threatened with harm (physical or mental) by other persons or by their own actions; or those whose cognitive functioning is impaired to the extent they require assistance and support in making and carrying out decisions regarding personal finances.

The participant may choose to receive counseling and therapeutic services (8.3, 8.4, and 8.5) either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described in the Waiver (Section 3.1530.2, Waiver Service Telehealth Requirements).

Social Support (8.3): this service includes periodic telephone contact, visiting or other social and reassurance services to verify that the individual is not in medical, psychological, or social crisis, or to offset isolation.

These services may be provided by volunteers or through Title III of the Older Americans Act; however, these services may not be available in a particular community. Waiver Service funds will be used to purchase social support only if the service is unavailable in the community or is inadequate as provided under other public or private programs.

Expenses for activities and supplies required for participation in rehabilitation programs, therapeutic classes and exercise activities can also be provided under Specialized Non-medical Home Equipment (2.3).

Social Support services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 8.3 services must contain language that addresses EVV requirements.

Therapeutic Counseling (8.4): This service includes individual or group counseling to assist with social, psychological, or medical problems which have been identified in the assessment process.

Therapeutic counseling is essential for preventing some participants from being placed in a nursing facility. This service may be utilized in situations where participants may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems.

Therapeutic Counseling is only allowable when State Plan services have been exhausted or are not otherwise available under the approved State Plan.

Money Management (8.5): This service assists the participant with activities related to managing money and the effective handling of personal finances. Services may be either periodic or as full-time substitute payee. Services may be provided by organizations or individuals specializing in financial management or performing substitute payee functions.

Waiver participants may be isolated by geography or by not having a trustworthy other person to rely upon. Failure to meet personal financial obligations frequently results in eviction, disconnection of utilities, or jeopardizes eligibility for maintenance programs such as Supplemental Security Income (SSI) and Medi-Cal. Money management services ensure a stable living environment and thereby avoid institutionalization.

Money Management services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 8.5 services must contain language that addresses EVV requirements.

Communications Services (9.1 and 9.2): These services are for participants with special communication problems such as vision, hearing, or speech impairments and persons with physical impairments likely to result in a medical emergency. Services shall be provided by organizations such as:

- Speech and hearing clinics.
- Organizations serving blind individuals.
- Hospitals.
- Senior citizens centers.
- Providers specializing in language translation and interpretation.
- Individual translators.
- Telephone companies or other providers specializing in communications equipment for disabled or at-risk persons.

Communication: Translation/Interpretation (9.1): The provision of translation and interpretive services for purposes of instruction, linkage with social or medical services, and conduct of business essential to maintaining independence and carrying out the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) functions.

For non-English speaking waiver participants, this service is the link to the entire home and community-based service delivery system. MSSP resources shall be used to support this service only where family and community resources are unable to meet the need as described in the care plan.

Communication: Device (9.2): The rental or purchase of 24-hour emergency assistance services, installation of a telephone, assistive devices for communication for participants who are at risk of injury or institutionalization due to conditions likely to result in a medical emergency.

Emergency communication and assistance services enable the participant to secure immediate assistance in the event of an emotional, physical, or environmental emergency. Training, installation, repair, maintenance, and response are included.

Purchase of emergency response systems (ERS) is limited to those participants who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The record must document consideration of available options and that the participant is able to understand and utilize the service and/or item being funded through Waiver Services.

Waiver participants who have diminished cognition and/or receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device; however, are not allowed to also receive ERS services. Devices/services such as ERS and medication reminder services are not intended for participants that do not have the cognitive capacity to safely operate the device independently. These

types of devices are intended to assist in keeping at-risk waiver participants safe in the home and are not intended to replace an in-person support staff.

The following are allowable:

1. Medic-alert type bracelets/pendants.
2. Intercoms.
3. Emergency response systems (Lifelines).
4. Wander-alerts.
5. Room/two-way monitors.
6. Light fixture adaptations (blinking lights).
7. Telephone adaptive devices not available from the telephone company or California Technology Assistance Project (CTAP).

Telephone installation/purchase or reactivation of service will only be authorized to allow the use of telephone-based electronic response systems where the participant has no telephone, or for the isolated participant who has no telephone and who resides where the telephone is the only means of communicating health needs. Waiver Service funds may **not** be used for ongoing monthly fees for telephone services/plans or cell phone minutes.

All types of personal emergency response devices shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment are allowable and shall be performed by the manufacturer's authorized dealers where possible. Any electronic communication/response device obtained for participant use must be of a type already in general use; product warranties and servicing for the unit must be available. Providers must be confident to meet applicable standards of installation, repair and maintenance of these systems and devices.

3.1500 Service Monitoring and Care Management Follow Up

3.1510 Recording Guidelines

Recording of monitoring and follow up activities is an integral part of care management activity. The documentation process includes obtaining and analyzing information and incorporating the results of this analysis into plans for future action and follow up.

It is important to capture the results of authorized services and any change in the participant's situation that affects the care plan. The documentation should serve to clarify both the necessity and appropriateness of all services (Section 3.820, What Progress Notes Include).

3.1520 Monitoring Activities

The care manager serves as a resource manager who arranges for timely, effective, and efficient mobilization and allocation of services to meet the participant's needs as defined in the care plan.

Care management monitoring and follow-up activities must occur at regular intervals that meet or exceed the following minimum parameters:

- Monthly contact – may occur by telephone, electronic methods (i.e., email, video conferencing), or face-to-face. Monitoring entails review of each care plan participant need statement and evaluating the effectiveness of the care plan through face-to-face or telephone contact. The preferred contact is between the care manager and the participant. If it is necessary to communicate with another party (support person or caregiver), the reason should be stated and permission from the participant should be granted, when possible. (Section 3.1520, Monitoring Activities). For all electronically transmitted PHI, sites must abide by their agencies' policies and procedures for complying with HIPAA guidelines (Chapter 5, Section 5.120, HIPAA Security Rule).

- Quarterly Contact– face-to-face in the participant's home or via telehealth visit (not to exceed 3-month intervals). The purpose of the home/telehealth visit is for the care manager to visually assess the participant and their home environment to ensure their health and safety needs are being met. The care manager should also assess for any new unmet needs. In the event that extenuating circumstances exist and the home/telehealth visit cannot be conducted in the participant's home, the reason must be documented in the progress notes. Sites have the flexibility to conduct these contacts via the telehealth service delivery option; however, quarterly contacts conducted as an in-person visit should be the default/preferred method of conducting quarterly contact, with telehealth provided as an option considering the participant's choice and circumstances (Section 3.1530.1, Telehealth as an Option for Quarterly Contact). If the participant chooses to have their quarterly contact be a home visit and it is missed, monthly contact must still occur by telephone and the home visit must be conducted the following month, or as soon as possible.

- Reassessments – face-to-face in the participant's home conducted annually not to exceed 13 months (one-month grace period). When using reassessments for LOC recertification, the grace period does not apply and they are not to exceed 12 months.

- LOC recertification – face-to-face (not to exceed 365 days from prior LOC). LOCs may be updated more often by the NCM when there is a change of condition, based on the site's discretion. Initial and Recertification LOCs must be submitted to CDA for final approval (Section 3.110.5, Submission to CDA for Final Determination of Initial LOC and Section 3.110.11, Submission to CDA for Final Determination of Recertification LOC).

- Alternate Discipline Visit – face-to-face visit in the participant's home conducted annually. This visit may be conducted as a monthly contact home visit, Quarterly visit, or Reassessment, but should be within 12-month intervals. If the site conducts the alternate discipline visit at the reassessment, it is acceptable to take advantage of the one-month grace period.

3.1530 Telehealth as a Service Delivery Method

Telehealth is defined as a service delivery method of contact that includes any of the following: telephone, email, or videoconferencing.

At a minimum*, the following MSSP requirements must be completed with an in-person home visit:

- Application and enrollment forms**
- Initial Health Assessment
- Initial Psychosocial Assessment
- Reassessment
- Annual Alternate Discipline Visit

After the year of enrollment, both disciplines, nurse and social work care managers, must visit the participant in the home at least once every 12 months. If any of these requirements are unable to be completed as an in-person home visit due to unforeseen circumstances (e.g., participant illness, environmental hazards, or temporary unsafe home conditions such as structural damage or infestation), the site may defer the in-home visit requirement and conduct the requirement(s) via telehealth. The home visit must be completed as soon as possible, but no later than 30 days of the telehealth contact (Section 3.1520, Monitoring Activities). The reason for the deferral of the in-home visit and timeframe to visit the participant must be documented in the progress notes. The sites must make reasonable attempts to conduct the requirements in-person, when possible, and document those attempts.

*If a site has a policy to operate above these minimum requirements, they may operationalize the use of telehealth under their site's policies.

**All documents requiring the participant's signature should be obtained in person, or via mail. If sites are unable to obtain the participant's signature, documentation should be included in the progress notes explaining that all documents were reviewed with the participant, the participant confirmed they understand them, as well as confirmation that the participant understands their rights to freedom of choice of services/providers and appeal rights. The required document (care plan, AUDPHI, etc.) should indicate the participant's verbal agreement on the form and the date of the agreement until the signature can be obtained. Sites may also utilize electronic signature options including DocuSign, the use of a tablet, or other means to electronically collect the participant's signature and authorization on required documents (Chapter 5, Section 5.820, Electronic Signatures for Participants).

3.1530.1 Telehealth as an Option for Quarterly Contact

Quarterly Contacts conducted as an in-person visit should be the default/preferred method of conducting quarterly contact, with telehealth provided as an option

considering the participant's choice and circumstances. Telehealth may be used for quarterly contact with the following requirements:

1. The participant is given the choice of having a home visit or doing telehealth, and
2. There are no health/safety issues or extenuating circumstances that would make an in-person home visit necessary (Section 3.1530.3, When Telehealth is Not Appropriate).

Both of these requirements should be documented in the progress notes for each occurrence of telehealth being chosen as the method of service delivery, in lieu of the Quarterly Home Visit.

For both service delivery methods, home visit or telehealth, progress notes for the quarterly contact must meet the requirements for quarterly contact documentation (Section 3.820, What Progress Notes Include). If the care manager is unable to visually see the participant or the participant's home environment, the care manager should ask questions to attempt to gather the related information. For example:

- Are your personal care needs continuing to be met?
- Have you had any issues getting dressed and groomed each day?
- How is your home environment?

In addition, it is helpful to focus the quarterly contacts to be an enhanced version of a monthly contact. Some ways to enhance the contact include providing education and/or following up on any deferred services/items or needed durable medical equipment/needs.

3.1530.2 Waiver Service Telehealth Requirements

The following waiver services may be provided via telehealth:

- Care Management
- Consultative Clinical Services
- Money Management
- Social Support
- Therapeutic Counseling

Waiver services provided via telehealth (in lieu of a home visit) must comply with all of the following requirements:

1. Participants must be allowed to choose to receive services via telehealth or in-person.
2. Services provided via telehealth must meet the individual's needs, as included in their person-centered care plan. Identifying whether services are provided via telehealth on the care plan is a best practice, though not required.
3. The waiver service provider believes that the service being provided via telehealth is clinically appropriate based upon evidence-based medicine or best practices or both.

4. Services will only be provided via telehealth if the needs of the participant can be met remotely. Telehealth must not replace direct care that can only be provided in-person.
5. Providing the service via telehealth must not impede, replace, or prevent the successful delivery of HCBS for individuals who need hands-on assistance/physical assistance. The goal of using technology is not to replace human assistance, but to increase access to care and maximize the use of technology to support people where appropriate.
6. Services provided via telehealth must be delivered in a way that respects the privacy of the individual.
7. Providing the service via telehealth must not prevent the facilitation of community integration as defined under Final Regulation CMS-2249-F/CMS-2296-F (HCBS Final Settings Rule).
8. Sites must inform the participant prior to the initial delivery of telehealth services about the use of telehealth and obtain consent from the individual for the use of telehealth as an acceptable mode of delivering health care services. Sites must document the participant's consent for the use of telehealth in the progress notes prior to the initial delivery.
9. Support must be provided to individuals who need assistance with using the technology required for the delivery of the HCBS via telehealth. The individual's person-centered planning team is responsible for determining the extent of training necessary for the individual to access their services remotely. Family members or caregivers may also be eligible for training, as appropriate, to support the provision of services if determined to be beneficial for the participant.
10. Waiver services can be provided pursuant to California's Medi-Cal Telehealth Policy, in alignment with California Welfare and Institutions Code section 14132.725, and as agreed upon by the applicant, participant, legal representative, and provider.
11. All authorized waiver service providers rendering Medi-Cal covered benefits or services under this policy must comply with all applicable state and federal laws.
12. Telehealth delivery services must meet Health Insurance Portability and Accountability Act (HIPAA) requirements (Chapter 5, Section 5.120, HIPAA Security Rule).

3.1530.3 When Telehealth is Not Appropriate

If the waiver participant's needs cannot be met via telehealth services because physical, in-person assistance is required to support the waiver participant's health and safety, then telehealth services shall not be an option and in-person service delivery shall be the method of service delivery. Sites may deny a participant's request for telehealth services with the appropriate documentation of the reasons why. For example, a participant is a fall risk and the care manager needs to observe the environment for applying appropriate interventions and education for the specific home setting. Other examples of health/safety reasons a site may deny a participant's request for telehealth may include but are not limited to the following: open Adult Protective Services (APS) cases, critical incidents, recent hospitalizations, unsafe home environment (i.e., hoarding, rodent/pest infestation, etc.).

Sites may not use telehealth as a service delivery method solely to meet site needs (i.e., low staffing, length of commute, etc.). However, in-person home visits may be deferred for safety reasons and emergencies, with the agreement of the participant and appropriate documentation. If the participant prefers a home visit and the visit must be deferred, the reason must be noted for using telehealth instead and a timeframe for scheduling the next in-person visit should be included in the progress notes. The home visit must be completed the next month, or as soon as possible (Section 3.1520, Monitoring Activities).

3.1700 Termination

The case record must contain documentation of the relevant actions and decisions leading up to the termination of a participant from MSSP. Termination plans must include how services will be provided after the participant leaves MSSP, except for reason codes 1, 7 and 10.

Termination actions are reported into the program's data system by completing the Termination section of the Participant Enrollment/Termination Form (PETIF; Appendix 22).

Termination reason codes and timeframes required for mailing NOAs are specified in Chapter 6, Participant Rights, Section 6.400, Notice of Action for Terminations.

3.1710 Rescission of Termination

A former MSSP participant can be reinstated into the program without completing a reenrollment packet if they return within 30 days of the termination date. If there has been a change in the participant's condition, the site shall use their clinical judgment to determine if a complete initial assessment is needed or if a reassessment will suffice for reinstatement. If the termination was done in error or there was no change in the participant's condition, no assessment is required. The rationale and justification for electing whether to complete an initial assessment, a reassessment, or no assessment must be documented in the progress notes and the care plan revised accordingly.

For MSSP participants that have lost full-scope Medi-Cal benefits and there is reasonable expectation that the Medi-Cal will be restored (within 90 days or less), MSSP termination procedures are not necessary. If it appears that the participant's Medi-Cal will not be restored for more than 90 days, termination procedures should be promptly initiated. A 10-day notification is required (Chapter 6, Section 6.400, Notice of Action for Terminations).

During the period that Medi-Cal benefits have been terminated, contacts by the care manager to obtain participant status and assist in restoration are appropriate. After 30 calendar days of termination, unless definite plans for restoration are being made by the County and are documented in the participant's record, the participant must be terminated from MSSP.

3.1720 Reenrollment

Unless the reenrollment is as a result of a rescission of termination (Section 3.1710, Rescission of Termination) whenever a participant reenrolls in MSSP, the process is similar to the initial enrollment process.

There are two levels for reenrollment – persons reenrolled within 31-90 days following program termination, and persons reenrolled that have been terminated from MSSP for more than 90 days.

Persons reenrolled within 31-90 days

The following forms must be completed and retained in the record for persons who are being reenrolled within 31-90 days of their termination:

- AUDPHIs (Appendix 17)
- A revised LOC Predetermination by the NCM. Submitting the revised LOC to CDA is not required; however, a recertification LOC package will still be required to be submitted to CDA at the original annual due date. If a site chooses to reset the LOC due date based on the reenrollment date, a complete LOC package must be submitted to CDA for final approval within 30 days of reenrollment (Section 3.110.11, Submission to CDA for Final Determination of Recertification LOC).
- Initial Health Assessment (Appendix 25) and Initial Psychosocial Assessment (Appendix 26) **or** Reassessment (Appendix 27). The record should support the selection of re/assessment. The site may choose to permanently reset their reassessment month at this time.
- A revised care plan (Appendix 37)

Persons reenrolled after 90 days

The following forms must be completed and retained in the record for persons who are being reenrolled after termination from the program for a period greater than 90 days:

- Application (Appendix 12)
- AUDPHIs (Appendix 17)
- A revised LOC Predetermination form by the NCM. Submitting the revised LOC to CDA is required for final approval. A complete LOC package must be submitted to CDA for final approval within 30 days of reenrollment (Section 3.110.11, Submission to CDA for Final Determination of Recertification LOC). The reenrollment date will be the participant's new anniversary date.
- Initial Health Assessment (Appendix 25)
- Initial Psychosocial Assessment (Appendix 26)
- A revised care plan (Appendix 37)

The participant’s original MSSP number will be reactivated (Chapter 7, Section 7.460, MSSP Participant Codes).

3.1800 Transfer of Participants Between Sites

When a participant of one MSSP site relocates to an area served by another MSSP site, care management services can continue at the new site, but only if the new site has an available vacancy. Sites should consider transferred participants a priority when considering wait list placement.

To facilitate this transition, the sending site and the receiving site must work together and coordinate the transfer. Since all MSSP sites bill as Fee-For-Service, it is not necessary to wait until the change of county is completed for Medi-Cal eligibility.

3.1810 Responsibilities of the Sending Site

The sending site should:

- Prepare the participant to expect that services may be different. There is no guarantee that services they received at one site will be replicated at another.
- Contact the receiving site early in the process to facilitate enrollment.
- Obtain a signed release from the participant to provide copies of pertinent case documents (current assessment, care plan, recent progress notes) to the receiving site. If there are documents from other sources (recent discharge summaries, report from a treating physician), the sending site must obtain releases if these documents are to be shared.

3.1820 Responsibilities of the Receiving Site

The receiving site should:

- Facilitate the enrollment process to coordinate with the participant's moving plans.
- After the participant has moved to their new home, complete the enrollment process including a new application, release forms, assessments, and care plan. The receiving site must follow the MSSP reenrollment process for the transitioning participant (Section 3.1720, Reenrollment) but will assign a new MSSP number.
- It is recommended that the receiving site maintain all pertinent case documents received from the sending site for continuity of care.

3.1830 Coordinate Billing

Only one site can bill for an individual participant in any given month. The sending and receiving sites will need to agree on the last month to be billed by the sending site and the first month to be billed by the receiving site.

3.1900 Emergencies and Disasters

MSSP sites should develop and implement an emergency preparedness plan that ensures the provision of services to meet the emergency needs of waiver participants during medical or natural disasters: a pandemic, earthquake, fire, flood, or public

emergencies, such as riot, energy shortage, hazardous material spill, etc. Aligned with CDA Standard Agreement requirements, the site should adopt policies and procedures and train staff on emergency preparedness annually. The MSSP Disaster Assistance Handbook and the CDA Emergency Preparedness Guide contain further emergency planning guidance and resources.

During emergencies and disasters, it may be possible for flexibilities on usual requirements to be granted by CMS, DHCS, and CDA via the Appendix K and/or Section 1135 processes. For example, it may be possible to conduct assessments remotely and/or provide Waiver Services in settings other than the home. CDA will advise sites once any flexibilities have been granted for the duration of an emergency or disaster. Once approved, care managers should capture the reasons why usual requirements aren't being adhered to in their documentation.

3.1910 Section Retired