ARTICLE II. MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP) OVERVIEW

The MSSP is a Medi-Cal Home and Community Based Services Waiver, Control Number CA.0141.R05.02 authorized pursuant to Section 1915(c) of Title XIX of the Social Security Act (HCBS Waiver). The primary objectives of the MSSP are to:

1. Avoid the premature placement of frail older persons in nursing facilities

2. Foster independent living in their communities

Pursuant to an Interagency Agreement between Department of Health Care Services (DHCS) and California Department of Aging (CDA), CDA contracts with local government entities and private nonprofit organizations for local administration of the MSSP throughout the State. The Contractor is responsible for arranging for and monitoring community services to the MSSP Waiver Participant population in the catchment area identified in Exhibit G of this Agreement. Individuals eligible for MSSP must be age sixty-five (65) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code for MSSP as described in the MSSP Medi-Cal Aid Codes, Article V of this Exhibit; be certifiable for placement in a nursing facility; live within a site's catchment area; be served within the program's cost limitations; and be appropriate for care management services.

The Contractor uses a care management team to assess eligibility and need, and provide for delivery of services. The Contractor is reimbursed for expenditures through a claims process operated by the State's Medi-Cal Fiscal Intermediary and a PLAN(S) (see definition in Article VI of this Exhibit).

ARTICLE III. MSSP PROGRAM OPERATIONS

The Contractor shall be responsible for all care management obligations including processing Waiver Participant applications, determining eligibility, conducting assessments, developing care plans, case recording and documentation, and providing follow-up. The Contractor shall directly provide or arrange for the continuous availability and accessibility of all services identified in each Waiver Participant's care plan. The Contractor shall also ensure that the administrative integrity of the MSSP is maintained at all times. In order to maintain adequate administrative control, the Contractor shall incorporate the following components into the scope of operations:

A. Care Management Team

1. The Contractor shall maintain and have on file a written description and an organizational chart that outlines the structure of authority, responsibility, and accountability within the MSSP and the MSSP parent organization. The Contractor shall provide to its assigned CDA analyst, a copy of the organization chart within thirty (30) days of the execution of this Agreement.

2. The Contractor shall employ a care management team, which consists of a social worker and a registered nurse, that meet the qualifications set forth in

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

the Waiver. The care management team shall determine Waiver Participant eligibility based on the criteria specified in the MSSP Site Manual. This team shall work with the Waiver Participant throughout the care management process (e.g., assessment, care plan development, service coordination, and service delivery).

3. The care management team shall: 1) provide information, education, counseling, and advocacy to the Waiver Participant and family, and 2) identify resources to help assure the timely, effective, and efficient mobilization and allocation of all services, regardless of the source, to meet the Waiver Participant's care plan goals.

4. The Contractor shall annually self-certify that staff meet the requirements as outlined in the MSSP site manual as well as participate in required trainings.

B. Care Plan

1. The Contractor's Care Management Team shall perform the MSSP Waiver Participant's assessments and work with the MSSP Waiver Participant, family, PLAN(S), and others to develop a care plan covering the full range of required psycho-social and health services. The Care Management Team shall continue to work with the MSSP Waiver Participant to assure that the Waiver Participant is receiving and benefiting from the services and to determine if modification of the care plan is required.

2. Such MSSP subcontracts shall specify terms and conditions and payment amount and shall assure that subcontractors shall not seek additional or outstanding unpaid amounts from the MSSP Participant or the PLAN(S).

C. Purchased Waiver Services

"Purchased Waiver Services" means goods and services approved for purchase under Title XIX of the Social Security Act, 1915(c) Home and Community Based Waiver authority. The list of MSSP Purchased Waiver Services is included in Article VI. The Contractor may purchase MSSP Purchased Waiver Services when necessary to support the well-being of a MSSP Waiver Participant.

1. Prior to purchasing services, the Contractor shall verify, and document its efforts, that alternative resources are not available (e.g. family, friends and other community resources
2. The Contractor may either enter into contracts with subcontractors to provide Purchased Waiver Services or directly purchase items through the use of a purchase order.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

3. The Contractor shall maintain written, signed and dated, subcontracts for the following array of Purchased Waiver Services as defined in MSSP Site Manual at all times during the terms of this Agreement:

   a) Adult Day Care (ADC)
   b) Housing Assistance
   c) Supplemental Personal Care Services
   d) Care Management
   e) Respite Care
   f) Transportation
   g) Meal Services
   h) Protective Services
   i) Special Communications

4. The Contractor shall assure that its subcontractors have the license(s), credentials, qualifications or experience to provide services to the MSSP Participant.

5. The Contractor shall be responsible for coordinating and tracking MSSP Purchased Waiver Services for a MSSP Waiver Participant.

6. The Contractor shall operate a Multipurpose Senior Services Program at a location and in a manner approved by the State, ensuring that Waiver Participant inquiries and requests for service(s) receive prompt response.

D. Case Files

The Contractor shall maintain an up-to-date, centralized, and secured case file record for each Waiver Participant, consisting, at a minimum, of the following documents prescribed by CDA:

1. Application for the MSSP

2. MSSP Authorization for Use and Disclosure of Protected Health Information

3. Client Enrollment/Termination Information

4. Level of Care Certification “Level of Care” (LOC) means a clinical certification by the Contractor that a MSSP Applicant or MSSP Waiver Participant meets the requirement(s) for a nursing facility placement.

5. MSSP Initial Health Assessment, MSSP Initial Psychosocial Assessment, and MSSP Reassessments

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

6. Care Plan and Service Planning and Utilization Summary (SPUS)

7. Waiver Participant monthly progress notes and other Waiver Participant-related information (e.g., correspondence, medical/psychological/social records, service delivery verification)

8. Denial or discontinuance letters (Notice of Action)

9. Termination documents

10. Fair Hearing documentation

E. Management Information Systems (MIS)

The Contractor shall maintain and operate an MIS at its site. The Contractor shall:

1. Maintain office space with proper security and climate control for on-site computer hardware, e.g., terminals, processors, modems, and printers.

2. Provide adequate staff for timely, accurate, and complete MIS data input, including but not limited to:

   a. Waiver Participant name, MSSP Waiver Participant number, Medi-Cal Aid Code, county code, Medicare and Social Security numbers, birth date, level of care, emergency contact information, physician information, and demographic information

   b. Tracking of waiver services and costs

   c. Enrollment and termination dates

   d. Provider Index Report

3. Accommodate State-required changes in MIS procedures which may be necessary from time to time.

4. Generate reports as required by the State.

5. Submit to CDA by the 5th working day of the month (unless otherwise specified by CDA), the end-of-month Waiver Participant count for the preceding month. The end-of-month Waiver Participant count consists of the number of Waiver Participants actively enrolled in MSSP on the last (business) day of the reporting month. This does not include Waiver Participant cases closed (or terminated) during the reporting month.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

6. Verify all service data within ninety (90) calendar days of the date of service. The Contractor shall submit this data to CDA by the 5th calendar day of the following month ninety-five (95) days from the end of the month of services).

7. Submit (Waiver) service claims to the State's Medi-Cal Fiscal Intermediary (FI), per instructions stated in the Medi-Cal Provider Manual.

F. Enrollment Levels

The Contractor shall maintain a monthly active participant count equal to one hundred percent (100%) of its budgeted waiver slots. This is a performance requirement to ensure compliance with the terms and conditions of this Agreement and Waiver requirements. If the Contractor's active participant count falls below ninety-five percent (95%) of the number of budgeted waiver slots for more than three (3) consecutive months, the Contractor shall be required to submit an enrollment plan for review, approval and monitoring by CDA.

"Active Waiver Participant count" is the total number of Waiver Participants served during each month. This will be the number of Waiver Participants enrolled in the MSSP as of the first of the month, plus the number enrolled during the month.

"Waiver slot" means a position, whether vacant or filled, which is funded according to a Contractor's site budget and allocated for a Participant during a given month.

G. Emergency Preparedness

1. The Contractor shall prepare and implement an emergency preparedness plan that ensures the provision of services to meet the emergency needs of Waiver Participants they are charged to serve during medical or natural disasters: a pandemic, earthquake, fire, flood, or public emergencies, such as riot, energy shortage, hazardous material spill, etc. This plan shall conform to any statewide requirements issued by any applicable State or local authority.

2. The Contractor shall adopt policies and procedures that address emergency situations and ensure that there are safeguards in place to protect and support Waiver Participants in the event of natural disasters or other public emergencies.

3. The Contractor shall ensure that emergency preparedness policies and procedures are clearly communicated to site staff and subcontractors in order to provide care under emergency conditions and to provide for back-up in the event that usual care is unavailable.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

4. The Contractor shall develop an emergency preparedness training plan to be provided to all staff at least annually or as needed when new staff are hired. The training shall consist of:

   a. Familiarity with telephone numbers of fire, police, and ambulance services for the geographic area served by the provider

   b. Techniques to obtain vital information from older individuals who require emergency assistance

   c. Written emergency procedures for all staff that have contact with older individuals

5. The Contractor shall develop a method for documenting the emergency preparedness training provided for all staff.

6. The Contractor shall develop a program for testing its emergency preparedness plan at least annually.

H. Other Provisions

1. The Contractor is relieved of all obligations to arrange for and provide services to a Waiver Participant under this Agreement after the Waiver Participant has been terminated from the MSSP and has exhausted his/her appeal rights.

2. The Contractor shall provide a notice of termination to a Waiver Participant prior to terminating the Participant from the MSSP and shall reference the MSSP Site Manual to determine how many days' notice are required based on the type of termination code that is used.

3. The Contractor shall administer a subcontractor appeal and adjudication process. The subcontractor appeal and adjudication process must be included in all subcontracts. This process shall assure fair consideration and disposition of subcontractor claims against the Contractor. Final authority to decide claims shall be vested with the Contractor. The subcontractor has no right of appeal to CDA.

4. The Contractor shall serve participants in the Catchment Area as defined in Exhibit G of this Agreement.

5. The Contractor shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA MSSP Branch. The Contractor

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

shall comply with any and all changes to State and federal law. The Contractor shall include this requirement in each of its subcontracts.

6. The Contractor shall make staff available to CDA for training and meetings which CDA may find necessary from time to time.

7. The Contractor must notify CDA, in writing, of any change of address. The notice must be on agency letterhead and addressed to the MSSP Branch Manager within thirty-five (35) days of relocation. An Agency Contract Representative form shall be required as stated in Exhibit D, Article XIX.

ARTICLE IV. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE COORDINATED CARE INITIATIVE (CCI) PAYMENT MODEL

A. Definitions specific to the CCI model:

1. "Coordinated Care Initiative" (CCI) means Coordinated Care Initiative enacted in California in July 2012 through SB 1036 and SB 1008.

2. "Member" means any person who is enrolled with the PLAN(S) and receives benefits from the PLAN(S).

3. "PLAN(S)" is an independent organization contracted directly with the DHCS to implement the CCI. PLAN(S) contract with MSSP providers to provide Medi-Cal covered benefits to Medi-Cal beneficiaries who are enrolled with the PLAN(S).

4. "Encounter" means any authorized service consistent with any of the three (3) MSSP service categories (Care Management, Care Management Support, or Purchased Waiver Services) provided to or purchased by the Contractor for an enrolled PLAN(S) Member during a given month. Each MSSP Waiver Participant incurs one encounter per month for care management and care management support. However, each MSSP Waiver Participant may incur more than one purchased waiver service encounter because each unit of purchased waiver service is counted as a separate encounter.

5. "MSSP Applicant" means a Member who has submitted an application to the Contractor to receive MSSP Waiver Services.

6. "Wait List" means a list of potential MSSP Participants, established and maintained by the Contractor, when the Contractor has reached its capacity. To ensure compliance with MSSP Waiver requirements and Centers for Medicare and Medicaid Services (CMS) direction, MSSP sites must develop and implement a wait list policy and procedure. The policy and procedure must include provisions for: prescreening individuals to determine eligibility; managing applicants' placement on and removal from the wait list; periodically reviewing the eligibility and identified needs of applicants on the wait list; and assigning priority for enrollment based on

ARTICLE IV. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE COORDINATED CARE INITIATIVE (CCI) PAYMENT MODEL (Continued)

identified needs and level of risk. The Contractor determines the priority of enrollment into the MSSP in accordance with CDA and CMS requirements.

7. "Eligibility Determination" means a process by which the Contractor determines whether a MSSP Applicant or MSSP Waiver Participant meets eligibility criteria to participate in the MSSP and receive MSSP Waiver Services.

B. Management Information Systems (MIS)

The Contractor shall maintain and operate an MIS at its site for submission of encounter data to PLAN(S), consistent with Exhibit A, Article IV., Section I, Encounter Data Submission.

C. Notice Requirements

The Contractor shall be responsible for providing written notice to PLAN(S) as follows:

1. Within five (5) business days after the following occurrences:

   a) Disenrollment of a MSSP Waiver Participant from MSSP due to death, relocation, or voluntary disenrollment.
   b) Enrollment in the MSSP Waiver of a PLAN Member who was not referred by PLAN(S).
   c) Referral of a PLAN(S) Member to MSSP by non-PLAN(S) sources.
   d) Determination by the Contractor that an MSSP Applicant referred by the PLAN(S) is ineligible for enrollment in MSSP.
   e) Placing PLAN(S) Member on a wait list.
   f) Enrollment of a PLAN(S) Member MSSP Applicant from the wait list to MSSP.
   g) Change of the Contractor ownership or legal name.
   h) Transition of MSSP Waiver Participants to another Contractor and location.
   i) Denial or discontinuation of services.

2. Within thirty-five (35) days of relocation of a MSSP site.

3. Within one hundred and eighty (180) days prior written notice to PLAN(S) of termination of the Contractor's agreement with PLAN(S).

4. Within thirty (30) days written notice to State of California prior to termination of the Contractor's Agreement with PLAN(S).

ARTICLE IV. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE COORDINATED CARE INITIATIVE (CCI) PAYMENT MODEL (Continued)

D. Transition Plan

In the event of termination of this Agreement, the Contractor shall work collaboratively with PLAN(S) to develop a plan to ensure safe transition of Waiver Participants out of MSSP.

E. Enrollment Verification

The Contractor shall verify monthly whether the MSSP Waiver Participant remains eligible for Medi-Cal and in which managed care PLAN(S) the MSSP Waiver Participant is enrolled. The Contractor shall verify PLAN(S) enrollment using the Medi-Cal Eligibility Determination System (MEDS) and/or directly with PLAN(S). This verification should occur prior to submitting monthly claims to PLAN(S) as outlined in Exhibit B, Article V., Section A.

1. Unencrypted Member electronic Protected Health Information (ePHI) sent to entities outside of the contracted PLAN(S) using internet-based services must be secured using virtual private networks (VPN), secure socket layer (SSL), transmission layer security (TLS), secure file transport protocol (SFTP), or other method that can encrypt communications over the public internet; and

2. Removable storage devices used to store ePHI must be encrypted before being sent to entities outside of PLAN(S).

F. Orientation

The Contractor shall provide orientation of MSSP to designated staff of PLAN(S).

G. Referrals

The Contractor shall establish a mechanism to receive referral of Members who are enrolled in the Medi-Cal PLAN(S) for Managed Long-Term Services and Support and are potentially eligible for the MSSP Program.

H. Care Coordination

The Contractor shall coordinate and work collaboratively with PLAN(S) on care coordination activities surrounding the MSSP Waiver Participant including, but not limited to, coordination of benefits between PLAN(S) and the Contractor to avoid duplication of services and coordinate Care Management activities particularly at the point of discharge from the MSSP.

ARTICLE IV. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE COORDINATED CARE INITIATIVE (CCI) PAYMENT MODEL (Continued)

I. Encounter Data Submission

1. The Contractor shall submit monthly to CA-MMIS and PLAN(S) zero-cost electronic encounter data for all MSSP Waiver Services rendered to MSSP Waiver Participants.

2. The Contractor shall submit all encounter data within three (3) months from the end of the month that service was provided.

ARTICLE V. MEDI-CAL AID DEFINITION & CODES

Contractors are to use the following codes to verify waiver participant eligibility. Multipurpose Senior Services Program Waiver Participants qualify under the following Medi-Cal Aid codes:

1. CASH GRANT

AID CODE		PROGRAM DEFINITION
10	AGED	SSI/SSP Aid to the Aged – Cash assistance program administered by the Social Security Administration, pays a cash grant to needy persons age sixty-five (65) or older.
20	BLIND	SSI/SSP Aid to the Blind – Cash assistance program administered by the Social Security Administration, pays a cash grant to needy blind persons of any age.
60	DISABLED	SSI/SSP Aid to the Disabled – Cash assistance program administered by the Social Security Administration, pays a cash grant to needy persons who meet the federal definition of disability.

2. PICKLE ELIGIBLES/20 PERCENT SOCIAL SECURITY DISREGARDS

AID CODE		PROGRAM DEFINITION
**16	AGED	Aid to the Aged-Pickle Eligibles – Persons age sixty- five (65) or older who were eligible for and receiving SSI/SSP and Title II Benefits concurrently in any month since April, 1977, and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with the provisions of the Lynch v. Rank lawsuit.

ARTICLE V. MEDI-CAL AID DEFINITION & CODES (Continued)

**26	BLIND	Aid to the Blind-Pickle Eligibles – Persons who meet the federal criteria for blindness and are covered by the provision of the Lynch v. Rank lawsuit. See Aid Code 16 for definition of Pickle Eligibles.
**66	DISABLED	Aid to the Disabled-Pickle Eligibles – Persons who meet the federal definition of disability and are covered by the provision of the Lynch v. Rank lawsuit. See Aid Code 16 for definition of Pickle Eligibles.

**NOTE: This also includes persons who were discontinued from cash grant status due to the twenty percent (20%) Social Security increase under Public Law 32-336. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with 22 CCR 50247.

3. MEDICALLY NEEDY, NO SHARE OF COST

AID CODE		PROGRAM DEFINITION
14	AGED-MN	Aid to the Aged-Medically Needy – Persons age sixty-five (65) or older who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.
24	BLIND-MN	Aid to the Blind-Medically Needy – Persons who meet the federal definition of disability and do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.
64	DISABLED MN	Aid to the Disabled-Medically Needy – Persons who meet the federal definition of disability and do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. No Share of cost required of the beneficiaries.

4. MEDICALLY NEEDY, SHARE OF COST

AID CODE		PROGRAM DEFINITION
***17	AGED-MN SOC	Aid to the Aged-Medically Needy, Share of cost – See Aid Code 14 for definition of AGED-MN. Share of cost is required of the beneficiaries.
***27	BLIND-MN	Aid to the Blind-Medically Needy, Share of cost – SOC See Aid Code 24 for definition of BLIND-MN. Share of cost is required of the beneficiaries.
***67	DISABLED MN-SOC	Aid to the Disabled-Medically Needy, Share of cost – See Aid Code 64 for definition of Disabled-MN. Share of cost is required of the beneficiaries.

ARTICLE V. MEDI-CAL AID DEFINITION & CODES (Continued)

***NOTE: As a result of the implementation of the In-Home Supportive Services (IHSS) Plus waiver, the special program codes of 1F, 2F, and 6F that were paired with the 17, 27, and 67 aid codes are no longer valid Medi- Cal aid codes as of November 1, 2005. MSSP sites are only required to serve Waiver Participants with the aid codes of 17, 27, or 67 who were active as of November 1, 2005 or were subsequently re-determined into aid codes 17, 27, or 67.

5. AGED AND DISABLED FEDERAL POVERTY LEVEL PROGRAM

AID CODE		PROGRAM DEFINITION
1H	AGED	Aged persons who, due to their income levels, would normally be included in the Medi-Cal Share of Cost population (Aid Code 17). Under this new program, those recipients with a Share of Cost of $1 to $326 will be given full scope, no Share of Cost Medi-Cal.
6H	DISABLED	Disabled persons who, due to their income levels, would normally be included in the Medi-Cal Share of Cost population (Aid Code 17). Under this program, those recipients with a Share of Cost of $1 to $326 will be given full scope, no Share of Cost Medi-Cal.

6. INSTITUTIONAL DEEMING

AID CODE		PROGRAM DEFINITION
1X	NO SOC	MSSP Medi-Cal Qualified. Eligible due to application of spousal impoverishment rules.
1Y	SOC	MSSP Medi-Cal Qualified. Eligible due to application of spousal impoverishment rules. Share of cost is required of the beneficiaries. These recipients are identified apart from the regular Medi-Cal SOC population by the Special Program Aid Code of 1F.

7. CONTINUED ELIGIBILITY – REDETERMINATION

AID CODE		PROGRAM DEFINITION
1E	AGED	Continued eligibility for the Aged - Former SSI beneficiaries who are aged until the county redetermines their eligibility.
2E	BLIND	Continued eligibility for the Blind - Former SSI beneficiaries who are blind until the county redetermines their eligibility.
6E	DISABLED	Continued eligibility for the Disabled - Discontinued SSI beneficiaries who are disabled until the county redetermines their eligibility.

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER

Services Provided Under the Waiver – Contractors must have the ability to provide the following services to MSSP Waiver Participants:

Definitions of each of the services approved by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services under the existing 1915 (c) Home and Community-Based Services Waiver are as follows. The numbers in parentheses are program code designations for the particular service.

1. **Adult Day Care** (1.1): Will be provided to MSSP Waiver Participants who are identified in their plan of care as benefiting from being in a social setting with less intense supervision and fewer professional services than offered in an adult day support center. Adult Day Care services will be provided when the Waiver Participant's plan of care indicates that the service is necessary to reach a therapeutic goal. Adult day care centers are community-based programs that provide nonmedical care to persons eighteen (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 on less than a 24-hour basis. The Department of Social Services (DSS) licenses these centers as community care facilities.

2. **Housing Assistance** (2.2, 2.3, 2.4, 2.5 and 2.6): These services are necessary to ensure the health, welfare, and safety of the Waiver Participant in his or her physical residence or home setting. As specified in the Waiver Participant's plan of care, services may include provision of physical adaptations and assistive devices, emergency assistance in situations which demand relocation and assistance to restore utility service. Housing Assistance services include:

    a. **Minor Home Repairs and Maintenance** (2.2): Minor Home Repairs do not involve major structural changes or repairs to a dwelling. Maintenance is defined as those services necessary for accessibility (e.g., ramps, grab bars, handrails, items above what is covered by the State Plan, and installation), safety (e.g., electrical wiring, smoke alarms), or security (e.g., locks). Eligible Waiver 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 Waiver Participants who are owners/occupiers of their own home, or those in rental housing where the owner refuses to make needed repairs or otherwise alter the residence to adapt to special Waiver Participant needs. Written permission from the landlord (including provision for removal of modifications, if necessary) is required before undertaking repairs or maintenance on leased premises. All services shall be provided in accordance with applicable State or local building codes.

    b. **Nonmedical Home Equipment** (2.3): Includes those assistive devices, appliances, and supplies which are necessary to assure the Waiver Participant's health, safety, and independence. This service includes the purchase or repair of nonmedical home equipment and appliances such as refrigerators, stoves, microwave ovens, blenders, kitchenware,

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

heaters, air conditioners, fans, washing machines, dryers, vacuum cleaners, furniture (i.e., couches, lamps, tables, chairs, mattresses, bedding, and emergency supply kits and goods) under the following circumstances:

i. The Waiver Participant is receiving Deinstitutionalized Care Management services, and the items are required to facilitate discharge from the institution to a community residence

ii. The Waiver Participant's assessment identifies the need for this service including how it is a necessary support if the Waiver Participant is to remain in the community, and the care plan specifies the required item(s)

iii. In either circumstance, the following criteria must be met and documented in the case record:

(a). The items are unobtainable through other resources, and their purchase would be a financial hardship for the Waiver Participant

(b). The items are necessary to preserve the Waiver Participant's health, improve functional ability and assure maximum independence, thereby preventing elevation to a higher level of care and avoiding more costly institutionalization

c. **Emergency Move** (2.4): Involves facilitating a smooth transition from one living situation to another. Eligible Waiver Participants are those who, due to loss of residence or the need for a change in residence, require assistance with relocation. Services may be provided by moving companies or other individuals who can guarantee the safe transfer of the Waiver Participant's possessions. Activities may include materials and labor necessary for such moves.

d. **Emergency Utility Service** (2.5): Allows for payment of utilities only when the Waiver Participant has no other resources to meet this need. Additionally, the Waiver Participant must be at risk to receive a shut-off notice and the potential shut off of utility services would place the health and safety of the Waiver Participant in jeopardy.

e. **Temporary Lodging** (2.6): Allows for payment of hotel or motel lodging for those Waiver Participants, usually from rural areas, who must travel long distances and stay overnight for medical treatments not available in their home area. Temporary lodging is also available in the event of an emergency. Lodging rates shall not exceed State limits in accordance with CalHR rates. (http://www.calhr.ca.gov/employees/Pages/travel-lodging- reimbursement.aspx)

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

3. **Supplemental Chore** (3.1): Is for purposes of household support and applies to the performance of household tasks rather than to the care of the Waiver Participant. Chore activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance, as long as the Waiver Participant does not live in a Residential Care Facility for the Elderly (RCFE). Waiver Participant instruction in performing household tasks and meal preparation may also be provided.

   This service is for purposes of household support for those services above and beyond those available through the State Plan. Examples include:

   a. The MSSP Waiver Participant has not yet been assessed for IHSS, and needs services in the interim until IHSS services can be arranged

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

   c. IHSS services are in place; however, MSSP has assessed a greater need. In these cases, every effort will be made to negotiate with IHSS towards an increase in those services before authorizing expenditure of waiver funds

4. **Supplemental Personal Care** (3.2): This service is provided to individuals whose needs exceed the maximum amount available under the State Plan or who are temporarily without a provider. This service provides assistance to maintain bodily hygiene, personal safety, and activities of daily living (ADL). These tasks are limited to nonmedical personal services: 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, and moving the individual from place to place (e.g., transferring). Waiver Participant instruction in self-care may also be provided; may also include assistance with preparation of meals, but does not include the cost of the meals themselves.

   Purchase of personal care supplies may be covered where there are no other resources and the purchase would create a financial hardship.
   These items include supplies not covered under the State Plan.

   When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting, and vacuuming, which are essential to the health and welfare of the recipient. The household chores which are performed by the worker are essentially ancillary to the provision of the Waiver Participant-centered care. Thus, if food is spilled, it may be cleaned up, and when bed linen is soiled it may be changed, washed, and put away. However, at no time would household chores become the central activity furnished by a personal care worker. When a personal care service is to be

performed by an unlicensed health care worker, permissible 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 individual's certification, if applicable.

Personal care service providers may be paid while the Waiver Participant is institutionalized. This payment is made to retain the services of the care provider and is limited to seven (7) calendar days per institutionalization.

5. **Supplemental Health Care** (3.3): Addresses the care of health problems by appropriately licensed or certified persons when such care is not otherwise available under the State Plan. Refer to MSSP Site Manual Chapter 3 for a list of criteria.

6. **Supplemental Protective Supervision** (3.7): Ensures provision of supervision in the absence of the usual care provider to persons residing in their own homes, who are very frail or otherwise may suffer a medical emergency. Such supervision serves to prevent immediate placement in an acute care hospital, skilled nursing facility, or other 24-hour care facility, e.g., Residential Care Facility for the Elderly (RCFE). 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 provide a visit to the Waiver Participant's home to assess a medical situation during an emergency (e.g., natural disaster). Waiver Service funds may not be used to purchase this service until existing county Title XX Social Services and Title XIX Medi-Cal resources have been fully utilized and an unmet need remains.

7. **Care Management**: Assists Waiver Participants in gaining access to needed Waiver and other State Plan services, as well as needed 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 Waiver Participant's plan of care. Additionally, care managers initiate and oversee the process of assessment and reassessment of Waiver Participant level of care and the monthly review of plans of care.

    a) **Site-Provided Care Management** (50): The MSSP care management system vests responsibility for assessing, care planning, authorizing, locating, coordinating and monitoring a package of long-term care services for community-based Waiver Participants with a local MSSP site contractor and specifically with the site care management team. The care management teams at each of the local sites are trained professionals working under the job titles of nurse care manager and social work care manager; these professionals may be assisted by care manager aides. The teams are responsible for care management services including the assessment, care plan development, service authorization/delivery, monitoring, and follow-up components of the program. Case records must document all Waiver Participant contact activity each month.

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

b) **Purchased Care Management** (4.3): For the vast majority of MSSP Waiver Participants, care management services are provided solely by site care management staff. However, Waiver Participants have the right to request care management by qualified outside Subcontractors. In some cases of temporary need, the site may retain an outside Subcontractor to provide the services of a care manager. If either of these two situations arises, the site must ensure that there is no overlap between Site-Provided Care Management (50) and Purchased Care Management (4.3). Any duplication of these services will be subject to recovery and will be collected through formal channels administered by DHCS Payment Systems Division, Recovery Section. Additional case-specific resources may be purchased from social, legal/paralegal specialists in the community in order to augment the resources and skills of site-based case managers. Examples include the purchase of more skilled diagnostic and consultant services by social and legal/paralegal professionals. Fees necessary to procure birth certificates or other legal documents required for establishment of public benefits or assistance are also covered.

8. **Deinstitutional Care Management (DCM)** (4.6): This service is used ONLY with individuals who are institutionalized. It allows care management and waiver services to begin up to one hundred eighty (180) days prior to an individual's discharge from an institution. It may be used in two situations, as follows:

   a. 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

   b. Where an established MSSP Waiver Participant is institutionalized and MSSP services are necessary for the person to be discharged back into the community

   In either situation, all services (monthly Administration and Care Management, plus any purchased services) provided during this period are combined into one unit of DCM and billed upon discharge. For those individuals who do not successfully transition to the waiver, all services provided are combined into one unit of DCM and billed at the end of the month the decision is made to cease MSSP activity.

9. **Respite** (5.1, 5.2): The State's Medicaid Plan does not provide for respite care. By definition, the purpose of respite care is to relieve the Waiver Participant's informal caregiver and thereby prevent breakdown in the informal support system. Respite service will include the supervision and care of a Waiver Participant, while the family or other individuals who normally provide primary care take short-term relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver.

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

As dictated by the Waiver Participant's circumstances, services will be provided In-Home (5.1) or Out-of-Home (5.2) through appropriate available resources such as board and care facilities, skilled nursing facilities, etc. Federal Financial Participation will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. Individuals providing services in the Waiver Participant's residence shall be trained and experienced in homemaker services, personal care, or home health services, depending on the requirements in the Waiver Participant's plan of care.

10. **Transportation** (6.3 [escort, hour] and 6.4 [one-way trip]): These services provide access to the community (e.g., non-emergency medical transportation to health and social service providers) and special events for Waiver Participants who do not have means for transportation or whose mobility is limited, or who have functional disabilities requiring specialized vehicles and/or escort. These services are in contrast to the transportation service authorized by the State Medicaid Plan which is limited to medical services, or Waiver Participants who have documentation from their physician that they are medically unable to use public or ordinary transportation. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

    Transportation services are usually provided under public paratransit or public social service programs (e.g., 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 or public mass transit; specialized transport for the older adults and adults with disabilities; private taxicabs where no form of public mass transit or paratransit is available or accessible; or private taxicabs when they are subsidized by public programs or local government to service the elderly and handicapped (e.g., in California, some counties provide reduced fare vouchers for trips made via private taxicabs for the elderly and handicapped).

    Escort services will be provided when necessary to assure the safe transport of the Waiver Participant. Escort services may be authorized for those Waiver Participants who cannot manage to travel alone, and require assistance beyond what is normally offered by the transportation provider. This service will be provided by trained paraprofessionals or professionals, depending on the Waiver Participant's condition and care plan requirements.

11. **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 (3) meals a day).

    a. **Congregate Meals** (7.1): Meals served in congregate meal settings for Waiver Participants who are able to leave their homes or require the social stimulation of a group environment in order to maintain a balanced

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

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 Waiver Participants through Title III of the Older Americans Act. MSSP funds shall only be used to supplement congregate meals when funding is unavailable or inadequate through Title III or other public or private sources.

b. **Home Delivered Meals** (7.2): Meals for Waiver Participants who are homebound, unable to prepare their own meals and have no caregiver at home to prepare meals for them. As with Congregate Meals, the primary provider of this service is Title III of the Older Americans Act. MSSP 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.

c. **Food** (7.3): Provision of food staples is limited to purchase of food to facilitate and support a Waiver Participant's return home following institutionalization, and to food purchases which are medically required.

If oral nutrition supplements (ONS) are to be purchased using waiver service funds, the following actions must occur and be documented in the Participant record:

(i) A nutritional screen is conducted by the primary care manager in consultation with the nurse care manager. The Progress Notes must reflect the collaboration between the SWCM and NCM.

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

(iii) All other options for payment of an ONS have been exhausted (Waiver Participant, family, etc.).

If all three criteria have been satisfied, an ONS may be purchased initially for a period of three (3) months. If an ONS needs to be continued beyond the three-month timeframe, a physician order must be obtained.

12. **Protective Services** (8.3, 8.4, and 8.5): These services include protection for Waiver 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.

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

13. **Social Support** (8.3): 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; expenses for activities and supplies required for Waiver Participant participation in rehabilitation programs; therapeutic classes and exercise classes are also provided. Such services shall be provided based on need, as designated in the Waiver Participant's plan of care. The MSSP has found that isolation and lack of social interaction can seriously impact some Waiver Participants' capacity to remain independent. Lack of motivation or incentive or the lack of any meaningful relationships can contribute to diminishing functional capacity and premature institutionalization.

    These services are often provided by volunteers or through Title III of the Older Americans Act; however, these services may not be available in a particular community and do, infrequently, require purchase. The waiver will be used to purchase friendly visiting only if the service is unavailable in the community or is inadequate as provided under other public or private programs.

    a. **Therapeutic Counseling** (8.4): Includes individual or group counseling to assist with social, psychological, or medical problems which have been identified in the assessment process and included in the Waiver Participant's care plan.

        The MSSP has found that therapeutic counseling is essential for preventing some Waiver Participants from being placed in a nursing facility (NF).

        This service may be utilized in situations where Waiver Participants or their caretakers may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems.

        Counseling by licensed or certified counselors in conjunction with other services (e.g., respite, IHSS, meals) may reverse some states of confusion and greatly enhance the ability of a family to care for the Waiver Participant in the community, or allow the Waiver Participant to cope with increasing impairment or loss.

    b. **Money Management** (8.5): This service assists the Waiver 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.

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

14. **Communications Services** (9.1 and 9.2): Waiver Participants who receive these services are those 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; and providers specializing in communications equipment for disabled or at-risk persons. Services shall be available on a routine or emergency basis as designated in the Waiver Participant's plan of care.

    a. **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 is essential to maintaining independence and carrying out the ADL and Instrumental Activities of Daily Living (IADL) functions.

    For non-English speaking Waiver Participants, this service is the link to the entire in-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, and as described in the care plan.

    b. **Communication/Device** (9.2): The rental/purchase of 24-hour emergency assistive services, or installation of a telephone to assist in communication (excluding monthly telephone charges) for Waiver Participants who are at risk of institutionalization due to physical conditions likely to result in a medical emergency. Purchase of emergency response systems is limited to those Waiver Participants who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The following are allowable:

        (i) 24-hour answering/paging
        (ii) Beepers
        (iii) Medic-alert type bracelets/pendants
        (iv) Intercoms
        (v) Life-lines
        (vi) Wander-alerts
        (vii) Monitoring services
        (viii) Light fixture adaptations (blinking lights, etc.)
        (ix) Telephone adaptive devices not available from the telephone company
        (x) Other electronic devices/services designed for emergency assistance

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

Telephone installation or reactivation of service will only be authorized to enable the use of telephone-based electronic response systems where the Waiver Participant has no telephone, or for the isolated Waiver Participant who has no telephone and who resides where the telephone is the only means of communicating health needs. This service will only be authorized when the Waiver Participant has a medical/health condition that makes him/her vulnerable to medical emergency (e.g., congestive heart failure or emphysema).