CHAPTER 1: Introduction

Policy: The current Multipurpose Senior Services Program (MSSP) Site Manual must be available either electronically or in hard copy to provide Multipurpose Senior Services Program (MSSP) site staff with requirements relevant to the program's federal Home and Community-Based Waiver authority and the California Department of Aging (CDA) Interagency Agreement (IA) with the single State Medicaid agency, the Department of Health Care Services (DHCS).

Purpose: The Manual is a compilation of State and federal law, regulations, and official guidance for MSSP. The purpose of the Manual is to make the Program's authorities easily accessible to assist staff in carrying out local program operations on behalf of the MSSP participants.

References:

- Social Security Act, Title XXI, Section 1915(c)
- Code of Federal Regulations, Title 42, Volume 3, Chapter IV, Section 440.180
- Welfare and Institutions Code 14132(t)
- Home and Community-Based Services Waiver #0141.R07.00
- CDA Standard Agreement (Site Contract)
- California Code of Regulations, Division 3, Chapter 3, Article 4, Section 51346
- Interagency Agreement between DHCS and CDA

1.000 Overview of MSSP

The objective of MSSP is to avoid premature placement of people in nursing facilities, while fostering independent living in the community. MSSP provides services to eligible participants enabling them to remain in or return to their homes. Services must be provided at a cost lower than that for nursing home placement.

1.100 Enabling Legislation

In 1977, the California Legislature authorized the Multipurpose Senior Services Project as a four-year research and demonstration project. The objective of the project was to obtain information on cost-effective methods of preventing inappropriate institutionalization of frail older adults.

The Torres-Felando Long Term Care Reform Act of 1982 (Chapter 1453) provided for the conditional continuation of MSSP beyond its sunset of June 30, 1983.

The program would thereafter be an ongoing program as long as it proved cost-effective, and the State could obtain federal authority to fund the program through a Medicaid Home and Community-Based Care Waiver. The authorizing State legislation is contained in California Welfare and Institution Code, Section 9560 et seq.

1.200 The Waiver and Program History

The 1981 Omnibus Budget Reconciliation Act added Section 1915(c) to the Social Security Act. This provision allows the Secretary of the U.S. Department of Health and Human Services (DHHS) to waive certain requirements to allow states to cover a wide range of home and community-based (HCB) services to persons who would otherwise need institutional care. These waivers allow states to provide services beyond those in their Medicaid State Plan. Federal statutory requirements for Medicaid that may be waived include:

- *Statewide*, which requires that services be available throughout the state.

- *Comparability*, which requires that all services be available to all eligible individuals. (Certain categories of eligible persons may be targeted for waiver services including elderly, disabled, develop-mentally disabled and individuals who have specific illnesses such as AIDS).

- *Income and resource rules*, which require states to use a single income and resource standard when determining eligibility for Medicaid, with the exception of institutional care. A waiver of this last requirement allows states to use more generous institutional eligibility criteria when determining financial eligibility for waiver services, thus extending eligibility to individuals in the community who would not otherwise qualify for Medicaid.

One condition of waiver approval is that services must be a cost-effective alternative to the institutional level of care that would have been required. States must also assure the health and safety of waiver participants.

In FY 1983-84, the first year of the Waiver, there were eight sites serving a caseload of 1,900 participants. In FY 1984-85, the Waiver's second year, the caseload increased to 3,400 participants and the number of sites expanded by ten for a total of eighteen.

On January 1, 1985, administration of MSSP was transferred from the California Health and Welfare Agency (now the California Health and Human Services Agency) to CDA. In FY 1985-86, the participant caseload increased to 5,400 and four new sites were added for a total of twenty-two.

For FY 1986-87, California received a one-year extension of the Waiver, which authorized the MSSP to operate at the same caseload level and number of sites as approved for 1985-86. A new three-year waiver was authorized for the FYs 1987-88, 1988-89 and 1989-90. This three-year waiver expanded the annual caseload size to 6,000, and the number of sites remained constant at twenty-two. Extensions to this waiver were granted for FYs 1991-92, 1992-93 and 1993-94. A five-year waiver was authorized for FYs 1994-95 through 1998-99.

The next round of growth occurred in FY 1998-99 when the number of sites increased to 35 and the number of slots to 9,300. The last expansion occurred with the waiver

renewal in FY 2000-01, increasing the number of sites to 41 and the number of slots to 11,789.

In 2000, the Centers for Medicare and Medicaid Services (CMS) revised its rules, permitting Medicaid payment for care management costs incurred while assisting nursing facility (NF) residents to transition from the facility into the community. In response to this opportunity, CDA submitted a request for a waiver amendment to implement these changes. This amendment made it possible for MSSP sites throughout the state to begin assisting NF residents with discharge planning toward the goal of moving out of the facility and into community living situations.

During the next several years, California experienced budget cuts that necessitated the reduction of MSSP slots. In FY 2008-09, MSSP received a 10% decrease in total funding, which resulted in a reduction of slots to 10,612. Two sites combined into one, while another gave up the program and was not replaced, bringing the total number of sites to 39. In FY 2010-11, MSSP received another 11% decrease in total funding, lowering the number of slots to 9,443.

Under California's Coordinated Care Initiated (CCI), Medi-Cal beneficiaries in seven demonstration counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara) were required to enroll in a participating Medi-Cal managed care health plan to receive their Medi-Cal benefits, including MSSP. San Mateo County transitioned to a fully integrated managed care benefit in October 2015, bringing the total number of sites to 38.

In FY 2019-20, MSSP received a one-time appropriation spread over a three-year period that allowed for a rate increase for care management and care management support services. During FY 2020-21 two sites combined into one, bringing the total number of sites to 37. Effective FY 2021-22, the California Legislature made the supplemental increase permanent and restored the slots that were removed in previous years.

The CCI was previously scheduled to transition the remaining MSSP CCI sites to a managed care benefit effective January 1, 2023; however, effective January 1, 2022 MSSP was carved out of CCI and did not transition to managed care. MSSP currently operates as a waiver benefit in all CCI demonstration counties, with the exception of San Mateo County, as it did prior to the implementation of CCI in 2014.

The latest five-year renewal of the Waiver was approved for FYs 2024-25 through 2028-29. Under this renewal, the Waiver was approved to expand statewide (among existing sites), expand the Medi-Cal aid codes served, and decrease the age of eligibility to 60 and above. During FY 2025-26, two sites combined into one, bringing the total number of sites to 36. During FY 2026-27, five sites combined into two, bringing the total number of sites to 33.

1.300 Program Operations

Section 1915(c) of Title XXI of the Social Security Act permits states to request waivers of federal law in order to provide certain services to people at home or in the community as a cost-neutral alternative to institutionalized health care.

CMS approves and oversees these agreements, granting the waivers to each state's designated Medicaid (Medi-Cal in California) agency. In California, this designated State agency is the Department of Health Care Services (DHCS).

The MSSP Waiver, one of several waivers administered by DHCS, is implemented by CDA under the supervision of DHCS through an Interagency Agreement (IA). Within DHCS, oversight of MSSP is provided by the Integrated Systems of Care Division (ISCD). ISCD is responsible for:

- Programmatic monitoring;
- Oversight reviews;
- All technical/programmatic compliance;
- Correctness of the IA; and
- Serves as the central point of contact for CMS.

Within the California Department of Aging, the MSSP Section is the unit responsible for reviewing and monitoring the local sites' compliance with the program contract. The MSSP Section oversees program and administrative elements of local site operation through policy directives, technical assistance, complaint investigation, and formal Medi-Cal Utilization Reviews (UR). The CDA Audits and Risk Management Branch conducts fiscal audits of local sites every three years at a minimum.

Following State contracting requirements, CDA contracts with local government and private nonprofit agencies to administer the program locally.

The local MSSP sites represent a wide variety of service delivery agencies and geographic areas with diversified participant populations. Each site is an administratively separate entity within its host agency. MSSP sites provide Care Management services which can include purchasing Waiver Services to establish a safety framework for participants to continue to live independently in their home.

Care management is the cornerstone of MSSP. It involves the coordination of existing community resources which provide the services required to enable participants to continue living at home.

MSSP care management includes participant assessment, care planning, service arrangement and monitoring. A team of health and social service professionals evaluates each participant, commencing with a complete health and psychosocial assessment to determine the services needed. The team then works with the participant and family to develop an individualized care plan.

Site care management staff will first explore informal support that might be available through family, friends and the voluntary community when arranging services. Staff then review existing publicly funded services and, whenever possible, make direct referrals. If needed services are not available through friends, family, and other programs, the care management team can authorize the purchase of Waiver Services from program funds.

1.400 Organization of This Manual

This Manual consists of two sections: Text and Appendix.

- The Text section: This section provides policy direction for casework and specified elements of site operation.

- The Appendix section: This section contains a variety of items including background information, reference sources, CDA forms, and links to various non-CDA forms. The forms in this section are also located on the Secure File Transfer site (SFT). Sites may adjust formatting, add fields, and reproduce the documents on their letterhead or within their respective care management systems. However, the information contained in CDA mandated forms (Chapter 5, Section 5.800, Case Documents) may not be altered without CDA approval.