#	Topic/Number of Comments	Question/Comment	CDA/DHCS RESPONSE
1	Appendix A language (1 comment)	Appendix A; Waiver Administration & Operation 4. Role of Local/Regional Non-State Entities Local/Regional non-governmental non-state entities Care management involves: (proposed addition) “A team of health and credentialed social service professionals with at least a BS/BA degree in Social Work, Gerontology or related human service degree. If the assigned Care Manager is completing a field assignment from an accredited university as an Intern, the MSSP Direct Supervisor must have an advanced degree with person-centered and care management education/experience. All assigned care managers and care manager interns must understand community resources for the geographic area they represent including making in person client home visits, documentation and actions required when receiving a referral regarding abuse, neglect or self-neglect regarding all clients under the MSSP umbrella. It is the responsibility of the contracting MSSP agency as a mandated report to follow through with a direct referral to Adult Protective Services (APS) with client follow up as required to assure the safety and well being of the MSSP client.”	Thank you for your review and feedback. CDA/DHCS declines to make updates to this section of the Waiver, as we do not want to duplicate the information that is already in other sections of the Waiver. This section is intended to describe the local/regional non-governmental/state entities that are contracted to provide Care Management Services. A full description of Care Management Services and the specific qualifications of care managers is included in Appendix C1/C-3: Service Specification: Care Management (pages 50-53). The recommended language for mandated reporter requirements is detailed in Appendix G-1: Response to Critical Events of Incidents (pages 136-138).

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2	Expanding access to the program statewide (9 comments)	**Expanding access to the program statewide.** MSA has advocated for and supports this proposed change, including giving preference to the neighboring MSSP provider to expand their service area as part of the agreement with the state. MSA believes the state should not require a current provider to manage a separate agreement for the new service area. The counties that currently lack MSSP services are largely rural, with associated challenges to health care delivery. Allowing a current, willing provider to expand to the new territory under their existing agreement would reduce unnecessary administrative burdens and operational barriers and increase the chances of successful expansion.	Thank you for your support and feedback. A Waiver update is not necessary to address this recommendation. CDA and DHCS will consider your feedback for the expansion implementation during the CDA Standard Agreement contract renewal process.
3	MSSP Site contracts (1 comment)	Lastly, we urge the state to address additional improvements beyond the waiver renewal but VITAL to ensuring equitable access to care, our providers, and the long-term success of MSSP. We request: • A single MSSP contract for each host institution, rather than a separate contract for each County. The number of slots per County is also irrational. We have two sites with 200 slots, yet one site has a total Medi-Cal population of more than double the other County. This is unequitable and unfair.	Thank you for your review and feedback. A Waiver update is not necessary to address this recommendation. CDA and DHCS will consider your feedback during the CDA Standard Agreement contract renewal process.

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4	Expanding aid code eligibility (7 comments)	**Expanding the Medicaid eligibility groups served in the waiver to include more eligible full scope Medi-Cal aid codes, including the Working Disabled Program.** MSA applauds this proposed waiver change to address and improve health equity by allowing access to the program to additional persons who can benefit.	Thank you for your support.
5	Age of Eligibility (9 comments)	**Age eligibility criteria**. Continuing to restrict the age of eligibility for the waiver to age 65 and above unnecessarily denies access to the services for age 60+ older adults who share many of the same challenges with managing complex medical and social needs. Therefore, we urge the state to reduce the age of eligibility for the waiver from 65 to 60 (*One comment recommended age 55*) to ensure access to services are more equitably available to individuals who are clinically eligible for the program.	CDA and DHCS acknowledge the insight of the need for MSSP services at the local level. CDA and DHCS have made updates to the Waiver language to address this recommendation and reduce the age requirement from 65 to 60.

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6	Simultaneous HCBS Waiver/ECM enrollment (9 comments)	**IV. Waiver Services and Operation Must Contemplate Interaction of Waiver With Other HCBS Services** While we understand that the Department aims to avoid duplication of services by prohibiting simultaneous enrollment in MSSP and other HCBS waivers, Enhanced Care Management (ECM) and other state plan benefits, the Department should ensure continuity of care and freedom of choice for Medi-Cal members by: • Requiring, as part of the Application's Freedom of Choice assurance, that participants be educated on all services provided by MSSP and other related programs such as ECM or California Care Transitions, and explaining to participants which services cannot be accessed simultaneously. • Including a transitional period during which participants may access overlapping MSSP and ECM or other similarly related services to ensure warm handoffs and continuity of care. MSSP participants should be allowed to access other waiver programs, to the extent that other waiver services are not duplicated. Given the extremely restrictive per participant MSSP budget, it is unlikely that the participant would be able to access the full menu of services available through the MSSP program within a given year.	Thank you for your review and feedback. Policy prohibiting simultaneous enrollment in more than one HCBS Waiver or ECM program precedes this Waiver renewal application. The intent of adding the language to the Waiver application is for clarity and consistency (i.e., to match other HCBS Waivers language and the current MSSP Site Manual policy). No update to the Waiver language is necessary, as CDA and DHCS will address these recommendations via MSSP policy letters and MSSP Site Manual revision, as appropriate. CDA and DHCS will continue to engage stakeholders to obtain additional input and determine next steps, as appropriate.

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7	Responsibility for LOC determinations (9 comments)	**Change to operating agency responsibility for Performing Evaluations and Reevaluations of Level of Care**. We acknowledge that this change is in response to CMS requirements. However, MSA is concerned about adding a bureaucratic process to this critical component of program enrollment, including potential for delays to needed care, and increased administrative burdens on providers to track and coordinate the process. This change has the real potential to delay or deny applicants access to emergency care plan provisions to address immediate needs identified by the clinical staff conducting the enrollment assessment. Such delays increase the risk of adverse outcomes including avoidable hospital and nursing facility readmissions. As such, MSA requests to be integrally involved in the design of this workflow, and a shared commitment to ensuring emergent participant needs will be addressed timely. We suggest that during times of staff shortages at the State that local sites would be able to temporarily approve LOCs and start services. We also suggest that there be a trigger of one month maximum for State approval before services can be started. We strongly encourage clear direction to sites about level of nursing staffing locally as to not denigrate one of the foundational parts of the MSSP program. We recommend adding more job titles and possible levels to the State list of staff who can approve LOCs.	Thank you for your review and feedback. According to 42 CFR Section 431.10, a Level of Care determination may only be made directly by the Medicaid agency or another government agency that has been designated by the Medicaid agency. To come into compliance with this requirement, CDA and DHCS plan to work collaboratively with CMS to establish a transition plan that will consider this feedback. After the Waiver is renewed, CDA and DHCS will address policy and procedural questions via MSSP policy letters and MSSP Site Manual revision, as appropriate. CDA will continue to engage stakeholders to obtain additional input throughout the implementation process.

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8	Questions and clarification for the LOC process (8 comments)	• Is it going to be kind of like HCBA where the sites' nurses do the evaluations and then submit all the paperwork to CDA for them to re-review the eligibility, and then determine the eligibility from date of when LOC was determined by the site nurse? • It just seems really convoluted to have that many channels to review a client. • Does that mean CDA will hire more nursing staff? • Do you have an estimated turnaround time for getting a response from CDA regarding the LOC? So like an estimated turnaround for the execution of the LOC? • Does this mean that our enrollments may be/will be denied if CDA will have review authority? • Would that mean that the nurse at the state would be writing the LOC statement?	Thank you for your questions and feedback. The specific details of the new LOC process have not been determined yet. CDA and DHCS plan to work collaboratively with CMS to establish a transition plan that will consider this feedback. After the Waiver is renewed, CDA and DHCS will address policy and procedural questions via MSSP policy letters and MSSP Site Manual revision, as appropriate. CDA will continue to engage stakeholders to obtain additional input throughout the implementation process.

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9	Nursing qualifications (1 comment)	If the LOC needs to be approved by a CDA nurse, is it possible to hire LVNs instead of RN?	Thank you for your question. Licensed Vocational Nurses (LVNs) may only provide care within the scope of their licenses, per Welfare & Institutions Code 2859-2873.6. LVNs are entry-level health providers who are responsible for rendering basic nursing care. For this reason, they may not provide care management or determine Nursing Facility Level of Care (NF-LOC). LVNs may provide in-home nursing services if they receive supervision from a Registered Nurse (2 hours/Month).
10	Additional Needed Information language (1 comment)	On page 12 of the renewal draft we suggest you remove the reference to an exemption for a second vehicle. Due to the elimination of asset limit requirements for non-MAGI Medi-Cal programs, assets are no longer considered for eligibility purposes. The inclusion of this language could create unnecessary confusion for some applicants or for MSSP program administrators and could potentially lead to people not applying for needed services or being denied MSSP participation.	Thank you for your review and feedback. CDA and DHCS have made updates to the Waiver language to address this recommendation.

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11	Waiver services (6 comments)	**Waiver services.** MSA providers encounter participants whose complexity of needs go beyond the authorized waiver services and would like to see greater flexibility to address crisis needs related to housing, including utility restoration, and relocating participants temporarily in a disaster or emergency, and permanently. Housing and community support services are not always prepared to serve this specialized population and their specialized needs that exceed other safety net resources place them at risk not just for becoming institutionalized, but also for joining the growing population of unhoused older adults.	Thank you for your review and feedback. According to recent CMS guidance, 1915(c) Waivers are subject to Medicaid room and board rules (42 CFR §441.310[a][2]) and cannot provide the requested types of services. A component of the Initial Psychosocial Assessment is an assessment of resources and needs, including food, housing, and transportation. If a care manager identifies a housing issue with their participant, they should refer them to local housing agencies for assistance. Some resources include California's Section 811 Project Rental Assistance Demonstration Program and the California Department of Housing and Community Development Affordable Housing Rental Directory.

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12	Provider rates and payment methodology (8 comments)	Lastly, we urge the state to address additional improvements beyond the waiver renewal but equally important to ensuring equitable access to care, our providers, and the long-term success of MSSP. These include expansion of waiver slots to address areas of the state with excessive waiting lists, **addressing provider rates** which lag the significant cost increases faced by our members and needed to address staff recruitment & retention as well as increases in vendor rates, and **revising the payment methodology** for MSSP from a line item budget to a per-participant per-month method, for greater flexibility in meeting participant needs and relief from costly administrative burdens that add no value.	Thank you for your review and feedback. At this time, CDA and DHCS decline to make updates to the Waiver to address this recommendation; however, CDA and DHCS will continue to engage stakeholders to obtain additional input. Note: Rate changes must first be authorized through the State budget process. CDA and DHCS acknowledge your concerns with rates and strongly suggest your organization work through the budget process to advocate for rate increases for the program.

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13	Slot Increase (7 comments)	**I. Statewide Expansion is a Positive Step Towards Increasing Equitable Access to MSSP But Additional Investments are Necessary** We support the expansion of MSSP services statewide to the counties that do not currently have MSSP sites. Making MSSP available in these remaining rural counties is consistent with the Master Plan for Aging goal of ensuring all Californians have "access to the care and services we need to optimize our health and quality of life and to continue to live where we choose." However, we are concerned that this expansion is combined with only a modest slot increase from 11,940 to 13,373. This is less than a 12% increase in the number of slots that were available as of 2008 when the state cut MSSP benefits. This is despite MSSP sites currently reporting ongoing waitlists and the significant and continuing growth in the older adult population eligible for the program. We urge CDA and DHCS to seek a slot increase in this renewal application that reflects both anticipates increases in the eligible population due to the statewide expansion and resolves current waitlists driven by inadequate slot availability.	Thank you for your review and feedback. At this time, CDA and DHCS decline to make updates to the Waiver to address this recommendation; however, CDA and DHCS will continue to engage stakeholders to obtain additional input. Note: Slot increases must first be authorized through the State budget process. CDA and DHCS acknowledge your concerns and strongly suggest your organization work through the budget process to advocate for slot increases for the program.

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14	Transparency measures (1 comment)	**II. Incorporate Transparency Measures into the Waiver** Transparency and data collection are key to identifying and addressing inequities in waiver access and service quality. DHCS and CDA should incorporate transparency requirements in the waiver including: • Establishing data collection and reporting on waitlists by MSSP site including number of individuals on the waitlist, length of time prior to service approval, and rate of individuals dropping off the waitlist prior to enrollment. This data should be stratified by demographic categories including race/ethnicity, age, disability, and gender, sexual orientation, and gender identity. • Providing a definition of “imminent needs” or the risks that trigger prioritized waiver enrollment or adjustments to waitlist placement. • Publishing participant satisfaction survey results, collected and analyzed by CDA, on the MSSP website. • Publishing bi-annual utilization reports on the MSSP website.	Thank you for your review and recommendations. No update to the Waiver language is necessary to address these recommendations. CDA and DHCS will continue to engage stakeholders to obtain additional input and determine next steps, as appropriate.

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15	Improve equitable access (1 comment)	**III. Improve Equitable Access to Program Services by Reducing Barriers** The Department should take affirmative steps to reduce barriers to access and utilization of waiver services: Federal regulations require that the inclusion of natural supports in participant's plan of care be voluntary. We recommend that the language in the waiver application make clear that unpaid family caregiving is included in the plan only where the caregiver voluntarily provides care, and at times that they are available to do so. We suggest the following change on pages 4 and 15: To arrange for services, site care management staff first explore informal support that might be available through family, friends, and the voluntary community. *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.*	Thank you for your review and feedback. CDA and DHCS are committed to health equity and are developing strategies to address equity issues across all Medi-Cal programs. CDA made updates to the Waiver language to address this recommendation.

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16	Quality measures (1 comment)	**V. Quality Measures Should Reflect Health Outcomes** Similar to those in other waivers, the quality measures in the MSSP waiver application focus on agency performance rather than on service quality. Last year, CMS released a recommended HCBS quality measure set that addresses waiver sub-assurances related to service planning, and health and welfare... The proposed measure set also addresses three key priority areas: access, rebalancing, and community integration. The waiver renewal process presents an opportunity for the state to adopt CMS's suggested quality measures focusing on access, care, and the welfare of waiver participants. We recommend the Department take the following steps to improve waiver quality measures and data in the Application: • Establish quality measures that aim to assess service quality and health outcome of participants. • Stratify quality measure data with demographic data such as race/ethnicity, gender and sexual orientation to help identify disparities in service quality. • Make quality measures data publicly available, in a timely fashion on the internet, in a format reasonably accessible to consumers, and organized by MSSP provider.	Thank you for your review and recommendations. At this time, CDA and DHCS decline to make updates to the Waiver to address these recommendations, as the CMS quality measure set is voluntary. However, CDA and DHCS will continue to engage stakeholders to obtain additional input and will consider making changes with future amendments.