Multipurpose Senior Services Program

Coordinated Care Initiative

Transition Plan Framework and Major Milestones

October 2017

DRAFT

VERSION 1.0

MSSP CCI Transition Plan Framework and Milestones
DRAFT October 2017

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Purpose

The purpose of this document is to provide updated guidance and clarification to Medi-Cal managed care health plans (MCPs), Medicare-Medicaid Plans (MMPs), and Multipurpose Senior Services Program (MSSP) providers on how MSSP will transition from a federal 1915(c) HCBS waiver to a fully integrated Medi-Cal managed care benefit in the Coordinated Care Initiative (CCI) counties pursuant to Welfare & Institutions Code (WIC) § 14186.3. This update also describes upcoming major activities and milestones associated with the MSSP transition. As notated above, this document is version-controlled and we expect that it will change as policy evolves.

Background

In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities by shifting service delivery away from institutional care to home and community-based settings. To implement that goal, Governor Brown enacted CCI by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012), SB 94 (Chapter 37, Statutes of 2013) and SB 75 (Chapter 23, Statutes of 2015). One component of the CCI is the provision of Long Term Services and Supports (LTSS), including MSSP, by MCPs and MMPs in CCI counties.

MSSP provides care management and supplemental services to assist Medi-Cal beneficiaries aged 65 and older who are at risk of nursing facility placement but wish to remain in the community. Currently, MSSP operates under federal 1915(c) Home and Community Based Services (HCBS) Waiver. Pursuant to WIC § 14186(b)(7), MSSP will continue to operate as a waiver program in CCI counties until no sooner than 01/01/20. In addition, all current MSSP Waiver policies and program standards remain in effect during the transition period prior to 01/01/20.

After 12/31/19, services formerly available under the MSSP waiver will transition from a federal 1915(c) waiver to a fully integrated Medi-Cal managed care LTSS benefit in the CCI counties. As of 12/01/16, San Mateo is the only county that already has transitioned MSSP to a managed care benefit. By 01/01/20, MSSP will transition from a waiver benefit to a Medi-Cal managed care benefit for MCPs and MMPs in the six remaining CCI counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego and Santa Clara.

Until the MSSP transition is complete in these remaining six CCI counties, MMPs and MCPs pay the 12 MSSP sites in these six counties a monthly all-inclusive rate of $357.08 for each MSSP Waiver participant who is enrolled with the MMP or MCP. MSSP Waiver participants in these six counties who are not enrolled with a MCP or MMP currently are receiving MSSP Waiver services from MSSP sites that are reimbursed through the Fee for Service (FFS) model.

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As of 12/01/16, there currently are 4,856 MSSP waiver slots in the six CCI counties where the MSSP waiver has not transitioned to a managed care benefit. Approximately 900 additional Medi-Cal beneficiaries are on waiting lists to receive MSSP Waiver services in these six counties but are not considered MSSP Waiver participants. These counts exclude San Mateo, where MSSP Waiver services already have transitioned to a CCI managed care benefit.

Major Activities and Milestones

The table and graphic below summarize the updated major milestones and target dates for the MSSP transition. These milestones are described in greater detail in the "Transition Plan Framework" section that follows.

ID	Milestone / Activity	Targets
1	**Release MSSP Archive Document** Document contains guidance developed from 2015 MSSP retreat through 2016	Through Oct-17
2	**Update MSSP contract amendments** MSSP contracts to be updated to reflect January 1, 2020 transition	Through Nov-17
3	**Release cumulative guidance** Document containing MSSP framework that describes proposed local stakeholder process, readiness benchmarks, and methods to ensure continuity of care; will be released in October for a 15 day comment period	Through Dec-17
4	**Complete local implementation** MMPs/MCPs will develop a local MSSP Transition Plan that will describe their stakeholder feedback, provider network, target population, readiness self-assessment, readiness transition activities and initial transition considerations in preparation for the 1/1/2020 transition	Through Oct-18
5	**Engage impacted MSSP participants** Transition outreach activities and beneficiary notices describing impact of MSSP transition	Oct-18 to Apr 19
6	**Review of transition plans** DHCS to review MMP/MCP transition plans	Oct-18 to Apr 19
7	**Complete readiness assessment** DHCS and CDA to conduct a readiness assessment that will require MMPs/MCPs to provide evidence of their ability to support the HCBS CPM benefit	May-19 to July-19
8	**Submit updated transition plan to legislature** DHCS to submit an updated Transition Plan to the legislature 90 days prior to the transition of the MSSP waiver services to a HCBS CPM benefit, per WIC §14186.3 (b)(4)(C)	Sept-19
9	**Notify legislature of intent to transition** At least 30 days before the intended transition date, DHCS will notify policy and fiscal committees of the Legislature of its intent to transition the MSSP waiver to a HCBS CPM benefit, per WIC § 14186.3 (b)(4)(E)	Nov-19

ID	Milestone / Activity	Targets
10	**MSSP waiver ends in CCI counties** MSSP waiver services become HCBS CPM benefit administered by MMPs/MCPs	Dec-19
11	**Complete transition and commence ongoing performance monitoring**	Jan-20

MSSP Transition ***Major Activities and Milestones***	**Description of** ***Major Activities and Milestones***	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
1. Release MSSP Archive document	Document contains guidance developed from 2015 MSSP retreat through 2016																																					
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5. Engage impacted MSSP participants	Beneficiary notices describing impact of MSSP transition																																					
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10. MSSP waiver ends in CCI counties	MMSP waiver services become HCBS CPM benefit administered by MMPs/MCPs																																					♦
11. Transition complete																																						♦

Transition Plan Framework

Each activity and major milestone described above includes the deliverables and activities that support various aspects of the transition of MSSP from a waiver service to a managed care benefit. These deliverables, and the actions required to complete them, are outlined in this section.

1. Release MSSP Archive Document

DHCS will release an archive document that contains guidance developed from the 2015 MSSP retreat through 2016.

2. Release Additional Guidance

DHCS and CDA will review various state documents controlling Medi-Cal health care delivery programs that may be impacted by the MSSP CCI Transition. Content from this Transition Plan Framework may be incorporated into new or existing policy and planning documents, examples of which are included in Appendix E. DHCS will work with other local, state, federal agencies as required to amend these documents where required.

3. Release Cumulative Guidance

DHCS and CDA have collaborated to develop guidance on the MSSP transition that clarifies operational issues raised during and after the 2015 stakeholder retreats. This section of the Transition Plan Framework provides guidance and technical support clarifying the agencies' approach to outstanding operational issues related to the MSSP transition. The cumulative MSSP transition guidance in this document will be reviewed with stakeholders during an upcoming State-level kickoff.

a. ***Services for Current MSSP Participants*:** In December 2016, DHCS released technical assistance and guidance describing how the transition will impact current MSSP participants. In summary, Medi-Cal beneficiaries who are enrolled in MSSP waiver slots in CCI counties on 12/31/19 may continue to access services at the same scope, duration and frequency as formerly available under the waiver. These MSSP participants are "grandfathered" into a status that maintains their current level of MSSP services after the transition. Participants who lose their grandfathered status after 12/31/19 are eligible for similar services under the HCBS Care Planning and Management (CPM) managed care benefit in CCI counties. HCBS CPM are defined as personal care services that was provided under the 1915(c) MSSP Waiver. These services are now integrated into the managed care benefit structure.

   MCPs and MMPs will be required to follow existing continuity of care guidance allowing MSSP participants to access the same providers under certain conditions if requested by the participants, their MSSP provider, or their authorized representatives. After the up to 12-month continuity of care period, grandfathered MSSP participants are eligible to access the same type, level and frequency of care described in the grandfathering guidance, however their providers may be different.

   Medi-Cal beneficiaries may not be enrolled in both the MSSP waiver and a SCAN or PACE plan due to duplication of services. These participants should chose to enroll in either a) the MSSP waiver or b) a SCAN or PACE plan. If a beneficiary is enrolled in both the waiver and a SCAN/PACE plan, the beneficiary must disenroll from either the MSSP waiver or the SCAN/PACE plan with the knowledge that the MSSP waiver is ending in CCI counties on 12/31/19. This restriction only applies to the Medi-Cal SCAN and PACE plans (i.e., MSSP participants currently may also be enrolled in a Medicare SCAN/PACE plan).

   Final MSSP grandfathering guidance, which incorporates stakeholder feedback on previous drafts, is included in Appendix A.

b. ***Managed Care Rate-Setting*:**

The primary goals of the DHCS rate development process are to ensure that rates are reasonable, appropriate and attainable, suitably match payment to risk, and encourage quality and efficiency in Medi-Cal health plans. DHCS uses a combination of plan-specific and risk-adjusted county average experience for each plan's rates. When populations or services are new to Medi-Cal or new to managed care, other data sources are required.

As part of the MSSP transition in CCI counties, the MSSP payment structure changed from a carved-out fee-for-service (FFS) payment to become part of the managed care capitated payment. MCPs and MMPs that serve MSSP waiver participants are responsible for payment to MSSP sites and will be fully at-risk for the cost of MSSP services provided to their members. Capitation rates paid to MMPs and MCPs in CCI counties for periods prior to 01/01/20 will factor in services currently covered under MSSP.

Effective 01/01/20, services formerly available under the MSSP waiver will be covered under the HCBS Care Planning and Management (CPM) benefit. Health plan rates will factor in services to both grandfathered MSSP waiver participants and new managed care enrollees accessing the HCBS CPM benefit.

In general, DHCS will continue to use actual health plan experience for a specified population, when appropriate, in setting rates for that managed care population. At any time, DHCS may request supplemental MSSP and HCBS CPM data to support rate development efforts, including beneficiary-level cost and utilization data.

c. ***Encounter data submissions*:**

DHCS requires MCPs and MMPs to send encounter data using national transaction standards, including but not limited to the X12 837I. Data submitted must be compliant with the formats and the specifications within the respective Implementation Guides (IG). The IGs are copyrighted and cannot be distributed by DHCS, however the IGs may be purchased from X12 at store.x12.org/store.

In addition to the IGs, DHCS issued Companion Guides (CGs) for each format which includes state-specific requirements in addition to the IGs requirements. The IGs and CGs combined make up the core DHCS encounter reporting requirements. DHCS CGs are available upon request by sending an email to DHCS at MMCDEncounterData@dhcs.ca.gov.

MCPs and MMPs currently are required to send MSSP encounter data to DHCS using the 837I. The 837I encounter data submission requirements will be

unchanged after the MSSP transition on 01/01/20, as these services will be covered under the HCBS CPM benefit.

The 837I IG refers to MSSP provider identifier and procedure code crosswalks, which are included in Appendix B. These crosswalks are the only versions valid for HCBS CPM providers after 12/31/19. In the event that any of the codes on the crosswalk become obsolete, it is the MSP's/MMP's responsibility to submit encounter data with valid code(s).

Currently, the MSSP Provider and Plan Agreement template refers to the 837I as the standardized data format for claims submitted from the MSSP sites to the MCPs and MMPs. Requirements for encounter data submissions to MCPs and MMPs for current MSSP providers and future HCBS CPM providers (i.e., after 12/31/19) are subject to negotiation between the providers and plans. In addition, MCPs and MMPs also may agree to convert data and codes sent by HCBS CPM providers into 837I-compliant transactions that can be submitted to DHCS.

As part of these negotiated conditions after 12/31/19, HCBS CPM providers may be able to use a modified version of the alternative MSSP billing form included the Appendix C to submit data required for monthly claims to the MCPs and MMPs. This form includes the minimum data necessary to process a monthly all-inclusive claim for a HCBS CPM recipient or a grandfathered MSSP Waiver participant. MCPs and MMPs may require HCBS CPM providers to use an updated version of this template with additional information, or they may require a different format.

d. ***Transitioning FFS Program Participants:*** The policy for this population is currently under development and will be released at a later date.

e. ***Impacts to Health Risk Assessments and Care Planning Processes:*** DHCS will require MCPs and MMPs to include HCBS CPM services in the existing health risk assessment (HRA) and care planning process, which includes the interdisciplinary care team and individualized care plan.

HRAs

MMPs and MCPs will continue to conduct the health risk assessment process as required for newly eligible Medi-Cal beneficiaries described in current policy guidance. As part of this assessment, MMPs and MCPs also will identify beneficiaries eligible for the new HCBS CPM benefit in lieu of nursing facility placement.

Long-Term Services and Supports Assessment Process

When applicable as described in current policy guidance , MMPs and MCPs are required to conduct a long-term services and supports assessment review. As

part of this review, MCPs and MMPs also are required to review any assessment conducted by a HCBS CPM provider.

Individual Care Plan (ICP)
MMPs and MCPs will continue to be required to establish an ICP for newly eligible and reassessed members meeting high risk criteria as described in current policy guidance. The ICP will also include care plans created on the member's behalf by a HCBS CPM provider. In addition, the ICP will identify beneficiaries potentially eligible for the new HCBS CPM benefit in lieu of nursing facility placement.

Interdisciplinary Care Team (ICT)
When applicable as described in current policy guidance, MMPs and MCPs will continue to offer an ICT to all high-risk members who demonstrate a need for an ICT or who request an ICT. If the member is receiving HCBS CPM benefits, the ICT will include the HCBS CPM provider.

f. ***Accessing the New HCBS CPM Benefit for Eligible Members*:** After 12/31/19, the new HCBS CPM benefit will be available to eligible MCP and MMP members in CCI counties. The HCBS CPM benefit provides health care management and supports for MMP and MCP members who are eligible for placement in a nursing facility but who wish to remain in the community. The goal of the benefit is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these members at a cost lower than what would otherwise have been paid for nursing facility care.

Eligibility for HCBS CPM benefits
The policy for this population is currently under development and will be released at a later date.

In general, MCP and MMP enrollees may be eligible for HCBS CPM benefits if they are certifiable for placement in a nursing facility, also known as "level of care", per California Code of Regulations, Title 22, § 51118, 51124, 51334 and 51335. To be eligible for this benefit, the plan also must be able to provide the member HCBS CPM services at a cost lower than if the member were institutionalized.

MCPs and MMPs may restrict HCBS CPM eligibility to members age 65 or older. They also may, at their option, extend the benefit to members of all ages who are eligible for nursing home placement and who may be served under the HCBS CPM benefit at a cost lower than what would be paid for nursing home care. MMPs and MCPs must include any age restrictions in its plan benefit package and notice of action describing the new HCBS CPM benefit to their members.

Prospective HCBS CPM recipients who meet nursing facility level of care requirements must be eligible for Medi-Cal using regular Medi-Cal rules through the county before they can receive Medi-Cal benefits. Spouses' income and property will be required to determine eligibility. Special rules apply to married couples with a spouse who is not requesting participation and resides in the community. Some individuals may then be eligible for Medi-Cal benefits, including HCBS CPM services if they enroll in a MMP or MCP in a CCI county.

Care Planning and Management Benefits

Care Planning and Management supports available under the HCBS CPM benefit include services for identifying health care problems, updating a care plan that addresses these problems, coordinating services, monitoring interventions, tracking outcomes, and record-keeping. These services are delivered in the context of avoiding institutionalization while cost-effectively allowing the member to remain in the community. Professionally knowledgeable, licensed and/or certified personnel responsible to review, analyze, identify and stratify health care needs for these higher risk enrollees include physicians, physician assistants, nurse practitioners, registered nurses, licensed social workers, and behavioral health specialists.

Members referred for HCBS CPM will receive a face-to-face initial assessment from a nurse case manager to verify eligibility, including verification of whether the member is certifiable for placement in a nursing home. If determined eligible for HCBS CPM services, the nurse case manager will create or update an ICP with information describing the member's health care problems, available resources, functional status, needs, and support necessary to remain in the community.

After the plan for HCBS CPM services is implemented, a licensed/certified member of the ICT must monitor the member at least monthly to ensure the interventions are effective. These monitoring interactions must occur face-to-face with the member at least quarterly. The care plan and nursing home level of care certification must be updated at least annually as part of a periodic re-assessment of the member's status and needs.

Additional HCBS CPM Services

In addition to the core Care Planning and Management services, HCBS CPM benefits include three major categories of services: Informal Support, Referred Services, and Supplemental Services. The benefits are provided to preserve the participant's health, improve functional ability, assure maximum independence, prevent elevation to a higher level of care, and avoid costlier institutionalization

Informal Support represents services provided to the member at no cost to the MMP, MCP or public agencies. Examples of Informal Support include, but are not

limited to, support services provided by a spouse, family members, friends, neighbors, religious organizations, charities and volunteers. All services available to the eligible member through Informal Support must be considered before other types of services are arranged under the HCBS CPM benefit.

Referred Services are supports and benefits available in the community, either as part of the member's existing managed care benefits or from health and human services programs funded through federal, state or municipal entities. These Referred Services will be considered for the eligible member only after the Informal Support services have been exhausted

Supplemental Services may be provided to the member under the HCBS CPM benefit only after Informal Support and Referred Services have been exhausted. Examples of Purchased Services are described in Appendix D and include:

- Adult day care
- Housing assistance
- Minor home repairs and safety modifications
- Medical and non-medical equipment
- Emergency supports
- Chore and personal care assistance
- Protective services
- Caregiver respite
- Transportation
- Food
- Social support
- Money management
- Communications services and equipment
- Care planning and management

g. ***Transition Readiness and Ongoing Oversight:*** Prior to implementing HCBS CPM, each MMP and MCP in the CCI counties will go through a readiness review process that will evaluate each MMP's and MCP's ability to support the HCBS CPM benefit, including coordination of services for MSSP grandfathered participants.

The review will assess transition requirements such as:

- the MMP's or MCP's care management staffing structure;
- the ability to accept and transition both grandfathered MSSP participants and newly eligible MMP or MCP members for the new benefit;
- the ability to provide adequate access to a network of providers capable of delivering HCBS CPM services, including providers of HCBS CPM Supplemental Services described above; and
- the ability to quickly and accurately process claims and enrollment information.

Additional details regarding the domains for the HCBS CPM readiness assessment can be found in Appendix F.

If an MMP or MCP retains the same delivery model (e.g., contracting with the same MSSP providers) for HCBS CPM services as it had in place for the MSSP waiver prior to the transition, its readiness review process may be abbreviated, and selected domains of the readiness assessment may be deemed adequate.

Ongoing Reporting Requirements
Starting on 01/01/20, MCPs and MMPs are required to submit information quarterly to DHCS on the administration of the HCBS CPM benefit, including services provided to grandfathered MSSP participants.

Prior to the transition, DHCS will develop HCBS CPM reporting requirements template (similar to other CCI reporting templates that have previously been developed) that the MCPs and MMPs will use to submit the required data.

In order to support reporting on these data elements, the following current MSSP waiver forms may be helpful to the MCPs and MMPs in their oversight of the new HCBS CPM benefit:

- MSSP 4- Notice of Action: https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2004%20Change%20in%20Services%20NOA.pdf
- MSSP 5- State Hearing Notice: https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2005%20Your%20Right%20to%20Appeal.pdf
- MSSP 14- AUDPHI: https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2014%20Authorization%20for%20Use%20&%20Disclosure%20of%20PHI.pdf)
- MSSP 16- Level of Care: https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2016%20LOC%20Certification%20draft.pdf)
- MSSP 18a- Initial Health Assessment: https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2018a%20Initial%20Health%20Assessment.pdf
- MSSP 18c- Medication List: https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2018c%20Client's%20Medications.pdf
- MSSP 19- Initial Psychosocial Assessment: https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2019%20Initial%20Psychosocial.pdf
- MSSP 19d- Functional Needs Assessment Grid: https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2019d%20Functional%20Needs%20Assessment%20Grid%20-%20Reassessment.pdf
- MSSP 20- Reassessment:

https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2020%20Reassessment.pdf

- MSSP 22- Care Plan: https://www.aging.ca.gov/docs/MSSP/SiteManual/Appendices/Ap%2022%20Care%20Plan.pdf

In addition to the reporting of these data elements, the MCPs and MMPs will be required to continue monthly submissions of the Institutional Indicator file. Beginning in January 2020, both the grandfathered participants as well as the members receiving HCBS CPM services will be required to be reported in this file.

4. Complete Local Implementation

MMPs and MCPs in CCI counties currently should be working with local MSSP sites and participants to prepare for the transition the MSSP waiver services to the HCBS CPM managed care benefit occurring on 01/01/20. The cumulative transition guidance described in this document, including the criteria required to verify local readiness, provides additional information to MMPs and MCPs on how to successfully implement their transition.

Local Transition Plans

By 09/30/18, the MMPs and MCPs are required to submit to DHCS Transition Plan for review and approval. These local Transition Plans will describe how MMPs and MCPs will incorporate the principles of the MSSP in the new HCBS CPM managed care benefit, including provisions to ensure seamless transitions and continuity of care.

Unless otherwise agreed by MMPs, MCPs and the county's Office of Aging (or its equivalent), the county's Office of Aging (or its equivalent) will be the lead agency in each county responsible for compiling and submitting the county's local Transition Plan. Each county's transition plan will include the following components:

- A "Background" section including but not limited to:
  - The names of the MMPs, MCPs, MSSP sites and municipal agencies currently involved with delivering and overseeing MSSP waiver services in the county;
  - The number of MSSP waiver slots, current waiver participants, and prospective participants on the waiting list(s);
  - Key past or future dates and events for the county's participation in the CCI demonstration; and
  - A description of the MSSP delivery system model, including current relationship between the MMPs, MCPs, MSSP sites and municipal agencies.

- A "Stakeholder Feedback" section describing the stakeholder input framework, process and outcomes, including steps to address any remaining stakeholder concerns or disagreements about the transition;
- A "Provider Network" section describing the expected relationships between the MMPs, MCPs, MSSP sites, municipal agencies or other entities who will coordinate care and deliver services to MSSP grandfathered participants and new HCBS CPM benefit recipients starting 01/01/2020, including any changes to the current relationships in the provider network;
- A "Target Population" section describing the unique characteristics of the county's current MSSP participants and any changes expected in these characteristics for MCP or MMP members who will be newly eligible for HCBS CPM services after 12/31/19;
- A "Readiness Self-Assessment" section describing whether the county currently meets the MSSP transition readiness requirements described earlier in the Transition Plan Framework;
- A "Readiness Transition Activities" section describing the outstanding tasks that must be completed to ensure the entities involved in the transition will be able to demonstrate county readiness to DHCS during its upcoming readiness assessment described later in this Transition Plan Framework;
- A "Initial Transition Considerations" section describing unusual characteristics or temporary circumstances that may be present during the period between the year prior to and the year after the transition date (i.e., 01/01/18 to 12/31/19), including planned performance improvement initiatives, provider network developments, or regional health care delivery system activities that may impact delivery MSSP or HCBS CPM services;
- An appendix with the names of the individuals or organizations invited to participate in the local stakeholder process;
- An appendix with the names of individuals or organizations participating in or contributing to the stakeholder process; and
- An appendix of Transition Plan amendments (if applicable) from MMPs, MCPs, local MSSP sites and municipal agencies describing additional services, capabilities, benefits or features they will offer to ensure transition readiness that supplement the content in the body of the county-level Transition Plan. These amendments may not include statements invalidating elements of the local Transition Plan or otherwise declaring aspects or the local Transition Plan inapplicable to an entity submitting an amendment.

<u>Local Stakeholder Process</u>
MMPs and MCPs, in partnership with each county's Office of Aging (or its equivalent) and local MSSP providers, will conduct a local stakeholder process to develop the local Transition Plans. The local stakeholder process should include the following elements:

- Identification of individuals to invite for input in the stakeholder process, including but not limited to MSSP participants (or their family members and advocates), MSSP site staff, MMP/MCP staff involved in administering LTSS

benefits, staff from the county Office of Aging (or its equivalent) and other municipal agencies impacted by the transition;
- One or more meetings where participants can join in-person, via phone, and/or the internet, each of which will be scheduled for no more than two hours between 9AM and 4PM during a non-holiday weekday;
- Introduction of key contacts from each of the entities and organizations represented in the stakeholder process;
- Recording of individuals' names and organizations participating in the stakeholder process;
- Orientation of stakeholders to the MSSP CCI Transition, including an overview of the components of this Transition Plan Framework;
- Identification of optional approaches for the local transition;
- Potential local transition impacts to area MSSP participants, MSSP sites, MMPs, MCPs and municipal agencies;
- Strategies for addressing potential local impacts;
- Additional transition readiness conditions, criteria or benchmarks unique to the county;
- Opportunities for participants to ask and answer questions about the transition; and
- A distribution list for interested local stakeholders to receive documents and updates, including the draft and final versions of the local Transition Plan.

MSSP participants and other stakeholders also will have an opportunity to review an updated and consolidated statewide Transition Plan consisting of both the state-level transition activities as well as each CCI county's Transition Plan. The final draft of this consolidated statewide Transition Plan will be distributed as part of the regularly scheduled MSSP transition stakeholder conference calls that include MSSP sites, MMPs and MCPs in CCI counties.

5. Engage impacted MSSP participants

Starting on or before 10/01/18, DHCS, CDA, the MMPs and MCPs will reach out to members and MSSP participants impacted by the MSSP transition in CCI counties. This outreach will involve the following activities, some of which may occur prior to 10/01/18, but all of which must be completed by 04/30/19:
- DHCS will develop a notice of action that MCPs and MMPs will send to their members describing the new HCBS CPM benefit.
- MMPs and MCPs will submit for approval draft language to DHCS for the notices of action they will send to their members describing the new HCBS CPM benefit.
- DHCS will review and approve the MMP and MCP notices of actions, or DHCS may request revisions. If revisions are required to the updated notice verbiage, DHCS must approve the final version.
- MMPs and MCPs will send notices of action, with verbiage approved by DHCS, to their members in CCI counties describing the new HCBS benefit.

- CDA [or DHCS] will send notices of action to MSSP participants describing the end of the MSSP waiver in CCI counties, eligibility for MSSP grandfather status, and the process for requesting continuity of care if the participant wishes to go to the same MSSP site to provide MSSP services post-transition. DHCS and CDA will work with MSSP sites to send additional notices to new MSSP participants who were enrolled in the waiver in CCI counties between the date the initial notices were sent and 12/31/19.

MSSP participants and other stakeholders also will have an opportunity to review an updated and consolidated statewide Transition Plan consisting of both the state-level transition activities as well as each CCI county's Transition Plan. The final draft of this consolidated statewide Transition Plan will be distributed as part of the regularly scheduled MSSP transition stakeholder conference calls that include MSSP sites, MMPs and MCPs in CCI counties.

6. Review of transition plans

Beginning in October 2018, DHCS and CDA will review the transition plans described above. This review will be completed and feedback provided to the MMPs/MCPs prior to the Readiness Assessment process beginning in May 2019.

7. Complete Readiness Assessment

Following the completion of local implementation described earlier, the readiness assessment phase will commence. By 04/30/19, in addition to participating in development of a county-level local Transition Plan, the MMPs and MCPs will be required to provide evidence of their ability to support the HCBS CPM benefit as described in the Transition Readiness and Ongoing Oversight section above.

Between 05/01/19 and 07/31/19, DHCS and CDA will administer a readiness assessment remotely for each MCP and MMP. DHCS and/or CDA may choose to visit a MCP or MMP to review evidence of transition readiness.

The readiness assessment process will, at a minimum, consist of the following domains:

- Data sharing
- Stakeholder engagement
- System/staffing readiness
- Messaging/communication strategies
- Monitoring and evaluation of transition
- Continuity of care
- Final transition plan

Additional readiness review benchmark detail can be found in the MSSP Readiness Review Tool located in Appendix F.

Starting on or before 05/01/19, DHCS and CDA will deliver a readiness assessment report to each of the MCPs and MMPs that will provide either an approval of the MCP or MMP's readiness assessment, or identification of deficiencies that that MCP or MMP must address prior to the transition to the HCBS CPM benefit. DHCS must receive evidence that all identified deficiencies are corrected satisfactorily, or have a satisfactory improvement plan in place, no later than 07/31/19.

8. Submit Updated Transition Plan to Legislature

As described in WIC § 14186.3 (b)(4)(C), DHCS will submit an updated Transition Plan to the legislature 90 days prior to the transition of the MSSP waiver services to a HCBS CPM benefit administered by MCPs and MMPs in CCI counties. This Transition Plan will be updated with input from CDA and DMHC.

Based on a transition target date of 12/31/19, DHCS plans to deliver the final version of the consolidated statewide MSSP CCI Transition Plan to the Legislature no later than 10/1/19. This final Transition Plan will incorporate the following updates:

- Necessary clarifications and corrections to the current state-level Transition Plan Framework outlined in this document;
- Results from the readiness assessment and activities to address the assessment findings, including verification that MMPs, MCPs counties and MSSP sites have met the readiness criteria described in this document (or have satisfactory improvement plans in place);
- Final Local Transition Plans for each CCI county; and
- Input from stakeholders on the draft statewide Transition Plan, including steps to address any remaining transition concerns or disagreements.

The final consolidated statewide Transition Plan also will be available to stakeholders and distributed as part of the regularly scheduled MSSP transition stakeholder conference calls.

9. Notify Legislature of Intent to Transition

WIC § 14186.3 (b)(4)(E) describes how DHCS will notify policy and fiscal committees of the Legislature of its intent to transition the MSSP waiver to a HCBS CPM benefit administered by MMPs and MCPS in CCI counties. This notification must occur at least 30 days before the intended transition date.

With the transition targeted for 12/31/19, DHCS plans to notify the Legislature of its intent to convert the MSSP waiver to a managed care benefit by 12/01/19. The final version of the statewide MSSP CCI Transition Plan will accompany this notification, and it will incorporate any updates since its earlier delivery to the legislature that was required 90 days in advance of the transition. Both the notification letter and the final Transition Plan also will be available to stakeholders and distributed as part of the regularly scheduled MSSP transition stakeholder conference calls.

10. MSSP Waiver Ends in CCI Counties

As described in WIC § 14186.3 (b)(4)(C), MSSP will transition to a Medi-Cal benefit available only through managed care health plans no later than 12/31/19. DHCS will not pay FFS claims from MSSP providers for services provided to Medi-Cal beneficiaries in CCI counties with dates of service after 12/31/19. The MSSP waiver will cease to operate in CCI counties, and contracts between CDA and MSSP sites operating in these counties will terminate. CDA will continue to contract with MSSP sites in non-CCI counties where the waiver remains active.

11. Complete Transition and Commence Ongoing Performance Monitoring

On 01/01/2020, MMPs and MCPs will begin to deliver services formerly available under the MSSP waiver as a managed care benefit. A grandfathered MSSP participant invoking the continuity of care process with a provider who meets the continuity conditions described under the grandfathering guidance in Appendix A will continue to receive services from that provider. Members newly eligible for HCBS CPM benefits will be assessed to verify their eligibility and to develop or update an ICP that delivers appropriate services to them under the new benefit.

Based on the monitoring requirements described previously in this document, MMPs and MCPs will begin to submit periodic data sets to DHCS describing the characteristics of benefits provided to grandfathered MSSP participants and new HCBS CPM recipients. DHCS will work with the MMPs and MCPs to address any concerns related to access, utilization, quality, cost and provider qualifications found in their administration of the HCBS CPM benefit for newly eligible members and grandfathered MSSP participants.

Appendix A: Guidance on Grandfathered MSSP Participants

Background

The purpose of this document is to provide guidance on how Multipurpose Senior Services Program (MSSP) services will transition from a federal 1915(c) home and community-based services (HCBS) waiver to a fully integrated Medi-Cal Managed Care benefit in the Coordinated Care Initiative (CCI) counties pursuant to WIC § 14186.3. MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are at risk of nursing facility placement but who wish to remain in the community.

On 01/01/20, services formerly available under the MSSP waiver will no longer be available in the CCI counties. No new MSSP waiver slots will be created, assigned or allocated in the CCI counties after 12/31/19. However, Medi-Cal beneficiaries who are enrolled in MSSP waiver slots in CCI counties on 12/31/19 may continue to access services formerly available under the waiver. The guidance below answers stakeholder questions on how these “grandfathered” MSSP participants will access services starting on 01/01/20.

Eligibility for MSSP “Grandfathered” Status

MSSP participants in any of the CCI counties on 12/31/19 will have “grandfathered” access to the same level of MSSP services starting on 01/01/20. These grandfathered MSSP participants will continue to have access to services that were provided under the MSSP waiver prior to 01/01/20 as long as their medical needs remain the same. Medi-Cal beneficiaries eligible for the MSSP waiver must be enrolled into an available MSSP site slot before 01/01/20 to become part of the grandfathered group. Beneficiaries enrolled in an MSSP waiver slot on 12/31/19 are included in the grandfathered group.

Regardless of the health care delivery model through which they are enrolled and/or receive services, grandfathered MSSP participants are eligible for the same level of MSSP services in CCI counties after 12/31/19.

Grandfathered MSSP participants who change MMPs or MCPs after 12/31/19 in the same county will maintain their grandfathered MSSP status after the change.

Grandfathered MSSP status is not available under the following circumstances:

- Medi-Cal beneficiaries not enrolled in a MSSP waiver slot in a CCI county on 12/31/19; or
- Medi-Cal beneficiaries on the MSSP wait list before 01/01/20; or
- Medi-Cal beneficiaries enrolled in the MSSP waiver in non-CCI counties before 01/01/20 who move into CCI counties after 12/31/19.

Modification or Termination of MSSP Grandfathered Services

MSSP grandfathered status is dependent upon an individual's ongoing need for MSSP services as documented in the participant's care plan. A participant's grandfathered status will be modified or terminated when the care plan indicates the participant no longer requires access to some or all grandfathered MSSP services. Any decision to modify or terminate MSSP services in a grandfathered participant's care plan will be based upon pre-existing MSSP program guidance on service termination.

When a grandfathered MSSP participant leaves a CCI county for a non-CCI county after 12/31/19, his or her grandfathered status will be terminated. Grandfathered MSSP participants who move from a CCI county to a non-CCI county after 12/31/19 will be reassessed to evaluate their continued eligibility for the waiver if MSSP exists in the non-CCI county.

Grandfathered MSSP status also may be terminated under the following circumstances:

- Grandfathered MSSP participants who become ineligible for Medi-Cal, unless their Medi-Cal eligibility is reinstated retroactively without a lapse (subject to a one-month deeming period to re-establish a beneficiary's Medi-Cal eligibility); or
- Grandfathered MSSP participants who move from one CCI county to another CCI county; or
- Grandfathered MSSP participants who are institutionalized more than 30 continuous days after 12/02/19; or
- Grandfathered MSSP participants who voluntarily terminate their grandfathered status; or
- Grandfathered MSSP participants who no longer meet MSSP eligibility criteria.

Services Available to Grandfathered MSSP Participants

Grandfathered individuals will have access to the same level of MSSP services available through the MSSP waiver prior to 01/01/20. Services provided to grandfathered MSSP participants will be based on each individual's need as documented in the participant's care plan until the participant is no longer eligible.

MMPs and MCPs must be prepared to provide grandfathered MSSP participants access to all services previously available under the MSSP waiver. As grandfathered MSSP participants' documented needs change, they will be eligible for the same services that were available to MSSP waiver enrollees prior to 01/01/20.

A list of current MSSP services available to program enrollees can be found in Chapter 3 of the MSSP Site Manual at:
http://www.aging.ca.gov/ProgramsProviders/MSSP/SiteManual/

Additional information about individual MSSP services can be found in the Medi-Cal MSSP Provider Manual found under the Inpatient/Outpatient heading at:

https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

Continuity of Providers for Grandfathered MSSP Participants

MMPs and MCPs will be required to provide continuity of care for up to 12 months for grandfathered MSSP recipients if the:

- MMP or MCP and provider can agree to a rate where the Medi-Cal fee-for-service rate ($357.08) is the rate floor;
- Provider shares care plan information with the MMP or MCP for care coordination purposes;
- Provider has no quality of care issues;
- MSSP recipient has a pre-existing relationship with the provider; and
- Provider is a State Plan approved provider.

After the twelve-month continuity of care period or if a provider and MMP or MCP cannot come to a continuity of care agreement, the vendors and staff providing MSSP services to grandfathered MSSP participants may be different after 12/31/19, however, MMPs and MCPs must ensure the same level of service will be available to the grandfathered MSSP participants.

To maintain continuity of services for grandfathered MSSP participants, MMPs and MCPs are encouraged to contract with existing MSSP sites and their provider networks after the continuity of care period. MMP and MCP rates paid to vendors who provide services to grandfathered MSSP participants after 12/31/19 will be subject to negotiation between MMPs or MCPs and vendors.

For additional details regarding MCP continuity of care requirements, please refer to All Plan Letter 15-019 which can be found at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-019.pdf.

For additional details regarding MMP continuity of care requirements, please refer to Duals Plan Letter 16-002 which can be found at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2016/DPL16-002.pdf.

Please note that both the APL and DPL will be updated to include information specific to the MSSP transition at a later date.

The Department of Health Care Services (DHCS) and the California Department of Aging (CDA) are developing reporting requirements and readiness criteria that will support the assessment of provider network adequacy and performance for services provided to grandfathered MSSP participants.

Financing Services for Grandfathered MSSP Participants

Before 01/01/20, payments to MSSP sites in CCI counties will be based on the currently active template agreement between MMPs or MCPs and MSSP sites. Medi-Cal beneficiaries enrolled into an available MSSP site slot between 12/02/19 and 12/31/19 are eligible for MSSP grandfathered status. However, sites may not be paid for services provided to beneficiaries enrolled between 12/02/19 and 12/31/19, as monthly payment requires MSSP participants to be enrolled in an MSSP slot on the first day of the month.

DHCS is in the process of assessing additional financial impacts of the MSSP transition in CCI counties (e.g., MMP and MCP rates, benefits for grandfathered MSSP participants receiving services through the fee-for-service program, tracking grandfathered MSSP participants). However, payment for services will be negotiated between MMPs and MCPs and providers effective 01/01/20; DHCS will not be involved in these negotiations.

Stakeholder Questions

MSSP stakeholders may send questions about the MSSP CCI transition to DHCS at Jessica.Ruth@dhcs.ca.gov or Susan Rodrigues at CDA at Susan.Rodrigues@aging.ca.gov.

Appendix B: Managed Care Encounter Crosswalks

Multipurpose Senior Services Program (MSSP)		
Local Codes to Healthcare Common Procedure Coding (HCPC) Guidance		
Item #	*Local Code*	*HCPC*
1	Z8550	T2022
2	Z8551	T2025
3	Z8554	S5102
4	Z8555	S5100
5	Z8556	S5165
6	Z8557	T2028
7	Z8558	T2034
8	Z8559	S5121
9	Z8560	S5120
10	Z8561	T1020
11	Z8562	T1019
12	Z8563	99509
13	Z8564	T1022
14	Z8565	99600
15	Z8566	99600
16	Z8567	S5126
17	Z8568	S5125
18	Z8572	T1016
19	Z8573	T1016
20	Z8574	S5151
21	Z8575	S5151
22	Z8576	S5151
23	Z8580	S5170
24	Z8581	S5170
25	Z8582	T1999
26	Z8583	S5135
27	Z8584	99404
28	Z8585	T2040
29	Z8586	T2040
30	Z8587	T1013
31	Z8588	S5162
32	Z8589	S5161
33	Z8590	S5199
34	Z8591	S5151
35	Z8592	T2022
36	Z8593	T2001
37	Z8594	T2022
38	Z8595	S5136
39	Z8596	S5136
40	Z8597	T2003
41	Z8598	T2032
42	Z8599	S9976
43	Z8600	T2024
44	Z8601	T2024
45	Z8603	S5121

Multipurpose Senior Services Program (MSSP)
Legacy Number - NPI Number

MSSP SITE	County	MSSP Legacy Number	NPI NUMBER
ALTAMED HEALTH SERVICES	Los Angeles	MSS00003F	1992135941
JEWISH FAMILY SERVICES-LOS ANGELES	Los Angeles	MSS00004F	1366872970
HUMAN SERVICES ASSOCIATION	Los Angeles	MSS00039F	1881024198
PARTNERS IN CARE FOUNDATION-NORTH	Los Angeles	MSS00040F	1841621919
PARTNERS IN CARE FOUNDATION-SOUTH	Los Angeles	MSS00043F	1851721476
PASADENA HOSPITAL ASSOCIATION	Los Angeles	MSS00016F	1982035713
SENIOR CARE ACTION NETWORK	Los Angeles	MSS00005F	1336570464
CALOPTIMA	Orange	MSS00041F	1699199596
COUNTY OF RIVERSIDE	Riverside	MSS00024F	1457782773
SAN BERNARDINO COUNTY	San Bernardino	MSS00017F	1669802708
AGING AND INDEPENDENCE SERVICES	San Diego	MSS00007F	1710308986
COUNTY OF SAN MATEO	San Mateo	MSS00013F	1609290030
SOURCEWISE	Santa Clara	MSS00020F	1598196651

Appendix C: Sample MSSP Billing Form

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Number	Member Name	Client Index Number (CIN)	Description/Notes
Example	Marty Allen	90000000A	
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Appendix D: Examples of HCBS CPM Purchased Services

These descriptions are based on the MSSP Site Manual available at:
https://www.aging.ca.gov/ProgramsProviders/MSSP/SiteManual/

Adult Day Care: Adult day care centers are community-based programs that provide non-medical care to persons 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 State Department of Social Services (DSS) licenses these centers as community care facilities.

Adult Day Care services may be provided when the member's plan of care indicates that the service is necessary to reach a therapeutic goal or provides respite for the family.

Housing Assistance: these services are necessary to ensure the health, welfare and safety of the member in their physical residence or home setting. Services may include provision of physical adaptations and assistive devices, and emergency assistance in situations which demand relocation and assistance to obtain or restore utility service.

Minor Home Repairs and Adaptive Equipment: minor home repairs do not involve major structural changes or major repairs to the dwelling. Adaptive equipment is defined as those services necessary for access (ramps, handrails, items above what are covered under other MMP or MCP benefits, including installation), safety (electrical wiring, smoke alarms, plumbing repair), or security (locks).

Eligible members are those whose health and/or safety or independence are jeopardized because of deficiencies in their place of residence.

This service is limited to members 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 member 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.

Non-medical Home Equipment: includes those assistive devices, appliances and supplies that are necessary to assure the member's health, safety and independence. This includes but is not limited to the purchase or repair of nonmedical home equipment and appliances such as refrigerators, stoves, microwave ovens, blenders, kitchenware, heaters, air conditioners, fans, washing machines, dryers, vacuum cleaners, furniture (mattresses and bedding, lamps, tables, couches, chairs), towels, medication dispensers and emergency supply kits.

Benefits may not be used to purchase clothing or shoes of any type.

Emergency Move: involves facilitating a smooth transition from one living situation to another. Eligible members 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 member's possessions.

Activities may include materials and labor but may not include rent or deposits on housing or storage units.

Emergency Utility Service: allows for payment of utilities only when the member has no other resources to meet this need.

The member must be at risk to receive or has already received a shut-off notice and the potential shut off of utility services would place the health and safety of the member in jeopardy.

Temporary Lodging: allows for payment of lodging for those members who must travel long distances for medical treatments unavailable locally. Temporary lodging is also available in the event of an emergency.

Lodging rates should not exceed State per diem limits; these limits vary depending on geographic area. State per diem limits can be found at the following link:

http://www.calhr.ca.gov/employees/Pages/travel-reimbursements.aspx

Supplemental Chore: is for purposes of household support and applies to the performance of household tasks rather than to the care of the member. Chore 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 member under this category.

This service is for purposes of household support for those services above and beyond those available through the In-Home Supportive Services (IHSS) Program or to members that are not eligible for IHSS. Supplemental chore services can supplement but not supplant IHSS. Examples include:

1. The member 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.
3. IHSS services are in place; however, the MMP or MCP has assessed a greater need. In these cases, the MMP or MCP may authorize increased IHSS time for those services before authorizing additional services.

Supplemental Personal Care: is provided to those members whose needs exceed the maximum amount available under IHSS or who are in circumstances where the

individual lacks a provider. Supplemental personal care services can supplement but not supplant IHSS.

Services under this category provide assistance to the member to maintain bodily hygiene, personal safety, and activities of daily living 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 and may include assistance with preparation of meals, excluding the cost of the food.

Any household chores which are performed by the personal care worker and are ancillary to the provision of the member's care may be included in this category but should not be the central activity. Therefore when bed linen is soiled, it may be changed, washed and put away.

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).

Personal care service providers may be paid while the member is institutionalized. This payment is made to retain the services of the care provider and may be for up to seven calendar days per institutionalization.

Purchase of personal care supplies may be covered where there are no other resources. These items include supplies not covered by MMP or MCP benefits.

Personal care services and supplies do not include Over the Counter (OTC) medications or remedies including topical ointments with the exception of those used with incontinence.

<u>Supplemental Health Care</u>: addresses the care of health problems by appropriately licensed or certified persons when such care is not otherwise available. 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).
- The MMP or MCP must utilize all of the health care services available under existing Medicare, Medi-Cal, or other health coverage benefits prior to accessing additional services.
- This service supplements benefits provided by the member's MMP or MCP.
- 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. Pharmacists: pharmacy consultations.
  2. Nutritionists/Registered Dietitians: nutritional assessment or counseling.
  3. Other health professionals specific to the identified need of the member.

<u>Supplemental Protective Supervision</u>: 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 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 include checking on a member through a visit to the member's home to assess the situation during an emergency.

<u>Care Management</u>: assists members in gaining access to MMP or MCP benefits 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 member's plan of care. Additionally, care managers initiate and oversee the process of recertification of member level of care, assessment, reassessment, and monthly review of care plans.

Care management services provided under the HCBS CPM include:

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

The ICT is responsible for care management services including the assessment, care plan development, service authorization/delivery, monitoring, and follow up components of the program. Typically care management services are provided by members of the ICT.

Additional case-specific resources may be available, including social and legal and/or paralegal specialists in the community in order to augment the resources and skills of site-based case managers. Examples include skilled diagnostic and consultant services by social and legal or paralegal professionals. Fees necessary to procure birth certificates or other legal documents required for establishment of public benefits or assistance also may be provided.

De-institutional Care Management: allows HCBS CPM benefits to begin prior to an individual's discharge from an institution. It may be used in two situations, as follows:

1. Where a care manager 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 HCBS CPM recipient is institutionalized and HCBS CPM services are necessary for the person to be discharged back into the community.

Respite: Respite services include the supervision and care of a member 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 member'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 provide additional benefits, appropriate services to consider include:

- Supplemental Chore
- Supplemental Personal Care
- Supplemental Protective Supervision

This benefit is not intended to compensate time during 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 this benefit.

Services may be provided In-Home or Out-of-Home.

This benefit may not be used for the cost of room and board except when provided as part of respite care in a facility licensed by the State that is not a private residence. Individuals providing services in the member's residence should be trained and experienced in personal care, homemaker services, or home health services, depending on the requirements in the member's care plan.

Transportation: these services provide access to the community (non-emergency medical transportation to health and social service providers) and special events for members 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 the Medi-Cal which is limited to medical services or members 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 should be obtained through these sources without the use of MCP or MMP resources, except in situations where such services are unavailable or inadequate.

Service providers may be:

- paratransit subsystems of public mass transit
- specialized transport for the elderly and handicapped
- private taxicabs when they are subsidized by public programs or local government to serve the elderly and handicapped
- private taxicabs 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 members who cannot manage to travel alone and require assistance beyond what is normally offered by the transportation provider.

Nutritional Services: these services may be provided daily but may not to constitute a full nutritional regimen (e.g., three meals a day).

Congregate Meals: meals served in congregate meal settings for members who are able to leave their homes or require the social stimulation of a group environment in order to maintain a balanced diet.

This service should be available to HCBS CPM recipients through Title III of the Older Americans Act. MMP or MCP benefits should only be used to supplement congregate meals when funding is not available or is inadequate through Title III or other public or private sources.

Home Delivered Meals: prepared meals for members 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. This

benefit should only be used to supplement home-delivered meals when they are unavailable or inadequate through Title III or other public or private sources.

Food: provision of food staples is limited to purchase of food to support a member's return home following institutionalization. Enteral therapy is a covered managed care benefit, however the use of home-prepared drinks / supplements (instant breakfast, pureed food) should first be explored and found not to meet the member's needs.

Protective Services: these services include protection for members 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.

Social Support: 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. This service will be provided if the service is unavailable in the community or is inadequate as provided under other public or private programs.

Activities and supplies required for participation in rehabilitation programs, therapeutic classes and exercise activities can also be provided.

Therapeutic Counseling: 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 members from being placed in a nursing facility. This service may be utilized in situations where members may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems.

Money Management: this service assists the member 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.

Communications Services: these services are for members with special communication problems such as vision, hearing, or speech impairments and persons with physical impairments likely to result in a medical emergency. Services should 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.

Translation/Interpretation: 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.

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

Monthly telephone charges are excluded from this category and are not permissible.

Provision of emergency response systems is limited to those members 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 member is able to understand and utilize the service and/or item being provided through the HCBS CPM benefit.

The following are examples of communication devices:

1. Medic-alert type bracelets/pendants
2. Intercoms
3. Emergency response systems (Life-lines)
4. Wander-alerts
5. Monitoring services and devices (baby monitor)
6. Light fixture adaptations (blinking lights)
7. Telephone adaptive devices not available from the telephone company or California Technology Assistance Project (CTAP)
8. Other electronic devices/services designed for monitoring or to summon emergency assistance
9. Medication reminder services or devices

Telephone installation/purchase or reactivation of service will only be provided to allow the use of telephone-based electronic response systems where the member has no telephone, or for the isolated member who has no telephone and who resides where the telephone is the only means of communicating health needs. This benefit may not be used for ongoing monthly fees for services/plans.

Appendix E: Selected State Authority, Contract and Policy References

State Plan:
http://www.dhcs.ca.gov/formsandpubs/laws/pages/californistateplan.aspx

MSSP Waiver:
http://www.dhcs.ca.gov/services/ltc/Pages/MSSP.aspx

Medi-Cal 2020 Waiver:
http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx

CCI Special Terms and Conditions (STCs):
http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCs11-22-16.pdf

CDA MSSP Manual:
https://www.aging.ca.gov/ProgramsProviders/MSSP/SiteManual/

MSSP Template Agreement with MCPs and MMPs:
http://www.calduals.org/wp-content/uploads/2014/02/MSSP-Contract-Template-revised-6-6-2013-2.pdf

Three-way Contract with CMS, DHCS, and MMPs / MCPs:
http://www.calduals.org/wp-content/uploads/2014/02/CAContractwithoutSub1.pdf

Medi-Cal Managed Care Boilerplate Contract:
http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf

All Plan Letters

Letter #	Link to Letter	Title
17-007	APL 17-007	Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption and Implementation of Monthly Medical Exemption Review and Denial Reporting
15-002	APL 15-002	Multipurpose Senior Services Program Complaint, Grievance, Appeal, and State Fair Hearing Responsibilities in Coordinated Care Initiative Counties
15-004	APL 15-004	Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
15-019	APL 15-019	Continuity of Care for Medi-Cal Beneficiaries Who Transition Into Medi-Cal Managed Care
17-012	APL 17-012	Care Coordination Requirements for Managed Long-Term Services and Supports

14-013	APL 14-013	Grievance Report Template
14-012	APL 14-012	Call Center Report Template

Duals Plan Letters

Letter #	Link to Letter	Title
16-001	DPL 16-001	Performance Improvement Project Requirements
16-002	DPL 16-002	Continuity of Care
15-001	DPL 15-001	Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
17-001	DPL 17-001	Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
14-001	DPL 14-001	Complaint and Resolution Tracking
13-006	DPL 13-006	Care Plan Option Services

Appendix F: Readiness Review Domains

The domains for readiness consist of benchmarks for DHCS and CDA to use when determining the Managed Care Health Plans' and HCBS CPM providers' preparedness to transition the MSSP waiver to a benefit managed and administered by the Managed Care Health Plans. Managed Care Plans and their contracted HCBS CPM providers must meet each of the following benchmarks satisfactorily before DHCS and CDA approve the transition of the MSSP into managed care benefit in an individual Coordinated Care Initiative county, MMP or MCP.

A. Data Sharing

1. Prior to transition - Share:
   - Care Plans
   - Assessment
   - Progress notes/monthly summary
   - Plan policy and procedure (P&P) draft of communication process addresses this benchmark.
   - Managed care plans have health record inclusive of these documents.
   - MSSP site has the ICP from the health plan.
2. Encounter Data
   - Summary of purchased / supplemental services, including Care Management (CM) and Care Management Support (CMS).
3. Monthly Claims

B. Stakeholder Engagement (State expectations for process)

1. Public Meetings
   - Plan
   - Number of meetings
   - Dates
   - Locations
   - Participants
   - Topics
     - Continuity of Care
     - FFS v. Plan participants
     - Care manager assignment

- Purchased services
- Eligibility Criteria

2. Composition of Stakeholders
   - Types of Stakeholders to Engage
   - Current Stakeholder Meetings

E. Monitoring and Evaluation of Transition
1. 365 Days ER Utilization Post-Transition • Data Elements • Collection/Reporting mechanisms • Reporting Deadlines
2. 365 days Inpatient Utilization Post-Transition • Data Elements • Collection/Reporting mechanisms • Reporting Deadlines
3. Consumer Satisfaction • Sample • Timeframes • Methods for obtaining • Elements • Reporting
4. Quality of Life
F. Continuity of Care
1. Frequency and Duration of Partnered • Will it stay the same as the current interaction? • Health Plans submit their plan of frequency interaction
2. Acuity-Based Transition Strategy • How will the current MSSP participants be grandfathered in/served? • Measures of Acuity o Level of Care o Frequency of ER visits o Frequency of in-patient hospitalization o Other measures?
G. Final Transition Plan
1. Stakeholder Engagement
2. Interdisciplinary Care Team (ICT)
3. Messaging/Communication Strategies
4. Continuity of Care
5. Data Sharing
6. Monitoring & Evaluation of Transition
7. Timeline of Activities

Appendix G: Glossary

Most descriptions are based on the CalDuals glossary available at: http://www.calduals.org/background/glossary/

Appeal — A request for a review of a health plan decision.

Beneficiary — A person who receives Medicare and/or Medicaid benefits.

Cal MediConnect Health Plans — Special health plans that provide both Medicare and Medi-Cal together for people who have both programs.

California Department of Aging (CDA) — The California state agency administering programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State, including MSSP.

Care Coordination — A process used by a person or team to assist beneficiaries in gaining access to necessary Medicare, Medicaid, and waiver services, as well as social, educational, and other support services, regardless of the funding source for the services.

Choice Form — The form you fill out to choose or change your health plan.

Community-Based Adult Services (CBAS) — CBAS is an outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family and caregiver training and support, meals, and transportation.

Coordinated Care Initiative (CCI) — The FY 2012-13 Governor's Budget proposes the Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for Medi-Cal beneficiaries, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community.

CMS — Centers for Medicare and Medicaid Services, a federal organization, that administers and oversees the Medicare and Medicaid programs.

Deductible — The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other coverage begins to pay.

Department of Health Care Services (DHCS) — The California state agency that administers the Medi-Cal program.

Department of Managed Health Care Services (DMHC) — The California state agency that oversees health plans that operate as health maintenance organizations (HMOs), which includes most MCPs and MMPs.

Demonstration Health Plan — The health plans selected to participate in the duals demonstration. Health plans sometimes are called “managed care organizations” or “HMOs.”

Dual Eligible Beneficiaries — People who receive both Medicare and Medi-Cal benefits.

Enrollee — A person enrolled in the integrated care demonstration or a health plan.

Fair Hearing — An official meeting with a judge about a Medi-Cal appeal or grievance. You must ask for a fair hearing within 90 days of the date that your Medi- Cal benefits were denied, reduced, or stopped.

Fee-for-Service (FFS) — A method of health care financing in which an established fee is paid for a unit of health care service, such as a doctor visit, test or surgery.

Grievance — A way to write or tell the health plan about your unhappiness with your provider or medical care service.

Health Plan — A group of doctors, specialists, clinics, pharmacies, hospitals, and long term care services and supports that provide health care services. Health plans are also called managed care plans. People enrolled in the health plan are called “members” and have a primary care provider who helps guidebook their health care.

Home and Community Based Services (HCBS) — Services and supports provided to individuals in their own home or other community residential settings that promote their independence, inclusion, and productivity.

Home and Community Based Services Care Planning and Management (HCBS CPM) — Services and supports provided to individuals in their own home or other community residential settings that promote their independence, inclusion, and productivity. In CCI counties prior to 01/01/20, these services were provided under the MSSP Waiver.

In-Home Supportive Services (IHSS) — The IHSS program provides in-home care for people who cannot safely remain in their own homes without assistance. To qualify for IHSS, a recipient must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program.

Integrated Care — Brings all covered Medicare and Medicaid covered benefits into one place so beneficiaries receive the right care at the right time and place. Integrated care uses a person-centered approach that takes into account individuals’ needs and preferences to ensure they have seamless access to the full continuum of care, including medical care, behavioral health services, long-term services and supports and

care coordination.

Integrated Financing — Federal and state Medicare and Medicaid funds combined at the health plan level for people who are eligible for both Medicare and Medicaid and enrolled in an integrated care plan.

Long-Term Services and Supports (LTSS) — LTSS include a range of home- and community-based services such as IHSS, Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) in addition to care in nursing facility services when needed.

Managed Medi-Cal Long-Term Supports and Services (MLTSS) — All Medi-Cal beneficiaries, including dual eligible beneficiaries, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.

Medicaid — The program established under authority of Title XIX of the Social Security Act that covers medical assistance for low-income people who meet specific eligibility criteria.

Medi-Cal Managed Care Health Plan (MCP) — A health plan covering benefits available under the Medi-Cal program.

Medi-Cal — This is what the Medicaid program is called in California.

Medicare — The federal health program to provide health care for people aged 65 and older, people younger than 65 with certain disabilities, and people with certain diseases.

a. **Medicare Part A** covers inpatient hospital services and other services, such as skilled nursing facilities, and home health agencies.
b. **Medicare Part B** covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies.
c. **Medicare Part C** provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan.
d. **Medicare Part D** provides coverage for most prescription drugs.

Medicare-Medicaid Plans (MMP) — A health plan covering benefits available under both the Medi-Cal and Medicare programs.

Member — A person enrolled in a managed care health plan, also called an "enrollee."

Multipurpose Senior Services Program (MSSP) — This waiver program provides both social and health care management services for Medi-Cal recipients aged 65 or older who meet the eligibility criteria for a skilled nursing facility. In addition to the care management service, each MSSP site has funds reserved for purchasing services necessary to maintain a person in the community after all other public or private

program options have been exhausted.

Preferred Drug List — A list of medications covered by a health plan offering prescription drugs.

Primary Care Provider — Your main health care provider. This may be a doctor, nurse practitioner, nurse midwife, or physician's assistant. They help connect you to all the services you need, including care from specialists.

Program of All-Inclusive Care for the Elderly (PACE) — Health plans for people age 55 and older who need a higher level of care to live at home.

Provider Directory — A list of doctors, clinics, pharmacies, and hospitals that are in a health plan's network. You must use the providers in your health plan's network.

Senior Care Action Network (SCAN) Health Plan — SCAN Health Plan is a Medicare Advantage Special Needs Plan providing services for the dual eligible Medicare/Medi-Cal population subset residing in selected counties. SCAN provides all services in the Medi-Cal State Plan, including home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care.

Skilled Nursing Facilities (SNFs) — SNFs encompass nursing homes and rehabilitation facilities and provide nursing, rehabilitative, and medical care.