Multipurpose Senior Services Program (MSSP)
Site Manual Revision – June 2026

Purpose

The revised Multipurpose Senior Services Program (MSSP) Site Manual reflects changes in policy. Content has been reorganized for clarity, and the terminology has been updated.

General

- "MSSP Bureau" has been updated to "MSSP Section."
- References have been updated to include hyperlinks to sources when available.
- References to appendices and CDA Standard Agreement sections were renumbered as applicable.
- Changed language from "certifying" to "predetermining" level of care.
- Changed language from "Quarterly Home Visits" to "Quarterly Contacts" and included references to the telehealth option when applicable.
- Made minor, non-substantive changes in various parts of the manual to correct identified mistakes and ensure consistency throughout the document.

The following constitutes a summary of substantive changes:

Chapter 1 Introduction

1.200 The Waiver and Program History

- Updated history regarding the CCI carve out.
- Added language regarding the changes made during the Waiver Renewal for FY 2024-25 through 2028-29.
- Added explanation of how MSSP is now serving 33 sites.

1300 Program Operations

- Removed: "MSSP sites in the CCI demonstration project counties also have entered into agreements with participating managed care plans."

1.400 Organization of this Manual.

- Added language clarifying reproduction of CDA forms and documents.

Chapter 2 Site Staffing

2.010.2 Supervising Care Manager (SCM)

- Updated approved fields of study to include public health and health care administration.

2.030.2 Procedure for Requesting and Exemption

- Changed title from “Criteria Rating Sheet” to “Orientation Checklist”.

2.030.3 CDA Exemption Approval Process

- Updated language: Submission should be sent to the site’s assigned CDA Analyst versus the MSSP Service Desk.

Chapter 3 Program Components

Purpose

- Added reference: CDA Standard Agreement, Exhibit A, Article II MSSP Program, Sections A, G, and H, and Exhibit D, Article XIX.
- Freedom of choice language was clarified as applicable to sites and care management staff.
- Updated level of care language to include:
  - LOC predetermination must be completed within 60 days of MSSP application.
  - The CDA-finalized LOC is a requirement for enrollment.
  - The final LOC determination will be made by a CDA MSSP Nurse, using assessment(s) and the LOC form completed at the site level.

3.020.1 Wait List Data

- Updated language: Wait List data must be reported monthly and on the Quarterly Report.

3.030 Standards

- Removed duplicative language that is referenced in later sections, such as Section 3.1520, Monitoring Activities.
- Added language for home visits and telehealth as an option for quarterly contacts: “While sites have the flexibility to conduct these contacts via the telehealth service delivery option, quarterly contacts conducted as an in-person visit should be the default/preferred method of conducting quarterly contact, with telehealth provided as an option considering the participant’s choice and circumstances.”

3.040 Sequence of Enrollment Processes

- Added applicable timeline requirements to the sequence of events.
- Separated the level of care predetermination process from the CDA submission process.
- Clarified when enrollment occurs:
  - After the participant has completed and signed the Application,
  - The Nurse Care Manager (NCM) has completed the initial LOC, and
  - The packet is submitted to CDA for approval.

- The enrollment effective date is the date that the completed LOC packet is submitted to CDA.

3.100 Eligibility

- Revised the age requirement for MSSP Services from age 65 to age 60.

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

- Added new LOC Predetermination form with FNAG (Appendix 20)
- Added LOC form requirements: NCM name, title, signature and date.
- Added LOC submission to CDA requirement for approval.

3.110.1 Clinical Judgment and Level of Care

- Additional paragraph citing the nurse's clinical judgment and if additional assistance is needed the site can contact MSSPLOC@aging.ca.gov.

3.110.3 Application of Title 22 Criteria

- Added "Diagnoses" as an additional area to be covered on the LOC form.
- Added clarification to the cognitive and sensory section regarding the number of errors on the SPMSQ.

3.110.4 Completion of LOC Predetermination Forms

- Previously provided LOC examples have been pulled out as separate appendices.
- Added language: "CDA does not require any specific format or style when completing the LOC form (Appendix 19 or 20) but has samples available for reference (Appendix 19A and 20A)."
- Added clarification of reporting signs and symptoms, descriptions when diagnosis is not available, documenting ADLs/IADLs, and an added example of a proper description.

3.110.5 Submission to CDA for Final Determination of Initial LOC

- Information from the previously released MSSP Advisory and Guidance Letter (MAGL) was added to this new section that provides information required for submission of the LOC to CDA. This information includes:
  - List of documents required to submit to CDA for LOC approval in the Unfoxer software system.
  - Both disciplines may complete the FNAG, but only the nurse may complete the LOC Predetermination with FNAG form.
  - Optional information that might be helpful to include.
  - Timelines for review of submission.

3.110.6 Consultation with CDA for Urgent/High-Need Cases

- This is a newly added section that provides guidance in the event the site identifies a critical situation that needs immediate attention for level of care approval.

3.110.7 Initial LOC Submissions Timing Consideration

- This is a newly added section regarding the provision of care management activities in the same month as initial LOC submission to CDA.

3.110.8 Unfoxer Case Status Updates and Notification

- New section discusses the different statuses of submitted LOC in Unfoxer, including:
  - What happens when more information is needed.
  - The approval process.
  - If the participant is denied due to not meeting eligibility or due to insufficient information to meet approval.

3.110.9 Retention of Finalized LOC

- New section with retention of LOC information by CDA and expectations for the site.
- Retention of records has changed from seven to ten years effective FY 26-27.

3.110.10 Recertification (Reevaluation) for LOC.

- Updated section regarding requirements for timely submission of the recertification LOC package to CDA.
- Provides new guidance on LOC planning, progress note documentation, and timeliness.

3.110.11 Submission to CDA for Final Determination of Recertification LOC

- New section added that provides instruction regarding submission of recertification LOC packages and what documents should be included with the LOC submission if done at the Alternative Discipline Visit (ADV) or done with the reassessment.

3.110.12 Requests to Reset a LOC Due Date

- New section added that provides sites with an option to permanently reset the LOC certification date, the circumstances when allowable, and how to submit the request.

3.110.13 Requests to Change Recertification LOC Assessment Method

- New section added that provides instruction for sites on how to request a change in the assessment method for the recertification LOC process. Sites have the option to complete a recertification LOC using one of two

assessment methods: ADV Assessment form or Reassessment but must choose one and adhere to that method for all submissions.

3.120 Age 60 or Older

- Updated title of section to reflect that the age requirement for eligibility has been changed from age 65 to 60.

3.130 Receiving Medi-Cal under an Appropriate Aid Code

- Removed list of qualifying Medi-Cal aid codes as it has expanded to include too many to list in paragraph format. A list of all aid codes with descriptions can be found in Appendix 10.
- The list of aid codes with a share of cost was expanded.
- Added new paragraph that explains aid codes can be prompts for discussion with participants but should not change how NCMs determine LOC using Title 22 standards.

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

- Added clarifying information for applying spousal impoverishment: “Submission to CDA is not required at the time of the deeming process; however, it will need to be submitted prior to enrollment.”

3.140 Residence Requirements

- Added new paragraph that clarifies Medi-Cal residency requirements when a participant leaves the State for a period of less than 30 days.

3.160 Appropriate for Care Management Services

- Added new information regarding required home visits, which includes the completion of the application/enrollment forms, Initial Health and Psychosocial Assessments, Alternate Discipline Visit, and Reassessment.

3.210 Screening Forms

- Updated screening form retention from seven years to ten years.

3.220 Screening Process

- Added the language, “if someone is enrolled in a duplicative program they do not intend to withdraw from” as a reason written notice would not be required at screening.

3.230 Referrals Not Accepted for MSSP Participation

- In alignment with the amended Welfare and Institutions Code effective Fiscal Year 2026-27, the retention period will be ten years from the date of the decision.

3.310 Non-enrolled Applicants

- Added Welfare and Institutions Code language regarding record retention.

3.320 Freedom of Choice

- Added language requiring sites to have a process for informing and/or responding to participants regarding freedom of choice.
- Rights added for participant choice of:
  - Care manager
  - Vendor
  - Services
  - Location, time, and method of *monthly* contacts
  - Whether *quarterly* contacts are conducted via telehealth.
- Language added, “Participants may request that a MSSP site contract with a willing and qualified vendor that meets all requirements.”

3.410 Requirements for Enrollment

- Added that LOC predetermination must be submitted to CDA within 60 days of application.
- Added that enrollment occurs after the LOC package has been submitted to CDA and a CDA MSSP nurse has finalized the LOC.

3.510 Confidentiality

- Added the CFR code that refers to case management and care coordination falling “under the subset of health care operations activities that can be disclosed without needing patient consent or authorization.”

3.530 Requests for Participant Information

- Added a hyperlink with information regarding the release of PHI during an emergency.

3.610 General Guidelines

- Clarified that assessments, reassessments, and Alternate Discipline visits need to be conducted at the participant’s residence.
- Clarified quarterly home/telehealth visits should also be conducted in the participant’s residence, “with telehealth provided as an option considering the participant’s choice and circumstances.”

3.620 Initial Health Assessment / Initial Psychosocial Assessment

- Clarification of the timeframe when an Initial Health/Psychological Assessment needs to take place.
- Added language to clarify that information should be gathered on the home environment, and what can be done if a participant is unable to complete the assessment in person.
- New paragraph regarding the completion of all check boxes on the assessments and adding written comments.
- Under Initial Health Assessments (IHA) requirements:
  - Removed IHA Summary (Optional)

- Under Initial Psychosocial Assessments (IPSA) requirements:
    - Removed CDA-Approved Cognitive Screening Tool and Functional Needs Assessment Grid (FNAG) as these can now be completed with either assessment.
    - Added the Safety and Special Equipment Checklist that was separated from the FNAG.

3.620.1 Vital Signs

- Added new section that recommends that nurses obtain vital signs during home visits as a best practice.

3.620.2 Cognitive Assessment Tools.

- Added that cognitive screening tools must be attempted during each assessment.
- Added guidance for CMs to use alternative cognitive screening tools (options provided) when a participant is unable to complete due to Alzheimer's, dementia or neurodegenerative disease.

3.630 Reassessment

- Added guidance that in-home visits are the default and preferred method of completing the assessments, but telehealth may be used in certain circumstances.
- Added new requirement for the reassessment:
    - Safety and Special Equipment Checklist (previously included with FNAG but now incorporated into the reassessment form).
- Added new language stating that cognitive screening tool, FNAG, and medication list can be completed with either the ADV form or reassessment, but must be completed every 12 months.
- Added that grace periods do not apply to reassessments that link to LOC redetermination.

3.360.1 Alternate Discipline Visits (ADV)

- Added additional guidelines regarding ADV requirements, incorporating the new ADV Assessment forms (Appendix 28 or 29).
- The ADV Assessment form is only required if it is submitted for LOC recertification instead of a reassessment.
- The ADV Assessment form is not required for ADVs that are not being submitted for LOC recertification.
- Examples provided.

3.640.1 General Guidelines

- Added "When applicable" for when NOAs are sent for additions to the care plan.

3.640.2 Emergency Care Plan

- Language moved for flow and clarity.
- Added language to reflect that a LOC must be finalized by CDA prior to an emergency care plan being approved. An emergency review of the LOC at the State level can be requested.

3.640.3 Care Plan Components

- Added additional guidance to Part F – Plan/Intervention regarding using generic categories of services until after purchase.
- Added recommendation that maximum quantities of items/services be added to the care plan.

3.640.4 Care Plan Activation: Signatures and Review Process

- Added language regarding care plan verbal acceptance.
- Added new language for when a participant chooses telehealth for quarterly contacts, the site should have a process established for obtaining the signature before or at the first quarterly contact.

3.640.5 Care Plan Implementation

- Added language regarding consideration of informal support for inclusion in the care plan.

3. 640.7 Changes to the Care Plan

- Added language to clarify 10-day NOAs are not just required for termination of the program, but reductions and terminations of Waiver Services as well.

3.730 Risk Management

- Added back-up plans to possible alternatives/interventions considered for negotiated risk agreements.

3.760 Critical Incident Reporting

- Added clarification on what critical incidents should be reported and how they are categorized.
  Added:
  - Psychological abuse
  - Other incidents with serious injuries
  - Unexplained/unanticipated death.

  Clarified:
  - Environmental incidents include, “a positive diagnosis during a pandemic, or natural disasters that directly impact the participant”
  - Housing issues include, “evictions, pest infestations and/or hoarding/safety concerns that require APS intervention.”
- Added new language regarding collaboration with the participant to achieve a resolution of a critical incident.

3.770 Fall Prevention Training for Care Management Staff

- Added a new section regarding the requirement for MSSP care management staff to complete annual fall prevention training.

3.780 Restrictive Interventions, Restraints, and Seclusion

- Additional regulatory language defining the use of restraints.
- Added for the purposes of reporting critical incidents to CDA, "A restraint does not include devices, such as lap belts or safety belts for wheelchairs or furniture when the participant can safely remove or release the device independently, or when the device does not otherwise restrict the participant's freedom of movement."

3.810 General Requirements

- Added reference to the alternate discipline visit and the ADV form.

3.820 What Progress Notes Include

- Added that type of contact (telephone, virtual, or in-person) should be included in the progress notes.
- Added documentation requirements for late LOCs.
- Added documentation requirements for telehealth:
  - Review of home environment,
  - The participant was given the choice of having a home visit or doing telehealth, and
  - There are no health/safety issues or extenuating circumstances that would make an in-person home visit necessary.

3.920 The Benchmark and Calculation of Costs

- Updated language for clarity: sites should be considering the *monthly* benchmark.

3.930 Authorization and Utilization of Services

- Added language clarifying when informal support should be added to a care plan.
- Added language regarding documenting the medical necessity for items typically covered by Medi-Cal/Medicare by obtaining a prescription.

3.1110 Non-Duplication of Care Management Services

- Clarified that participants cannot be enrolled in MSSP and Senior Care Action Network (SCAN) Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) at the same time.
- Added to the list of 1915(c) Waivers to now include Self-Determination Program (SDP) Waiver.

- Added that participants can receive both MSSP and Community Supports through the county or Managed Care Plan at the same time as long as there is no duplication.

3.1120 Coordinating MSSP and Other Care Management Services

- Updated language removing “care management” to apply more broadly to duplication of any MSSP services.

3.1310 Background

- Removed old language describing the approved amendment in 2002.
- Added clarification that Waiver Services need to be billed separately from DCM.

3.1370 Plan for Deinstutional Services

- Added language, “Sites will not be able to bill for Care Management, Care Management Support or Waiver Services provided under DCM, if the participant does not ultimately transition into the Waiver.”

3.1380 Conclusion of CDM Services

- Added language to include the requirement of the submission of the LOC to CDA with section reference.

3.1380.1 Data Reporting

- Section retired. The DCM Data Tracking form will no longer be required.

3.1420 Referred Services

- Updated language from “elderly” to “frail old adults” and “people with disabilities”.
- Added clarification that hospital insurance covers short-term skilled nursing facility costs.
- Replaced the Appendix for Title III Services with the CDA Service Categories and Data Dictionary reference hyperlink.
- Additional language added for clarification.

3.1430 Purchased Waiver Services

- Updated services/items to include those necessary for health *and safety*.
- Language moved for flow and clarity.
- Duplicative language removed.
- Services that are applicable to Electronic Visit Verification (EVV) requirements were identified with a statement added that vendor contracts must contain language addressing EVV.
- Services that are allowable for telehealth were identified.
- Added language to Minor Home Repairs and Maintenance (2.2), “Services should address imminent needs and do not include ongoing subscriptions

for household maintenance (e.g. pest control services to address an infestation are allowable versus an ongoing subscription for prevention would not be)."

- Updated title of Non-Medical Home Equipment (2.3) to *Specialized* Non-Medical Home Equipment and made other language adjustments to align with the definition in the Waiver:
  - Added paragraph of what is included.
  - Added that specific items should be listed out for incontinence supplies versus using the generic "incontinence supplies" to cover all.
- Updated Community Transition Services to combine (2.4) and (2.5):
  - Moving services were incorporated into the service definition for 2.4 from the previous 2.5 service.
  - Added clarification of what community transition services do not include.
- Updated Assistive Technology (2.6):
  - Added language regarding billing for an evaluation of assistive technology.
  - Added language clarifying items that were previously billed under 2.3 that now should be billed under 2.6.
  - Added criteria needed to purchase a device and/or technical assistance to facilitate telehealth.
- Added to Supplemental Services (3.1, 3.2, and 3.7):
  - Example now states, "and IHSS cannot provide a substitute."
  - Added to 3.1 – language that states homemaker services can be purchased to prepare for a participant's discharge from an institution.
  - Removed from 3.2 – "May include assistance with preparation of meals, excluding the cost of food."
  - Clarified that ERS cannot be paid for *by Waiver Services funds* if the participant is receiving supplemental protective supervision.
- Added Consultative Clinical Services (4.3):
  - Examples of social services and legal/paralegal consultation.
- Added to Deinstitutional Care Management Services (4.6):
  - Clarification that, "Any purchased Waiver Services would be billed separately."
- Added to Respite (5.1 and 5.2):
  - Clarification that respite care cannot last more than 30 days, or for "any combination of direct care and protective supervision that exceeds 24 hours of care per day."
- Added to Transportation (6.3 and 6.4):
  - Definition for one way trip and round trips.
- Added to Nutritional Services (7.1, 7.2, and 7.3):
  - Explanation of Congregate Meals as a preventative measure.

    - 7.3 – Oral Nutritional Supplements (ONS) – removed old language from a 2014 change.
- Added to Counseling & Therapeutic Services (8.4 and 8.5):
    - 8.4 –Therapeutic Counseling is only allowed when the state plan benefits have been exhausted.
    - 8.5 – Description of when waiver participants may need this service, including isolation or lack of community support.
- Added to Communications Services (9.1 and 9.2)
    - 9.1 – "MSSP resources shall be used to support this service only where family and community resources are unable to meet the need as described in the care plan".
    - 9.2 –
        - Added language regarding emergency communications services.
        - Medication reminder services or devices removed (now under 2.6)
        - Paragraph added – all types of personal emergency response devices shall meet specific standards.

3.1520 Monitoring Activities

- Monthly contact language was updated and includes what monitoring entails, preferred contact with the participant, and documentation.
- Updated Quarterly Home Visit - now Quarterly Contact.
    - Updated language to include:
        - The purpose of the home visit
        - When telehealth can be used
        - If the home visit was the participant's chosen method and if it is missed.
- Updated Reassessments – when using reassessments for LOC recertification, the grace period does not apply, and they are not to exceed 12 months.
- Updated LOC – added language about LOC updates by the NCM if there is a change of condition.

3.1530 Telehealth as a Service Delivery Method

- Information from the previously released MAGL was added to this new section that includes the definition of telehealth, requirements, and timing.

3.1530.1 Telehealth as an Option for Quarterly Contact

- Information from the previously released MAGL was added to this new section that includes requirements of the use of telehealth during a quarterly contact.

3.1530.2 Waiver Service Telehealth Requirements

- Information from the previously released MAGL was added to this new section that provides a list of which Waiver Services can be provided via telehealth, and the requirements needed.

3.1530.3 When Telehealth is not Appropriate

- Information from the previously released MAGL was added to this new section that lists guidelines for when telehealth cannot be used and examples.

3.1700 Termination

- Removed recission of termination language from this section to create a new section.

3.1710 Rescission of Termination

- New section that added requirements for rescission of terminations that are less than 30 days.
- Added guidance regarding participants that have lost Medi-Cal benefits.

3.1720 Re-Enrollment

- Under Persons re-enrolled within 31-90 days:
  - Revised LOC certification – language has been added regarding the choice of submitting the LOC to CDA.
  - Language added regarding resetting the reassessment month.
- Under Persons re-enrolled after 90 days:
  - Revised LOC certification – LOCs are required to be submitted to CDA.

3.1800 Transfer of Participants Between Sites

- Updated language stating that the site does not need to wait until the change of county is completed for Medi-Cal eligibility.

3.1900 Emergencies and Disasters

- Added link to the CDA Emergency Preparedness Guide.
- Added and removed language regarding flexibilities during emergencies.

3.1910 Alternate Remote Enrollment Process

- Section retired as references to the COVID-19 pandemic are no longer valid.

Chapter 4 Quality Assurance and Program Review

4.120 Levels of UR

- Updated – follow-up reviews can be on-site or in person.

4.130.1 Elements of the CDA UR

- Updated language to include remote utilization reviews.

4.130.3 Areas of Site Operation to Be Reviewed

- Updated language to replace “home visit” with “interview” with a participant.
- Added language stating that the LOC is to be finalized by CDA.
- Under payment, indicators – references vendors completing all required training.

4.130.5 UR Report

- Updated language from 45 “working” to “business” days.

4.150 Recovery of Funds

- Added reference to new section 4.150.1, UR Recovery Appeal Process
- Clarified that fiscal audits’ appeals procedures are sent by DHCS, Third Party Liability and Recovery Division.

4.150.1 UR Recovery Appeals Process

- New section that discusses the MSSP Utilization Review recovery appeal process and the timeline for response.

Chapter 5 Participant Records and Information

5.300 Maintenance and Storage

- Added language regarding the change in retention period from seven to ten years that goes into effect FY 2026-2027.

5.400 Access to Minimum Necessary Information

- Added “managed care health plans” as entities that may need to share/receive information about participants.

5.610 Electronic Record Keeping

- Added Participant Enrollment/Termination Information form (PETIF) to the list of required forms that may be converted to an electric format for sites seeking partial/total conversion.

5.700 Corrections

- Added an additional circumstance when corrections need to be initialed and dated.

5.800 Case Documents

- Adjusted language regarding the LOC that is stored in the participant's record needs to include the finalized version from CDA.
- Removed the requirement that the unapplicable reasons ("remaining options") be deleted from the NOA.

5.810 Staff Signatures and Signature Requirements

- Added that all signatures should include the title of the person completing the form.
- Added guidance regarding timeliness for document signatures and exceptions. Specifically, "Documents should be signed when completed, or as soon as possible, but no later than one month after completion. Exceptions to this timeframe can be made for SPUS, which can allow up to three months to verify delivery of services. Any other circumstances where documents cannot be finalized and signed within this timeframe must have explanations documented in the progress notes."
- Adjusted the list of documents that require staff signatures:
  - LOC must have finalizing CDA MSSP nurse signature.
  - The ADV Assessment form is required to be signed by the NCM or SWCM, as applicable.
  - Assessment summaries were removed from the list.
- Added clarification that the benchmark for expenses is *monthly*.

5.820 Electronic Signatures for Participants

- New section that explains that sites may choose to use electronic methods of obtaining participant signatures.
- Provides rules, regulations, and requirements for specific e-signature software.
- Added list of software options that the sites can use for e-signatures.

5.830 Timing Intervals Required for Case Documentation.

- Added description of enrollment to incorporate the new LOC submission process.
- Removed prior definition of enrollment and defined the effective date of enrollment.
- Changed that initial assessments must be completed within two weeks of the application versus enrollment.
- Added that ADVs that are used for LOC redetermination are not granted the 13-month grace period.

Chapter 6 Participant Rights

6.000 MSSP Participant Rights

- Updated the brochure title from “Welfare” to “Public Benefit”**.**

6.230 Notice of Action

- Added language regarding the 10-day notice period being required, “…unless the participant has requested the reduction, suspension, or termination of Waiver Services and waives their right to a Fair Hearing. A copy of each NOA with hearings rights notification must be maintained in the participant’s record.”

6.300 State Medi-Cal Fair Hearing

- Added note that CDA will be responsible for the position statement(s) and hearing presence for any appeals filed due to CDA’s determination that the applicant/participant fails to meet level of care certification requirements for program eligibility.

6.400 Notice of Action for Terminations

- Reordered list of termination reasons to match the NOA.

6.500 Final Rule Section 1557 Requirements

- Added language regarding required content for nondiscrimination notices.
- Added language clarifying when the notifications of nondiscrimination are to be provided to the participant.
- Added the definition of a qualified interpreter.

Chapter 7 Information System Components

7.310 Transmission of Data to CDA

- Updated the types of files that are accepted to .json formatting.

7.410 Services Codes.

- Waiver services codes updated:
  - 2.3 – Title updated to *Specialized* Non-Medical Home Equipment
  - 2.5 – Removed separate definition, now combined with 2.4

7.410.1 Healthcare Common Procedure Coding System (HCPCS) Codes

- New section explains that nationally recognized HCPCS codes are now required to be used under the Health Insurance Portability and Accountability Act (HIPAA) Public Law.

7.410.2 Modifiers and Revenue Codes

- New section adds the importance and purpose of modifiers and revenue codes.
- Language added regarding using revenue codes as they relate to Electronic Visit Verification (EVV) requirements. “For all non-EVV

impacted MSSP services, MSSP sites will use the revenue code 3109. For all EVV-impacted MSSP services, MSSP sites will need to select the appropriate revenue code, depending on whether the service was provided in the participant's home, via telehealth, or neither."
- Includes a reference to Appendix 46, which contains a list of all modifiers and revenue codes.

7.410.3 Unit Type
- Updated language regarding how each service is associated with a specific unit or set of units: 15 minutes, hour, diem, visit, event, service, purchase, each, meal, and month.
- Added language – "Diem" is now used in place of day.
- Removed "OTO" and "OWT" unit type descriptions as they are no longer in use.

7.440 Site Codes
- Updated site list:
  - Removed defunct site numbers
  - Added:
    - # 58 – Self for the Elderly (SHE)
    - # 61 – OneGeneration
  - Total of 33 Sites in Operation

Chapter 8 Service Vendors

8.100 Vendor Contracts/Agreements

- Updated the required provisions related to vendor contracts/agreements, adding "Electronic Visit Verification (EVV) self-registration and ongoing program compliance".

8.400 Vendor Rates

- Rate changes should be sent to MSSPService@aging.ca.gov

Chapter 9 Site Budget and Claims Reimbursement

9.030.1 Threshold Rate Change Request
- Updated guidance on submitting rate requests to MSSPservice@aging.ca.gov.
- Removed reference to ZCodes.

9.040 Slot Allocation and Enrollment Levels

- Added a new section that provides a definition of slots and how they are funded based on a site's budget.
- Added site requirements for caseload enrollment of no less than 95 percent.
- Added how CDA will track a site's enrollment, require enrollment plans for noncompliance over three consecutive months, and may ultimately decrease a site's caseload if a site is unable to demonstrate improvement.

9.040.1 Slot Allocation Change Requests by Sites

- New section provides guidance on how sites may request to "Voluntarily Relinquish Slots" and "Request Additional Slots."
- Provides direction on how a site can start the slot change process and the information required to be included in the written request.
- If slots are available, CDA will notify the site of its determination within 60 days.

9.110 Billing Process

- Clarified that Care Management Support can be billed in addition to Care Management under a special single unit of DCM, under the HCBS FFP rate.
- Clarified that any Waiver Services purchased must be billed separately from the single unit of DCM.

9.120 Reimbursement & Remittance Advice Details (RADs)

- Updated language and links on how RADs can be downloaded in an online PDF format from the Provider Portal.
- Updated links for more information on the reconciliation of RADs and the Medi-Cal Claims Inquiry Form (CIF) process.

Chapter 10 Equipment

10.300 Equipment Inventory

- Updated the link to the new CDA 9023A Property Acquisition form.

Appendices

General

- All appendices were renumbered.
- References have been updated to include hyperlinks to sources when available.
- Appendices were reformatted and simplified to meet accessibility standards.

New Appendices Added:

- Appendix 3: Applicant Denial NOA
- Appendix 19A: LOC Predetermination Sample
- Appendix 20A: LOC Predetermination with FNAG Samples
- Appendix 21: LOC Reference Guide
- Appendix 28: NCM ADV Assessment Form
- Appendix 28A: Sample NCM ADV Assessment Form
- Appendix 29: SWCM ADV Assessment Form
- Appendix 31: Safety and Special Equipment Checklist

Previous Appendices Removed:

- Appendix 10: Institutional Deeming Waiver Aid Codes
- Appendix 15: Deinstitutional Services Data Tracking Form
- Appendix 24A: Initial Health Assessment Summary (Optional)
- Appendix 25A: Initial Psychosocial Assessment Summary (Optional)
- Appendix 26: Psychological Functioning (moved to IPSA)
- Appendix 44: Title III Services (similar chart now accessible by link in Chapter 3)
- Appendix 47: SCAN Policy Letter 17-01

Appendix 1: Rights to State Medi-Cal Fair Hearing

- Added note: “Citations are only partial quotes from relevant code sections.”
- Aligned language to match current regulations online.
- Added section 10959 that provides an explanation of what occurs after an administrative law judge has held a hearing and a proposed decision is issued.

Appendix 2: Termination of Services NOA

- Removed all references to denials and applicants as there is now a separate NOA for denials.
- Removed site instructions for completing the form, such as, “Select one of the options below and insert here as appropriate and delete non-applicable season” and “Select only one of the following two paragraphs.”
- Added “The following checked status applies to you:”
- Updated closing sentence from “interest” to “participation.”

Appendix 3: Applicant Denial NOA

- New form that separates the Termination NOA from the Denial NOA.
- Mirrors termination NOA language but uses the “denial” and “applicant” language that was removed from Appendix 2.

Appendix 4: Change in Services NOA

- Added Name, Address, MSSP ID fields to match the formatting of the other NOAs.
- Updated the option to select “or denied.”
- Removed site instructions for completing the form, “Select one of the options…”

Appendix 5: Your Right to Appeal This Decision

- Aligned language with California Department of Social Services (CDSS) forms.
- Added language to the first paragraph, “in most cases” for the timeframe of 90 days from the date of the attached notice.
- Added new paragraph discussing the time frame for a State Hearing to take place.
- Added paragraph discussing the option for an Expedited Hearing request.
- Updated contact information for requesting a State Hearing, including instruction on creating an ACMS account online or submitting without creating an account.

Appendix 6: Request For State Hearing Form

- Aligned language with California Department of Social Services (CDSS) forms.
- Updated form now includes fields for Date of Birth, Phone Number, Email and Medi-Cal Number/Social Security if applicable.
- Additional questions about the MSSP site and appealing the case to the MSSP site.
- Updated the questions regarding Request for Special Accommodation, including expedited hearing requests, continued services, interpreter services, reasonable accommodation for disability, and need for a representative.
- Additional instruction regarding submission of a request for hearing.

Appendix 7: Withdrawal of Request for State Hearing Form DPA 315 (2/25)

- Updated link and image of the Withdrawal/Conditional Withdrawal of Request for Hearing form.

Appendix 8: Participant Non-Discrimination Notice

- Aligned language with the Department of Health Care Services form.
- Added additional categories for non-discrimination and grievances.
- Added fields for site hours of operation.
- Added that upon request this document can be available in other formats.
- Updated how to file a grievance including an electronic option by visiting the site’s website (if applicable).
- Updated and added the contact information for the Office of Civil Rights.

Appendix 10: Medi-Cal Aid Codes

- This list includes Medi-Cal aid codes as defined by the state Medicaid plan that are allowable for MSSP.

Appendix 12: Application

- Added clarification that information may be shared with the managed care health plan.
- Added language for freedom of choice of care management/services.
- Added language regarding refusal or inability to cooperate with program requirements, such as home visits.
- Added Applicant signature date line.
- Changed the “County’s equivalent notice” to specify California Department of Social Services notice, "Your Rights Under California Public Benefits Programs."

Appendix 13: Application for Institutional Deeming Procedures

- Added clarification that information may be shared with the managed care health plan.
- Added language for freedom of choice of care management/services.
- Added language regarding refusal or inability to cooperate with program requirements, such as home visits.
- Added Applicant signature date line.
- Changed the “County’s equivalent notice” to specify California Department of Social Services notice, "Your Rights Under California Public Benefits Programs."

Appendix 14: Request for Deinstitutional Services

- Added clarification that information may be shared with the managed care health plan.
- Added clarification regarding receiving benefits from more than one Medi-Cal funded program and eligibility.
- Added language regarding refusal or inability to cooperate with program requirements, such as home visits.
- Added bullet for estate recovery to mirror Application language.
- Removed contact information for California Department of Social Services State hearing division, as this is provided separately.
- Added bullet regarding notification of rights that mirrors the Application language.

Appendix 15: Participant Rights in MSSP

- Language added regarding cooperation with program requirements, including required annual home visits by both Nurse and Social Work Care Managers.
- Updated list of rights, including:

    - Choose the location, time (within business hours) and method of how **monthly** contact is conducted;
    - Choose whether **quarterly** contact is in-person or via telehealth, if there are no health or safety issues that would necessitate an in-home visit.
- Added Fax number, Email address, and online website to file a hearing.

Appendix 16: Your Rights Under California Public Benefits Programs Brochure

- Updated brochure version/date from August 2020 to May 2022.

Appendix 17: Authorization for Use and Disclosure of Protected Health Information (AUDPHI)

- Added section clarifying the purpose of the release of information.
- Added a line for IHSS Caregiver/Provider under disclosing providers.
- Added clarification regarding disclosing individuals and a space to list the relationship with the individual.
- Added required language for redisclosures.
- Added “Type of Representative” checkboxes for Authorized Representative information.

Appendix 18: Title 22 Level of Care (LOC) Criteria

- Added note: “Citations are only partial quotes from relevant code sections”.

Appendix 19: Level of Care Predetermination

- Updated form name to include “predetermination” to be submitted to CDA for final LOC approval.
- Added categories for basis of LOC:
    - Cognitive and Sensory
    - Diagnoses
    - Functional Status of ADLs/IADLs
    - Additional Information/comments
    - Statement of Attestation

Appendix 19A: LOC Predetermination Example

- New appendix that gives an example of a completed LOC Predetermination form.

Appendix 20: LOC Predetermination with FNAG

- New LOC form that includes a FNAG to be submitted to CDA for final LOC approval.

Appendix 20A: LOC Predetermination with FNAG Examples

- New appendix that gives two examples of completed LOC Predetermination forms with FNAG.

Appendix 21: LOC Reference Guide for MSSP Sites

- This new reference tool provides frequently provided technical assistance for the LOC process. It covers initial and recertification LOC submissions to CDA, package requirements, date classifications, timeframe for review, and other requirements.

Appendix 22: Participant Enrollment/Termination Information Form (PETIF)

- Added check boxes for race and ethnicity types.
- Added explanation of the narrative on termination.

Appendix 23: MSSP Assessment Cover Sheet (Optional)

- Added checkbox for Alternative Discipline Assessment.

Appendix 24: Deinstitutional Services Assessment

- Added admission questions.
- Updates to Section 1:
  - Changed name from “Diagnoses” to “Health-Related Services”.
  - Updated check box list.
  - Removed previous tables and referred to completion of the Initial Health Assessment.
- Section 2 removed with subsequent sections renumbered.
- Updates to Section “Planning Issues for Housing”:
  - Removed “Location”
  - Added “Pest Abatement”, “Fall Prevention”, and “Community Supports (Managed Care Plan)”.
- Added checkbox for attesting that the participant/caregiver was provided with education for transitioning, as well as a signature and date line.

Appendix 25: Initial Health Assessment

- Added Staff Name/Title.
- Removed “(Subjective/Objective)” instructions for comments throughout the assessment.
- Removed checkboxes when a narrative was required.
- Clarified participant’s *reported* appetite.
- Added reminder note for Oral Nutritional Supplements requiring the completion of the Appendix 31: Determine Your Nutritional Health.
- Added additional fields for vital signs, including an optional pain level and a request for an explanation if not taken.
- Added a question for advanced directive with comments.

Appendix 26: Initial Psychosocial Assessment

- Added Staff Signature Date, Staff Name/Title.
- Moved question for apartment manager/neighbor contact information from "Social Network" to "Living Arrangements".
- Reworded questions under Financial, including Authorized Representative and potential money handling challenges.
- Added a new question regarding risk for social isolation.
- Moved the Psychological Functioning form to be incorporated within this form, with some new instructions for when comments are required and when a care manager is unable to complete.
- Updated section regarding home environment and added check boxes for additional problems.
- Added more items in the Special Equipment Checklist:
  - Bathmats for shower/tub
  - Non-slip floor mats
  - Bed cane/rail
  - Ramp
  - Other (Explain in comments)
- Added additional formal services, including Enhanced Care Management and/or Community Support.

Appendix 26: Psychological Functioning Instructions and Definitions

- Added instructions for how to include history of impairment.

Appendix 27: MSSP Reassessment

- Instructions moved and updated to mirror the format of initial assessment instructions, and to "Focus on new information since the last assessment."
- Changed the format of the fields for Name, MSSP #, Reassessment date, Staff Name/title, Staff Signature and Date.
- Added new questions asking which documents were completed with the reassessment.
- Reordered questions for flow and clarity.
- Moved "Home Environment" to be included with "Participant Description." Added check boxes for problems in the home environment.
- Added "Safety and Special Equipment Checklist."
- Added additional question regarding hospitalization, SNF admissions, or ER visits.
- Updated Medications section to include new questions regarding prescriptions or changes in medications.
- Added instruction to complete ADL/IADL question if FNAG is not completed within 30 days of this assessment.
- Updated IHSS/Caregiver question to include number of hours and whether adequate for the participant.
- Added threats of social isolation or withdrawal to "Social Support".

- Renamed “Abuse” section to “Critical Incidents”, added falls, and added a question if incidents were reported on the Critical Incident Report.
- Expanded questions regarding “Finances” and “Formal Services”.
- Removed “Indications for Care Management” section.

Appendix 28: NCM ADV Assessment

- New form to be used by nurse care managers during the alternative discipline visit. This form must be fully completed when the ADV assessment form is submitted instead of the reassessment for LOC recertification.

Appendix 28A: NCM ADV Assessment Example

- New appendix that contains an example of a completed NCM ADV assessment form.

Appendix 29: SWCM ADV Assessment

- New form that is only required when the Social Work Care Manager is the alternate discipline and the ADV is the site’s method for LOC recertification.
- Added note for Question 7. ADL/IADL Functioning Levels, that it is only required to be completed if FNAG is not completed within 30 days of this assessment.

Appendix 30: Functional Needs Assessment Grid

- Added line for Care Manager name and title.
- Removed environmental safety checklist as it is now a separate form.

Appendix 30A: Functional Needs Assessment Grid Instructions

- Updated description of the “Stand-by assist” category in “Transfers” to include assistive devices, and if participant requires assistive device to complete tasks.
- Updated descriptions and examples of the categories in “Toileting”, “Medications”, and “Transportation” for clarity.

Appendix 31: Safety and Special Equipment Checklist.

- Removed this from the FNAG to now be a separate form.
- Added the purpose of the checklist to determine what type of equipment the participant may need.
- Added items to the checklist:
    - Bathmats for shower/tub
    - Non-slip floor mats
    - Bed cane/rail
    - Ramp
    - Other (Explain in comments)

Appendix 32: Participant's Medications

- Updated two columns to include:
  - Expiration Date
  - Comments (covered by Medicare, Discontinued, Interactions, etc.).

Appendix 33: Approved Cognitive Screening Tools

- Added that the Cognitive Screening Tool can be completed with either the Initial Health or the Initial Psychosocial Assessment.
- Added guidance regarding completion of the cognitive screening tool when a participant is unable to complete to due to a diagnosis of Alzheimer's Disease, dementia, or neurodegenerative disease.
- Added links for alternate cognitive screening tools for dementia: FAST, and DSRS.
- Added, "If the participant is unable to complete either tool, the reason must be documented on the assessment or in the progress notes".

Appendix 35: Participants Physicians and Other Health Professionals

- Removed "MSSP Assessment" and "Date Last Seen by HP."
- Added additional tables.

Appendix 36: Institutionalization Form

- Added a "Comments (Optional)" column.

Appendix 37A: Care Plan Instructions

- Clarified that the care plan conference date must be documented on the care plan form but *may also* be documented in the progress notes.
- Added that new needs may be electronically entered on the existing care plan.
- Updated example for using a generic category of services at the onset of an intervention.
- Added recommendation that maximum quantities (monthly) of items/services to be purchased be added to the care plan.
- Under Signatures guidance was given for reviewing the care plan and obtaining verbal acceptance when a site is unable to obtain the participant's signature.
- Added, "The revised care plan must have the PCM and SCM signatures prior to the commencement of any new services".

Appendix 38: Negotiated Health Risk Form

- Updated name fields and added printed name for the signatures required at the bottom of the form.

Appendix 38A: Negotiated Risk Agreement Example A

- Added minor details to the example of a completed Risk Agreement Form.

Appendix 39: SPUS

- Updated formatting and language to now include HCPCS codes, modifiers, and revenue codes.
- Removed "Date Primary Case Manager Discussed Plan Change with Participant".

Appendix 40: Provider Qualifications: Licensure and Certification

- Information updated in Provider Type, License, and Certification columns.
- Updated service names and codes to match Waiver renewal changes:
  - 2.5 "Community Transition Services- Housing and Utility Set-up" has been combined with 2.4 "Community Transition Services-Moving". Ongoing code is 2.4.
  - 3.7 "Supplemental Protective Supervision" has been added to the row for 3.1 and 3.2 since the requirements are the same.
  - 6.4 Transportation now has a reference to the CDA Standard Agreement section for vehicle insurance requirements.

Appendix 41: Vendor Application Form

- Field added to capture the vendor's email.
- Question 13 table was updated, removing "Performance" and "General Fidelity Bond."

Appendix 44: Site Rate Sheet Sorted by Procedure Code

- Removed Z-codes from chart; current version now contains HCPCS codes with modifier(s), revenue codes, new unit types and standardized descriptions.
- Updated service names and codes to match Waiver renewal changes

Appendix 46: Equipment and Property

- Clarified as applicable to equipment/property *purchased with MSSP Waiver funds*.
- Updated Property Acquisition Form reference.

Appendix 50: Requesting an Exemption to Minimum Qualifications for Care Management Staff

- Updated approved fields of study to include public health and health care administration.

Appendix 52: Nurse Care Manager/Social Work Care Manager Exemption Training and Developmental Plan

- Added boxes for Orientee Name/Title and Supervisor Name/Title.

Appendix 53: SWCM – NCM Orientation Checklist

- Updated the following:
  - (2) “Source of information” was removed.
  - (3) Added “Freedom of Choice”.
  - (6) Changed from 2 weeks of enrollment to application.
  - (7) Added Safety and Special Equipment Checklist and removed Summary (optional)
  - (13) Added “Provide necessary referrals, resources, and education”.
  - (18) Added “tracking critical incidents until resolved” and applicant’s choice to receive services via telehealth.

A**ppendix 54: Social Work Care Manager Training and Development Pathway**

- Updated Suggested Courses/Workshops to include fall prevention and mandated reporter training.
- Updated language to include critical incidents in part 7.

Appendix 55: Supervising Care Manager Exemption Training and Development

- Added names boxes for Orientee Name/Title and Supervisor Name/Title.

Appendix 56: Supervising Care Manager Exemption Recommended Orientation checklist

- Updated language regarding mandated reporter and fall prevention training.
- Added clarification to Part 5, (c.) now says “critical” incident reporting.

Appendix 57: Supervising Care Manager Training and Development Pathway

- Added “mandated reporting” to section 9, suggested courses/workshops.

Appendix 58: Utilization Review (UR) Tools

- Updated image to reflect the most current UR Tool