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CHCF Explainer

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Multipurpose Senior Services Program Waiver and Key CalAIM Services

Understanding Overlaps and Gaps

This explainer describes overlaps and gaps between three Medi-Cal programs: the Multipurpose Senior Services Program waiver, Enhanced Care Management, and Community Supports, with the latter two being initiatives of CalAIM (California Advancing and Innovating Medi-Cal). The explainer is part of a series exploring how Community Supports intersect with Medi-Cal home and community-based services (HCBS) waiver and demonstration programs. The series highlights key issues policymakers and stakeholders should consider if responsibility for some HCBS programs shifts from fee-for-service Medi-Cal to managed care plans. Find related explainers on the CHCF website.

Overview of the Multipurpose Senior Services Program Waiver

Description and Goals

The Multipurpose Senior Services Program (MSSP) waiver, one of California's HCBS programs, began as a demonstration project in 1977 and has been a Medicaid 1915(c) waiver program in Medi-Cal since 1983.[1] Through the MSSP waiver, older adult Medi-Cal enrollees can receive care management that helps them live independently at home and avoid placement in a nursing facility. MSSP provides a wide range of health and social services to assist older adults in preventing or delaying institutionalization.[2]

Geographic Reach

Previously, MSSP services were available in 48 of California's 58 counties. The 2024 waiver renewal included authorization for a statewide expansion, but that change has not yet been fully implemented while the state is coordinating with MSSP providers on the expansion.

Eligibility

To be eligible for MSSP, a person must:

- Be a Medi-Cal enrollee age 60 and older
- Meet the state's "level of care" requirements for placement in a nursing facility

The minimum eligible age was lowered from 65 to 60 when the waiver was renewed in 2024, but the state is still in the process of making necessary system changes to support this eligibility update.

Enrollment

During the previous MSSP waiver period (2019-2024), 11,370 waiver slots were available each year. The most recent available enrollment data shows that 11,614 people were enrolled in MSSP in fiscal year 2022-2023. For the current MSSP waiver period (2024-2029), the maximum number of MSSP waiver slots for each year was increased to 11,940.

Sources: *Application for a 1915(c) Home and Community Based Waiver: Multipurpose Senior Services Program* (PDF), California Department of Health Care Services (DHCS), July 1, 2024; and information obtained from California Department of Aging (CDA) leadership team, March 2025.

Note: The state's "level of care" determination must be consistent with the need for institutionalization, per the California Code of Regulations. MSSP Site Manual: Appendix 19 (PDF), CDA, November 2021.

In 2014, under California's Coordinated Care Initiative (CCI), MSSP was "carved in" to Medi-Cal managed care plans in seven counties. Under this arrangement, plans in the seven CCI counties were responsible for processing payments to MSSP providers for their members as well as coordinating referrals and some data sharing, while the state and federal government retained responsibility for waiver administration and oversight. Then, in 2022, MSSP was "carved out" of managed care in six of the seven CCI counties, meaning plans in those counties no longer had responsibility for the program.[3] This MSSP carve-in pilot with CCI counties offers lessons as policymakers consider integrating some HCBS into managed care.

Program Operations

The MSSP waiver is a Medi-Cal program administered by the California Department of Aging (CDA) under an interagency agreement with the California Department of Health Care Services (DHCS). CDA contracts with local government and private nonprofit agencies as MSSP providers to administer the program locally. These MSSP providers offer care management services and administer and pay for additional MSSP waiver services through agreements with local vendors.[4]

MSSP participants receive care management through a team consisting of, at a minimum, a social worker and a nurse. MSSP care management consists of:

- **Assessment:** The social worker and nurse work together as a team to assess a participant's needs through standardized health and psychosocial assessments, which evaluate physical, mental, emotional, and environmental health; social well-being; and unmet needs.[5]
- **Care planning:** The team works with the participant and their family or other designated representative to develop a person-centered care plan. The care plan is revised as the participant's needs change.
- **Service arrangement:** The care management team explores informal supports, community resources, and other publicly funded services, and makes referrals to programs including In-Home Supportive Services (IHSS). If needed services or supplies are unavailable through community resources or publicly funded sources, the care management team can purchase them as waiver services for MSSP participants.[6]
- **Participant monitoring:** At a minimum, the team monitors participants through monthly telephone calls, quarterly face-to-face home or telehealth visits, and annual reassessments.

Included Services

To supplement care management and the coordination of the above services, MSSP providers also subcontract with local vendors or providers to arrange and pay for additional services, including:[7]

- Respite care
- Supplemental homemaker services
- Supplemental personal care services
- Supplemental protective supervision
- Adult day care
- Assistive technology
- Communication devices
- Translation and interpretation services
- Community transition services
- Consultative clinical services
- Counseling and therapeutic services, including money management, social support, therapeutic counseling, and therapeutic services
- Minor home repairs and maintenance
- Specialized non-medical home equipment
- Nutritional services
- Transportation

Room and Board

Waiver participants are required to pay their own room and board expenses.

Overlap and Considerations with Key CalAIM Services

MSSP Waiver Comparison to Enhanced Care Management and Community Supports

The MSSP waiver offers a comprehensive set of supports for older adults. Some of these services overlap with those offered through two key CalAIM programs, Enhanced Care Management (ECM) and Community Supports. ECM provides care coordination for both clinical and non-clinical needs as well as comprehensive care management for individuals with high needs, including older adults with complex health and social needs. Much like an MSSP provider's care management team, an ECM lead care manager coordinates the individual's health care services and links them directly to community-based social services.[8]

However, not all MSSP recipients may qualify for ECM; therefore, if MSSP services were to shift to managed care, the state could consider policy requirements that ensure MSSP recipients maintain equivalent care coordination services and don't face gaps in essential care. In addition, many MCPs authorize ECM for shorter periods of time until their members progress to a lower level of acuity, whereas most MSSP waiver participants require intensive care management for extended periods of time and are not likely to improve or graduate to a lower level of care.

MSSP also has similarities to a subset of Community Supports offered as part of the CalAIM initiative (Table 1).

Table 1. MSSP Waiver Services vs. Community Supports

MSSP WAIVER SERVICES	COMMUNITY SUPPORTS PROGRAMS
Respite care	Respite Services
Homemaker services	Personal Care and Homemaker Services
Personal care	
Community transition services	Community Transition Services/ Nursing Facility Transition to a Home
Minor home repairs and maintenance	Environmental Accessibility Adaptations (Home Modifications)
Nutritional services	Medically Tailored Meals/Medically Supportive Food

Sources: *Application for a 1915(c) Home and Community Based Waiver: Multipurpose Senior Services Program* (PDF), California Department of Health Care Services (DHCS), July 1, 2024; and *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), DHCS, July 2023.

Notes: Personal care and homemaker services in both Community Supports and the MSSP waiver extend beyond any county-approved In-Home Supportive Services (IHSS) hours when additional hours are required and/or if IHSS benefits are exhausted.

While some waiver services share similarities with Community Supports, the definitions and intensity of services can vary. Several key social services provided through MSSP are not available through Community Supports, including:[9]

- Adult day care
- Communication services and devices (e.g., emergency response system devices, translation/interpretation)
- Consultative clinical services (e.g., nutrition counseling, medication training and support, social work visits, telemonitoring of patient, legal/paralegal services)
- Therapeutic services (e.g., physical therapy, activity therapy, foot care)
- Social support
- Non-medical home equipment
- Supplemental protective supervision
- Money management
- Non-medical covered transportation, including escorted transportation

These critical health and social services are not covered by other payers and enable MSSP to assist older adults who qualify for a nursing facility level of care to continue to live independently and safely in the community. Additionally, MSSP services are bundled as a package and administered through one provider, unlike Community Supports, where individual services are typically provided by different organizations and reimbursed separately. In addition, unlike MSSP services, which are provided under fee-for-service Medi-Cal, Community Supports are optional services provided through managed care. This means availability of the services and specific approaches to implementation of the services can vary based on the plan and/or county. Appendix A provides additional information on how MSSP services compare to Community Supports.

Challenges and Opportunities

As California considers integrating some HCBS into managed care, it is important to consider the current challenges of ECM, Community Supports, and MSSP implementation and opportunities for improving service delivery. Challenges and opportunities were identified through a review of literature and interviews with HCBS stakeholders.

MCPs lack experience providing the comprehensive services offered through MSSP. MSSP providers coordinate a robust set of medical and social services, and only some of these services are covered through ECM and Community Supports. The MSSP waiver is for a specific Medi-Cal population: those age 60 and older who are certified for nursing facility level of care, who tend to have multiple chronic conditions and complex needs that lead them to rely on these services to help avoid emergency department visits, hospitalizations, or nursing facility stays. The extra services offered through MSSP — including adult day care, counseling and therapeutic services, and social supports — are critical to enabling older adults to live independently and successfully at home and in their community.

While ECM and Community Supports provide some services that overlap with MSSP, they do not encompass the full range of supports MSSP offers. Even for the services that do overlap, MCPs' levels of experience with implementing ECM and Community Supports vary, and many MCPs have had limited exposure to long-term, ongoing service coordination for populations with complex functional and medical needs. Furthermore, while ECM and Community Supports are often used as time-limited interventions, people served by MSSP typically require sustained, comprehensive support.

Opportunity: If MCPs are to take on a greater role in delivering the full suite of MSSP waiver services, strong partnerships with MSSP providers will be critical. MCPs should leverage MSSP providers' expertise and their established relationships with local community vendors who supply key services and supports, such as home repairs, medical equipment and devices, supplemental personal care, adult day care, and home delivered meals. DHCS and MCPs would need to ensure continued access to these critical social services, particularly for people who may rely on them for years. To support continuity of care if these services shift to managed care, MCPs should, where possible, adopt existing MSSP policies and procedures for serving this population. DHCS could also work with MCPs to develop robust monitoring practices that promote accountability and help prevent service gaps, lapses, or delays in timely access to care.

Most MSSP providers lack the infrastructure and systems needed to meet MCP data and reporting requirements. As most MSSP providers are community-based organizations with limited resources, many have not been able to invest in fully interoperable electronic health record (EHR) systems to manage participant data. While MSSP providers currently report program data to the state, the care management system and/or documentation requirements from MCPs are more extensive than those needed for MSSP administration. Interviewees noted that many

MSSP providers would struggle with the administrative burden of meeting reporting requirements across multiple MCPs, particularly because the operations and interpretations of these requirements would vary across plans.

Opportunity: MCPs could work closely with MSSP providers to better understand and address the challenges they face in adapting to plan operations. Regional collaboration among MCPs to standardize reporting requirements could help reduce administrative burden for providers. DHCS and CDA could streamline requirements and provide resources and technical assistance to MSSP providers to strengthen their reporting capacity and infrastructure. These efforts would align with the state's longer-term goal of ensuring that EHR systems for medical and health-related social supports are interoperable, enabling providers and plans to seamlessly share and exchange data to improve care.

The previous carve-in of MSSP into managed care created confusion and implementation challenges for some MSSP providers and MCPs, leading to reluctance from both to collaborate again. The prior managed care carve-in and subsequent carve-out of MSSP in CCI counties highlighted several challenges. MCPs had limited experience with the intent and structure of the MSSP care model, which is designed to help people age in place through a long-term care management program. MSSP providers struggled with the administrative burden of working with multiple plans, each with different processes and expectations. Interviewees noted significant challenges in collaboration between MCPs and MSSP providers, including confusion over roles and administrative complexities. For example, because providers had flexibility to purchase needed waiver services under fee-for-service Medi-Cal, some struggled with MCP authorization processes for purchased services during the carve-in.

Opportunity: DHCS and CDA can apply lessons learned from the earlier experience of carving MSSP into managed care in CCI counties when shaping policy for any future transition of MSSP waiver services into managed care. Interviewees suggested that standardizing MCP operations — including eligibility and reporting definitions, authorization forms, provider portals, and payment mechanisms — could help reduce administrative burdens for providers. Clear guidelines on whether the plan or provider is responsible for approving and purchasing certain services would be needed. MCPs and/or DHCS could also consider establishing a list of pre-approved purchased services to ensure timely access and prevent administrative delays.

Interviewees also suggested that transparency and information exchange — including visibility into MSSP enrollment status for MCPs, MSSP providers, and other medical providers — could improve coordination and provider support. Strengthening these communication pathways would help facilitate meaningful co-management and improved care for enrollees. Furthermore, MCPs could build upon the strengths of MSSP's operational model by collaborating with MSSP providers in ways that reinforce the trust these providers have established within local communities. Proactively defining roles and responsibilities ahead of any transition would help ensure smoother implementation and stronger partnerships between plans and providers.

Member Case Study

Juana is an 81-year-old bilingual Latina whose preferred language is Spanish. She owns a single-family home in Los Angeles and lives with her daughter and granddaughter. Juana has multiple chronic conditions which require several prescribed medications and continuous oxygen support. In the past year, she had three emergency department visits and two hospitalizations. Her daughter and granddaughter have assisted her as much as they can but have felt overwhelmed at times.

During her last hospitalization, a hospital social worker referred Juana to MSSP. Juana qualified for MSSP due to her age, Medi-Cal coverage, and health conditions, which include congestive heart failure, hypertension, cognitive deficits from Alzheimer's disease, and the need for assistance with activities of daily living. After 10 weeks on the waitlist, the MSSP care management team met Juana at her home to assess her strengths, deficits, relevant history, and unmet needs in order to develop a person-centered care plan and determine appropriate interventions.

Juana agreed to a care plan focusing on health, safety and fall prevention, and personal care needs, including interpreter services for communications with non-Spanish speaking staff; supplemental personal care and homemaker services; in-home therapeutic counseling; incontinence supplies; and bathroom safety equipment, including grab bars, to support fall prevention. Her care team assisted with hiring an IHSS caregiver, ensured interventions were received as planned and to Juana's satisfaction, and educated Juana on injury prevention. She also received monthly phone calls and quarterly home visits by her care team. Additionally, every 12 months, the care team reassessed Juana and developed a new care plan.

The care management team built a relationship with Juana and her family, serving as a trusted resource as her health and social service needs evolved. Along with support from her family caregivers, Juana was able to remain safely at home and in her community. The care team served a critical role for Juana and acted as a coach; counselor; resource connector; and advocate for health-related social needs, public benefits, family dynamics, socialization, and other needs.

Transitioning MSSP waiver services to ECM and Community Supports through Medi-Cal MCPs could offer Juana some of the services and supports she needs without requiring that she first spend time on a waitlist. However, MCPs would need to learn about the complex needs of MSSP recipients, including the essential health and social service supports needed to allow the recipients to live safely in their own homes. This would include offering the same set of robust services as MSSP (not currently possible through Community Supports) and providing ECM on a long-term basis to ensure that there are no service gaps for recipients like Juana. To mitigate against potential service gaps, MCPs should utilize MSSP providers' robust care management approach and relationships with local vendors. This would help promote timely access to services for MSSP recipients and their families.

Appendix A. Comparison of Multipurpose Senior Services Program Waiver to Relevant Community Supports

MSSP and Enhanced Care Management: Appendix A compares MSSP to Community Supports but does not offer direct comparisons between MSSP and Enhanced Care Management (ECM), due to the complexity of displaying information on eligibility, services, and providers for ECM's nine distinct Populations of Focus in this table format. As the state considers how MSSP services might be integrated into Medi-Cal managed care, it is important to understand the similarities and differences between MSSP care management and ECM. Currently, MSSP waiver recipients cannot receive ECM because both programs offer comprehensive care management. While Medi-Cal members who qualify for MSSP may qualify for ECM through one of the Populations of Focus (most likely either At-Risk for Institutionalization and Eligible for Long-Term Care, or Nursing Facility Residents Transitioning to Community), not every MSSP-eligible Medi-Cal member may qualify for ECM. In addition, while MSSP is an ongoing, continuous waiver program with an annual reassessment, ECM is initially authorized for 12 months. Following reauthorizations every 6 months, members may be reassessed at the ECM provider's discretion to determine whether they achieved the care plan goals and therefore should "graduate" from ECM.

	CURRENT HCBS WAIVER	COMMUNITY SUPPORTS*					
CHARACTERISTICS	MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)	PERSONAL CARE AND HOMEMAKER SERVICES	COMMUNITY TRANSITION SERVICES/NURSING FACILITY TRANSITION TO HOME	HOUSING BUNDLE†	MEDICALLY TAILORED MEALS/ MEDICALLY SUPPORTIVE FOOD	RESPITE SERVICES	ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (HOME MODIFICATIONS)
Eligibility	**Local MSSP providers screen potential waiver participants to determine eligibility. To be eligible, participants must be:** ▸ Certifiable for placement in nursing facility ▸ Age 60 and older ▸ Eligible for Medi-Cal ▸ Within expected service cost limitations‡ ▸ Appropriate for care management services but not receiving Medi-Cal ECM or TCM services§ **Waiver slots are limited to 11,940 per year and provided based on "imminent need" for services.**‖	**Medi-Cal enrollees of all ages who either:** ▸ Are at risk for hospitalization or institutionalization in NF, or ▸ Have functional deficits and no other adequate support system, or ▸ Are approved for IHSS If not already approved for IHSS, **enrollees must be referred to the IHSS program** when they meet referral criteria. This service cannot be used in lieu of referring to IHSS. It can be used to supplement IHSS beyond approved hours, during a waiting period before receiving IHSS, or for up to 60 days following an IHSS denial.	**Enrollees of all ages who:** ▸ Are receiving medically necessary NF LOC services and choosing to transition home to continue receiving NF LOC services and ▸ Have lived 60+ days in a nursing home and/or medical respite setting ▸ Are interested in moving back to the community ▸ Are able to reside safely in the community with appropriate and cost-effective supports and services ▸ Need to transition to ensure their health, welfare, and safety; without it, they would require re-institutionalization **No established lease or ownership in enrollee's name is required.**	**Enrollees of all ages are prioritized through the local homeless Coordinated Entry System to identify highly vulnerable enrollees who:#** ▸ Have disabilities, or ▸ Have one or more serious chronic conditions and/or serious mental illness, or ▸ Are institutionalized or require residential services due to SUD, or ▸ Are exiting incarceration **Enrollees who meet the HUD definition of homelessness,** are enrolled in ECM, and meet one of the eligibility criteria above.** **Enrollees who meet the HUD definition of at risk of homelessness**,††**	**Enrollees of all ages with chronic conditions or other serious health conditions that are nutrition sensitive, including:** ▸ Cancer ▸ Cardiovascular disorders ▸ Chronic kidney disease ▸ Pulmonary conditions ▸ Congestive heart failure ▸ Diabetes or other metabolic conditions ▸ HIV ▸ Chronic or disabling mental/behavioral health disorders **Other entry points for referral include:** ▸ Enrollees being discharged from an acute hospital or NF ▸ Those with high risk of hospitalization or NF placement ▸ Those with extensive care coordination needs	**Enrollees of all ages who:** ▸ Live in the community ▸ Are compromised in their ADLs ▸ Are dependent on a qualified caregiver for support to avoid institutional placement‡‡	**Enrollees of all ages who are at risk of institutionalization in an NF**

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Services§§	**Services provided by MSSP provider care management staff include:** ▸ Annual standardized health and psychosocial assessments ▸ Development of an individualized care plan to meet health and other needs ▸ Arranging for needed services ▸ Monitoring well-being ▸ Advocacy **Services provided by qualified service providers in coordination with the MSSP provider include:** ▸ Respite care ▸ Supplemental homemaker, personal care, and protective supervision services‖‖ ▸ Adult day care ▸ Assistive technology ▸ Communications services, including 24-hour emergency communication and assistance services and translation/ interpretation services (*continues next page*)	**Same as IHSS program, which includes:** ▸ Cleaning, meal preparation, laundry, grocery shopping ▸ Personal care services (e.g., bowel/bladder care, bathing grooming, paramedical services) ▸ Accompaniment to medical appointments ▸ Protective supervision for those who are mentally impaired	**Services are provided under two distinct components** **1) Time-limited transition services and expenses, including:** ▸ Assessing enrollee housing needs ▸ Assisting with the search, application, and documentation needed for housing ▸ Coordinating move with landlord ▸ Establishing procedures and contacts to retain housing ▸ Securing or funding transportation to assist mobility (non-emergency, non-medical) ▸ Identifying need and coordinating funding for home modifications **2) One-time set-up expenses, including:** ▸ Security deposits required to obtain a lease on an apartment or home ▸ Set-up fees for utilities or service access and up to six months payment in arrears (phone, electricity, heating, and water) (*continues next page*)	**Housing Transition Navigation Services,††† which include:** ▸ Tenant screening and housing assessment services ▸ Individualized housing support plans ▸ Application assistance ▸ Benefits advocacy (e.g., SSI eligibility, application) ▸ Resource identification (e.g., HUD Section 8, state and local assistance programs) ▸ Communication and advocacy support with landlords **Housing Deposits fund one-time services and modifications, such as:** ▸ Medically necessary adaptive aids and services (e.g., air conditioning, heaters, hospital beds, Hoyer lifts) ▸ Apartment security deposits ▸ Utility set-up fees and deposits ▸ First and last month's rent for tenancy occupation (*continues next page*)	**Medically Tailored Meals (MTM) and Groceries must:** ▸ Follow nutrition assessment conducted by an RDN ▸ Meet two-thirds of enrollee's daily nutrient/energy needs as estimated by the RDN/clinician ▸ Not contain ultra-processed foods or excess sugar or salt **Medically Supportive Food (MSF):** ▸ Adheres to national nutritional guidelines for nutrition-sensitive conditions ▸ Consists of supplemental food packages tailored to the enrollee's diet (and are not intended to replace meals) ▸ Is designed and signed off by an RDN or appropriate clinician **Nutritional Education services:** ▸ Include health coaching, counseling, classes, and behavioral supports vetted by an RDN (*continues next page*)	**Services provided are not medical in nature. Instead, they include attending to:** ▸ Basic self-help needs ▸ ADLs ▸ Usual daily routines provided by the caregivers ▸ Interaction/socialization **Services may be provided as follows:** ▸ On an hourly or episodic basis, or overnight when usual caregivers need relief ▸ In the home of the care recipient ("in-home respite") ▸ In an approved out-of-home location ("facility respite") **The following service restrictions and limitations apply:** ▸ Respite Services in combination with any direct care (*continues next page*)	**Physical home adaptations necessary to ensure health, welfare, and safety, including:** ▸ Ramps and grab-bars ▸ Widening doorways for wheelchairs ▸ Stair lifts ▸ Bathroom and shower wheelchair accessibility ▸ Specialized electrical and plumbing systems for necessary medical equipment ▸ PERS installation and testing **The following service restrictions and limitations apply:** ▸ State Plan services like DME should be used if they are available and accomplish the goals of having independence and avoiding institutional placement (*continues next page*)

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Services§§ (continued)	➤ Community transition services (from SNF to home)## ➤ Consultative clinical services ➤ Counseling and therapeutic services ➤ Home repairs and maintenance (minor) ➤ Money management ➤ Nutritional services ➤ Social support ➤ Specialized non-medical home equipment ➤ Transportation ➤ Supplemental protective supervision *(These services do not have a lifetime limit but annual service cost limits apply.)*		➤ Air conditioner or heater ➤ Adaptive aids to preserve health, such as hospital beds and Hoyer lifts ➤ Pest eradication and one-time cleaning prior to occupancy **The following service restrictions and limitations apply:** ➤ Non-recurring set-up expenses for enrollees transitioning from an NF to a private residence in the community are payable up to a total lifetime maximum amount of $7,500***	➤ First month utilities coverage (i.e., phone, gas, electricity, heating, water) ➤ Pest eradication and cleaning of premises **Housing Tenancy and Sustaining Services include:** ➤ Identification of behaviors that risk housing (e.g., late payment, hoarding, substance use) ➤ Tenants' rights education ➤ Coaching for relationships with property managers and landlords ➤ Coordination with case managers and landlords ➤ Dispute resolution assistance	➤ Do not alone constitute delivery of this Community Support **The following service restrictions and limitations apply:** ➤ Maximum two meals per day ➤ Maximum 12 weeks MTM/ MSF (longer if medically necessary) ➤ Meals eligible for or reimbursed by other programs are not eligible for this program ➤ Meals are not covered if they respond solely to food insecurity	services the enrollee is receiving may not exceed 24 hours per day of care or 336 hours a year ➤ This service is only to avoid placements for which the MCP would be responsible ➤ Services cannot be provided virtually	➤ Maximum lifetime of $7,500, exceptions apply‡‡‡ ➤ Modifications do not include adaptations or improvements to general utility of the household ➤ The state is not responsible for maintenance/repair/ removal of any modification if the enrollee ceases to reside at the residence

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Providers§§§	**MSSP Provider Agency Staff:** ▸ Social work care manager ▸ Nurse care manager **Contracted Providers:‖‖‖‖** ▸ Home care organizations ▸ Adult day care providers ▸ Congregate meal sites ▸ Home delivered meal providers ▸ Individual translators/ interpreters ▸ Public or private utility companies ▸ Social, legal, and health care professionals ▸ Individual money managers ▸ Building contractors/ handymen ▸ Licensed/certified social workers, counselors, therapists, psychologists and psychiatrists ▸ Dance therapists ▸ Exercise/physical fitness trainers ▸ Music therapists ▸ Ambulance, wheelchair van, or paratransit agencies List of MSSP Providers	**Providers listed below are not exhaustive; providers must have experience with the required services.** ▸ Home health agencies ▸ Personal care agencies ▸ County agencies ▸ Area Agencies on Aging	**Providers listed below are not exhaustive; providers must have experience with the required services.** ▸ CCT/Money Follows the Person providers ▸ Case management agencies ▸ Home health agencies ▸ County behavioral health providers ▸ 1915(c) HCBA/ALW providers	**Providers listed below are not exhaustive; providers must have experience with the required services.** ▸ Vocational service agencies ▸ Service providers for enrollees experiencing homelessness ▸ County agencies ▸ Public hospital systems ▸ Mental health or SUD treatment providers ▸ Social services agencies ▸ Affordable housing providers ▸ Supportive housing providers ▸ Federally Qualified Health Centers and Rural Health Clinics	**Providers listed below are not exhaustive; providers must have experience with the required services.** ▸ MTM providers ▸ MSF and nutrition providers (produce prescription service providers) ▸ Medically tailored or supportive grocery providers (food banks) ▸ Home delivered meal providers ▸ Area Agencies on Aging ▸ Nutrition education providers to help sustain healthy cooking and eating habits	**Providers listed below are not exhaustive; providers must have experience with the required services.** ▸ Home health agencies ▸ Respite agencies ▸ Congregate living health facilities ▸ Providers contracted by county behavioral health ▸ Adult family home/ family teaching home ▸ Certified family homes for children ▸ County agencies ▸ RCFEs	**Providers listed below are not exhaustive; providers must have experience with the required services.** ▸ Local health departments ▸ Community-based providers and organizations ▸ Area Agencies on Aging **Home Modifications that are physical adaptations to a residence must be performed by an individual holding a California contractor's license (except for a PERS installation).**

Source: Authors' analysis of multiple sources, including 1915(c) approved state waiver application, regulations, and California Department of Health Care Services (DHCS) policy guidance.

Notes: This information is not exhaustive but aims to provide an illustrative and comparative understanding of the potential options available to Medi-Cal enrollees who could benefit from home and community-based services. For a comprehensive understanding of program policy and guidance, please refer to official DHCS documents for detailed program requirements, processes and procedures. *ADL* is activity of daily living; *ALW* is Assisted Living Waiver; *CCT* is California Community Transitions; *DME* is durable medical equipment; *ECM* is Enhanced Care Management; *HCBA* is Home and Community-Based Alternatives waiver; *HCBS* is home and community-based services; *HUD* is Department of Housing and Urban Development (federal); *ICF/DD* is Intermediate Care Facility for Developmentally Disabled; *IHSS* is In-Home Supportive Services; *LCSW* is licensed clinical social worker; *MCP* is managed care plan; *NF* is nursing facility; *NF LOC* is nursing facility level of care; *PERS* is Personal Emergency Response System; *RCFE* is Residential Care Facility for the Elderly; *RDN* is registered dietitian nutritionist; *RN* is registered nurse; *SSI* is Social Security Insurance; *SUD* is substance use disorder; *TCM* is Targeted Care Management.

* In February 2025, DHCS released the Community Supports: Select Service Definition Updates for select Community Supports, including Community Transition Services/Nursing Facility Transition to Home and Medically Tailored Meals/Medically Supportive Food. Chart information for these Community Supports have been updated accordingly. These policy changes are effective July 2025 and will be amended in a future update to the Community Supports Policy Guide.

† Housing Bundle refers to the "Housing Trio" of Community Supports (Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services).

‡ The waiver describes the need to consider an enrollee's expected ongoing costs when considering enrollment.

§ MSSP applicants must not simultaneously receive Enhanced Care Management Services or Targeted Care Management through the county or their MCP. *Application for a §1915(c) Home and Community-Based Services Waiver* (PDF), DHCS, 2024.

‖ The state determines slot allotment using a need-based formula. Counties with a higher percentage of need can be allotted additional slots. Statewide waitlist policy includes methods to assign priority enrollment based on the applicant's identified needs and risk for poor outcomes.

For a comprehensive description of Housing Bundle eligibility requirements by age, see: *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), DHCS, July 2023.

** Enrollees who meet the HUD definition of homeless or at-risk for homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (24 CFR § 91.5).

†† Those who are "at-risk of homelessness" are eligible for Housing Transition Navigation Services and Housing Tenancy and Sustaining Services, but not for Housing Deposits.

‡‡ Other subsets may include children who previously were covered for respite services under the Pediatric Palliative Care Waiver, foster care program beneficiaries, enrollees in either California Children's Services or the Genetically Handicapped Persons Program (GHPP), and members with complex care needs. *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), DHCS, July 2023.

§§ Services provided under Community Supports must supplement, not supplant, services received through state, local, or federally funded programs.

‖‖ Supplemental Homemaker Services under the MSSP Waiver are limited to additional services not otherwise covered under the state plan or under IHSS, but consistent with the waiver objectives of avoiding institutionalization. This service is for purposes of household support for those services above and beyond those available through the State Plan when the regular IHSS provider is not available and IHSS cannot provide a substitute.

Eligible waiver participants are those who reside in a facility/institution or care provider-owned residence and are transitioning from a facility/institution to their own home or apartment in the community where the participant is directly responsible for his or her own living expenses. *Application for a §1915(c) Home and Community-Based Services Waiver* (PDF), DHCS, 2024.

*** The only exception to the $7,500 maximum is if the enrollee is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond their control.

††† Housing Transition Navigation Services and Housing Tenancy Sustaining Services are also available to transition-age youth with significant barriers to housing stability.

‡‡‡ The only exceptions to the $7,500 total maximum are if the enrollee's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the enrollee, or are necessary to enable the enrollee to function with greater independence in the home and avoid institutionalization or hospitalization.

§§§ Community Supports availability varies by county and MCP. Information on MCP contracts with Community Support providers is available from DHCS. As of publication of this table, DHCS last updated the data in March 2025.

‖‖‖ Contractors can be private nonprofits or proprietary agencies with a local California business license.

About the Authors

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About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. Multipurpose Senior Services Program (MSSP) Site Manual: Chapter 1 (PDF), California Department of Aging (CDA), November 2021.
2. *Application for a 1915(c) Home and Community Based Waiver: Multipurpose Senior Services Program* (PDF), California Department of Health Care Services (DHCS), July 1, 2024.
3. San Mateo County kept MSSP as a managed care plan benefit, while the other CCI counties carved the benefit out in 2022.
4. *Application: MSSP Waiver*, DHCS. Care Management in MSSP also includes care management for those transitioning from institutions, allowing care management to begin up to 180 consecutive days prior to an individual's discharge from an institution. As well, if and when successfully transitioned, that person may enroll in the waiver as a regular MSSP participant.
5. The psychosocial assessment, as defined in the MSSP Site Manual, includes assessing an individual's living arrangements, financial status, family and social network and support system, and environmental safety.
6. *Application: MSSP Waiver,* DHCS.
7. *Application: MSSP Waiver,* DHCS.
8. *CalAIM Enhanced Care Management Policy Guide* (PDF), DHCS, August 2024.
9. MSSP Site Manual: Appendix 42 HCPCS Billing Codes (PDF), CDA, September 2023.