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California Advancing and Innovating Medi-Cal (CalAIM) Community Supports Fact Sheet

A key feature of CalAIM is the statewide introduction of a new menu of 14 Community Supports, which, at the option of a Medi-Cal managed care health plan (MCP) and a member, can substitute for covered Medi-Cal services as cost-effective alternatives. A key goal of Community Supports is to allow Members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate. Community Supports build on Whole Person Care (WPC) and Health Homes Program (HHP) efforts and expand access to services that were previously available only through home and community-based services initiatives while addressing health-related social needs. Contra Costa Health Plan (CCHP) will develop a network of providers that have the expertise and capacity to provide the above services for its members. CCHP is looking to partner with Community Based Organizations (CBO) and providers for Community Supports.

Effective January 1, 2022, CCHP offers the following DHCS approved CS services:

1. Housing Transition Navigation Services
2. Housing Tenancy and Sustaining Services
3. Short-Term Post-Hospitalization Housing
4. Recuperative Care (Medical Respite)
5. Medically Tailored Meals/ Medically Supportive Food
6. Asthma Remediation

Effective July 1, 2022, CCHP offers the following DHCS approved CS services:

7. Housing Deposits

Effective October 1, 2023, CCHP offers the additional DHCS approved CS services:

8. Respite Services
9. Personal Care and Homemaker
10. Environmental Accessibility Adaptations (Home Modifications)
11. Nursing Facility Transition/Diversion to RCFE/ARF
12. Community Transition Services/Nursing Facility Transition to a Home

Effective July 1, 2024, CCHP offers the additional DHCS approved CS services:

13. Day Habilitation
14. CCHP is currently electing not to provide Sobering Centers currently.

Additional information on each Community Supports service is provided below.

Housing Transition Navigation Services

Overview

Housing transition navigation services assist members with obtaining housing and include screenings, development of housing support plans, assistance in housing searches and securing housing, identification and education surrounding housing finances, communications with landlords, move coordination, and more. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

Eligibility Criteria

a. Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System; or

b. Individuals experiencing homelessness:
    i. Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; and
    ii. Who are receiving enhanced care management (ECM); or
    iii. who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization; or
    iv. requiring residential services because of a substance use disorder.

c. Individuals at risk of homelessness:
    i. Individuals at risk for homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations as:
        1. Has an annual income below 30 percent of median family income for the area, as determined by HUD; and
        2. Does not have sufficient resources or support networks, immediately available to prevent them from becoming homeless; and
            a. Meets one of the following conditions:
                i. Has moved because of economic reasons two or more times in the last 60 days, or living in the home of another because of economic hardship, or has been notified in writing that their current housing will be terminated within 30 days.
            b. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations, federal, State, or local government programs for low-income individuals; or
            c. Lives in a single-room occupancy or efficiency apartment in which there are more than 2 persons or lives in a larger housing unit in which there are more than 1.5 people per room; or
            d. Lives in housing that has characteristics associated with instability and increased risk of homelessness, as identified in the recipient's approved consolidated plan.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive housing transition navigation services if they have significant barriers to housing stability and meet at least one of the following:

1) Have one or more serious chronic conditions; or
2) Have a severe mental illness; or
3) Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents); or
4) Are receiving Enhanced Care Management; or
5) Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions/Limitations

a. Member may not receive duplicate support from other State, local, or federally funded programs.

Licensing/Allowable Providers

Providers must have demonstrated experience with providing housing-related services and supports. Examples of such providers include:

1) Vocational services agencies
2) Providers of services for individuals experiencing homelessness
3) Life skills training and education providers
4) County agencies
5) Public hospital systems
6) Mental health or substance use disorder treatment providers, including county
7) behavioral health agencies
8) Social services agencies
9) Affordable housing providers
10) Supportive housing providers
11) Federally qualified health centers and rural health clinics

Housing Deposits

Overview

The housing deposits program assists with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household. This includes security deposits, set-up fees/deposits for utilities, or first-and-last months' rent as required by landlord for occupancy. The services will be based on individualized assessment of needs and documented in the individualized housing support plan.

Eligibility Criteria

a. Any individual who has received housing transition navigation services Community Support in counties that offer housing transition navigation services; or

b. Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system; or

c. Individuals experiencing homelessness:
    i. Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; and
    ii. Who are receiving enhanced care management (ECM); or
    iii. who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization; or
    iv. requiring residential services because of a substance use disorder.

d. Must provide income and housing subsidy verification if applicable:
    i. Verification of income can include but is not limited to SSI/SSDI income verification letter, most recent 2 months of pay stubs, self-attestation, or cash aid award letter.
    ii. Section 8 voucher or other housing subsidy letter stating member's portion of rent.

Restrictions/Limitations

a. Housing deposits are available once in an individual's lifetime, up to $5000. Housing deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing housing deposits would be more successful on the second attempt.
b. To assess the viability of a housing plan, CCHP will use a rent-to-income ratio of 40% as a benchmark of affordability. This benchmark will guide CCHP's review, and ultimately all housing deposit requests will be considered on case-by-case basis, including consideration of all contextual factors and resources available to the member. Housing navigator must submit supporting statement for consideration.
c. These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the member is unable to meet such expense.
d. Individuals must also receive Housing Transition Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.
e. Member may not receive duplicate support from other State, local, or federally funded programs.

Licensing/Allowable Providers

The entity that is coordinating an individual's housing transition navigation services, or the Medi-Cal managed care plan case manager, care coordinator, or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services. Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Housing and Tenancy Sustaining Services

Overview

Housing tenancy and sustaining services are provided with a goal of maintaining safe and stable tenancy once housing is secured. Individual services include identification, education, and intervention surrounding behaviors and needs that may jeopardize housing, assistance and advocacy surrounding disputes and finances, health, and safety visits, and more.

Eligibility Criteria

a. Any individual who has received Housing Transition/Navigation Services Community Support in counties that offer Housing Transition/Navigation Services; or

b. Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system; or

d. Individuals experiencing homelessness:
    i. Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; and
    ii. Who are receiving enhanced care management (ECM); or
    iii. who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization; or
    iv. requiring residential services because of a substance use disorder.

c. Individuals at risk of homelessness:
    i. Individuals at risk for homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations as:
        1. Has an annual income below 30 percent of median family income for the area, as determined by HUD; and
        2. Does not have sufficient resources or support networks, immediately available to prevent them from becoming homeless; and
            a. Meets one of the following conditions:
                i. Has moved because of economic reasons two or more times in the last 60 days, or is living in the home of another because of economic hardship, or has been notified in writing that their current housing will be terminated within 30 days.
            b. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations, federal, State, or local government programs for low-income individuals; or

c. Lives in a single-room occupancy or efficiency apartment in which there are more than 2 persons or lives in a larger housing unit in which there are more than 1.5 people per room; or
d. Lives in housing that has characteristics associated with instability and increased risk of homelessness, as identified in the recipient's approved consolidated plan.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing and Tenancy Sustaining Services if they have significant barriers to housing stability and meet at least one of the following:

1) Have one or more serious chronic conditions; or
2) Have a severe mental illness; or
3) Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents); or
4) Are receiving Enhanced Care Management; or
5) Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions/Limitations

a. Members who have previously received Housing and Tenancy Sustaining Services Community Support unless good cause is shown as to why additional services would be beneficial and indicated and that member did not lose previous housing due to unwillingness to cooperate in good faith with necessary actions required for housing and tenancy sustaining services.
b. Member may not receive duplicate support from other State, local, or federally funded programs.

Licensing/Allowable Providers

Providers must have demonstrated experience with providing housing-related services and supports. Examples of such providers include:

1) Vocational services agencies
2) Providers of services for individuals experiencing homelessness
3) Life skills training and education providers
4) County agencies
5) Public hospital systems
6) Mental health or substance use disorder treatment providers, including county
7) behavioral health agencies
8) Social services agencies
9) Affordable housing providers
10) Supportive housing providers
11) Federally qualified health centers and rural health clinics

Short-Term Post-Hospitalization Housing

Overview

Short-term post-hospitalization housing will provide members the opportunity to continue medical/psychiatric/substance use disorder recovery in a housed setting with necessary supports for recuperation and recovery.

Eligibility

a. Must be ≥ 18 years old; and

b. Exiting recuperative care; or

c. Exiting an inpatient hospital stay, long-term care facility, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, skilled nursing facility (SNF), or emergency department (ED) and who meet any of the following criteria:
   i. Individuals experiencing homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution); and
   ii. Who are receiving enhanced care management (ECM); or
   iii. Who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services because of a substance use disorder.

d. Have high medical or behavioral needs with the opportunity to continue medical/psychiatric/substance use disorder recovery while residing in this housing thereby likely preventing hospitalization or rehospitalization; and

e. Benefit from ongoing supports for recuperation and recovery and beginning to access other housing supports, such as housing transition navigation; and

f. Must agree to housing transition navigation supports to prepare them for transition from this setting.

B. Individuals at risk of homelessness:
   i. Individuals at risk for homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations as:
      1. Has an annual income below 30 percent of median family income for the area, as determined by HUD; and
      2. Does not have sufficient resources or support networks, immediately available to prevent them from becoming homeless; and
         a. Meets one of the following conditions:
            i. Has moved because of economic reasons two or more times in the last 60 days, or is living in the home of another

because of economic hardship, or has been notified in writing that their current housing will be terminated within thirty (30) days.

b. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations, federal, State, or local government programs for low-income individuals; or
c. Lives in a single-room occupancy or efficiency apartment in which there are more than 2 persons or lives in a larger housing unit in which there are more than 1.5 people per room; or
d. Lives in housing that has characteristics associated with instability and increased risk of homelessness, as identified in the recipient's approved consolidated plan.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization Housing if they have significant barriers to housing stability and meet at least one of the following:

1) Have one or more serious chronic conditions; or
2) Have a severe mental illness; or
3) Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents); or
4) Are receiving Enhanced Care Management; or
5) Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions/Limitations

b. Member must not have financial means to go elsewhere (e.g. motel/hotel/SRO, etc.)
c. Member may not be receiving duplicate support from other State, local, or federally funded programs.
d. Members who have previously received Short-Term Post-Hospitalization Housing Community Support if they did not cooperate in good faith with housing transition navigation services and housing and tenancy sustaining services, as provided.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

1) Interim housing facilities with additional on-site support
2) Shelter beds with additional on-site support
3) Converted homes with additional on-site support
4) County directly operated or contracted recuperative care facilities
5) Supportive housing providers
6) County agencies

7) Public hospital systems
8) Social service agencies
9) Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short term post-hospitalization housing.

Recuperative Care (Medical Respite)

Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management, and other supportive social services, such as transportation, food, and housing. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

Eligibility Criteria

a. Must be ≥ 18 years old; and

b. Must be able to live independently with no formal supports (e.g. 24/7 supervision); and
c. Exiting an inpatient hospital stay, long-term care facility, or skilled nursing facility (SNF), or at risk for of hospitalization; and

d. Not medically appropriate for a SNF (does not meet InterQual/Apollo guidelines based on acuity); and

e. Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification; and

f. Have a defined home health skilled need that is appropriate for respite and can be effectively addressed ≤ 6 weeks, such as:
    i. Physical therapy, occupational therapy, or speech therapy
    ii. Wound Care

g. Medically appropriate for respite, including:
    i. Have at least one COVID-19 vaccination two weeks prior to admission and/or COVID-19 infection within the last 90 days with COVID-19 vaccine on admission.
    ii. Must be able to perform all activities of daily living independently, including taking own medications.
    iii. Must be independently mobile and able to self-transfer in and out of bed.
    iv. Must be independent with wound care, or need assistance less than 4 times a week, or have home health nursing provided.

v. Must be continent of urine and stool.
vi. Must not have received benzodiazepine for alcohol withdrawal in past 24 hours.
vii. Must be alert and oriented.
viii. Must be medically and behaviorally appropriate for a group setting.

e. Individuals experiencing homelessness:
    i. Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; and
    ii. Who are receiving enhanced care management (ECM); or
    iii. who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization; or
    iv. Requiring residential services because of a substance use disorder.

h. Individuals at risk of homelessness:
    i. Individuals at risk for homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations as:
        1. Has an annual income below 30 percent of median family income for the area, as determined by HUD; and
        2. Does not have sufficient resources or support networks, immediately available to prevent them from becoming homeless; and
            a. Meets one of the following conditions:
                i. Has moved because of economic reasons two or more times in the last 60 days, or is living in the home of another because of economic hardship, or has been notified in writing that their current housing will be terminated within 30 days.
            b. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations, federal, State, or local government programs for low-income individuals; or
            c. Lives in a single-room occupancy or efficiency apartment in which there are more than 2 persons or lives in a larger housing unit in which there are more than 1.5 people per room; or
            d. Lives in housing that has characteristics associated with instability and increased risk of homelessness, as identified in the recipient's approved consolidated plan.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Recuperative Care (Medical Respite) if they have significant barriers to housing stability and meet at least one of the following:

1) Have one or more serious chronic conditions; or
2) Have a severe mental illness; or
3) Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents); or

4) Are receiving Enhanced Care Management; or
5) Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions/Limitations

a. Member may not be receiving duplicate support from other State, local, or federally funded programs.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

1) Interim housing facilities with additional on-site support
2) Shelter beds with additional on-site support
3) Converted homes with additional on-site support
4) County directly operated or contracted recuperative care facilities

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained.

Respite Services

Overview

Respite services are provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from recuperative care (medical respite) and is rest for the caregiver only provided to the member in his or her home or another location being used as the home. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

Eligibility

a. Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Exclusions/Limitations

a. In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.
b. Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode.

c. Respite services cannot be provided virtually, or via telehealth.
d. This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.
e. Member may not receive duplicate support from other State, local, or federally funded programs.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

1) Home health or respite agencies that provide services in:
   a) Private residence
   b) Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
   c) Providers contracted by county Behavioral Health
2) Other community settings that are not a private residence, such as:
   a) Adult Family Home/Family Teaching Home
   b) Certified Family Homes for Children
   c) County Agencies
   d) Residential Care Facility for the Elderly (RCFE)
   e) Child Day Care Facility; Child Day Care Center; Family Child Care Home
   f) Respite Facility; Residential Facility: Small Family Homes (Children Only)
   g) Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
   h) Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
   i) Respite Facility; Residential Facility: Group Homes (Children Only)
   j) Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
   k) Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
   l) Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)
   m) Short-term Residential Therapeutic Program Providers or other care providers who are serving youth with complex needs
   n) Community-Based Adult Services (CBAS) Facilities/Providers

Day Habilitation Programs

Overview

Day Habilitation Program services include, but are not limited to, training on the use of public transportation; personal skills development in conflict resolution; community participation; developing and maintaining interpersonal relationships; daily living skills (cooking, cleaning, shopping, money management); and community resource awareness such as police, fire, or local services to support independence in the community. Programs may include assistance with, but not limited to, the following selecting and moving into a home, locating and choosing suitable housemates, locating household

furnishings, settling disputes with landlords, and managing personal financial affairs. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

Eligibility

a. Individuals experiencing homelessness:
    i. Individuals who meet the HUD definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations and who are receiving enhanced care management (ECM) or other case management services.

b. Individuals at risk of homelessness:
    i. Individuals at risk for homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations.

c. Individuals who exited homelessness and entered housing in the last 24 months; and

d. Individuals whose housing stability can be improved through participation in a day habilitation program.

Restrictions/Limitations

a. Member may not receive duplicate support from other State, local, or federally funded programs.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

1) Mental health or substance use disorder treatment providers, including county Behavioral Health agencies
2) Licensed Psychologists
3) Licensed Certified Social Workers
4) Registered Nurses
5) Home Health Agencies
6) Professional Fiduciary
7) Vocational Skills Agencies

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

Overview

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet

eligibility requirements. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

Eligibility

For Nursing Facility Transition:

a. Has resided 60+ days in a nursing facility; and
b. Willing to live in an assisted living setting as an alternative to a nursing facility; and
c. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

For Nursing Facility Diversion:

a. Interested in remaining in the community; and
b. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
c. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

a. Individuals are directly responsible for paying their own living expenses.
b. Member may not receive duplicate support from other State, local, or federally funded programs.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

1) Case management agencies
2) Home Health agencies
3) Medi-Cal managed care plans
4) County mental health providers
5) 1915c HCBA/ALW providers
6) CCT/Money Follows the Person providers

Community Transition/Nursing Facility Transition to a Home

Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization. Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

Eligibility

a. Currently receiving medically necessary nursing facility Level of Care (LOC) services and in lieu of remaining in the nursing facility or medical respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and

b. Has lived 60+ days in a nursing home and/or medical respite setting; and

c. Interested in moving back to the community; and 4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

a. Community transition services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
b. Member may not receive be receiving duplicate support from other State, local, or federally-funded programs.
c. Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

1) Case management agencies
2) Home Health agencies
3) Medi-Cal managed care plans
4) ARF/RCFE Operators

Personal Care and Homemaker Services

Overview

Personal care services and homemaker services provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal care services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal care and homemaker programs aid individuals who could otherwise not remain in their homes. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

The Personal Care and Homemaker Services can be utilized:

1. Above and beyond any approved county IHSS hours, when additional hours are required and if IHSS benefits are exhausted; and

2. As authorized during any IHSS waiting period (member must be already referred to IHSS); this approval period includes services prior to and up through the IHSS application date.
3. For members not eligible to receive IHSS, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Eligibility

a. Individuals at risk for hospitalization, or institutionalization in a nursing facility; or

b. Individuals with functional deficits and no other adequate support system; or

c. Individuals approved for in-home supportive services.

Restrictions/Limitations

a. This service cannot be utilized in lieu of referring to the IHSS program. Member must be referred to the IHSS program when they meet referral criteria.
b. Similar services available through IHSS should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by IHSS.
c. If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to IHSS for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.
d. Member may not receive duplicate support from other State, local, or federally funded programs.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

1) Home health agencies
2) County agencies
3) Personal care agencies
4) AAA (Area Agency on Aging)

Environmental Accessibility Adaptations (Home Modifications)

Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home. Without these adapations, the member would require institutionalization. Examples include, ramps, grab bars, and chair/stair lifts. The services are available in a home that is owned, rented, leased, or occupied by the Member. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

Eligibility

a. Individuals at risk for institutionalization in a nursing facility.

When authorizing environmental accessibility adaptations as a Community Support, the managed care plan must receive and document an order from the member's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment where appropriate.

The managed care plan must also receive and document:

1) A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. The physical or occupational therapy evaluation and report should contain at least the following:
   a) An evaluation of the member and the current equipment needs specific to the member, describing how/why the current equipment does not meet the needs of the member; and
   b) An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the member and reduces the risk of institutionalization. This should also include information on the ability of the member and/or the primary caregiver to learn about and appropriately use any requested item; and
   c) A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the member and a description of the inadequacy.

Restrictions/Limitations

b. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
a. Cannot be receiving duplicate service from other programs.
b. EAAs must be conducted in accordance with applicable State and local building codes.
c. EAAs are payable up to a total lifetime maximum of $7,500.
d. EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
e. Modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household.
f. Member may not receive duplicate support from other State, local, or federally funded programs.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service. Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

1) Area Agencies on Aging (AAA)

2) Local health departments
3) Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California contractor's license except for a PERS installation, which may be performed in accordance with the system's installation requirements.

Medically Tailored Meals/Medically Supportive Foods

Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status, and increased member satisfaction. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

Eligibility

a. Gestational Diabetes

b. Obesity with significant comorbidity (e.g. DM, HTN, OSA and BMI 30 to 39)

c. Severe Obesity (BMI Over 40)

d. Pediatric/Adolescent and Adult Metabolic Syndrome

e. Pediatric Obesity (BMI 95th percentile and greater)

f. ESRD (GFR less than 15 and on HD/PD)

g. Members with poorly controlled DM, defined as A1c greater than 7 for at least 6 months (2 measurements at Q3 month intervals) that have not improved despite diet/lifestyle modification education and medication optimization and education.

h. Members with poorly controlled heart failure (CHF), defined as a diagnosis of CHF with an emergency department or inpatient hospitalization related to their CHF in the last 6 months.

Members must agree to enroll and complete behavioral, cooking, and/or nutrition education course to qualify for ongoing services. Members must agree to and complete a visit with a dietician and any follow-up visits as deemed appropriate by the dietician.

Restrictions/Limitations

a. If member is already under the care of a dietician and following with that provider, only the initial intake to tailor their meals must be completed.

b. Up to two (2) meals per day and/or medically supportive foods or up to 12 weeks, or longer if medically necessary.
c. Members excluded include those with the following:
    i. Meals that are eligible for or reimbursed by alternate programs are not eligible; or
    ii. Member does not have access to food storage/preparation; or
    iii. Member is in hospice, skilled nursing facility, or incarcerated; or
    iv. Meals are not covered to respond solely to food insecurities.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

1) Home delivered meal providers
2) Area agencies on aging
3) Nutritional education services to help sustain healthy cooking and eating habits
4) Meals on Wheels providers
5) Medically-supportive food & nutrition providers

Sobering Centers

Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate. This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to sobering centers. Sobering centers must be prepared to identify members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.

Eligibility

a. Individuals ages 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a sobering center.

Restrictions/Limitations

a. This service is covered for a duration of less than 24 hours.
b. Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services with these unique populations. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

1) Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
2) These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
3) All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Asthma Remediation

Overview

Environmental asthma trigger remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual or to enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. This Community Support includes home-based asthma self-management education and an in-home assessment for eligible members. Members should contact their primary care provider (PCP) or Member Services for a Community Support referral.

Eligibility

CCHP will provide asthma self-management education to all Medi-Cal members with a diagnosis of asthma. Members must have stable housing and a current diagnosis of poorly controlled asthma, as defined below:

a. Member has a diagnosis of poorly controlled asthma as defined by either:
    i. An Emergency Department (ED) visit or hospitalization for asthma in the past 12 months; or
    ii. Two sick or urgent care visits for asthma in the past 12 months; or
    iii. A score of 19 or lower on the asthma control test; and

b. Member has:
    i. Environmental asthma trigger(s) within his/her housing that can be resolved by remediation, as identified by a home visit assessment using a standardized assessment tool such as the CDC tool: https://www.cdc.gov/asthma/pdfs/home_assess_checklist_P.pdf ; and
    ii. Agreed to and completed asthma education; and
    iii. Agreed to and completed medication reconciliation and medication use education.

c. Current licensed healthcare provider requesting the service must submit:
    i. Documentation that primary care provider (PCP) or specialist has reviewed and optimized medication regimen; and
    ii. A brief written evaluation specific to the member describing why the remediation(s) meets the needs of the individual and will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations:

a. If another State Plan service, such as durable medical equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
b. Asthma remediations must be conducted in accordance with applicable State and local building codes.
c. Asthma remediations are payable up to a total lifetime maximum of $7,500.
d. Asthma remediation modifications are limited to those that are of direct medical/remedial benefit to the member and exclude adaptations/improvements that are of general utility to the household. Remediations may include finishing to return the home to a habitable condition, but do not include aesthetic embellishments.
e. CCHP and DHCS are not responsible for the maintenance, repair, or removal of any permanent modifications under any circumstance.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization, or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education. Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

1) Lung health organizations
2) Healthy housing organizations
3) Local health departments
4) Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California contractor's license.

1) Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
2) All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.