State of California—Health and Human Services Agency

Department of Health Care Services

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Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide

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I.   Introduction to Community Supports (ILOS)

California Advancing and Innovating Medi-Cal (CalAIM), establishes the framework to address social determinants of health and improve health equity statewide. A key feature of CalAIM is the introduction of a menu of Community Supports, or in lieu of services (ILOS), in managed care.

What are Community Supports?

Community Supports are services or settings that MCPs may offer in place of services or settings covered under the California Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Community Supports are optional for MCPs to offer and for Members to utilize. MCPs may not require Members to use a Community Support instead of a service or setting listed in the Medicaid State Plan.

This Program Guide

Community Supports are a significant change and a high priority for DHCS. DHCS recognizes the work California MCPs and communities will be doing to operationalize these new initiatives under CalAIM and transition smoothly services provided under the Whole Person Care Pilots and Health Home Program even as they continue to address the COVID-19 Public Health Emergency.

Throughout 2021, DHCS is offering a range of technical assistance and support including detailed implementation requirements and guidance presented in this Program Guide. In addition, DHCS is making available materials posted on the DHCS CalAIM ECM and Community Supports website, webinars, non-binding Community Supports pricing information, and other opportunities for discussion to support the implementation of these initiatives. All information provided in this fact sheet is preliminary and subject to change. This Program Guide is for informational purposes and is not intended to replace future guidance and state and/or federal requirements.

For specific questions about Community Supports, please submit to: CalAIMECMILOS@dhcs.ca.gov. Questions about CalAIM generally should be submitted to: CalAIM@dhcs.ca.gov.

An FAQ which provides up-to-date information about the Community Supports implementation and will be updated regularly and is available from the Community Supports Resource Directory.

Requirements for Providing Community Supports

Pursuant to 42 CFR 438.3, MCPs may not provide Community Supports without first applying to the State and obtaining State approval to offer the Community Support by demonstrating all the requirements will be met. MCPs may voluntarily agree to provide any service to a Member outside of an approved Community Supports construct; however, the cost of any such voluntary services may not be included in determining MCP rates.

Once approved by DHCS, the Community Support will be added to the MCP's contract and posted on the DHCS website as a State-Approved ILOS.

Community Supports may be offered by MCPs beginning January 1, 2022. Additional Community Supports may be added thereafter on a 6-month cadence.

II.   What are Community Supports, or ILOS?

Introduction

CalAIM is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, programmatic, and payment system reforms. A key feature of CalAIM is the introduction of a new menu of in lieu of services (ILOS), or 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. MCPs will be responsible for administering Community Supports. For more information about CalAIM, see DHCS' Revised CalAIM Proposal released on 1/8/21.[1]

Overview of Community Supports

Community Supports are medically appropriate and cost-effective alternatives to services covered under the State Plan. Federal regulation allows states permit Medicaid managed care organizations to offer Community Supports as an option to Members.[2] Community Supports can substitute for and potentially decrease utilization of a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use.

Community Supports are an important part of care delivery for Members enrolled in Enhanced Care Management (ECM), another CalAIM initiative that will address the clinical and non-clinical needs of high-need, high-cost Medi-Cal Members through systematic coordination of services and comprehensive care management.[3] As such, DHCS encourages MCPs to offer a robust menu of 14 pre-approved Community Supports to comprehensively address the needs of Members—including those with the most complex challenges affecting health such as homelessness, unstable and unsafe housing, food insecurity, and/or other social needs. Note that ECM and Community Supports are separate initiatives, and some Medi-Cal Members will qualify for only ECM, or only Community Supports.

By design, the list of pre-approved Community Supports is drawn in part from the foundational work done as part of the Whole Person Care (WPC) Pilots and Health Homes Program (HHP). 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 will build on WPC and HHP efforts and activities and expand access to services that were previously available only through home and community-based services initiatives while addressing health-related social needs.

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[1] Revised CalAIM Proposal, January 2021.
[2] 42 CFR 438.3(e)(2).
[3] ECM Fact Sheet

MCPs will have the opportunity to provide details on their elected Community Supports to DHCS as part of their Model of Care (MOC) responses to DHCS. MCPs in all Counties are encouraged to offer one or more of the following Community Supports starting on January 1, 2022:[4]

- Housing Transition Navigation Services;
- Housing Deposits;
- Housing Tenancy and Sustaining Services;
- Short-Term Post-Hospitalization Housing;
- Recuperative Care (Medical Respite);
- Respite Services;
- Day Habilitation Programs;
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF);
- Community Transition Services/Nursing Facility Transition to a Home;
- Personal Care and Homemaker Services;
- Environmental Accessibility Adaptations (Home Modifications);
- Medically-Supportive Food/Meals/Medically Tailored Meals;
- Sobering Centers; and
- Asthma Remediation.

Community Supports are Optional, but Strongly Encouraged

MCPs are strongly encouraged to elect to offer some or all of these pre-approved Community Supports and are expected to detail their Community Supports offerings in their MOC. As part of the MOC response, MCPs will describe which Community Supports they will offer, the date each elected Community Support is expected to launch, and the MCP's plans for operationalizing the Community Support including the Community Support provider network. DHCS expects that MCPs in WPC and HHP counties will offer the pre-approved Community Supports that correspond to the services previously offered through those programs to ensure a seamless transition for those Members. MCPs may propose additional Community Supports to DHCS for review and approval. MCPs may choose to offer different Community Supports in different Counties. MCPs may add or remove Community Supports at defined intervals: every six (6) months for an addition and annually for removal of a previously offered Community Support.

Community Supports Implementation Timeline

MCPs in all Counties may launch pre-approved Community Supports beginning January 1, 2022. DHCS strongly encourages all MCPs to begin offering Community Supports at this time. The timely offering of Community Supports will help to improve care for Members, support the goals of CalAIM, and contribute to the smooth transition of Members receiving services through WPC Pilots into Medi-Cal managed care.

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[4] See the "Community Supports Service Descriptions" for more detail about each Community Support option.

Enhanced Care Management (ECM) and Community Supports Website Requirements

Managed Care Plan websites must be updated to include the following for Enhanced Care Management (ECM) and Community Supports:

- Up to date Member and provider facing information about ECM and how to request access to ECM.
- As required in A.B. 133 14184.206(e), Cal Assembly, 2021 Reg. Sess. (CA 2021) https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133: Up to date information about all the Community Supports being offered by the MCP, including, at minimum:
  - o A short description of each available service that is consistent with the service definitions listed in the DHCS Community Supports Policy Guide. Terminology should not differ from DHCS' terminology.
  - o The eligible population(s) for each service, inclusive of any **DHCS approved** approach to narrow or limit the eligible populations (Reminder: any such limitation must meet the requirements in the CalAIM Waiver Special Terms and Conditions, pp. 7-8 and be approved by DHCS). Any such limitations must also be included in Member Handbooks.
  - o Member and provider facing information about how to access the Community Supports offered by the MCP.

III. Community Supports – Service Definitions

Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) Members are not required to use the Community Supports and 3) the Community Supports are authorized and identified in the managed care plan contracts.

Each set of pre-approved services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically-Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist Members with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the member's housing needs, potential housing transition barriers, and identification of housing retention barriers.

2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

3. Searching for housing and presenting options.

4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

6. Identifying and securing available resources to assist with subsidizing rent (such as HUD's Housing Choice Voucher Program (Section 8), or state and local assistance programs) and matching available rental subsidy resources to Members.

7. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.[5]

8. Assisting with requests for reasonable accommodation, if necessary.[6]

9. Landlord education and engagement

10. Ensuring that the living environment is safe and ready for move-in.

11. Communicating and advocating on behalf of the Member with landlords.

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[5] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

[6] Related to expenses incurred by the housing navigator supporting the member moving into the home

12. Assisting in arranging for and supporting the details of the move.

13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[7]

14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.

15. Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptations Community Support).

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy. These entities may include County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs, community-based organizations housing providers, local housing agencies, and housing development agencies. For Members who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full-Service Partnership Members) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted Community Supports providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Transition Navigation Services Community Support.

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[7] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration; or

- 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 (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institutions for Mental Disease, and State Hospitals; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

  - (1) An individual or family who:

    - Has an annual income below 30 percent of median family income for the area, as determined by HUD;

    - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and

      - Meets one of the following conditions:

        - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

        - Is living in the home of another because of economic hardship;

        - Has been notified in writing that their right to occupy their current housing or living situation will be

terminated within 21 days after the date of application for assistance;

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- (3) A child or youth who does not qualify as "homeless" under this section but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

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:

- Have one or more serious chronic conditions;

- Have a Serious Mental Illness;

- 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);

- o Are receiving Enhanced Care Management; or

- o 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.

MCPs may accept an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status.

Restrictions and Limitations

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. Service duration can be as long as necessary.

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 in a culturally and linguistically appropriate manner. 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.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;

- Providers of services for individuals experiencing homelessness;

- Life skills training and education providers;

- County agencies;

- Public hospital systems;

- Mental health or substance use disorder treatment providers, including county behavioral health agencies;

- Social services agencies;

- Affordable housing providers;

- Supportive housing providers; and

- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider. Members who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers. When members receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.[8]

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

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[8] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.

2. Set-up fees/deposits for utilities or service access and utility arrearages.

3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

4. First month's and last month's rent as required by landlord for occupancy.

5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services Community Support in counties that offer Housing Transition/Navigation Services.

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration; or

- 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 (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

MCPs may accept an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status.

Restrictions and Limitations

Housing Deposits are available once in an individual's lifetime. 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. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

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.

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.

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 and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. 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.

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.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

2. Education and training on the role, rights, and responsibilities of the tenant and landlord.

3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.

6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

8. Assistance with the annual housing recertification process.

9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.

11. Health and safety visits, including unit habitability inspections[9].

12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

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[9] Does not include housing quality inspections.

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy. Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless serving to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services Community Support.

Services do not include the provision of room and board or payment of rental costs.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services Community Support in counties that offer Housing Transition/Navigation Services.

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration; or

- 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 (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
  - (1) An individual or family who:
    - Has an annual income below 30 percent of median family income for the

area, as determined by HUD;

- Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and

  - Meets one of the following conditions:

    - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

    - Is living in the home of another because of economic hardship;

    - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

  - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

  - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

  - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

  - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of

the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- o (3) A child or youth who does not qualify as "homeless" under this section but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

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

- o Have one or more serious chronic conditions;

- o Have a Serious Mental Illness;

- o Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

- o Are receiving Enhanced Care Management; or

- o 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.

MCPs may accept an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status.

Restrictions/Limitations

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services. Service duration can be as long as necessary.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment, and individualized

housing support plan) in conjunction with this service, but it is not a prerequisite for eligibility.

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 in a culturally and linguistically appropriate manner. 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.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies

- Providers of services for individuals experiencing homelessness

- Life skills training and education providers

- County agencies

- Public hospital systems

- Mental health or substance use disorder treatment providers, including county behavioral health agencies

- Supportive housing providers

- Federally qualified health centers and rural health clinics

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Members who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have

received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers. When Members receive more than one of these services, the managed care plan should ensure coordination by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

Short-Term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization Housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of State plan services.[10]

This setting must provide individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management, and beginning to access other housing supports such as Housing Transition Navigation.[11]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Members must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization Housing.[12]

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.

- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

- 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 (including those exiting institutions but not including any limits on the number of

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[10] Up to 90 days of recuperative care is available under specified circumstances as a separate Community Support.

[11] Housing Transition/Navigation is a separate Community Support.

[12] The development of a housing assessment and individualized support plan are covered as a separate Community Support under Housing Transition/Navigation Services.

days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institutions for Mental Disease, and State Hospitals. If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless to thirty (30) days;

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

  o (1) An individual or family who:

    ▪ Has an annual income below 30 percent of median family income for the area, as determined by HUD;

    ▪ Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and

      • Meets one of the following conditions:

        o Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

        o Is living in the home of another because of economic hardship;

        o Has been notified in writing that their right to occupy their current housing or living situation will be terminated within thirty (30) days after the date of application for assistance;

      • Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

      • Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives

in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

o (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

o (3) A child or youth who does not qualify as "homeless" under this section but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

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

o Have one or more serious chronic conditions;

o Have a Serious Mental Illness;

o Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

o Are receiving Enhanced Care Management; or

o 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.

In addition to meeting one of these criteria at a minimum, individuals must have

medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

MCPs may accept an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status.

Restrictions/Limitations

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are not to exceed a duration of six (6) months (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

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. 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.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems
- Social service agencies
- 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. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Recuperative Care (Medical Respite)

Description/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.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs

2. Coordination of transportation to post-discharge appointments

3. Connection to any other on-going services an individual may require including mental health and substance use disorder services

4. Support in accessing benefits and housing

5. Gaining stability with case management relationships and programs

Recuperative Care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other available housing Community Supports should be provided to Members onsite in the recuperative care facility. When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

- Individuals who are at risk of hospitalization or are post-hospitalization;

- Individuals who live alone with no formal supports;

- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification; [13]

- 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 (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals. If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless to thirty (30) days;

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

  - (1) An individual or family who:

    - Has an annual income below 30 percent of median family income for the area, as determined by HUD;

    - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and

      - Meets one of the following conditions:

        - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

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[13] For this population, the service could be coordinated with home modifications (which are covered as a separate Community Support) and serve as a temporary placement until the Member can safely return home.

- o Is living in the home of another because of economic hardship;

- o Has been notified in writing that their right to occupy their current housing or living situation will be terminated within thirty (30) days after the date of application for assistance;

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- o (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- o (3) A child or youth who does not qualify as "homeless" under this section but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

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

- o Have one or more serious chronic conditions;

- o Have a Serious Mental Illness;

o Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

o Are receiving Enhanced Care Management;

o 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;

o Able to transition out of inpatient facility care, skilled nursing facility care, or other health care facility, and Recuperative Care is medically appropriate and cost-effective.

MCPs may accept an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status.

Restrictions/Limitations

Recuperative care/medical respite is an allowable Community Supports service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

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. 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.

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

Facilities are 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 recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Respite Services

Description/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 medical respite/recuperative care and is rest for the caregiver only.

Respite Services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.

2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

3. Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routinesthat would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite Services are provided to the Member in his or her own home or another location being used as the home.

Facility Respite Services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

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.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

Restrictions/Limitations

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.

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, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Respite services cannot be provided virtually, or via telehealth.

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. 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.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living HealthFacilities (CLHFs)
  - Providers contracted by county behavioral health
- Other community settings that are not a private residence, such as:
  - Adult Family Home/Family Teaching Home
  - Certified Family Homes for Children
  - County Agencies
  - Residential Care Facility for the Elderly (RCFE)
  - Child Day Care Facility; Child Day Care Center; Family Child Care Home
  - Respite Facility; Residential Facility: Small Family Homes (Children Only)
  - Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified FamilyHomes (Children Only)
  - Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
  - Respite Facility; Residential Facility: Group Homes (Children Only)
  - Respite Facility; Residential Facility: Family Home Agency (FHA): Adult

FamilyHome (AFH)/Family Teaching Home (FTH)

- o Respite Facility; Residential Facility: Adult Residential Facility for Persons withSpecial Health Care Needs

- o Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

- o Short-term Residential Therapeutic Program Providers or other care providers who are serving youth with complex needs

- o Community-Based Adult Services (CBAS) Facilities/Providers

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for Members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

Day Habilitation Program services include, but are not limited to, training on:

1. The use of public transportation;

2. Personal skills development in conflict resolution;

3. Community participation;

4. Developing and maintaining interpersonal relationships;

5. Daily living skills (cooking, cleaning, shopping, money management); and,

6. 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:

1. Selecting and moving into a home;[14]

2. Locating and choosing suitable housemates;

3. Locating household furnishings;

4. Settling disputes with landlords;[15]

5. Managing personal financial affairs;

6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;

7. Dealing with and responding appropriately to governmental agencies and personnel;

8. Asserting civil and statutory rights through self-advocacy;

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[14] Refer to the Housing Transition/Navigation Services Community Support
[15] Refer to the Housing Tenancy and Sustaining Services Community Support

9. Building and maintaining interpersonal relationships, including a circle of support;

10. Coordination with Medi-Cal managed care plan to link Member to any Community Supports and/or enhanced care management services for which the Member may be eligible;

11. Referral to non-Community Supports housing resources if Member does not meet Housing Transition/Navigation Services Community Support eligibility criteria;

12. Assistance with income and benefits advocacy including General Assistance/ General Relief and SSI if Member is not receiving these services through Community Supports or Enhanced Care Management; and

13. Coordination with Medi-Cal managed care plan to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or Enhanced Care Management.

The services provided should utilize best practices for Members who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Program services are available for as long as necessary. Services can be provided continuously, or through intermittent meetings, in an individual or group setting.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

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. 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.

- o Mental health or substance use disorder treatment providers, including county behavioral health agencies

- o Licensed Psychologists

- o Licensed Certified Social Workers

- o Registered Nurses

- o Home Health Agencies

- o Professional Fiduciary

- o Vocational Skills Agencies

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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

Description/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.

The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF). Includes wrap-around services: assistance w/ ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. Includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

1. Assessing the Member's housing needs and presenting options.[16]
2. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.
   A. Managed care plans may also fund RCFE/ARF operators directly to provide these enhanced services.

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[16] Refer to Housing Transition/Navigation Services Community Support for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:

1. Has resided 60+ days in a nursing facility;

2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and

3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:

1. Interested in remaining in the community;

2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

3. 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

Individuals are directly responsible for paying their own living expenses.

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 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.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is

no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

Community Transition Services/Nursing Facility Transition to a Home
Description/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. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the Member's housing needs and presenting options.[17]

2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

3. Communicating with landlord (if applicable) and coordinating the move.

4. Establishing procedures and contacts to retain housing.

5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[18]

Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.[19]

Eligibility (Population Subset)

1. Currently receiving medically necessary nursing facility Level of Care (LOC)

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[17] Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services Community Support for additional details.

[18] Refer to the Environmental Accessibility Adaptations and/or Asthma Remediation Community Support for additional details.

[19] Refer to the Housing Deposits Community Support for additional details.

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

2. Has lived 60+ days in a nursing home and/or Medical Respite setting; and

3. 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

- 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.

- 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.

- Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re- institutionalization.

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. The 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.

- Case management agencies

- Home Health agencies

- Medi-Cal managed care plans

- County mental health providers

- 1915c HCBA/ALW providers

- CCT/Money Follows the Person providers

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Personal Care and Homemaker Services

Description/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.

Includes services provided through the In-Home Support Services (In-Home Supportive Services) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

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.

The Personal Care and Homemaker Services Community Support can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and

- As authorized during any In-Home Supportive Services waiting period (Member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.

- For Members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services 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 In-Home Supportive Services.

Eligibility (Population Subset)

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

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

- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions/Limitations

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services 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.

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. 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.

- Home health agencies

- County agencies

- Personal care agencies

- AAA (Area Agency on Aging)

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Environmental Accessibility Adaptations (Home Modifications)
Description/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 which the Member would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist Members in accessing the home;

- Doorway widening for Members who require a wheelchair;

- Stair lifts;

- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).

- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and

- Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

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. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the Member describing how and why the equipment or service meets the needs of the Member will still be necessary.

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. This should typically come from an entity with no connection to the provider of the requested equipment or service. 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;

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.

2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

3. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

- 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.

- EAAs must be conducted in accordance with applicable State and local building codes.

- EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

- EAAs may include finishing (e.g., drywall and painting) to return the home to a

habitable condition, but do not include aesthetic embellishments.

- 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. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.

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

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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.

- Area Agencies on Aging (AAA)
- Local health departments
- 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 Food
Description/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.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.

2. Medically Tailored Meals: meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.

3. Medically Tailored meals are tailored to the medical needs of the Member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.

5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

Managed care plans have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members (e.g., Medically Tailored meals, groceries, food vouchers, etc.).

Eligibility (Population Subset)

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

3. Individuals with extensive care coordination needs.

Restrictions/Limitations

- Up to two (2) meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.

- Meals that are eligible for or reimbursed by alternate programs are not eligible.

- Meals are not covered to respond solely to food insecurities.

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. 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.

- Home delivered meal Providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels Providers
- Medically-Supportive Food & Nutrition Providers

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Sobering Centers

Description/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.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.

- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment andhousing 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.

- The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

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

This service is covered for a duration of less than 24 hours.

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.

- 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.

- 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.

- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Asthma Remediation[20]

Description/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 enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver.

When authorizing Asthma Remediation as a Community Support, the managed care plan must receive and document:

- A current licensed health care provider's order specifying the requested remediation(s) for the Member;

- A brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective.;

- That a home visit has been conducted to determine the suitability of any requested remediation(s) for the Member.

Asthma Remediation includes providing information to Members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.

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[20] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided, and Community Supports should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.

3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

The Centers for Disease Control, the Environmental Protection Agency, and Housing and Urban Development collaborated to produce an asthma trigger checklist[21] which MCPs may utilize in determining the appropriateness of these interventions. An accompanying training[22] provides additional details about the connections between asthma triggers and lung health.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

- Asthma remediations must be conducted in accordance with applicable State and local building codes.

- Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma Remediation modifications are limited to those that are of direct medical orremedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

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[21] https://www.cdc.gov/asthma/pdfs/home_assess_checklist_P.pdf
[22] https://www.epa.gov/sites/production/files/2020-06/home_characteristics_and_asthma_triggers_training_for_home_visitors_0.pptx

- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the managed care plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable mattress and pillow dust covers; high-efficiency particulate air (HEPA) filtered vacuums; de-humidifiers; portable air filters; and asthma-friendly cleaning products and supplies.

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

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.

- Lung health organizations
- Healthy housing organizations
- Local health departments
- 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.

- 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.

- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including

Provider Credentialing/Recredentialing and Screening/Enrollment [APL 19-004](). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

IV. Community Supports to State Plan Service Crosswalk

Background: The below chart summarizes potential state plan services or settings that each of California's "pre-approved" Community Supports may substitute for. Community Supports may represent an immediate substitute for a State Plan-covered service/setting or a substitute for a State Plan-covered service/setting over a longer timeframe. Additional detail on the cost-effectiveness and medical appropriateness of each service/setting is available in the CA ILOS Evidence Library Executive Summary document posted on the Department's website at: https://www.dhcs.ca.gov/Documents/MCQMD/CA-ILOS-Evidence-Library-Executive-Summary-August-2021.pdf

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
1	Housing Transition/ Navigation Services	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Skilled Nursing Facility Services
		Transitional Inpatient Care Services
2	Housing Deposits	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Skilled Nursing Facility Services
		Transitional Inpatient Care Services
3	Housing Tenancy and Sustaining Services	Emergency Department Visit
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Skilled Nursing Facility Services
		Transitional Inpatient Care Services
4	Short-Term Post-Hospitalization Housing	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
		Post-Acute care
		Skilled Nursing Facility Services
5	**Recuperative Care (Medical Respite)**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Post-Acute care
		Skilled Nursing Facility Services
6	**Respite Care**	Home Health Agency
		Home Health Aide
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Personal Care Services
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
7	**Day Habilitation Programs**	Emergency Department Services
		Occupational Therapy
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Targeted Case Management and Services
8	**Nursing Facility Transition/**	Emergency Department Visit
		Inpatient Services

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
	Diversion to Assisted Living Facility	Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
9	**Community Transition Services/Nursing Facility Transition to Home**	Emergency Department Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Intermediate Care Facility Services for the Developmentally Disabled - Nursing
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
10	**Personal Care and Homemaker Services**	Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Skilled Nursing Facility Stay

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
11	Environmental Accessibility Adaptations (Home Modifications)	Emergency Department Services
		Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Personal Care Services
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
12	Medically Tailored Meals/Medically Supportive Foods	Emergency Department Services
		Emergency Transport Services
		Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Outpatient Hospital Services
		Personal Care Services
13	Sobering Centers	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Emergency Transport Services
14		Asthma-related primary care and specialty visits

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
	Asthma Remediation	Emergency Department Services
		Home Health Aide
		Home Health Agency
		Inpatient Stay
		Outpatient Hospital Services
		Personal Care Services

V.   Requesting Approval for New Community Supports

MCPs must apply for and obtain State approval prior to offering any new Community Support, and demonstrate that all the following requirements will be met through the submission of a Community Supports Model of Care:

- Community Supports are voluntary. MCPs cannot require a Member to use a Community Support instead of a State Plan-covered service.
- The alternative services are medically appropriate and cost-effective.
- The population and criteria for the Community Support is clearly defined, and the Community Support will be offered in an equitable and nondiscriminatory manner to eligible Members.
- The MCP has demonstrated capability to calculate the cost-benefit analysis for each Community Support, including tracking and reporting on Community Supports expenditures in a manner and format established by DHCS.
- MCPs must use the HCPCS rate codes through encounter data that have been approved by DHCS to track the claiming and provision of Community Supports.
- Community Supports may not include expenditures prohibited by CMS, such as room and board.

Once DHCS approves an MCP's submitted Community Supports Model of Care, the Community Support must be added to the MCP's contract, subject to federal approval, and will be posted on the DHCS website as a State Approved Community Support. The cost and utilization of the Community Support will be factored into the medical portion of the MCP's rates.

Members always retain the right to file appeals and/or grievances if they request one or more Community Support offered by the MCP but were not authorized to receive the requested Support because of a determination that it was not medically appropriate or cost effective. Community Supports are additionally subject to the State Fair Hearings process. DHCS may terminate an MCP's Community Supports offering if it is determined to be harmful to the Member or is not cost-effective. MCPs may terminate a Community Support upon notice to DHCS once annually at the end of the calendar year, except in cases where the Community Support is terminated due to Member health, safety, or welfare concerns. If an MCP terminates a Community Support, they must publicize the service end date and provide at least 30 days' notice to their Members and implement a plan for continuity of care for Members receiving that Community Support.

See the Community Supports Resource Directory for more information and to access the Model of Care.

VI. Provider Enrollment, Credentialing, and Vetting Requirements

Community Supports Providers as Medi-Cal Enrolled Providers

MCP Network Providers (including those who will operate as Community Supports Providers) are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. However, many Community Supports Providers (e.g., housing agencies, medically tailored meal Providers) may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program. Instead, these Providers must be vetted by the MCP to participate as Community Supports Providers.

Process for Medi-Cal enrollment

For those Community Supports Providers with a state-level Medi-Cal enrollment pathway, the Provider would have to enroll through the DHCS Provider Enrollment Division or the MCP can choose to have a separate enrollment process.

Clarifying the Provider "Credentialing" Requirements of APL 19-004

The credentialing requirements articulated in [APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment](#) only apply to Providers with a state-level pathway for Medi-Cal enrollment. Therefore, Community Supports Providers without a state-level pathway to Medi-Cal enrollment are not required to meet the credentialing requirements in APL 19-004 to become "in-network" ECM and/or Community Supports Providers but must be vetted by the MCP to participate.

MCP Requirements Related to Vetting Community Supports Providers Without a State-level Pathway for Medi-Cal Enrollment

To include a Community Supports Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to be a Community Supports Provider. MCPs must submit Policies and Procedures for how they will vet the qualifications of ECM and Community Supports Providers in their Part 2 submission of the MOC. MCPs must create and implement their own processes to do so. Factors MCPs may want to consider as part of their process includes, but are not limited to:

- Ability to receive referrals from MCPs for the authorized Community Supports;
- Sufficient experience to provide services similar to the specific Community Supports for which they are contracted to provide within the service area;
- Ability to submit claims or invoices for Community Supports using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste, and/or abuse;

- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
- History of liability claims against the Provider.

VII. Billing & Payments

Community Supports Billing and Invoicing Guidance

DHCS has developed more comprehensive guidance that describes the minimum set of data elements required to be included in an invoice, available from the [Community Supports Resource Directory](#).

Non-Binding Community Supports Pricing Guidance

The Cal-AIM initiative and, in particular, the introduction of the 14 pre-approved health-related Community Supports, prompts MCPs to work and contract with a new set of "non-traditional" Providers that offer services and supports that historically have not been well integrated into the health care system. These Providers include, but are not limited to, housing service Providers, home modification companies, sobering centers, and organizations that prepare and deliver medically-supportive food and nutrition. While many MCPs and Community Supports Providers have some experience working together, particularly in WPC Pilot counties, CalAIM is designed to encourage and support broader contracting and partnerships throughout the State. In recognition that this requires MCPs and Community Supports Providers to engage in new contracting and payment relationships, DHCS has prepared non-binding Community Supports Pricing Guidance. It offers information on potential rates for each of the 14 pre-approved Community Supports, including mid-point benchmarks and a discussion of key cost drivers that MCPs and Community Supports Providers may want to consider as they establish their own contracting and payment arrangements.

Critically, this pricing guidance is designed to serve as a tool to support discussions regarding rates**; it is in no way binding on MCPs or Community Supports Providers**. MCPs and Community Supports Providers have full flexibility and discretion to agree to Community Supports rates that are different than those outlined in this document, particularly because the rates in the pricing guidance are based on data and assumptions that reflect the statewide average cost of inputs. DHCS reserves the right to make modifications to the pricing guidance on an as needed basis based on experience with the Community Supports initiative and its evolution over time.

The Non-Binding Community Supports Pricing Guidance can be accessed from the [Community Supports Resource Directory](#).

Community Supports HCPCS Codes

The [ECM and Community Supports Coding Options](#) guidance lists the HCPCS codes that must be used for Community Supports services. The HCPCS code and modifier combined define the service as Community Supports.

MCPs must use the HCPCS codes listed in the table to report Community Supports services. The HCPCS code and modifier combined define the service as Community Supports.

DHCS expects MCPs to support their Community Supports Providers in reporting and translating their delivered Community Supports to these required HCPCS codes. While MCPs must use the below HCPCS codes and modifiers for reporting applicable Community Supports encounters to DHCS, MCPs may utilize alternative payment approaches with Community Supports providers. For example, an MCP might opt to pay a provider for Housing Transition and Navigation Services as a per member per month (PMPM) payment. That MCP must still report encounters to DHCS as a per diem for every service rendered by that provider, using the HCPCS codes and modifiers below. **If a Community Support is provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.**[23]

The Finalized ECM & Community Supports (ILOS) Coding Options can be accessed from the [Community Supports Resource Directory](#).

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[23] For more information refer to the DHCS [Medi-Cal Provider Manuals](#)

VIII. Consent, Authorization, & Data Sharing

The vision of Community Supports is to embrace and integrate a diversity of Providers in the delivery of whole-person care, and not just traditional health care providers. DHCS acknowledges the tremendous investment required of both MCPs and Provider organizations to realize this from an information technology infrastructure and data sharing perspective. To that end, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and Community Supports Providers.

Data System Requirements

MCPs are required to have an IT infrastructure and data analytic capabilities to support Community Supports, including the capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in Community Supports Contract Template Section 7: Identifying Members for Community Supports;
- Assign Members to Community Supports Providers;
- Keep records of Members receiving Community Supports and their consent;
- Securely share data with Community Supports Provider;
- Receive, process, and send encounters and invoices from Community Supports Providers to DHCS in accordance with DHCS standards;
- Receive and process supplemental reports from Community Supports Providers;
- Send Community Supports supplemental reports to DHCS; and
- Open, track, and manage referrals to Community Supports Providers.

Data Sharing Requirements for MCPs

To support Community Supports, MCPs shall provide, at a minimum, the following information to all Community Supports Providers:

- Physical, behavioral, administrative, and information indicating Member social determinants of health (SDOH) needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS)[24] for assigned Members; and
- Reports of performance on quality measures and/or metrics, as requested.

MCPs are required to use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

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[24] As part of the population health management (PHM) initiative of CalAIM, DHCS has issued guidance encouraging MCPs to incorporate the use of DHCS Priority SDOH Codes; please refer to APL 21-009 for more information.

Data Sharing Requirements for Community Supports Providers

DHCS' vision is that Community Supports Providers will submit encounters to MCPs for transmission to DHCS. Providers that do not have these capabilities will be allowed to submit invoices to MCPs and MCPs will then convert the invoices to encounters for submission to the DHCS.

DHCS is not specifying the payment model between MCPs and Providers for Community Supports, though DHCS encourages plans and Providers to adopt or progress to value based payment (VBP) models for Community Supports.

If the Community Supports Provider is paid by the MCP on a fee-for-service (FFS) basis, they will be expected to generate a claim and send it to the MCP for payment processing. If the Community Supports Provider is unable to send a compliant 837P claim to the MCP, they will be expected to send an invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that they will subsequently submit to DHCS according to current DHCS policy.

If a Community Supports Provider is paid by the MCP on a capitated basis, then the Provider will still be expected to generate and submit a compliant encounter to MCPs. In the event that Community Supports Provider is unable to submit a compliant 837P encounter, they will be expected to send a paid invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that the plan will subsequently submit to DHCS according to current DHCS policy.

Community Supports Providers and MCPs may need to re-configure their existing systems to meet these requirements.

Authorization Process

To support Members' access to any offered Community Supports, MCPs must have nondiscriminatory authorization processes in place to determine eligibility for Members for each Community Support, in accordance with the service definitions or other narrower eligibility definitions that have been approved by the Department in advance, in accordance with the MCP's contract with DHCS.

As part of the authorization process, MCPs must document their process for ensuring documentation of appropriate clinical support for the medical appropriateness of the Community Support. This process must detail that provision of the Community Support, recommended by a provider at the plan or network level using their professional judgement, is likely to reduce or prevent the need for acute care or other Medicaid services, including but not limited to inpatient hospitalizations, skilled nursing facility stays, or emergency department visits. Therefore, the Community Support is medically appropriate for that Member.

This process may be incorporated into the MCP's utilization management process or may include provider-level documentation in an individual's care plan or other record. The service definitions for several Community Supports already require this documentation. For example:

- Recipients of the Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services Community Supports are required to have individualized housing support plans. MCPs may use these plans to document the member needs that qualify them for this service and ensure it is a medically appropriate substitute for State Plan services. Per the service definitions, this documentation could include, for example, documented evidence of a serious chronic condition and/or serious mental illness and could include a documented risk of institutionalization or requiring residential services because of a substance use disorder.

- When authorizing Asthma Remediation Services, managed care plans are required to provide a written evaluation specific to the member describing how and why the remediation meets the member's needs. MCPs may use these evaluations to document the member needs that qualify them for this service and ensure it is a medically appropriate substitute for State Plan services. Per the service definition, this documentation could include documentation of poorly controlled asthma and documentation from a licensed health care Provider that the service will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

In addition to these specific examples, most individuals who receive Community Supports will also qualify for either enhanced care management (ECM) or Complex Case Management (CCM). In these instances, MCPs may use ECM or CCM care plans to document member needs that qualify them for a Community Support and ensure it is a medically appropriate substitute for a State Plan service. This process may apply to any Community Support provided to a recipient who is also in one of these care/case management programs.

MCPs may review requests or referrals for Community Supports services for cost-effectiveness as part of MCPs' utilization management processes during authorization.

Requirement for Expedited Authorization Timeframes

MCPs must have Policies and Procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate. MCPs are required to submit their Policies and Procedures for situations that may be appropriate for expedited authorization of a Community Support (e.g., for sobering center visits where a 48-hour+ authorization timeline would preclude effective use of the service). DHCS has determined the following Community Supports are inherently time sensitive and are subject to expedited authorization:

- Recuperative Care

- Short Term Post Hospitalization Housing
- Sobering Centers
- Medically Tailored Meals being offered post-acute care

Prime & Subcontractor Authorization Alignment

Prime MCPs and their subcontractors must align all standards and Policies and Procedures related to authorizations for ECM and Community Supports, including both the adjudication standards and the documentation used for referrals and authorizations. This requirement applies to each Community Support commonly offered across a prime and its subcontractors. Subcontractors may still make different decisions than the prime regarding which Community Supports to elect.

Continuity of Care for Members Receiving Community Supports

If a member transfers MCPs and their new MCP offers the same Community Support(s) as the member received under their previous MCP, then the new MCP must honor the Community Support authorization for that member. Where the new MCP offers the same Community Supports(s) as the previous MCP, the new MCP must:

- Automatically authorize newly enrolled MCP members who were receiving a Community Support through their previous MCP, adapting the specifications (e.g., amount and duration) to be consistent with the parameters of the new MCP's offered Community Support

    o Applies only to Community Supports that do not have a "once in a lifetime" restriction

- Have a process of engaging the previous MCP, member, and/or Community Supports Provider to mitigate gaps in care

- Have a process for reviewing historical utilization data using a 90-day look-back period to identify members receiving Community Supports

- The MCP is also encouraged to bring in network new members' out-of-network Community Supports providers.

Graduation/Deauthorization Process

MCPs must have processes in place for graduating or discontinuing Community Supports for members who no longer qualify for, no longer require, or no longer want to receive Community Supports services. A Notice of Action Letter is required in all situations except for when an eligible member chooses not to participate.

IX. Monitoring, Oversight, and Reporting

Oversight of Community Supports Providers

MCP Requirements

MCPs are required to perform oversight of Community Supports Providers, holding them accountable to all Community Supports requirements contained in the ECM and Community Supports Contract Template, the MCP's MOC, and any associated guidance issued by DHCS. MCPs are expected to use Community Supports Provider Standard Terms and Conditions to develop Community Supports contracts with Community Supports Providers and are expected to incorporate all Community Supports Provider requirements reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting criteria. To streamline the Community Supports implementation:

- MCPs must hold Community Supports Providers responsible for the same reporting requirements as those that the MCP must report to DHCS.

- The MCPs will not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting; and

- MCPs are encouraged to collaborate with other MCPs within the same county on oversight of Community Supports Providers.

Subcontractors

MCPs may subcontract with other entities to administer Community Supports, provided they adhere to the below requirements:

- MCPs will maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting;
- MCPs will be responsible for developing and maintaining DHCS approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services;
- MCPs will remain responsible for ensuring the Subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members;
- MCPs will report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or Counties in which Members are served; and
- MCPs will make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation.

MCPs will ensure their agreements with any Subcontractor mirrors the requirements set forth in ECM and Community Supports Contract Template, and the ECM and Community Supports Provider Standard Terms and Conditions, as applicable to Subcontractor. MCPs are encouraged to collaborate with their Subcontractors on the approach to Community Supports to minimize variance in how Community Supports will be implemented and to ensure a streamlined, seamless experience for Community Supports Providers and Members.

Model of Care (MOC) and Approval Process

The ECM and Community Supports MOC is each MCP's framework for providing ECM and Community Supports. Each MCP's MOC will include its overall approach to ECM and Community Supports; its detailed Policies and Procedures regarding ECM and Community Supports Provider (including non-traditional Providers) contracting and oversight; its ECM and Community Supports Provider network capacity; and the contract language that will define key aspects of its arrangements with its ECM and Community Supports Providers. The MOC also includes specific "Transition and Coordination" content for MCPs operating in Whole Person Care (WPC) and/or Health Home Program (HHP) Counties. MCPs in these Counties must describe how they will ensure smooth transitions for their Members from WPC and HHP into ECM and Community Supports.

DHCS will use each MCP's MOC submission to determine its readiness to meet ECM and Community Supports requirements. MCPs must lay out their MOCs using the DHCS-developed standard template (MOC Template) and submit them to DHCS for review and approval prior to initial ECM and Community Supports implementation in 2022. MCPs must make updates to their MOCs to reflect any Community Supports changes.

MCPs should expect review of the MOC to be an iterative process with DHCS during each review period. DHCS may require resubmission of certain questions or additional material to ensure alignment with DHCS requirements.

Encounter Data Submission Process

DHCS requires MCPs to submit encounter data in accordance with requirements in the MCP contract and All Plan Letter 14-019, or any subsequent updates. MCPs are required to submit encounter data for Community Supports through the existing encounter data reporting mechanisms for all covered services for which they have incurred any financial liability, whether directly or through subcontracts or other arrangements, using ASC X12 837 version 5010 x223 Institutional and Professional transactions or NCPDP 2.2 or 4.2 transactions and the new Community Supports coding requirements, to the Post Adjudicated Claims and Encounters System (PACES) beginning on January 1, 2022.

Scope of Monitoring Activities

DHCS will monitor MCPs implementation of and compliance with ECM and Community Supports requirements across multiple domains including, Membership, Service Provision, Grievances and Appeals, Provider Capacity, and Quality. DHCS will monitor MCP compliance with ECM and Community Supports using existing monitoring processes as well as through submission of time-limited quarterly Implementation Monitoring Report Templates.

X.   Performance Incentive Program

CalAIM's ECM and Community Supports programs will require significant new investments in care management capabilities, Community Supports infrastructure, information technology (IT) and data exchange, and workforce capacity at both the MCP and Provider levels. Incentive payments will be a critical component of CalAIM to promote MCP and Provider participation in, and capacity building for, ECM and Community Supports.

DHCS has designed an incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022 for the achievement of defined milestones. Infrastructure development, ECM and Community Supports Provider capacity building, and Community Supports take-up are priority areas for Program Year 1 (i.e., Calendar Year 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas. Quality will emerge as a priority area for Program Year 2 (i.e., Calendar Year 2023).

Additional guidance on the Performance Incentive Program, as well more details on available Projects for Assistance in Transition from Homelessness (PATH) Funding, is available on the ECM & Community Supports webpage.

Listed below are the goals and design principles of the program.

Performance Incentive Goals:

- Build appropriate and sustainable ECM and Community Supports capacity
- Drive MCP investment in necessary delivery system infrastructure
- Incentivize MCP take-up of Community Supports
- Bridge current silos across physical and behavioral health delivery
- Reduce health disparities and promote health equity
- Achieve improvements in quality performance

Performance Incentive Design Principles:

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably
2. Set ambitious, yet achievable measure targets
3. Ensure efficient and effective use of all performance incentive dollars
4. Drive significant investments in core priority areas up front
5. Minimize administrative complexity
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC) / Health Home Program (HHP) Counties and non-WPC/HHP Counties
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates
8. Measure and report on the impact of incentive funds

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XI. Community Supports Resource Directory

Community Supports Resource Directory	
Resource	**Description**
ECM and Community Supports (ILOS) Website	Online repository for ECM & Community Supports (ILOS) program documents and technical assistance. Future guidance will be posted here.
Community Supports Fact Sheet	Overview of Community Supports and DHCS' vision for the Community Supports initiative
Frequently Asked Questions Document	Answers to key Community Supports policy questions. Document will be updated with new questions/answers on an ad hoc basis
ECM & Community Supports Change Memo	Summary of key policy changes DHCS made to ECM and Community Supports requirements documents based on stakeholder feedback.
DHCS-MCP ECM and Community Supports (ILOS) Contract Template	Community Supports contract requirements for MCPs.
ECM and Community Supports (ILOS) Standard Provider Terms and Conditions	Standardized language that MCPs must include in all contracts with Community Supports Providers.
CalAIM ECM and Community Supports Model of Care Cover Note: Instructions and Timeline **CalAIM ECM and Community Supports (ILOS) Model of Care Template**	Template for MCP to outline proposed protocols for implementation and provision of Community Supports. Each MOC must be reviewed and approved by DHCS prior to Community Supports implementation.
ECM and Community Supports (ILOS) Coding Guidance	Guidance on encounter data submissions and a list of HCPCS Level II Codes for Community Supports services delivered.

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Community Supports (ILOS) Evidence Library – Executive Summary	Select highlights and key findings of DHCS' research on the measurable impacts Community Supports may have on health care costs, utilization, and health outcomes
Non-Binding Community Supports Pricing Guidance*	Non-Binding guidance on pricing for Community Supports services.
Community Supports Billing & Invoicing Guidance*	Guidance defining the standard, "minimum necessary" data elements MCPs will collect from Community Supports Providers.
Community Supports Quarterly Implementation Reporting Framework*	Guidance defining DHCS' strategy for monitoring the implementation of Community Supports.
Community Supports Explainer	Overview of Community Supports for providers or others interested in learning more about these services.

*Check the ECM and Community Supports (ILOS) Website for the latest updates and versions of Community Supports documents.

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XII. Glossary of Terms

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative isan "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexityand increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term

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services and supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and need ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e., both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Community Supports (In lieu of services): Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and a Member cannot be required to use them.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020, when the Medi-Cal 2020 demonstration expires.

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Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the 2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020, and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, andcommunity-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

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Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long-Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

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Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value-based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See SMD #18-011)

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;

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- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December 31, 2020, with approval pending to extend through calendar year 2021.