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

Background

The Whole Person Care (WPC) pilots and Health Homes Program (HHP) built a foundation for an integrated approach to coordinating medical care, behavioral health and social services to improve beneficiary health outcomes. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing Community Supports coverage will make a statewide offering of these critical interventions for Medi-Cal beneficiaries.

The Department of Health Care Services (DHCS) is proposing to implement Community Supports, which are flexible wrap-around services that a Medi-Cal managed care plan (MCP) will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay.

According to federal Medicaid program rules, Community Supports are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. Community Supports can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service
- The services are optional for the MCP to provide
- The services are optional for beneficiaries
- The Community Supports are authorized and identified in the state's Medi-Cal MCP contracts.

MCPs will develop a network of providers that have the expertise and capacity regarding specific types of services.

DHCS is proposing to include the following 14 distinct services as Community Supports under Medi-Cal managed care. Each service will have defined eligible populations, code sets, potential providers, restrictions and limitations:

- 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 and adult residential facilities
- Community transition services/nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations (home modifications)
- Meals/medically tailored meals
- Sobering centers
- Asthma remediation

In order to be equipped with the required managed long-term services and supports (MLTSS) and housing infrastructure, DHCS must provide MCPs with financial incentive payments for providers. MCPs will work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and Community Supports services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

Each Community Supports offered by CalOptima is explained further below.

Housing Transition/Navigation Services

- Housing transition/navigation services assist beneficiaries with obtaining housing and include:
  - » Conducting a tenant screening and housing assessment that identifies the member's preferences and barriers related to successful tenancy
  - » Developing an individualized housing support plan based upon the housing assessment. It should address identified barriers, include short- and long-term measurable goals for each issue, establish the member's approach to meeting the goal, and identify when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal
  - » Searching for housing and presenting options
  - » Assisting with:
    - ◦ Securing housing, including the completion of housing applications and securing required documentation
    - ◦ Requests for reasonable accommodation, if necessary
    - ◦ Arranging for and supporting the details of the move
    - ◦ Benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process
  - » Identifying and securing available resources to assist with:
    - ◦ Subsidizing rent and matching available rental subsidy resources to members
    - ◦ Covering expenses if included in the housing support plan
  - » Educating and engaging with landlords
  - » Ensuring the living environment is safe and ready for move-in
  - » Communicating and advocating on behalf of the member with landlords
  - » 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
  - » 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
  - » Identifying and coordinating environmental modifications to install necessary accommodations for accessibility
- The services provided:
  - » Should be based on individualized assessment needs and documented in the individualized housing support plan. Members may require and access only a subset of the services listed above
  - » Should use best practices for members who are experiencing homelessness and who have complex health, disability and/or behavioral health conditions
  - » May involve coordination with other entities to ensure the member has access to supports needed for successful tenancy
  - » Do not include the provision of room and board or payment or rental costs
  - » Should adopt, as a standard, the demonstrated need to ensure seamless service to members experiencing homelessness entering the housing transition navigation services community supports
  - » Will require close coordination with local Coordinated Entry Systems (CES), homeless services authorities, public housing authorities and other operators of local rental subsidies for members who need rental subsidy support to secure permanent housing

Eligibility Criteria:

Members must meet one of the following:

- Member is prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES
- Member meets the Housing and Urban Development (HUD) definition of homeless
- Member meets the HUD definition of at risk of homelessness and meet certain other DHCS criteria
- Member is determined to be at risk of experiencing homelessness and meet other DHCS criteria

Restrictions and Limitations:

- Housing transition navigation services must be identified as reasonable and necessary in the member's individualized housing support plan

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner
- Members who meet the eligibility requirements should also be assessed for Enhanced Care Management (ECM) and housing tenancy and sustaining services (if provided in their county)

Housing Deposits

- 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 does not constitute room and board, such as:
  - » Security deposits required to obtain a lease on an apartment or home
  - » Set-up fees/deposits for utilities or service access and utility arrearages
  - » First month coverage of utilities, including, but not limited to, telephone, gas, electricity, heating and water
  - » First and last month's rent as required by a landlord for occupancy
  - » Services necessary for the members' health and safety, such as pest eradication and one-time cleaning prior to occupancy
  - » Goods and other medically necessary adaptive aids and services designed to preserve a member's health and safety in the home, such as air conditioning, heating, hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies, etc.
- The services provided should utilize best practices for members who are experiencing homelessness and 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

Eligibility Criteria:

Members must meet one of the following:

- Member has received housing transition navigation services community supports
- Member is prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES
- Member meets the HUD definition of homeless

Restrictions and Limitations:

- Housing deposits are an allowable Community Supports if:
  - » They are available once in a member's 's lifetime
    - ◦ They can be approved one additional time only with documentation as to what conditions have changed to demonstrate why providing housing deposits would be more successful on the second attempt. CalOptima is expected to make a good faith effort to review information available to determine if the member has previously received services
  - » Housing depostis are identified as reasonable and necessary in the member's individualized housing support plan and are available only when the member is unable to meet such expenses
  - » Members also receive housing transition navigation services in conjunction with this service (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan)

Licensing and Allowable Providers:

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

Housing Tenancy and Sustaining Services

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy for members once housing is secured and includes:

- Providing early identification and intervention for behaviors that may jeopardize housing
- Providing independent living and life skills, including assistance with and training on budgeting, including financial literacy and connection to community resources
- Providing education and training on the roles, rights and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized
- Health and safety visits, including unit habitability inspections
- Coordinating with the landlord and case management provider to address identified issues that could impact housing stability. Further coordinating with the tenant for modifications to their housing support and crisis plan on a regular basis
- Assistance with:
  - » Resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action
  - » Benefits advocacy, including assistance related to SSI eligibility and the SSI application process.
  - » The annual housing recertification process
  - » Lease compliance, including ongoing support with activities related to household management
- Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized

The services provided:

- Should be based on individualized assessment needs and documented in the individualized housing support plan
- 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
- May involve coordination with other entities to ensure the member has access to supports needed to maintain successful tenancy
- Do not include the provision of room and board or payment of rental costs

Eligibility Criteria:

Members who:

- Received housing transition navigation services Community Supports
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES
- Meet HUD definition of homelessness
- Who are determined to be at risk of experiencing homelessness

Restrictions and Limitations:

- Available from the initiation of services through the time when the member's housing support plan determines they are no longer needed
- Available for a single duration in a member's lifetime
- Can be approved one additional time with appropriate documentation as to what conditions have changed to demonstrate why providing housing tenancy and sustaining services would be more successful on the second attempt
- Services must be identified as reasonable and necessary in the member's individualized housing support plan and are available only when the member is unable to successfully maintain longer-term housing without such assistance
- Many members will have also received Housing Transition/Navigation Services in conjunction with this service, but it is not a prerequisite for eligibility

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner
- Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports
- Members who meet the eligibility requirements for housing tenancy and sustaining services should also be assessed for ECM and may have received housing transition navigation services (if provided in the county)

Short-Term Post-Hospitalization Housing

- Short-term post-hospitalization housing assists members who do not have a residence and who have high medical or behavioral health needs and avoid further utilization of State Plan services. It provides the opportunity for members to continue their medical, psychiatric or substance use disorder recovery immediately after exiting an inpatient hospital (either an acute, 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
- This setting must provide members with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living (ADLs); receiving necessary medical, psychiatric or substance use disorder care; case management; and beginning to access other housing supports such as housing transition navigation
- This setting may include an individual or shared interim housing setting, where residents receive the services described above
- Members must be offered the housing transition navigation Community Support 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 an individualized housing support plan to identify preferences and barriers related to successful housing tenancy after short-term post-hospitalization housing
- 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 Criteria:

Members who are:

- Exiting recuperative care
- Exiting an inpatient hospital stay (either an acute, 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
- Meet the HUD definition of homeless
- Meet the HUD definition of at risk of homelessness and meet certain other DHCS criteria
- Determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization services if they have significant barriers to housing stability
- 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, rehospitalization, or institutional readmission

Restrictions and Limitations:

- Short-term post-hospitalization services are available once in an individual's lifetime and are not to exceed a duration of six months (but may be authorized for a shorter period based on individual needs). MCPs are expected to make a good faith effort to review information available to them to determine if an individual has previously received services
- The service is only available if enrollee is unable to meet such an expense

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services. Licensing and allowable providers include, but are not limited to:
  - » Interim housing facilities with additional on-site support
  - » Shelter beds with additional on-site support
  - » Converted homes with additional on-site support
  - » Directly operated or contracted county 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
- CalOptima must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained

Note: CalOptima will be implementing this Community Support no sooner than July 1, 2022.

Recuperative Care

- Recuperative care, or medical respite care, is short-term residential care for members 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
- At a minimum, the service will include interim housing with a bed and meals and monitoring of the members ongoing medical or behavioral health condition
- Based on the member needs, the recuperative care may also include:
  - » Limited or short-term assistance with instrumental activities of daily living (IADLs) and/or activities of daily living
  - » Coordination of transportation to post-discharge appointments
  - » Connection to any other ongoing services a member may require, including mental health and substance use disorder services
  - » Support in accessing benefits and housing
  - » Gaining stability with case management relationships and programs
- Should not replace or be duplicative of the services provided to members utilizing the enhanced care management program
- May be utilized in conjunction with other housing Community Supports services
- 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 Criteria:

Members who are:

- At risk of hospitalization or are post-hospitalization
- Live alone with no informal supports
- Face housing insecurity or have housing that would jeopardize their health and safety without modification

Restrictions and Limitations:

- Necessary to achieve or maintain medical stability and prevent hospital admission or readmission
- Not more than 90 days in continuous duration
- Does not include funding for building modification or building rehabilitation

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services. Licensing and allowable providers include, but are not limited to:
  - » 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
- CalOptima must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained

Day Habilitation Programs

- Day habilitation programs are provided in a member's home or an out-of-home, non-facility setting
- Designed to assist the member in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in their 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 ECM or other Community Supports, day habilitation programs can provide a physical location to meet with and engage with providers
- When possible, 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:
  - » The use of public transportation
  - » Personal skills development in conflict resolution
  - » Community participation
  - » Developing and maintaining interpersonal relationships
  - » Daily living skills (cooking, cleaning, shopping, money management)
  - » Community resource awareness such as police, fire or local services to support independence in the community
- Programs may include assistance with, but not limited to, the following:
  - » Selecting and moving into a home
  - » Locating and choosing suitable housemates
  - » Locating household furnishings
  - » Settling disputes with landlords
  - » Managing personal financial affairs
  - » Recruiting, screening, hiring, training, supervising and dismissing personal attendants
  - » Dealing with and responding appropriately to governmental agencies and personnel
  - » Asserting civil and statutory rights through self-advocacy
  - » Building and maintaining interpersonal relationships, including a circle of support
  - » Coordination with CalOptima to link member to any Community Supports and/or ECM services for which the member may be eligible
  - » Referral to non-Community Supports housing resources if member does not meet housing transition or navigation services Community Support eligibility criteria
  - » Assistance with income and benefits advocacy including general assistance/general relief and SSI if member is not receiving these services through Community Supports or ECM
  - » Coordination with CalOptima to link member to health care, mental health services and substance use disorder services based on individual needs, if member is not receiving similar service through Community Supports or ECM
- 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 Criteria:

Members who are:

- Experiencing homelessness, have exited homelessness and entered housing in the last 24 months, or at risk of homelessness or institutionalization and whose housing stability could be improved through participation in a day habilitation program

Restrictions and Limitations:

- None indicated by DHCS

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services. Licensing and allowable providers include, but are not limited to:
  - » Mental health or substance use disorder treatment providers, including county behavioral health agencies
  - » Licensed psychologists
  - » Licensed certified social workers
  - » Registered nurses
  - » Home health agencies
  - » Professional fiduciary
  - » Vocational skills agencies

Note: CalOptima will be implementing this Community Support no sooner than July 1, 2022.

Personal Care and Homemaker Services

- Personal care services and homemaker services are provided to members who need assistance with ADLs such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with IADLs such as meal preparation, grocery shopping and money management
- Includes services provided through the 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
- 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
  - » As authorized during any In-Home Supportive Services waiting period (the 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
  - » By members not eligible to receive In-Home Supportive Services to 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
- 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 Criteria:

Members who are:

- At risk for hospitalization or institutionalization in a nursing facility
- With functional deficits and no other adequate support system
- Meet the HUD definition of at risk of homelessness and meet certain other DHCS criteria
- Approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services

Restrictions and 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 personal care and homemaker services Community Support during this reassessment waiting period

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services. Licensing and allowable providers include, but are not limited to:
  - » Home health agencies
  - » County agencies
  - » Personal care agencies
  - » Area Agency on Aging (AAA)

Note: CalOptima will be implementing this Community Support no sooner than July 1, 2022.

Medically Tailored Meals/Medically Supportive Food

- 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 nutrition goals at critical times to help regain and maintain health
- Results include improved member health outcomes, lower hospital readmission rates, well-maintained nutritional health status and increased member satisfaction
- Meals are delivered to the home immediately following discharge from a hospital or nursing home, when members are most vulnerable to readmission
- Medically tailored meals: Meals provided to the member at home that meet the unique dietary needs of those with chronic diseases
- Medically tailored meals are made to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional. They reflect appropriate dietary therapies and evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management or side effects to ensure the best possible nutrition-related health outcomes
- Medically supportive food and nutrition services, including medically tailored groceries, healthy food vouchers and food pharmacies
- Behavioral, cooking and nutrition education is included when paired with the direct food assistance as enumerated above
- CalOptima has 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 Criteria:

Members who:

- Have 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
- Are discharged from the hospital or a skilled nursing facility or are at high risk of hospitalization or nursing facility placement
- Have extensive care coordination needs

Restrictions and 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 are not eligible is they qualify for or are reimbursed by alternate programs
- Meals are not covered to respond solely to food insecurities

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services. Licensing and allowable providers include, but are not limited to:
  - » 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 and nutrition providers

Note: CalOptima will be implementing this Community Support no sooner than July 1, 2022.

Sobering Centers

- Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol 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
  - » Homeless care support services
  - » Screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate
- Direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged
- Partnership with law enforcement, emergency personnel and outreach teams is required 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 Criteria:

Members who are:

- Age 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 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 and Limitations:

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

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services with these unique populations. Licensing and allowable providers include, but are not limited to:
  - » Sobering centers, or other appropriate and allowable substance use disorder facilities
    - ◦ CalOptima will 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
    - ◦ CalOptima will apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. CalOptima will monitor the provision of all the services included above
  - » All allowable providers must be approved by the CalOptima to ensure adequate experience and appropriate quality of care standards are maintained

Note: CalOptima will be implementing this Community Support no sooner than July 1, 2022.