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cchealth.org/healthplan

Contra Costa Health Plan (CCHP)
Community Supports (CS) Program Overview & Eligibility

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

CCHP offers the following DHCS-approved CS services:

1. Housing Transition Navigation Services
2. Housing Tenancy and Sustaining Services
3. Short-Term Post-Hospitalization Housing
4. Recuperative Care (Medical Respite)
5. Medically Tailored Meals/ Medically Supportive Food
6. Asthma Remediation
7. Housing Deposits
8. Respite Services
9. Personal Care and Homemaker
10. Environmental Accessibility Adaptations (Home Modifications)
11. Nursing Facility Transition/Diversion to RCFE/ARF
12. Community Transition Services/Nursing Facility Transition to a Home
13. Day Habilitation (Go Live July 2024)
14. CCHP is currently electing not to provide Sobering Centers currently.

Community Support (CS) referrals can be submitted through ccLink or by calling our Case Management Department at (925) 313-6887 (TTY 771). If you have questions or need assistance entering referrals, please contact CCHPCalAIM@cchealth.org.

Additional information on each Community Supports service is provided below.

April 2024

1. Housing Transition Navigation Services

A. Service Overview

Housing Transition Navigation Services assist members with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the preferences and barriers related to successful tenancy. The assessment may include collecting information on the 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 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.
8. Assisting with requests for reasonable accommodation, if necessary.
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.
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.
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; 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.

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.

B. Eligibility Criteria:
    a. Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or 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.
    b. Individuals experiencing homelessness:
        i. Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution); and
        ii. Who are receiving enhanced care management (ECM); or
        iii. who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization; or

        requiring residential services because of a substance use disorder. 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.
    c. Individuals at risk of homelessness:
        i. Individuals at risk for homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations as:
            1. Has an annual income below 30 percent of median family income for the area, as determined by HUD; and
            2. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from “Homeless” as defined above; and
                i. Has moved because of economic reasons two or more times in the last 60 days; or
                ii. Is living in the home of another because of economic hardship; or
                iii. Has been notified in writing that their current housing will be terminated within thirty (30) days; or

iv. 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; or
v. 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; 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.

d. 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
e. 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:

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

C. Restrictions/Limitations:
   a. Member may not receive duplicate support from other State, local, or federally funded programs.
   b. Members should be disenrolled/graduate from Housing Transition Navigation Services when stable housing is found, and they are enrolled in Housing and Tenancy Sustaining Services.
   c. 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.

2. Housing Deposits

A. Service 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 months 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 as noted above. To assess the viability of a housing plan, CCHP will use a rent-to-income ratio of 40% as a benchmark of affordability. This benchmark will guide CCHP review, and ultimately all Housing Deposit requests will be considered on case-by-case basis, including consideration of all contextual factors and resources available to member.

B. Eligibility Criteria:

a. Any individual who received Housing Transition and Navigation Services Community Support in Contra Costa County and counties that offer Housing Transition and Navigation Services; or

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.

b. 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.

c. Member must provide W9, Lease agreement, proof of income, and housing subsidy verification if applicable:
    i. Proof of income can include but is not limited to SSI/SSDI income verification letter, most recent 2 months of pay stubs, cash aid award letter, or self-attestation.
    ii. Section 8 Voucher or other housing subsidy letter stating members portion of rent.
d. For deposit requests including set-up fees/deposits for utilities or service access and utility arrearages; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; goods such as an air conditioner or heater, and other medically necessary adaptive aids and services. An invoice/receipt for the above services needs to be attached to referral for processing, these requests will be reimbursed to the member. Please notate in the comment section the amount that needs to be paid to the member for such services.

C. Restrictions/Limitations:

a. Housing Deposits are available once in an 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.

b. 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.

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

c. 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.

3. Housing Tenancy and Sustaining Services

A. Service 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 inspections13.
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).
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 Criteria:

Any individual who received Housing Transition Navigation Services Community Support in Contra Costa County or counties that offer Housing Transition Navigation Services; or

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

a. Individuals experiencing homelessness:

i. Individuals who meet the HUD definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution); and
ii. Who are receiving enhanced care management (ECM); or
iii. who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization; or

requiring residential services because of a substance use disorder. 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.

b. Individuals at risk of homelessness:
    i. Individuals at risk for homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations as:
        1. Has an annual income below 30 percent of median family income for the area, as determined by HUD; and
        2. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from "Homeless" as defined above; and
            a. Meets one of the following conditions:
                i. Has moved because of economic reasons two or more times in the last 60 days; or
                ii. Is living in the home of another because of economic hardship; or
                iii. Has been notified in writing that their current housing will be terminated within thirty (30) days; or
                iv. 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; or
                v. 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; or
                vi. 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.

c. 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

d. 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:

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

B. Restrictions/Limitations:

a. These services are available from the initiation of services through the time when the individuals housing support plan determines they are no longer needed. They are only available for a single duration in the 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.
b. These services must be identified as reasonable and necessary in the individuals 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.

4. Short-Term Post-Hospitalization Housing

Service 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.

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.

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.

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.

Given CCHP's experience to date, CCHP now offers this service county-wide. CCHP is working with the housing providers in the county to understand the feasibility and process for expanding this benefit as creating additional housing capacity requires capital infrastructure, permitting, and licensing, which cannot be paid for directly out of Medi-Cal dollars.

A. Eligibility:

Individuals exiting recuperative care; or

a. 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:
    i. Individuals experiencing homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution); and
    ii. Who are receiving Enhanced Care Management (ECM); or

    Who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services because of a substance use disorder.

b. Individuals at risk for homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    i. (1) An individual or family who:
        1. Has an annual income below 30 percent of median family income for the area, as determined by HUD; and
        2. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from "Homeless" as defined above; and
            a. Meets one of the following:
                i. Has moved because of economic reasons two or more times in the last 60 days; or

ii. Is living in the home of another because of economic hardship; or
iii. Has been notified in writing that their current housing will be terminated within thirty (30) days; or

b. 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; or
c. 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; or
d. 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
e. 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.

ii. (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
iii. (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 if they have significant barriers to housing stability and meet at least one of the following:

1) Have one or more serious chronic conditions; or
2) Have a severe mental illness; or
3) Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); or
4) Are receiving Enhanced Care Management; or

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.

5) Member must agree to Housing Transition Navigation Supports to prepare them for transition from this setting.

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, rehospitalization, or institutional readmission.

B. Restrictions/Limitations:

Short-Term Post-Hospitalization services are available once in a lifetime and are not to exceed a duration of six (6) months (but may be authorized for a shorter period based on individual needs).

a. The service is only available if enrollee is unable to meet such an expense.
b. Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.
c. Member may not be receiving duplicate support from other State, local, or federally funded programs.

5. Recuperative Care (Medical Respite)

A. Service 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 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.

Eligibility Criteria:

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

a. Individuals who live alone with no formal supports (e.g., 24/7 supervision); or
b. Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification;
c. Individuals who meet the 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 (ECM); **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 because 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;

d. Individuals at risk for homelessness as defined by the HUD definition in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    i. (1) An individual or family who:
        1. Has an annual income below 30 percent of median family income for the area, as determined by HUD; and
        2. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from “Homeless” as defined above; and
            a. Meets one of the following:
                i. Has moved because of economic reasons two or more times in the last 60 days; or
                ii. Is living in the home of another because of economic hardship; or
                iii. Has been notified in writing that their current housing will be terminated within thirty (30) days; or
            b. 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; or
            c. 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; or
            d. 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

e. 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.

ii. (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

iii. (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 (Medical Respite)if they have significant barriers to housing stability and meet at least one of the following:

1) Have one or more serious chronic conditions; or
2) Have a severe mental illness; or
3) Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); or
4) Are receiving Enhanced Care Management; or
5) Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.
6) 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.

C. Restrictions/Limitations:

1. Recuperative care/medical respite is an allowable Community Supports service if it is:
    a. Necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions,
    b. Not more than 90 days in continuous duration, and
    c. Does not include funding for building modification or building rehabilitation.

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

2. 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.

6. Respite Services

A. Service Overview
Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from Recuperative Care (Medical Respite) and is rest for the caregiver only.

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 basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that 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.

B. Eligibility:

1. 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.
    a. Children who were previously 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 qualify for services if they meet the above eligibility requirements.

C. Exclusions/Limitations:

1. 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.
2. 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.
3. Respite services cannot be provided virtually, or via telehealth.
4. This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.
5. Member may not receive duplicate support from other State, local, or federally funded programs.
6. 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.

7. Day Habilitation

A. Service Overview

Day Habilitation Programs are provided in a 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 persons 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;
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords;
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;
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.

B. Eligibility:

1. 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.

C. Restrictions/Limitations:

a. Member may not receive duplicate support from other State, local, or federally funded programs.
b. Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance

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

A. Service 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:

Assessing the Member's housing needs and presenting options.

1. 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.
2. 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).
3. Communicating with facility administration and coordinating the move.
4. Establishing procedures and contacts to retain facility housing.
5. 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.

B. Eligibility:

A. For Nursing Facility Transition:

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

b. Willing to live in an assisted living setting as an alternative to a Nursing Facility; **AND**
Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

For Nursing Facility Diversion:

a. Interested in remaining in the community;
AND

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

c. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

C. Restrictions/Limitations:

Individuals are directly responsible for paying their own living expenses.

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

b. Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

9. Community Transition Services/Nursing Facility Transition to a Home

A. Service 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.
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.
7. 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.

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 (Housing Deposits CS); services necessary for the health and safety, such as pest eradication and one-time cleaning prior to occupancy (Housing Deposits CS); 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 (Environmental Accessibility Adaptations CS).

B. Eligibility:
    a. Currently receiving medically necessary nursing facility Level of Care (LOC) services and in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
    b. Has lived 60+ days in a nursing home and/or Medical Respite setting; and
    c. Interested in moving back to the community; and
    d. Able to reside safely in the community with appropriate and cost-effective supports and services.

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

10. Personal Care and Homemaker Services

Service 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 (IHSS) 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 can be utilized:

1. Above and beyond any approved county IHSS hours, when additional hours are required and if IHSS benefits are exhausted; and
2. As authorized during any IHSS waiting period (Member must be already referred to IHSS); this approval period includes services prior to and up through the IHSS application date.
3. For Members not eligible to receive IHSS, to help avoid a short-term stay in a skilled nursing facility **(not to exceed 60 days).**

Similar services available through IHSS should always be utilized first. These Personal Care and Homemaker services should only be utilized if member is at risk for institutionalization and if additional hours/supports are not authorized by IHSS.

B. Eligibility:

a. Individuals at risk for hospitalization, or institutionalization in a nursing facility; and Individuals with functional deficits and no other adequate support system and ineligible for IHSS; or
b. Individuals approved for IHSS. Eligibility criteria can be found at: https://www.cdss.ca.gov/in-home-supportive-services

C. Restrictions/Limitations:

a. This service cannot be utilized in lieu of referring to the IHSS program. Member must be referred to the IHSS program when they meet referral criteria.
b. Personal Care and Homemaker services are for 8 hours per day or 500 hours per 12-month period combined.
c. If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to IHSS for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.
d. Member may not receive duplicate support from other State, local, or federally funded programs.
e. 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.

11. Environmental Accessibility Adaptations (Home Modifications)

A. Service 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 adaptations include, but are not limited to:

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

2. Doorway widening for Members who require a wheelchair;
3. Chair/Stair lifts;
4. Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
5. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and
6. 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.). A home visit must be conducted to determine the suitability of any requested equipment or service and CCHP will attempt to obtain a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties.

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

The managed care plan may also request 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; and
    b) An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item; and
    c) A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

Currently CCHP has elected to not require a PT/OT evaluation for grab bars, ramps, or chair/stair lifts. This decision is based on feedback received from referring providers that this requirement was creating a barrier to utilization of the community support. CCHP has decided to make the decision for medical necessity based on the referring providers attestation of need.

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.

B. Eligibility:

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

C. Restrictions/Limitations:
   a. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
   a. Cannot be receiving duplicate service from other programs (Medi-Cal is a payor of last resort).
   b. 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 CCHP and 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.

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

12. Medically Tailored Meals/Medically Supportive Foods

Service 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.

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

B. Eligibility
   a. 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 disorder; **and**
   b. Individuals being discharged from the hospital or a skilled nursing facility and at high risk of hospitalization or nursing facility placement; **or**
   c. Individuals with extensive care coordination needs.

Members must agree to complete monthly dietician and/or nutrition education course to qualify for ongoing services beyond the initial 12-week authorization. This is to ensure that the members diet is medically appropriate and will not cause any undue hard as medical/health status can and do change.

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.).

Restrictions/Limitations:

Up to two (2) meals per day and/or up 13 boxes of groceries per 3 months, or longer if medically necessary.

a. Members excluded include those with the following:
   i. Meals that are eligible for or reimbursed by alternate programs are not eligible; or
   ii. Member does not have access to food storage/preparation; or
   iii. Member is in Hospice, Skilled Nursing Facility, or incarcerated; or
   iv. Meals are not covered to respond solely to food insecurities.
b. Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

13. Asthma Remediation

Service Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual or to enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include, but are not limited to:

1. Allergen-impermeable mattress and pillow dustcovers.
2. High-efficiency particulate air (HEPA) filtered vacuums.
3. Integrated pest management (IPM) services.
4. Dehumidifiers.
5. Air filters.
6. Other moisture-controlling interventions.

7. Minor mold removal and remediation services.
8. Ventilation improvements.
9. Asthma-friendly cleaning products and supplies.
10. 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:

1. A current specifying the requested remediation(s) for the Member;
2. 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 interventions identified to be medically appropriate and cost-effective.;
3. 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.
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 which MCPs may utilize in determining the appropriateness of these interventions. An accompanying training provides additional details about the connections between asthma triggers and lung health.

A. Eligibility:
   a. Member has a diagnosis of poorly controlled asthma as defined by either:
      i. An ED visit or hospitalization for asthma in the past 12 months; or
      ii. Two sick or urgent care visits for asthma in the past 12 months; or
      A score of 19 or lower on the Asthma Control Test.
   b. Member has stable housing i.e., housing that is owned, rented, leased, or occupied by the member or his/her caregiver; and
   c. Member has:
      i. Environmental asthma trigger(s) within his/her housing that can be resolved by remediation, as identified by a home visit assessment using a standardized assessment tool such as the CDC tool: https://www.cdc.gov/asthma/pdfs/home_assess_checklist_P.pdf ; and
      Agreed to and completed asthma education, medication reconciliation and education.
   d. Current licensed healthcare provider requesting the service must submit:
      i. Documentation that primary care provider (PCP) or specialist has reviewed and optimized medication regimen; and

ii. A brief written evaluation specific to the Member describing why the remediation(s) meets the needs of the individual and will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

B. Restrictions/Limitations:
   a. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
   b. Asthma remediations must be conducted in accordance with applicable State and local building codes.
   c. Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the 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.
   d. Asthma Remediation 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. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
   e. CCHP and DHCS are not responsible for the maintenance, repair, or removal of any permanent modifications under any circumstance.
   f. 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 CCHP and 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.
   g. 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.