Community Supports Services Eligibility Criteria and Restrictions/Limitations Guide

Blue Shield of California Promise Health Plan

This guide provides information for both **General (Section A)** and **Service-Specific (Section B)** criteria for Community Supports (CS) under CalAIM, in accordance with the Department of Health Care Services (DHCS) Medi-Cal Community Supports, or In Lieu of Services (ILOS) Policy Guide – July 2023.

A. GENERAL CRITERIA

General Criteria for Community Supports (CS) Referrals:
☐ Active Medi-Cal with Blue Shield Promise at the time of request for referral. ☐ Documentation of member's written or verbal consent for the CS referral.
General Exclusions:
☐ Member is receiving a similar program and a referral for CS would be duplication of services. ☐ 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.

B. SERVICE-SPECIFIC CRITERIA

Environmental Accessibility Adaptations (Home Modifications)
Description: 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 participant would require institutionalization.
Eligibility (Population Subset):
☐ Individuals at risk for institutionalization in a nursing facility.
Additional Service Details:
☐ EAA 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.). ☐ The 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 Plan must also receive and document: o Member has received a physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the Plan determines it is appropriate to approve without an evaluation. The physical or occupational therapy evaluation and report should contain at least the following: ▪ 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; ▪ 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
        - 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.
    - If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and
    - That a home visit has been conducted to determine the suitability of any requested equipment or service.
- ☐ The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Restrictions/Limitations:

- ☐ If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- ☐ EAAs must be conducted in accordance with applicable State and local building codes.
- ☐ EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the member's place of residence changes or if the member's condition has changed so significantly that 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 Plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.
- ☐ Services 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.

Housing Deposits
Description: 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 or payment of ongoing rental costs beyond the first and last month's coverage
Eligibility (Population Subset):
☐ Member who received or is receiving housing transition/navigation services; ☐ Member who is prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed 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 ☐ Member who meets 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.
Restrictions and Limitations:
☐ Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. ☐ These 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 meet such expense. ☐ Members must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service. ☐ Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Housing Tenancy and Sustaining Services

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

Eligibility (Population Subset):

- A member who received Housing Transition/ Navigation Services Community Support.
- A member who is 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 member who meets the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- A member who meets the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations.
    - Members 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:
        - Have one or more serious chronic conditions;
        - Have a Serious Mental Illness;
        - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);
        - 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.

Note: An attestation of the need for housing to satisfy any documentation requirements regarding the Member's housing status is acceptable.

Restrictions/Limitations:

- These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt.
- These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

- Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service, but it is not a prerequisite for eligibility.
- Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Housing Transition Navigation Services
Description: Housing Transition Navigation services assist beneficiaries with obtaining housing. Services do not include the provision of room and board or payment of rental costs.
Eligibility (Population Subset):
☐ A member who is 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 member who meets the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institutions for Mental Disease, and State Hospitals; or ☐ A member who meets the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations. • Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining services if they have significant barriers to housing stability and meet at least one of the following: o Have one or more serious chronic conditions; o Have a Serious Mental Illness; o Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents); o Are receiving Enhanced Care Management; or o Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence. Note: An attestation of the need for housing to satisfy any documentation requirements regarding the Member's housing status is acceptable.
Restrictions and Limitations:
☐ Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. ☐ 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.

Medically Tailored Meals/Medically-Supportive Food
Description: 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. Managed care plans have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members (e.g., Medically Tailored meals, groceries, food vouchers, etc.).
Eligibility (Population Subset):
- Members with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders. - Members being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or Members with extensive care coordination needs.
Restrictions/Limitations:
- Up to two (2) meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary. - Meals that are eligible for or reimbursed by alternate programs are not eligible. - Meals are not covered to respond solely to food insecurities. Community Supports shall supplement and not supplant services received by the Medi- Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Personal Care & Homemaker Services
Description: Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Includes services provided through the In-Home Support Services (In-Home Supportive Services) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes. Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.
Eligibility (Population Subset):
☐ Members at risk for hospitalization or institutionalization in a nursing facility; or ☐ Members with functional deficits and no other adequate support system; or ☐ Members approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.
Restrictions/Limitations:
☐ This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Members 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 in lieu of services during this reassessment waiting period. ☐ Community Supports shall supplement and not supplant services received by the Medi- Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Recuperative Care (Medical Respite)

Description: Recuperative Care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing. At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). 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.

Eligibility (Population Subset):

- ☐ Member who is at risk of hospitalization or are post-hospitalization;
- ☐ Member who lives alone with no formal supports;
- ☐ Member who faces housing insecurity or has housing that would jeopardize their health and safety without modification;
- ☐ Member who meets the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals. If exiting an institution, members are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless to thirty (30) days;
- ☐ Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations.

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

- ☐ **Have** one or more serious chronic conditions;
- ☐ Have a Serious Mental Illness;
- ☐ Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);
- ☐ Are receiving Enhanced Care Management;
- ☐ 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;
- ☐ 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.

Restrictions/Limitations:

- Recuperative care/medical respite is an allowable Community Supports service if it is:
  1. necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions,
  2. not more than 90 days in continuous duration, and
  3. does not include funding for building modification or building rehabilitation.
- Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Short-Term Post-Hospitalization Housing

Description: 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.

Eligibility (Population Subset):

- ☐ Member exiting recuperative care.
- ☐ Member exiting an inpatient stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:
  - ☐ Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institutions for Mental Disease, and State Hospitals. If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless to thirty (30) days;
  - ☐ Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations.
- ☐ Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization Housing services if they have significant barriers to housing stability and meet at least one of the following:
  - ☐ Have one or more serious chronic conditions;
  - ☐ Have a Serious Mental Illness;
  - ☐ Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);
  - ☐ 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.
- ☐ **In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re- hospitalization, or institutional readmission** .

Restrictions/Limitations:
• Short-Term Post-Hospitalization services are available once in an individual's lifetime and are not to exceed a duration of six (6) months (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services. • The service is only available if the member is unable to meet such an expense. • Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Respite Services
Description: Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.
Eligibility (Population Subset):
☐ Members who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement. ☐ Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, members enrolled in California Children's Services or Genetically Handicapped Persons Program (GHPP), and members with Complex Care Needs.
Restrictions/Limitations:
☐ In the home setting, these services, in combination with any direct care services the member is receiving, can provide up to 24 hours per day of care. ☐ The 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 limit of 336 hours per calendar year can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit. ☐ This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible. ☐ Respite services cannot be provided virtually, or via telehealth. ☐ Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Sobering Centers
Description: Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (alcohol and/or drug) 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, and homeless care support services.
Eligibility (Population Subset):
☐ Members aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.
Restrictions/Limitations:
☐ This service is covered for a duration of less than 24 hours. ☐ Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Day Habilitation
Description: Day Habilitation Programs are provided in a member's home or an out-of-home, non- facility setting. The programs are designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.
Eligibility (Population Subset):
☐ Member who is experiencing homelessness; or ☐ Member who exited homelessness and entered housing in the last 24 months; or ☐ Member at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.
Restrictions/Limitations:
☐ Services 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.

Asthma Remediation

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

Eligibility (Population Subset):

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

Additional Service Details:

- 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 Plan must receive and document:
  - A current licensed health care provider's order specifying the requested remediation(s) for the Member;
  - A brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective;
  - That a home visit has been conducted to determine the suitability of any requested remediation(s) for the Member.

Restrictions/Limitations

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.
- Asthma Remediation modifications are limited to those that are of direct medical 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.
- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the managed care plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen- impermeable mattress and pillow dust covers; high-efficiency particulate air (HEPA) filtered vacuums; de-humidifiers; portable air filters; and asthma-friendly cleaning products and supplies.

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

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

Description: 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.

Eligibility (Population Subset):

A. For Nursing Facility Transition:
- Has resided 60+ days in a nursing facility;
- 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.

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

Restrictions/Limitations:
- Individuals are directly responsible for paying their own living expenses.
- Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Community Transition Services/Nursing Facility Transition to a Home
Description: Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.
Eligibility (Population Subset):
☐ 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 ☐ Has lived 60+ days in a nursing home and/or Medical Respite setting; and ☐ Interested in moving back to the community; and ☐ Able to reside safely in the community with appropriate and cost-effective supports and services.
Restrictions/Limitations:
☐ Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes. ☐ Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control. ☐ Community Transition Services must be necessary to ensure the health, welfare, and safety of the member, and without which the member would be unable to move to the private residence and would then require continued or re- institutionalization. ☐ Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.