California Advancing and Innovating Medi-Cal (CalAIM)
In Lieu of Services (ILOS) Fact Sheet

Overview

Background

CalAIM is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal members by implementing broad delivery system, program and payment reform across the Medi-Cal program. A key feature of CalAIM is the introduction a new menu of ILOS.

To build upon and transition the excellent work done under California's Whole Person Care (WPC) Pilots, DHCS is proposing to implement ILOS, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. ILOS would be integrated with care management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health.

The current list of ILOS includes:

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

ILOS are alternative services covered under the Medi-Cal State Plan, but are delivered by a different provider or in a different setting than a traditional State Plan. ILOS can only be covered if:

- The State determines they are medically- appropriate and cost-effective substitutes or settings for the State Plan service,
- The services are both optional for managed care plans to provide and for beneficiaries to use.
- The ILOS are authorized and identified in the managed care plan contracts.

PHC will develop a network of providers that have the expertise and capacity regarding specific types of services. PHC is looking to partner with Community Based Organizations (CBO) and providers for ILOS. To be an ILOS provider, providers that have a state level enrollment pathway must enroll in Medi-Cal program. If there is no state level enrollment pathway, PHC will conduct an enrollment process.

Additional information on each ILOS is further defined below.

ILOS: Definitions

Housing Transition/Navigation Services

About the Service

Housing transition services assist beneficiaries with obtaining housing and include:

- Conducting a tenant screening and housing assessment.
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers.
- Searching for housing and presenting options.
- Assisting with securing housing and benefit advocacy.
- Identifying and securing available resources to assist with subsidizing rent, matching available rental subsidy resources to members, to cover expenses.
- Assisting with requests for reasonable accommodation, if necessary.
- Landlord education and engagement.
- Ensuring that the living environment is safe and ready for move-in.
- Communicating and advocating on behalf of the client with landlords.
- Assisting in arranging for and supporting the details of the move.
- Establishing procedures and contacts to retain housing.
- Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodationsand access to housing options prior to transition and on move in day.
- Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

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.
- Should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

- The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy.
- Do not include the provision of room and board or payment of rental costs.

Eligibility Criteria

Individuals who:

- Are prioritized for a permanent supportive housing unit or rental subsidy resource through CES.
- Meet the Housing and Urban Development (HUD) definition of homeless.
- Meet the definition of an individual experiencing chronic homelessness.
- Meet the HUD definition of at risk of homelessness.
- Are determined to be at risk of experiencing homelessness.
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

Restrictions and Limitations

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

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.
- Providers must have demonstrated experience with providing housing-related services and supports.
- Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for ECM and Housing and Tenancy Support Services (if provided in their county).

Housing Deposits

About the Service

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

- Security deposits required to obtain a lease on an apartment or home.
- Set-up fees/deposits for utilities or service access and utility arrearages.
- First month coverage of utilities, including but not limited to telephone, gas, electricity,heating, and water.
- First month's and last month's rent as required by landlord for occupancy.
- Services necessary for the individual's health and safety.

- 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 homesuch as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc.

Service Providers

- 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.
- Should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.
- Do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility Criteria

Individuals who:

- Received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES.
- Meet the Housing and Urban Development (HUD) definition of homeless.
- Meet the HUD definition of at risk of homelessness
- Are determined to be at risk of experiencing homelessness
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

Restrictions and Limitations

- Only available in an individual's lifetime. Housing Deposits can onlybe approved one additional time with documentation as to what conditions have changed todemonstrate why providing Housing Deposits would be more successful on the secondattempt.
- Must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable tomeet such expense.
- Individuals must also receive Housing Transition Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique servicesin a culturally and linguistically appropriate manner.
- Providers must have demonstrated or verifiable experience and expertise with providingthese unique services.

Housing Tenancy & Sustaining Services

About the Service

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

- Providing early identification and intervention for behaviors that may jeopardize housing.
- Education and training on the role, rights and responsibilities of the tenant and landlord.
- Coaching on developing and maintaining key relationships with landlords/propertymanagers with a goal of fostering successful tenancy.
- Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
- Advocacy and linkage with community resources to prevent eviction when housingis or may potentially become jeopardized.
- Assisting with benefits advocacy.
- Assistance with the annual housing recertification process.
- 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.
- Continuing assistance with lease compliance.
- Health and safety visits.
- Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized.
- Providing independent living and life skills.

Services Provided

- Should be based on individualized assessment of needs and documented in the individualized housing support plan.
- Should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.
- May involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.
- Services do not include the provision of room and board or payment of rental costs. Please see housing deposits ILOS.

Eligibility Criteria

Individuals who:

- Received Housing Transition/Navigation Services ILOS incounties that offer Housing Transition/Navigation Services.
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES.
- Meet the Housing and Urban Development (HUD) definition of homeless.
- Meet the definition of an individual experiencing chronic homelessness.
- Meet the HUD definition of at risk of homelessness.
- Are determined to be at risk of experiencing homelessness.
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

Restrictions and 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.
- Only available for a single duration in the individual's lifetime. They can only 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 individualizedhousing support plan) in conjunction with this service but it is not a requirement.

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique servicesin a culturally and linguistically appropriate manner.
- Providers must have demonstrated or verifiable experience or expertise with providing housing-related services.
- Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for ECM and may have receivedHousing Transition/Navigation services (if provided in their county).

Short-Term Post-Hospitalization Housing

About the Service

Short- Term Post Hospitalization Housing provides members who do not have a residence and who have high medical or behavioral needs with the opportunity to continue their recovery immediately after exiting discharge.

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.

Service Provided

- Should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.
- Allows individuals with ongoing support necessary for recovery and may include an individual or shared interim housing setting.

Eligibility Criteria

Individuals who:

- Are exiting recuperative care.
- Individuals exiting an inpatient hospital stay 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.
- Meet the Housing and Urban Development (HUD) definition of homeless.
- Meet the definition of an individual experiencing chronic homelessness.
- Meet the HUD definition of at risk of homelessness.
- Who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services.
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

Restrictions and Limitations

- Only available once in an individual's lifetime andare limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.
- The service is only available if enrollee is unable to meet such an expense.

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services.

Recuperative Care

About The Service

Recuperative care, also referred to as medical respite care, is short-term residential carefor individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and would be exacerbated by an unstable living environment. It 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, suchas transportation, food, and housing.

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

- Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs.
- Coordination of transportation to post-discharge appointments.
- Connection to any other on-going services an individual may require.
- Support in accessing benefits and housing.
- Gaining stability with case management relationships and programs.

Services Provided

- Should not replace or beduplicative of the services provided to members utilizing the enhanced care managementprogram. Recuperative Care may be utilized in conjunction with other housing ILOS.
- Should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

Eligibility Criteria

- Individuals who are at risk of hospitalization or are post-hospitalization.
- Individuals who live alone with no formal supports.
- Individuals who face housing insecurity or have housing that would jeopardize theirhealth and safety without modification.

Restrictions and Limitations

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

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services.

Respite Services

About the Service

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 themand are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

- Services provided by the hour on an episodic basis because of the absence of or needfor relief for those persons normally providing the care to individuals.
- Services provided by the day/overnight on a short-term basis because of the absenceof or need for relief for those persons normally providing the care to individuals.
- Services that attend to the participant's basic self-help needs and other activities of daily living.

The Home Respite services are provided to the participant in his or her own home or another location being used as the home.

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

Eligibility Criteria

- 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 mostof 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, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions and Limitations

- In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.
- Service limit is up to 336 hours per calendar year.
- This service is only to avoid placements for which the Medi-Cal managed care plan wouldbe responsible.

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services.

Day Habilitation

About the Service

Day Habilitation Programs are provided in a participant's home or an out-of-home, non- facility setting. The programs are designed to assist the participant in acquiring, retaining,and improving self-help, socialization and adaptive skills necessary to reside successfullyin the person's natural environment. The services are often considered as peer mentoringwhen provided by an unlicensed caregiver with the necessary training and supervision.

Day habilitation program services include, but are not limited to, training on:

- The use of public transportation.
- Personal skills development in conflict resolution.
- Community participation.
- Developing and maintaining interpersonal relationships.
- Daily living skills (cooking, cleaning, shopping, money management).
- Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to:

- Selecting and moving into a home
- Locating and choosing suitable housemates
- Locating household furnishings
- Settling disputes with landlords
- Managing personal financial affairs
- Recruiting, screening, hiring, training, supervising, and dismissing personalattendants.
- Dealing with and responding appropriately to governmental agencies andpersonnel
- Asserting civil and statutory rights through self-advocacy
- Building and maintaining interpersonal relationships

The services provided should utilize best practices for clients who are experiencing homelessness or formerly experienced homelessness.

Eligibility Criteria

- 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.

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services.

Nursing Facility Transition/ Diversion to Assisted Living Facilities

About the Service

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The assisted living provider is responsible for meeting the needs of the participant, 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 non-room and board costs Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

- Assessing the participant's housing needs and presenting options.
- Assessing the service needs of the participant to determine if the participant needsenhanced onsite services at the RCFE/ARF so the client can be safely and stablyhoused in an RCFE/ARF.
- Assisting in securing a facility residence.
- Communicating with facility administration and coordinating the move.
- Establishing procedures and contacts to retain facility housing.
- Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in ILOS and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

Eligibility Criteria

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

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

Restrictions and Limitations

- Individuals are directly responsible for paying their own living expenses.

Licensing and Allowable Providers

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

Community Transition Services/ Nursing Facility Transition to a Home

About the Service

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live 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 herown 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:

- Assessing the participant's housing needs and presenting options.
  - Assisting in searching for and securing housing.
  - Communicating with landlord, if applicable and coordinating the move.
  - Establishing procedures and contacts to retain housing.
  - Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
  - Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.
  - 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.

Eligibility Criteria

- Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services.

- Has lived 60+ days in a nursing home.
- Interested in moving back to the community.
- Able to reside safely in the community with appropriate and cost-effective supportsand services.

Restrictions and 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 amountof $5,000.00. The only exception to the $5,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to aliving arrangement in a private residence through circumstances beyond his or hercontrol.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the participant, and without which the participant would be unable tomove to the private residence and would then require continued or re- institutionalization.

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services.

Personal Care & Homemaker Services

About the Service

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shoppingand money management.

Personal Care and Homemaker Services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Servicesapplication date.
- For members not eligible to receive In-Home Supportive Services, to help avoid ashort-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker ILOS should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services

Eligibility Criteria

- Individuals at risk for hospitalization, or institutionalization in a nursing facility.
- Individuals with functional deficits and no other adequate support system.
- Individuals approved for In-Home Supportive Services. Eligibility criteria can befound at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions and Limitations

- This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.
- If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessmentand determination of additional hours. Members may continue to receive Personal Care and Homemaker ILOS during this reassessment waiting period.

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services.

Environmental Accessibility Adaptations (Home Modifications)

About the Service

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 inthe home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist beneficiaries in accessing the home.
- Doorway widening for beneficiaries who require a wheelchair.
- Stair lifts.
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-inshower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary.
  Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and whootherwise require routine supervision.

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

Eligibility Criteria

- Individuals at risk for institutionalization in a nursing facility.

Restrictions and Limitations

- If another State Plan service such as Durable Medical Equipment, is available andwould 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 $5,000. The only exceptions to the $5,000 total maximum are if the beneficiary's place of residence changes orif the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of thebeneficiary, or are necessary to enable the beneficiary 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 beneficiary and exclude adaptations or improvements that are of general utilityto the household. Adaptations that add to the total square footage of the home areexcluded 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 careplan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenanceor repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Licensing and Allowable Providers

- The Medi-Cal managed care plan may manage these services directly or may coordinatewith a provider to manage the service.
- Providers must have experience and expertise with providing these unique services.

Medically Tailored Meals/ Medically Supported Food

About the Service

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 maintaintheir health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

- Meals/Food delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
- Medically-Tailored Meals/food: meals/food provided to the member at home that meet the unique dietary needs of those with chronic diseases.
- Medically-Tailored meals/food 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 side effects to ensure the best possible nutrition-related healthoutcomes.
- Medically-supportive food and nutrition services.

Eligibility Criteria

- Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
- Individuals being discharged from the hospital or a skilled nursing facility or at highrisk of hospitalization or nursing facility placement.
- Individuals with extensive care coordination needs.

Restrictions and Limitations

- Up to two medically-tailored meals per day and/or medically-supportive food andnutrition 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.

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services.

Sobering Centers

About the Service

Sobering centers are alternative destinations for individuals who are found to be publiclyintoxicated (due to alcohol and/or other drugs) and would otherwise be transported to theemergency department or jail. Sobering centers provide these individuals, primarily thosewho are homeless or those with unstable living situations, with a safe, supportiveenvironment 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, showerand laundry facilities,

substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services,and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housingoptions, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, andoutreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions.

Eligibility Criteria

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk,nonviolent, free from any medical 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 and Limitations

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

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services.

Asthma Remediation

About the Service

Environmental A Asthma Trigger Remediation's are physical modifications to a home environment that are necessary a homeenvironment 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 episodescould result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediation's include:

- Allergen-impermeable mattress and pillow dustcovers
- High-efficiency particulate air (HEPA) filtered vacuums

- Integrated Pest Management (IPM) services
- De-humidifiers
- Air filters
- Other moisture-controlling interventions.
- Minor mold removal and remediation services
- Ventilation improvements
- Asthma-friendly cleaning products and supplies
- Other interventions identified to be medically appropriate and cost effective

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

Eligibility Criteria

- Individuals with poorly controlled asthma for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions and Limitations

- If another State Plan service such as Durable Medical Equipment, is available andwould accomplish the same goals of preventing asthma emergencies or hospitalizations
- Asthma remediation must be conducted in accordance with applicable Stateand local building codes.
- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before usingMedi-Cal funding.
- Asthma remediation are payable up to a total lifetime maximum of $5,000. The only exception to the $5,000 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure thehealth, welfare, and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and avoidinstitutionalization or hospitalization.
- Asthma remediation modifications are limited to those that are of direct medical orremedial benefit to the beneficiary and exclude adaptations or improvements thatare of general utility to the household. Remediation may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not includeaesthetic embellishments.
- Before commencement of a physical adaptation to the home or installation of equipment in the home, the managed care plan must provide the owner and beneficiary 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 participant ceases to reside at the residence.

Licensing and Allowable Providers

- Providers must have experience and expertise with providing these unique services.
- Asthma Remediation that is a physical adaptation to a residence must be performed byan individual holding a California Contractor’s License.