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

Overview

Background

California Advancing and Innovating Medi-Cal (Cal-AIM) Community Supports (CS) Fact Sheet is intended to serve as a resource for Medi-Cal Managed Care health plans (or “Managed Care Plans” (MCPs)) in the implementation of Community Supports, which, by January 1st, 2024, MCPs must adhere to the full DHCS-established Community Supports service definitions without modifications or restrictions.

CalAIM is an initiative of the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal members by implementing a broad delivery system, program, and payment reform across the Medi-Cal program. CalAIM – Community Supports are substitute services or settings that are cost-effective alternatives to health plans. MCPs may select and offer from the list of 14 pre-approved Community Supports services drawn in part from the foundational work done in the Whole Person Care (WPC) Pilot and Health Homes Program (HHP).

Starting January 1, 2022, MCPs in all counties have been strongly encouraged to offer one or more of the following 14 pre-approved Community Supports:

- 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
- Personal Care and Homemaker Services;
- Medically Tailored Meals or Medically Supportive Food;

DHCS has determined the pre-approved Community Supports services to be cost-effective and medically appropriate substitutes for covered Medi-Cal benefits. These services are optional for MCPs to provide and for beneficiaries to use, CS services are covered under the Medi-Cal State Plan but are delivered by different providers. The Community Supports Services are authorized and identified in the MCP contract(s).

Partnership HealthPlan of California (PHC) has developed a network of providers that have the expertise and capacity regarding specific types of CS services. PHC is actively looking to partner with Community-Based Organizations (CBOs), non-profit facilities, and providers for Community Supports services. To be a Community Supports service provider, providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, PHC will conduct an enrollment process that includes vetting providers to ensure they can meet the

capabilities and standards required by DHCS. (See APL 19-004)

Additional information on each Community Supports services is further defined below.

Community Supports: Definitions

Housing Transition Navigation Services

About the Service
Housing Transition Navigation Services assist beneficiaries with obtaining housing and include:

- Conducting a tenant screening and housing assessment that identifies the member's preferences and barriers related to a successful tenancy.
- Develop an individualized housing supporting plan based on the housing assessment.
- Searching for housing and presenting options.
- Assisting with securing housing and benefit advocacy.
- Identifying and securing available resources to assist with subsidizing rent, and matching available rental subsidy resources to members, to cover expenses.
- Assisting with requests for reasonable accommodations, 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 accommodations and access to housing options before transition and on move-in day.
- Identifying, and coordinating, environmental modifications to install necessary accommodations for accessibility.

Services Provided

- Should be based on an 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 support needed for a successful tenancy.
- Do not include the provision of room and board or payment of rental cost.

Eligibility Criteria
Individuals who:

- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the

Coordinated Entry System (CES).

- 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.
- Meet the definition of an individual experiencing chronic homelessness.
- Meet the HUD definition of at risk of homelessness.
- 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 or meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents);
    - 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.

Restrictions and Limitations

- Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.
- The intent of this service is for the provider to work with one member per household

Licensing and Allowable Providers

- Providers must have experience and expertise in 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 for Housing Transition/Navigation services should also be assessed for Enhanced Care Management (ECM) and Tenancy Supportive Services (if provided in their counties).

Housing Deposits

(Pending updated DHCS policy revisions)

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 household that does not constitute room and board, such as:

- Security deposits are required to obtain a lease on an apartment or home.
- Set up fees/deposits for utilities or services 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 rest as required by the 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 individual's health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies, etc.

Service Providers

- Should be based on an 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.
- De not include the provision of room and board or payments of ongoing rental costs beyond the first and last month's coverage as noted above.
- Should include the following when submitting an authorization for Housing Deposits:
    - A completed CS Referral Form
    - Housing Plan – including activities conducted to prepare the member for housing
    - A copy of the intended lease agreement
    - A list of expenses included in the requested total amount (i.e. application fees, and requested household items)

Eligibility Criteria

Individuals who:

- Received Housing Transition/Navigation services and Community Supports services in counties that offer Housing Transition/Navigation services.
- Are prioritized for a permanent supportive housing unit or rental subsidy recourse through the Coordinated Entry System (CES).
- 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.
- Are determined to be at risk of experiencing homelessness.
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

- Recommend that at the member has received at least 30 days of Housing Transition Navigation service, so that the best outcome for stable long-term housing is achieved

Restrictions and Limitations

- Only available 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 proving Housing Deposits would be more successful on the second attempt.
- Must be identified as reasonable and necessary in the individual's individualized housing supports plan and are available only when the enrollee is unable to meet such expense.
- Individuals must also receive Housing Transition Navigation services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service.

Licensing and Allowable Providers

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

Housing Tenancy and Sustaining Services

About the Service

This service provides tenancy and sustaining services, to maintain safe and stable tenancy once housing is secured. Services include:

- Providing early identification and intervention for behavior 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/property managers to foster 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 the risk of eviction or other adverse action.
- Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
- Assisting with benefits advocacy.
- Assistance with the annual housing recertification process.
- Coordinate with the tenant to review, update, and modify their housing support and crisis plan regularly 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 an 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 support needed to maintain a successful tenancy.
- Services do not include the provision of room and boards or payments of rental costs. (Please see Housing Deposits)

Eligibility Criteria
Individuals who:
- Received Housing Transition/Navigation services in counties that offer Housing Transition Navigation Services.
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the Coordinated Entry System (CES).
- Meet the Housing and Urban Development (HUD) definition of homeless.
- 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.
- 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 supportive plan determines they are no longer needed.
- Only available for a single duration in the individual's lifetime.
    - Housing Tenancy and Sustaining Services 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 individualized housing

support plan) in conjunction with this service but it is not a requirement.

Licensing and Allowable Providers

- Providers must have experience and expertise in providing these unique services in a culturally and linguistically appropriate manner.
- Providers must have demonstrated or verifiable experience or expertise in 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 received Housing 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 the transition from this setting.

Services 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.
- Are receiving Enhanced Care Management.
- 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 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.
- 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 or significant barriers to housing stability 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 and are limited and are not to exceed 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 an individual has previously received services.
- The service is only available if the enrollee is unable to meet such an expense.

Licensing and Allowable Providers

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

Recuperative Care (Medical Respite)

About the Service

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 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, 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, and medication monitoring). Based on individual needs, the service may also include:

- Limited or short-term assistance with instrumental Activities of Daily Living and/or ADLs.
- Coordination of transportation to post-discharge appointments.
- Connection to any other ongoing 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 be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing services.
- 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 support.
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.

Restrictions and Limitations

- Recuperative care/medical respite is an allowable Community Supports service if it is:
    - Necessary to archive 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 modifications or building rehabilitation.

Licensing and Allowable Providers

- Providers must have experience and expertise in 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 the person and are non-medical. 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 need for relief for those persons normally providing the care to individuals.
- 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.
- 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 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, beneficiaries enrolled in California Children's Services, and Generically Handicapped Person Program (GHPP), and

Clients with Complex Care needs.

Restrictions and Limitations

- Respite Services cannot be provided virtually, or via telehealth.
- 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 would be responsible.

Licensing and Allowable Providers

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

Day Habilitation Program

(Pending DHCS approval for effective date 07/01/2024 for providers with existing infrastructure and live a program)

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 successfully in the person's natural environment. The services are often considered peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision.

For members experiencing homelessness who are receiving Enhanced Care Management (ECM) or other Community Supports service, Day Habilitation programs can provide a physical location for members to meet and engage, when possible, these services should be provided by the same entity to minimize transitions experienced by members and improve oval care coordination and management.

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

- The use of public transportation;
- Personal skills development in conflict resolution;
- Community participation;
- Developing and maintaining interpersonal relationships;
- Daily living skills (cooking, cleaning, shopping, money management); and,
- 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;

- Setting disputes with landlords;
- Managing personal financial affairs;
- Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
- Dealing with and responding appropriately to governmental agencies and personnel;
- Asserting civil and statutory rights through self-advocacy;
- Building and maintaining interpersonal relationships;

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.

Restrictions and Limitations

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

Licensing and Allowable Providers

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

Personal Care and Homemaker Services

About the service

Personal Care Services and homemaker services are 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 (IADL) such as meal preparation, grocery shopping, and 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 period includes services before and up through the In-Home Supportive Services application date.
- For members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker Community Supports services 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 be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions and Limitations

- This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. 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 Community Supports services during this reassessment waiting period.

Licensing and Allowable Providers

- Providers must have experience and expertise in 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 maintain their 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 health outcome.
- Medically-Tailored Meals/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, and chronic or disabling mental/behavioral health disorders.
- Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement.
- Individuals with extensive care coordination needs.

Restrictions and Limitations

- Up to two (2) medically-tailored 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.

Licensing and Allowable Providers

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