**THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:**

**COUNTIES:**

☐ Imperial
☒ Riverside/San Bernardino
☐ Los Angeles
☐ Orange
☐ Sacramento
☐ San Diego

**LINES OF BUSINESS:**

☒ Molina Medi-Cal Managed Care
☐ Molina Medicare Options Plus
☐ Molina Marketplace (Covered CA)

**PROVIDER TYPES:**

☒ **Medical Group/ IPA/MSO**
**Primary Care**
☒ IPA/MSO
☒ Directs
**Specialists**
☒ Directs
☒ IPA
☒ **Hospitals**
**Ancillary**
☒ CBAS
☒ SNF/LTC
☒ DME
☒ Home Health
☒ Other

## Community Supports Inland Empire

This is an advisory notification to Molina Healthcare of California (MHC) network providers.

Beginning January 1, 2022, Molina Healthcare of California implemented the Department of Health Care Services (DHCS) CalAIM Community Supports (CS) services to address social determinants of health and improve health equity for Medi-Cal beneficiaries. Please note that two (2) new CS will be going live January 1, 2023.

Molina is excited to share the following information regarding CS and to increase support for Molina Members.

**What are Community Supports (CS)?**

CS are services or settings that Molina may offer in place of services or settings covered under the California Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. CS are optional for Molina to offer and for Members to utilize. Molina may not require Members to use a Community Support instead of a service or setting listed in the Medicaid State Plan.

CS 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.

**Eligibility Criteria**

Medi-Cal only, Partial Duals (Medicare Part B and/or D and Medi-Cal with Molina), and Molina D-SNP members with aligned enrollment (D-SNP and Medi-Cal with Molina) are eligible for Community Supports.

**Criteria for each Community Supports is as follows:**

**Housing Transition Navigation Services:** Assists members experiencing homelessness with obtaining housing by providing support with items such as housing applications, benefits advocacy, securing available resources, and providing help with landlords upon move-in.

- Members prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System (CES) or similar system; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving Enhanced Care Management (ECM), or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members 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; or
- Members at risk of experiencing homelessness and 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 ECM; 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.

**Housing Deposits:** Assists members experiencing homelessness 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. These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the member is unable to meet such expense. Members must be receiving or be referred for Housing Transition Navigation Services CS.

- Members who received Housing Transition Navigation Services CS; or
- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES or similar system; or
- Members who meet the HUD definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder.
- *Restriction/Limitation:* Available once in a member's lifetime with a lifetime maximum of $5,000. Housing Deposits can only be approved one additional time. Referrer must provide documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.

**Housing Tenancy and Sustaining Services:** Provides tenancy and sustaining services to maintain safe and stable residency once housing is secured for members who had been experiencing homelessness and are now newly housed.

- Members who received Housing Transition/Navigation Services CS; or
- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES or similar system; or
- Members who meet the HUD definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members 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; or
- Members at risk of experiencing homelessness and 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 ECM; 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.
- *Restriction/Limitation:* Housing Tenancy and Sustaining Services are only available for a single duration in the individual's lifetime and can be approved one additional time. Referrer must provide documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt.

**Short-Term Post-Hospitalization Housing (7/1/2022):** 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, 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.

- Members who have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, rehospitalization, or institutional readmission; and
- Members who are exiting recuperative care; or
- Members who are exiting an inpatient hospital stay (acute, psychiatric, or Chemical Dependency and Recovery hospital), residential substance use disorder treatment/recovery facility, residential mental health treatment facility, correctional facility, or nursing facility AND who meet one of the following three (3) criteria:
- Members who meet the HUD definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members 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; or
- Members at risk of experiencing homelessness and 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 ECM; 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.
- *Restriction/Limitation:* Members must be offered Housing Transition Navigation Services during Short-Term Post-Hospitalization Housing. Short-Term Post-Hospitalization Housing is available once in a member's lifetime and cannot exceed six (6) months (but may be authorized for a shorter period based on member's needs).

**Recuperative Care (Medical Respite):** Members needing short-term residential care 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. Clinical information must be provided.

- Members who are at risk of hospitalization or are post-hospitalization and live alone with no formal supports; or face housing insecurity or have housing that would jeopardize their health and safety without modification; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members who meet the HUD definition of at risk of homelessness; or
- Members at risk of experiencing homelessness and 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 ECM; 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.
- *Restriction/Limitation:* Recuperative Care is not more than ninety (90) days in continuous duration. The ninety (90) day recuperative care period may start over if the member is re-hospitalized with a different diagnosis during and/or after the initial ninety (90) day authorization, provided that recuperative care criteria is met.

**Respite Services - Home (7/1/2022):** Provided to caregivers when it is useful and necessary to maintain a member in their own home and to preempt caregiver burnout to avoid institutional services. The services are provided on a short-term basis because of the absence or need for relief for the caregiver and are non-medical in nature. This service is rest for the caregiver only and only to avoid Long-Term Care placements. o Members who live in the community and are compromised in their Activities of Daily Living (ADLs) requiring dependency on a qualified caregiver, and the qualified caregiver, who provides most of the member's support, requires caregiver relief to avoid institutional placement for the member; or

- Member is a child who previously received Respite Services under the Pediatrics Palliative Care Waiver.
- *Restriction/Limitation:* These services, in combination with any direct care services being received, may not exceed 24 hours per day of care. Respite Services are maxed at 336 hours per calendar year.

**Day Habilitation Programs (7/1/2022):** Provided in an out-of-home, non-facility setting to assist members in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the member's natural environment.

- Members who are experiencing homelessness; or
- Members who exited homelessness and entered housing in the last 24 months; and are at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

**Community Transition Services/Nursing Facility Transition to a Home:** Assists members who have been living in a skilled nursing facility to live in the community and avoid further institutionalization by supporting members with becoming newly housed and covering nonrecurring setup expenses.

- Members 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
    - Is interested in moving back to the community; and
    - Is able to reside safely in the community with appropriate and cost-effective supports and services.
- *Restriction/Limitation:* California Community Transitions Project must be explored and utilized prior to the CS. Community Transition Services/Nursing Facility Transition to a Home is available once in an individual's lifetime with a lifetime maximum of $7,500. Community Transition Services/Nursing Facility Transition to a Home can only be approved one additional time. Referrer must provide documentation that the member was compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond their control.

**Personal Care and Homemaker Services:** Provides care for members who need assistance with Activities of Daily Living (ADLs)and Instrumental Activities of Daily Living (IADLs).

- Members at risk for hospitalization or institutionalization in a nursing facility or with functional deficits and no other adequate support system with:

- Needs above and beyond any approved county In-Home Supportive Services (IHSS) hours when additional hours are required (pending reassessment); or
- Initially referred to IHSS and during the IHSS waiting period to be approved and hire a caregiver (Member must be already referred to In-Home Supportive Services); or
- Members not eligible to receive In-Home Supportive Services and need help to avoid a short-term stay in a skilled nursing facility which cannot exceed 60 days.

**Medically Supportive Food/Meals/Medically Tailored Meals:** Provides meals for members recently discharged from a hospital or skilled nursing facility. Meals are delivered weekly by UPS or FedEx and are tailored to the member's dietary needs.

- Members discharged from the hospital or a skilled nursing facility who are referred and meet criteria will receive up to two (2) meals per day, and/or medically supportive food for up to four (4) weeks per hospitalization at a maximum of twelve (12) weeks in a calendar year.

**Sobering Centers (Riverside Only):** Provides alternative destinations for members who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. The service covered is for a duration of less than 24 hours.

- 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 jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

**Asthma Remediation:** Assists members by identifying, coordinating, securing, or funding services and modifications necessary to a home environment to ensure the health, welfare, and safety of the individual or to enable the individual to function in the home without acute asthma episodes, which could result in the need for emergency services and hospitalization. The referral must be signed by a licensed health care professional.

- Members with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two Primary Care Physician (PCP) 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 services will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.
- *Restriction/Limitation:* Asthma Mitigation Project funding must be explored and utilized prior to the CS. Asthma Remediation are available once in an individual's lifetime with a lifetime maximum of $7,500. Asthma Remediation can only be approved one additional time. Referrer must provide documentation describing the significant changes to condition 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.

**Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities (1/1/2023):** Assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

- Eligibility (Population Subset)
  A. For Nursing Facility Transition:

1. Has resided 60+ days in a nursing facility;
2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
1. Interested in remaining in the community;
2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
3. 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.

**Environmental Accessibility Adaptations (EAAs also known as Home Modifications) (1/1/2023)** are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist Members in accessing the home;
- Doorway widening for Members who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and `
- Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as a Community Support, the managed care plan must receive and document an order from the Member's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the Member describing how and why the equipment or service meets the needs of the Member will still be necessary.

The managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
   a. An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;
   b. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This

should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and

c. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and
3. 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.

- Eligibility (Population Subset)
  - Individuals at risk for institutionalization in a nursing facility.
- 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 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.

Referral forms are available on the Provider website:
https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

For additional detail on CS, please reference the DHCS Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide on the DHCS CalAIM website:
https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

**Community Supports Contact**

Provider questions can be emailed to MHC_CS@molinahealthcare.com.

**QUESTIONS**

If you have any questions regarding the notification, please contact your Molina Provider Services Representative. Please refer to the phone numbers listed below:

| Service County Area | Provider Services Representative | Contact Number | Email Address |
|---|---|---|---|
| California Hospital Systems | Deletha Foster<br>Shelly Lilly | 909-577-4351<br>858-614-1586 | Deletha.Foster@molinahealthcare.com<br>Michelle.Lilly@molinahealthcare.com |
| Los Angeles | Clemente Arias | 562-517-1014 | Clemente.Arias@molinahealthcare.com |
| Los Angeles / Orange County | Maria Guimoye | 562-549-4390 | Maria.Guimoye@molinahealthcare.com |
| Sacramento | Jennifer Rivera Carrasco | 562-542-2250 | Jennifer.RiveraCarrasco@molinahealthcare.com |
| San Bernardino | Luana McIver | 909-501-3314 | Luana.Mciver@molinahealthcare.com |
| San Bernardino / Riverside County | Vanessa Lomeli | 909-577-4355 | Vanessa.Lomeli2@molinahealthcare.com |
| San Diego / Imperial County | Briana Givens<br>Carlos Liciaga<br>Salvador Perez | 562-549-4403<br>858-614-1591<br>562-549-3825 | Briana.Givens@molinahealthcare.com<br>Carlos.Liciaga@molinahealthcare.com<br>Salvador.Perez@molinahealthcare.com |

*If you are not contracted with Molina and wish to opt out of the Just the Fax, email: mhcproviderjustthefax@molinahealthcare.com*
*Please include provider name and fax number and you will be removed within 30 days.*