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Medi-Cal In Lieu of Services (ILOS) Policy Guide

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I. Introduction to In Lieu of Services (ILOS)

California Advancing and Innovating Medi-Cal (CalAIM) establishes the framework to address social determinants of health and improve health equity statewide. A key feature of CalAIM is the introduction of a menu of in lieu of services (ILOS) in managed care.

What Are In Lieu of Services?

ILOS are services or settings that managed care plans (MCPs) may offer in place of services or settings covered under the California Medicaid State Plan and that are medically appropriate, cost-effective alternatives to a State Plan covered service. ILOS are optional for MCPs to offer and for Members to utilize. MCPs may not require Members to use an ILOS instead of a service or setting listed in the Medicaid State Plan.

This Policy Guide

ILOS is a significant change and a high priority for the Department of Health Care Services (DHCS). DHCS recognizes the work California MCPs and communities will be doing to operationalize these new initiatives under CalAIM and smoothly transition services provided under the Whole Person Care Pilots and Health Home Program even as they continue to address the COVID-19 Public Health Emergency.

Throughout 2021, DHCS is offering a range of technical assistance and support including detailed implementation requirements and guidance presented in this Policy Guide. In addition, DHCS is making available materials posted on the DHCS CalAIM Enhanced Care Management (ECM) and ILOS website, webinars, non-binding ILOS pricing information, and other opportunities for discussion to support the implementation of these initiatives. All information provided in this fact sheet is preliminary and subject to change. This Policy Guide is for informational purposes and is not intended to replace future guidance and state and/or federal requirements.

Please submit specific questions about ILOS to CalAIMECMILOS@dhcs.ca.gov. Questions about CalAIM generally should be submitted to CalAIM@dhcs.ca.gov.

An FAQ that provides up-to-date information about the ILOS implementation and will be updated regularly is available on the DHCS ECM and ILOS website.

Requirements for Providing ILOS

Pursuant to 42 CFR §438.3, MCPs may not provide ILOS without first applying to the State and obtaining State approval to offer the ILOS by demonstrating that all the requirements (see [ILOS Model of Care](#)) will be met. MCPs may voluntarily agree to provide any service to a Member outside of an approved ILOS construct; however, the cost of any such voluntary services may not be included in determining MCP rates.

Once approved by DHCS, the ILOS will be added to the MCP's contract and posted on the DHCS website as a State-Approved ILOS.

ILOS may be offered by MCPs beginning January 1, 2022. Additional ILOS may be added thereafter on a six-month cadence.

II. What Are In Lieu of Services, or ILOS?

April 7, 2021

Introduction

CalAIM is a new initiative by DHCS to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, programmatic, and payment system reforms. A key feature of CalAIM is the introduction of a new menu of (ILOS), which, at the option of a Medi-Cal MCP and a Member, can substitute for covered Medi-Cal services as cost-effective alternatives. MCPs will be responsible for administering ILOS. For more information about CalAIM, see DHCS' [Revised CalAIM Proposal](#) released on January 8, 2021.¹

Overview of ILOS

ILOS are medically appropriate and cost-effective alternatives to services covered under the State Plan. Federal regulation allows states to permit Medicaid managed care organizations to offer ILOS as an option to Members.² ILOS can substitute for and potentially decrease utilization of a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department use.

ILOS are an important part of care delivery for Members enrolled in ECM, another CalAIM initiative that will address the clinical and nonclinical needs of high-need, high-cost Medi-Cal Members through systematic coordination of services and comprehensive care management.³ As such, DHCS encourages MCPs to offer a robust menu of 14 preapproved ILOS to comprehensively address the needs of Members—including those with the most complex challenges affecting health such as homelessness, unstable and unsafe housing, food insecurity, and/or other social needs.

By design, the list of preapproved ILOS is drawn in part from the foundational work done as part of the Whole Person Care (WPC) Pilots and Health Home Program (HHP). A key goal of ILOS is to allow Members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate. ILOS will build on WPC and HHP efforts and activities and expand access to services that were previously available only through home and community-based service initiatives while addressing health-related social needs.

MCPs will have the opportunity to provide details on their elected ILOS to DHCS as part of their Model of Care (MOC) responses to DHCS. MCPs in all counties are encouraged to offer one or more of the following ILOS starting on January 1, 2022⁴:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)

¹ [Revised CalAIM Proposal](#), January 2021.

² 42 CFR §438.3(e)(2).

³ [ECM Fact Sheet](#).

⁴ See the [ILOS Service Descriptions](#) for more detail about each ILOS option.

- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFEs) and Adult Residential Facilities (ARFs)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

In Lieu of Services Are Optional but Strongly Encouraged

MCPs are strongly encouraged to elect to offer some or all of these preapproved ILOS and are expected to detail their ILOS offerings in their MOC. As part of the MOC response, MCPs will describe which ILOS they will offer, the date each elected ILOS is expected to launch, and the MCP's plans for operationalizing the ILOS, including the ILOS Provider network. DHCS expects that MCPs in WPC and HHP counties will offer the preapproved ILOS that correspond to the services previously offered through those programs to ensure a seamless transition for those Members. MCPs may propose additional ILOS to DHCS for review and approval. MCPs may choose to offer different ILOS in different counties. MCPs may add or remove ILOS at defined intervals: every six (6) months for an addition and annually for removal of a previously offered ILOS.

ILOS Implementation Timeline

MCPs in all counties may launch preapproved ILOS beginning January 1, 2022. DHCS strongly encourages all MCPs to begin offering ILOS at this time. The timely offering of ILOS will help to improve care for Members, support the goals of CalAIM, and contribute to the smooth transition of Members receiving services through WPC Pilots into Medi-Cal managed care.

III. In Lieu of Services – Service Definitions

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: (1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service, (2) Members are not required to use the in lieu of services, and (3) the in lieu of services are authorized and identified in the managed care plan contracts.

Each set of preapproved services is described in detail below:

- 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 Elderly (RCFEs) and Adult Residential Facilities (ARFs)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist Members with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs and on potential housing transition barriers, as well as identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the Member's approach to meeting the goal, and identifies when other Providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skill set.
6. Identifying and securing available resources to assist with subsidizing rent (such as U.S. Department of Housing and Urban Development's Housing Choice Voucher Program (Section 8) or state and local assistance programs) and matching available rental subsidy resources to Members.
7. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.⁵
8. Assisting with requests for reasonable accommodation, if necessary.⁶
9. Educating and engaging with landlords.
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the Member with landlords.
12. Assisting with arranging for and supporting the details of the move.

⁵ Actual payment of these housing deposits and move-in expenses is a separate ILOS under Housing Deposits.

⁶ This is related to expenses incurred by the housing navigator supporting the Member moving into the home.

13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.⁷
14. Identifying, coordinating, securing, or funding non-emergency, nonmedical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
15. Identifying and coordinating environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptations ILOS).

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy. These entities may include County Health, Public Health, Substance Use, Mental Health, and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs; community-based organizations; housing Providers; local housing agencies; and housing development agencies. For Members who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership Members) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted ILOS Providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Transition Navigation Services ILOS.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

⁷ The services associated with the crisis plan are a separate ILOS under Housing Tenancy and Sustaining Services.

Eligibility (Population Subset)

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness or institutionalization or requiring residential services as a result of a substance use disorder and/or exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, Institutions for Mental Diseases, and state hospitals; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
 - (1) An individual or family who:
 - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
 - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
 - Meets one of the following conditions:
 - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
 - Is living in the home of another because of economic hardship;
 - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
 - Lives in a hotel or motel and the cost of the hotel or motel

stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
 - Is exiting a publicly funded institution or system of care (such as a health care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
- (2) A child or youth who does not qualify as "homeless" under this section but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
 - (3) A child or youth who does not qualify as "homeless" under this section but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

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

- Have one or more serious chronic conditions;
- Have a serious mental illness;
- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents);
- Are receiving Enhanced Care Management; or
- Are 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 serious mental illness

and/or are children or adolescents 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. Service duration can be as long as necessary.

Individuals may not be receiving duplicative support from other State or local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include Providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education Providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment Providers, including county behavioral health agencies
- Social services agencies
- Affordable housing Providers
- Supportive housing Providers
- Federally qualified health centers and rural health clinics

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS All Plan Letters (APLs) including Provider Credentialing/Recredentialing and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider. Members who meet the eligibility requirements for Housing Transition/Navigation Services should also be assessed for

enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management Providers. When Members receive more than one of these services, the managed care plan should ensure services are coordinated by an enhanced care management Provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.⁸

If the Medi-Cal managed care plan case manager, care coordinator, or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services that have the potential to be avoided if a Member receives ILOS services include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

⁸ One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

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

1. Security deposits required to obtain a lease on an apartment or home.
2. Setup fees/deposits for utilities or service access and utility arrearages.
3. First-month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services designed to preserve an individuals' health and safety in the home, such as hospital beds, Hoyer lifts, air filters, and specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on 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.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage, as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services;
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness or institutionalization or requiring residential services as a result of a substance use disorder and/or exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of

homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, Institutions for Mental Diseases and State Hospitals.

Restrictions and Limitations

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine whether an individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the Member is unable to meet such expense.

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.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator, or housing navigator, may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Rec credentialing and Screening/Enrollment ([APL 19-004](#)). If there

is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

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

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the roles, rights, and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management Provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skill set.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.⁹
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).
13. Providing independent living and life skills, including assistance with and training on budgeting, including financial literacy and connection to community resources.

⁹ Does not include housing quality inspections.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy. Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services ILOS.

Services do not include the provision of room and board or payment of rental costs.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services;
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization, or requiring residential services as a result of a substance use disorder, and/or exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, Institutions for Mental Diseases, and State Hospitals; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
 - (1) An individual or family who:
 - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
 - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to

prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

- Meets one of the following conditions:
 - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
 - Is living in the home of another because of economic hardship;
 - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
 - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
 - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
 - Is exiting a publicly funded institution or system of care (such as a health care facility, mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient’s approved consolidated plan;
- (2) A child or youth who does not qualify as “homeless” under this section but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. [254b\(h\)\(5\)\(A\)](#)), section 3(m) of the [Food and Nutrition Act of 2008](#) ([7 U.S.C. 2012\(m\)](#)), or section 17(b)(15) of the [Child Nutrition Act of 1966](#) ([42 U.S.C. 1786\(b\)\(15\)](#)); or
 - (3) A child or youth who does not qualify as “homeless” under this section but qualifies as “homeless” under section 725(2) of the McKinney-Vento

Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining Services if they have significant barriers to housing stability and meet at least one of the following:

- Have one or more serious chronic conditions;
- Have a serious mental illness;
- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents);
- Are receiving Enhanced Care Management; or
- Are 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 serious mental illness and/or are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions/Limitations

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine whether the individual has previously received services. Service duration can be as long as necessary.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation Services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service, but it is not a prerequisite for eligibility.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include Providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education Providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment Providers, including county behavioral health agencies
- Supportive housing Providers
- Federally qualified health centers and rural health clinics

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recertification and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

If the Medi-Cal managed care plan case manager, care coordinator, or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Members who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management Providers. When Members receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management Provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

Short-Term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization Housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery Hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of State plan services.¹⁰

This setting must provide individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management, and beginning to access other housing supports such as Housing Transition Navigation.¹¹

This setting may include an individual or shared interim housing setting where residents receive the services described above.

Members must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization Housing to prepare them for transition from this setting. These services should include a housing assessment and the development of an individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization Housing.¹²

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care;
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery Hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:
 - Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions

¹⁰ Up to 90 days of recuperative care is available under specified circumstances as a separate ILOS.

¹¹ Housing Transition/Navigation is a separate ILOS.

¹² The development of a housing assessment and individualized support plan are covered as a separate ILOS under Housing Transition/Navigation Services.

and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, Institutions for Mental Diseases, and State Hospitals.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

Short-Term Post-Hospitalization Housing services are available once in an individual's lifetime and are not to exceed a duration of six (6) months (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine whether the individual has previously received services.

The service is only available if the enrollee is unable to meet such an expense.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of Providers that may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive housing Providers
- County agencies
- Public hospital systems
- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum

standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for Short-Term Post-Hospitalization Housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recertification and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative Care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management, and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the 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:

1. Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs)
2. Coordination of transportation to post-discharge appointments
3. Connection to any other ongoing services an individual may require, including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment but who are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to Members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to Members on-site in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management Providers.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and

- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.¹³

Restrictions/Limitations

Recuperative care/medical respite is an allowable ILOS if it (1) is necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions; (2) is not more than 90 days in continuous duration; and (3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

¹³ For this population, the service could be coordinated with home modifications (which are covered as a separate ILOS) and serve as a temporary placement until the individual can safely return home.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility services, and emergency department services.

Respite Services

Description/Overview

Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are nonmedical in nature. These services are distinct from medical respite/recuperative care and provide rest for the caregiver only.

Respite Services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite Services are provided to the Member in his or her own home or another location being used as the home.

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

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Eligible individuals include those who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in California Children's Services or Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

Restrictions/Limitations

In the home setting, these services, in combination with any direct care services the Member is receiving, can provide up to 24 hours per day of care.

The service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the limit of 336 hours per calendar year can

be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization, that leaves a Medicaid Member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only provided to avoid placements for which the Medi-Cal managed care plan would be responsible.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Home health or respite agencies to provide services in:
 - Private residence
 - Residential facility approved by the State, such as Congregate Living Health Facilities (CLHFs)
 - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult family home/family teaching home
- Certified family homes for children
- County agencies
- Residential care facility for the elderly (RCFE)
- Child day care facility; Child day care center; Family child care home
- Respite facility; Residential facility: Small Family Home (children only)
- Respite facility; Residential facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite facility; Residential facility: Adult residential facilities (ARFs)
- Respite facility; Residential facility: Group Home (children only)
- Respite facility; Residential facility: Family Home Agency (FHA); Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite facility; Residential facility: Adult Residential Facility for Persons with Special Health Care Needs

- Respite facility; Residential facility: Foster Family Homes (FFHs) (children only)
- Short-Term Residential Therapeutic Program Providers or other care Providers that are serving youth with complex needs

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recertification and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving enhanced care management or other in lieu of services, the Day Habilitation Program can provide a physical location for Members to meet with and engage with these Providers. When possible, these services should be provided by the same entity, to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

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

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and
6. Awareness of community resources, such as police, fire, and local services, to support independence in the community.

Programs may include assistance with, are but not limited to, the following:

1. Selecting and moving into a home;¹⁴
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords;¹⁵
5. Managing personal financial affairs;
6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;

¹⁴ Refer to the Housing Transition/Navigation Services ILOS.

¹⁵ Refer to the Housing Tenancy and Sustaining Services ILOS.

9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with the Medi-Cal managed care plan to link the Member to any ILOS and/or enhanced care management services for which the Member may be eligible;
11. Referral to non-ILOS housing resources if the Member does not meet Housing Transition/Navigation Services ILOS eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if the Member is not receiving these services through ILOS or ECM; and
13. Coordination with the Medi-Cal managed care plan to link the Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member, for Members who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for Members who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Program services are available for as long as necessary. Services can be provided continuously or through intermittent meetings, in an individual or group setting.

Eligibility (Population Subset)

Eligible individuals include those 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/Limitations

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Mental health or substance use disorder treatment Providers, including county behavioral health agencies
- Licensed psychologists
- Licensed certified social workers

- Registered nurses
- Home health agencies
- Professional fiduciary
- Vocational skills agencies

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recertification and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility services, and emergency department services.

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

Description/Overview

Nursing Facility Transition/Diversion services help individuals 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 the 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 helping with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs) and providing meals, transportation, and medication administration, as needed.

The service is for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facility for the Elderly (RCFE) or an Adult Residential Facility (ARF). It includes wraparound services such as assistance with ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming, provided in a home-like environment. It also includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence and to provide supervision, safety, and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including but not limited to:

1. Assessing the Member's housing needs and presenting options.¹⁶
2. Assessing the service needs of the Member to determine whether the Member needs enhanced on-site services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services.
 - A. Managed care plans may also fund RCFE/ARF operators directly to provide these enhanced services.

¹⁶ Refer to Housing Transition/Navigation Services ILOS for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:

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

B. For Nursing Facility Diversion:

1. Is interested in remaining in the community;
2. Is 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.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of Providers that may offer the services.

- Case management agencies
- Home Health Agencies
- Medi-Cal managed care plans
- ARF/RCFE operators

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including

Provider Credentialing/Recredentialing and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

RCFEs/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services, inpatient hospital services, and psychiatric inpatient stays.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home covers nonrecurring setup expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the Member's housing needs and presenting options.¹⁷
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with the landlord (if applicable) and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, nonmedical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.¹⁸
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household refers to funding that does not constitute room and board, such as security deposits required to obtain a lease on an apartment or home; setup fees for utilities or service access; first-month coverage of utilities, including telephone, electricity, heating, and water; funds for services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; funds for home modifications, such as an air conditioner or heater; and funds for other medically necessary services, such as hospital beds and Hoyer lifts, etc. to ensure access and reasonable accommodations.¹⁹

¹⁷ Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services ILOS for additional details.

¹⁸ Refer to the Environmental Accessibility Adaptations and/or Asthma Remediation ILOS for additional details.

¹⁹ Refer to the Housing Deposits ILOS for additional details.

Eligibility (Population Subset)

1. Is 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
2. Has lived 60+ days in a nursing home and/or Medical Respite setting; and
3. Is interested in moving back to the community; and
4. Is able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of \$7,500.00. The only exception to the \$7,500.00 total maximum is if the Member is compelled to move from a Provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re-institutionalization.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Case management agencies
- Home Health Agencies
- Medi-Cal managed care plans
- County mental health Providers

- 1915c Home and Community Based Alternatives/Assisted Living Waiver Providers
- California Community Transitions/Money Follows the Person Providers

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Rec credentialing and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Personal Care and Homemaker Services

Description/Overview

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 (IADLs) such as meal preparation, grocery shopping, and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Services also include help with tasks such as cleaning, shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes.

In lieu of 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.
- 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 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 in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

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

Restrictions/Limitations

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Members must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Home Health Agencies
- County agencies
- Personal care agencies
- AAA (Area Agencies on Aging)

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Rec credentialing and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing facility services.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

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

Examples of environmental accessibility adaptations 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 an in lieu of service, 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 individual 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. Proof 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 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 they 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 stating that the modifications are permanent and that the State is not responsible for maintenance or repair of any modification or for removal of any modification if the Member ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with Providers to manage the services.

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recertification and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based Providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to nursing facility services, inpatient and outpatient hospital services, emergency department services, and emergency transport services.

Medically Supportive Food/Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among Members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved Member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status, and increased Member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.
2. Medically Tailored Meals: meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically Tailored Meals are tailored to the medical needs of the Member by a registered dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes.
4. Medically supportive food and nutrition services include medically tailored groceries, healthy food vouchers, and food pharmacies.
5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

Managed care plans have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members (e.g., Medically Tailored Meals, groceries, food vouchers, etc.).

Eligibility (Population Subset)

1. 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.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement.
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

- Service covers up to three 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.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers
- Medically supportive food and nutrition providers

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recertification and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services and emergency department services.

Sobering Centers

Description/Overview

Sobering Centers are alternative destinations for individuals 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. Sobering Centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment in which to become sober.

Sobering Centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, 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 housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering Centers must be prepared to identify Members 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 Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

Individuals aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

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

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services with these unique populations. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow-up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable Providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recertification and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and emergency transportation services.

Asthma Remediation²⁰

Description/Overview

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

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers
- High-efficiency particulate air (HEPA) filtered vacuums
- Integrated pest management (IPM) services
- Dehumidifiers
- 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 Member or their caregiver.

When authorizing Asthma Remediation as an in lieu of service, the managed care plan must receive and document:

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

Asthma Remediation includes providing information to Members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations, such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.

²⁰ Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided, and ILOS should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B.

2. Using dust-proof mattress and pillow covers, HEPA vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

The Centers for Disease Control and Prevention, the Environmental Protection Agency, and Housing and Urban Development collaborated to produce an [asthma trigger checklist](#),²¹ which MCPs may utilize in determining the appropriateness of these interventions. An accompanying [training](#)²² provides additional details about the connections between asthma triggers and lung health.

Eligibility (Population Subset)

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

Restrictions/Limitations

- If another State Plan service, such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, that service should be used.
- Asthma remediations must be conducted in accordance with applicable State and 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 using Medi-Cal funding.
- Asthma remediations are payable up to a total lifetime maximum of \$7,500. The only exception to the \$7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.
- Asthma Remediation modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that

²¹ https://www.cdc.gov/asthma/pdfs/home_assess_checklist_P.pdf.

²² https://www.epa.gov/sites/production/files/2020-06/home_characteristics_and_asthma_triggers_training_for_home_visitors_0.pptx.

are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but they do not include aesthetic embellishments.

- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the managed care plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification or for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to allergen-impermeable mattress and pillow dust covers, HEPA filtered vacuums, dehumidifiers, portable air filters, and asthma-friendly cleaning products and supplies.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly; coordinate with an existing Medi-Cal Provider to manage the services; and/or contract with a county agency, community-based organization, or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of Providers that may offer the services.

- Lung health organizations
- Healthy housing organizations
- Local health departments
- Community-based Providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable Providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are

maintained.

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recertification and Screening/Enrollment [APL 19-004](#). If there is no state-level enrollment pathway, managed care plans must have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

State Plan Service(s) That Are Likely to Be Avoided with the Provision of ILOS

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services and emergency department services.

IV. Requesting Approval for New ILOS

MCPs must apply for and obtain State approval prior to offering any new ILOS, and they must demonstrate that all of the following requirements will be met through the submission of an ILOS Model of Care:

- ILOS are voluntary. MCPs cannot require a Member to use an ILOS instead of a State Plan covered service.
- The alternative services are medically appropriate and cost-effective.
- The population and criteria for the ILOS are clearly defined, and the ILOS will be offered in an equitable and nondiscriminatory manner to eligible Members.
- The MCP has demonstrated capability to calculate the cost-benefit analysis for each ILOS, including tracking and reporting on ILOS expenditures in a manner and format established by DHCS.
- MCPs must use the Healthcare Common Procedure Coding System (HCPCS) rate codes through encounter data that have been approved by DHCS to track the claiming and provision of ILOS.
- ILOS may not include expenditures prohibited by CMS, such as room and board.

Once DHCS approves an MCP's submitted ILOS Model of Care, the ILOS must be added to the MCP's contract and will be posted on the DHCS website as a State-Approved ILOS. The cost and utilization of the ILOS will be factored into the medical portion of the MCP's rates.

Members have the right to file a grievance and request an appeal regarding the denial of a State-Approved ILOS being offered by the MCP. ILOS are additionally subject to the State Fair Hearings process. DHCS may terminate an MCP's ILOS offering if it is determined to be harmful to the Member or is not cost-effective. MCPs may terminate an ILOS upon notice to DHCS once annually at the end of the calendar year, except in cases where the ILOS is terminated due to Member health, safety, or welfare concerns. If an MCP terminates an ILOS, they must publicize the service end date and provide at least 90 days' notice to their Members and implement a plan for continuity of care for Members receiving that ILOS.

See the [ILOS Resource Directory](#) for more information and to access the Model of Care.

V. Provider Enrollment, Credentialing, and Vetting Requirements

ILOS Providers as Medi-Cal Enrolled Providers

MCP Network Providers (including those who will operate as ILOS Providers) are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. However, many ILOS Providers (e.g., housing agencies, medically-tailored meal Providers) may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program. Instead, these Providers must be vetted by the MCP in order to participate as ILOS Providers.

Process for Medi-Cal Enrollment

For those ILOS Providers with a state-level Medi-Cal enrollment pathway, the Provider would have to enroll through the DHCS Provider Enrollment Division or the MCP can choose to have a separate enrollment process.

Clarifying the Provider “Credentialing” Requirements of APL 19-004

The credentialing requirements articulated in [APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment](#) only apply to Providers with a state-level pathway for Medi-Cal enrollment. Therefore, ILOS Providers without a state-level pathway to Medi-Cal enrollment are not required to meet the credentialing requirements in APL 19-004 in order to become “in-network” ECM and/or ILOS Providers, but they must be vetted by the MCP in order to participate.

MCP Requirements Related to Vetting ILOS Providers Without a State-Level Pathway for Medi-Cal Enrollment

To include an ILOS Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to be an ILOS Provider. MCPs must submit Policies and Procedures for how they will vet the qualifications of ECM and ILOS Providers in their Part 2 submission of the MOC. MCPs must create and implement their own processes to do so. Factors MCPs may want to consider as part of their process include, but are not limited to:

- Ability to receive referrals from MCPs for the authorized ILOS;
- Sufficient experience to provide services similar to the specific ILOS they are contracted to provide within the service area;
- Ability to submit claims or invoices for ILOS using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste, and/or abuse;
- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
- History of liability claims against the Provider.

VI. Billing and Payments

ILOS Billing and Invoicing Guidance

DHCS is developing more comprehensive guidance that will describe the minimum set of data elements required to be included in an invoice, to be finalized by September 2021.

Non-Binding ILOS Pricing Guidance

The CalAIM initiative and, in particular, the introduction of the 14 preapproved health-related ILOS prompt MCPs to work and contract with a new set of “nontraditional” Providers that offer services and supports that historically have not been well integrated into the health care system. These Providers include, but are not limited to, housing service Providers, home modification companies, sobering centers, and organizations that prepare and deliver medically supportive food and nutrition. While many MCPs and ILOS Providers have some experience working together, particularly in WPC Pilot counties, CalAIM is designed to encourage and support broader contracting and partnerships throughout the State. In recognition that this requires MCPs and ILOS Providers to engage in new contracting and payment relationships, DHCS has prepared non-binding ILOS Pricing Guidance. It offers information on potential rates for each of the 14 preapproved ILOS, including midpoint benchmarks and a discussion of key cost drivers that MCPs and ILOS Providers may want to consider as they establish their own contracting and payment arrangements.

Critically, this pricing guidance is designed to serve as a tool to support discussions regarding rates; **it is in no way binding on MCPs or ILOS Providers**. MCPs and ILOS Providers have full flexibility and discretion to agree to ILOS rates that are different from those outlined in this document, particularly because the rates in the pricing guidance are based on data and assumptions that reflect the statewide average cost of inputs. DHCS reserves the right to make modifications to the pricing guidance on an as-needed basis based on experience with the ILOS initiative and its evolution over time.

The Non-Binding ILOS Pricing Guidance can be accessed from the [ILOS Resource Directory](#).

ILOS HCPCS Codes

The [ECM and ILOS Coding Options](#) guidance lists the HCPCS codes that MCPs must use for ILOS (see the table below) services. The HCPCS code and modifier combined define the service as ILOS.

As an example, HCPCS code H0043 by itself does not define the service as a Housing Transition/Navigation ILOS. HCPCS code H0043 must be reported with modifier U6 for the supported housing services to be defined and categorized as an ILOS.

DHCS expects MCPs to support their ILOS Providers in reporting and translating their delivered ILOS to these required HCPCS codes. While MCPs must use the below HCPCS codes and modifiers for reporting applicable ILOS encounters to DHCS, MCPs may utilize alternative payment approaches with ILOS Providers. For example, an MCP might opt to pay a Provider for Housing Transition and Navigation Services as a per Member per month (PMPM) payment. That MCP must still report encounters to DHCS as a per diem for every service rendered by that Provider, using the HCPCS codes and modifiers below. **If an ILOS is provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.**²³

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
Housing Transition/Navigation Services			
H0043	Supported housing; per diem	U6	Used by Managed Care with HCPCS code H0043 to indicate In Lieu of Services supported housing
H2016	Comprehensive community support services; per diem	U6	Used by Managed Care with HCPCS code H2016 to indicate In Lieu of Services comprehensive community support services
Housing Deposits			
H0044	Supported housing, per month. Requires deposit amounts to be reported on the encounter. Modifier used to differentiate Housing Deposits from Short-Term Post-Hospitalization Housing.	U2	Used by Managed Care with HCPCS code H0044 to indicate In Lieu of Services Housing Deposit

²³ For more information, refer to the DHCS [Medi-Cal Provider Manuals](#).

Housing Tenancy and Sustaining Services²⁴			
T2040	Financial management, self-directed; per 15 minutes	U6	Used by Managed Care with HCPCS code T2040 to indicate In Lieu of Services Housing Tenancy and Sustaining Services ²⁵
TBD	Financial management, self-directed; per diem	U6	Used by Managed Care with HCPCS code TBD to indicate In Lieu of Services Housing Tenancy and Sustaining Services
T2041	Support brokerage, self-directed; per 15 minutes	U6	Used by Managed Care with HCPCS code T2041 to indicate In Lieu of Services Housing Tenancy and Sustaining Services ²⁶
TBD	Support brokerage, self-directed; per diem	U6	Used by Managed Care with HCPCS code TBD to indicate In Lieu of Services Housing Tenancy and Sustaining Services
Short-Term Post-Hospitalization Housing			
H0044	Supported housing, per month. Modifier used to differentiate Short-Term Post-Hospitalization Housing from Housing Deposits.	U3	Used by Managed Care with HCPCS code H0044 to indicate In Lieu of Services Short-Term Post-Hospitalization Housing
Recuperative Care (Medical Respite)			
T2033	Residential care, not otherwise specified (NOS), waiver; per diem	U6	Used by Managed Care with HCPCS code T2033 to indicate In Lieu of Services Recuperative Care (Medical Respite)

²⁴ DHCS has requested that CMS designate per diem codes for Housing Tenancy and Sustaining Services. Once available, the codes will be added to this table.

²⁵ MCPs should process service encounters using this code. The modifier indicates to DHCS that this is the Housing Tenancy and Sustaining Services ILOS. The use of this encounter code will signal the capturing of the service, as alternative per diem codes are not available.

²⁶ MCPs should process service encounters using this code. The modifier indicates to DHCS that this is the Housing Tenancy and Sustaining Services ILOS. The use of this encounter code will signal the capturing of the service, as alternative per diem codes are not available.

Respite Services			
H0045	Respite care services, not in the home; per diem	U6	Used by Managed Care with HCPCS code H0045 to indicate In Lieu of Services Respite Services
S5151	Unskilled respite care, not hospice; per diem	U6	Used by Managed Care with HCPCS code S5151 to indicate In Lieu of Services Respite Services
S9125	Respite care, in the home; per diem	U6	Used by Managed Care with HCPCS code S9125 to indicate In Lieu of Services Respite Services
Day Habilitation Programs			
T2012	Habilitation, educational; per diem	U6	Used by Managed Care with HCPCS code T2012 to indicate In Lieu of Services Day Habilitation Programs
T2014	Habilitation, prevocational; per diem	U6	Used by Managed Care with HCPCS code T2014 to indicate In Lieu of Services Day Habilitation Programs
T2018	Habilitation, supported employment; per diem	U6	Used by Managed Care with HCPCS code T2018 to indicate In Lieu of Services Day Habilitation Programs
T2020	Day habilitation; per diem	U6	Used by Managed Care with HCPCS code T2020 to indicate In Lieu of Services Day Habilitation Programs
H2014	Skills training and development; per 15 minutes ²⁷	U6	Used by Managed Care with HCPCS code H2014 to indicate In Lieu of Services Day Habilitation Programs
TBD	Skills training and development; per diem	U6	Used by Managed Care with HCPCS code TBD to indicate In Lieu of Services Day Habilitation Programs

²⁷ DHCS has requested CMS designate a per diem code for Day Habilitation Programs – Skills Training. Once available, the code will be added to this table. MCPs should process service encounters using this code. The modifier indicates to DHCS that this is the Day Habilitation Programs ILOS. The use of this encounter code will signal the capturing of the service, as alternative per diem codes are not available.

H2024	Supported employment; per diem	U6	Used by Managed Care with HCPCS code H2024 to indicate In Lieu of Services Day Habilitation Programs
H2026	Ongoing support to maintain employment; per diem	U6	Used by Managed Care with HCPCS code H2026 to indicate In Lieu of Services Day Habilitation Programs
Nursing Facility Transition/Diversion to Assisted Living Facilities²⁸			
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Community Transition Services/Nursing Facility Transition to a Home.	U4	Used by Managed Care with HCPCS code T2038 to indicate In Lieu of Services Nursing Facility Transition/Diversion to an Assisted Living Facility
H2022	Community wraparound services; per diem. Requires billed amount(s) to be reported on the encounter.	U5	Used by Managed Care with HCPCS code H2022 to indicate In Lieu of Services Community Transition Services/Nursing Facility Transition to a Home
Community Transition Services/Nursing Facility Transition to a Home			
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Nursing Facility Transition/Diversion to Assisted Living Facilities.	U5	Used by Managed Care with HCPCS code T2038 to indicate In Lieu of Services Community Transition Services/Nursing Facility Transition to a Home
Personal Care/Homemaker Services			
S5130	Homemaker services; per 15 minutes	U6	Used by Managed Care with HCPCS code S5130 to indicate In Lieu of Services Personal Care/Homemaker Services
T1019	Personal care services; per 15 minutes	U6	Used by Managed Care with HCPCS code T1019 to indicate In Lieu of Services Personal Care/Homemaker Services

²⁸ Multiple encounters may be submitted for a single transition if different services are involved. A transition can also be indicated on a single encounter with a Begin and End date.

Environmental Accessibility Adaptations			
S5165	Home modifications; per service. Requires billed amount(s) to be reported on the encounter.	U6	Used by Managed Care with HCPCS code S5165 to indicate In Lieu of Services Accessibility Adaptations/Home Modifications
Medically Supportive Food/Meals/Medically Tailored Meals			
S5170	Home-delivered prepared meal	U6	Used by Managed Care with HCPCS code S5170 to indicate In Lieu of Services Medically Supportive Food/Meals/Medically Tailored Meals
S9470	Nutritional counseling, diet	U6	Used by Managed Care with HCPCS code S9470 to indicate In Lieu of Services Medically Supportive Food/Meals/Medically Tailored Meals
S9977	Meals; per diem, not otherwise specified	U6	Used by Managed Care with HCPCS code S9977 to indicate In Lieu of Services Medically Supportive Food/Meals/Medically Tailored Meals
Sobering Centers			
H0014	Alcohol and/or drug services; ambulatory detoxification	U6	Used by Managed Care with HCPCS code H0014 to indicate In Lieu of Services Sobering Centers alcohol and/or drug services; ambulatory detoxification services
Asthma Remediation			
S5165	Home modifications; per service	U5	Used by Managed Care with HCPCS code S5165 to indicate In Lieu of Services Asthma Remediation

VII. Consent, Authorization, and Data Sharing

The vision of ILOS is to embrace and integrate a diversity of Providers in the delivery of whole-person care, and not just traditional health care Providers. DHCS acknowledges the tremendous investment required of both MCPs and Provider organizations to realize this from an information technology infrastructure and data sharing perspective. To that end, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and ILOS Providers. DHCS is developing more comprehensive guidance that will describe the minimum set of data elements required to be included in an invoice, which will be finalized by September 2021.

Data System Requirements

MCPs are required to have an IT infrastructure and data analytic capabilities to support ILOS, including the capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in ILOS Contract Template Section 7: Identifying Members for ILOS;
- Assign Members to ILOS Providers;
- Keep records of Members receiving ILOS and their consent;
- Securely share data with ILOS Providers;
- Receive, process, and send encounters and invoices from ILOS Providers to DHCS in accordance with DHCS standards;
- Receive and process supplemental reports from ILOS Providers;
- Send ILOS supplemental reports to DHCS; and
- Open, track, and manage referrals to ILOS Providers.

Data Sharing Requirements for MCPs

In order to support ILOS, MCPs shall provide, at a minimum, the following information to all ILOS Providers:

- Physical, behavioral, administrative, and information indicating Member social determinants of health (SDOH) needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS)²⁹ for assigned Members; and
- Reports of performance on quality measures and/or metrics, as requested.

MCPs are required to use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ILOS Providers and with DHCS.

²⁹ As part of the population health management (PHM) initiative of CalAIM, DHCS has issued guidance encouraging MCPs to incorporate the use of DHCS Priority SDOH Codes; please refer to APL 21-009 for more information.

Data Sharing Requirements for ILOS Providers

DHCS' vision is that ILOS Providers will submit encounters to MCPs for transmission to DHCS. Providers that do not have these capabilities will be allowed to submit invoices to MCPs, and MCPs will then convert the invoices to encounters for submission to the DHCS.

DHCS is not specifying the payment model between MCPs and Providers for ILOS, though DHCS encourages plans and Providers to adopt or progress to value-based payment (VBP) models for ILOS.

If the ILOS Provider is paid by the MCP on a fee-for-service (FFS) basis, they will be expected to generate a claim and send it to the MCP for payment processing. If the ILOS Provider is unable to send a compliant 837P claim to the MCP, they will be expected to send an invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that they will subsequently submit to DHCS according to current DHCS policy.

If an ILOS Provider is paid by the MCP on a capitated basis, then the Provider will still be expected to generate and submit a compliant encounter to MCPs. In the event that the ILOS Provider is unable to submit a compliant 837P encounter, they will be expected to send a paid invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that the plan will subsequently submit to DHCS according to current DHCS policy.

ILOS Providers and MCPs may need to reconfigure their existing systems to meet these requirements.

VIII. Monitoring, Oversight, and Reporting

Oversight of ILOS Providers

MCP Requirements

MCPs are required to perform oversight of ILOS Providers, holding them accountable to all ILOS requirements contained in the ECM and ILOS Contract Template, the MCP's MOC, and any associated guidance issued by DHCS. MCPs are expected to use ILOS Provider Standard Terms and Conditions to develop ILOS contracts with ILOS Providers, and they are expected to incorporate all ILOS Provider requirements reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting criteria. To streamline the ILOS implementation:

- MCPs must hold ILOS Providers responsible for the same reporting requirements as those that the MCP must report to DHCS;
- The MCPs will not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting; and
- MCPs are encouraged to collaborate with other MCPs within the same county on oversight of ILOS Providers.

Subcontractors

MCPs may subcontract with other entities to administer ILOS, provided they adhere to the below requirements:

- MCPs will maintain and be responsible for oversight of compliance with all contract provisions and covered services, regardless of the number of layers of subcontracting;
- MCPs will be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services;
- MCPs will remain responsible for ensuring the Subcontractor's ILOS Provider capacity is sufficient to serve eligible Members;
- MCPs will report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served; and
- MCPs will make all Subcontractor agreements available to DHCS upon request. Such agreements must contain the minimum required information specified by DHCS, including method and amount of compensation.

MCPs will ensure their agreements with any Subcontractor mirrors the requirements set forth in ECM and ILOS Contract Template, and the ECM and ILOS Provider Standard

Terms and Conditions, as applicable to Subcontractor. MCPs are encouraged to collaborate with their Subcontractors on the approach to ILOS to minimize variance in how ILOS will be implemented and to ensure a streamlined, seamless experience for ILOS Providers and Members.

Model of Care (MOC) and Approval Process

The ECM and ILOS MOC is each MCP's framework for providing ECM and ILOS. Each MCP's MOC will include its overall approach to ECM and ILOS; its detailed Policies and Procedures with regard to ECM and ILOS Providers (including nontraditional Providers) contracting and oversight; its ECM and ILOS Provider network capacity; and the contract language that will define key aspects of its arrangements with its ECM and ILOS Providers. The MOC also includes specific "Transition and Coordination" content for MCPs operating in Whole Person Care (WPC) and/or Health Home Program (HHP) counties. MCPs in these counties must describe how they will ensure smooth transitions for their Members from WPC and HHP into ECM and ILOS.

DHCS will use each MCP's MOC submission to determine its readiness to meet ECM and ILOS requirements. MCPs must lay out their MOCs using the DHCS-developed standard template (MOC Template) and submit them to DHCS for review and approval prior to initial ECM and ILOS implementation in 2022. MCPs must make updates to their MOCs (1) ahead of new ECM Populations of Focus being implemented in January and July 2023 and (2) to reflect any ILOS changes.

MCPs should expect review of the MOC to be an iterative process with DHCS during each review period. DHCS may require resubmission of certain questions or additional material to ensure alignment with DHCS requirements.

Encounter Data Submission Process

DHCS requires MCPs to submit encounter data in accordance with requirements in the MCP contract and All Plan Letter 14-019, or any subsequent updates. MCPs are required to submit encounter data for ILOS through the existing encounter data reporting mechanisms for all covered services for which they have incurred any financial liability, whether directly or through subcontracts or other arrangements, using ASC X12 837 version 5010 x223 Institutional and Professional transactions or NCPDP 2.2 or 4.2 transactions and the new ILOS coding requirements outlined in this document, to the Post Adjudicated Claims and Encounters System (PACES) beginning on January 1, 2022.

Scope of Monitoring Activities

DHCS will monitor MCPs' implementation of and compliance with ECM and ILOS requirements across multiple domains, including Membership, Service Provision, Grievances and Appeals, Provider Capacity, and Quality. DHCS will monitor MCP compliance with ECM and ILOS using existing monitoring processes as well as through

submission of time-limited quarterly Implementation Monitoring Report Templates.

IX. Performance Incentive Program

CalAIM's ECM and ILOS programs will require significant new investments in care management capabilities, ILOS infrastructure, information technology (IT) and data exchange, and workforce capacity at both the MCP and Provider levels. Incentive payments will be a critical component of CalAIM to promote MCP and Provider participation in, and capacity building for, ECM and ILOS.

DHCS has designed an incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022 for the achievement of defined milestones. Infrastructure development, ECM and ILOS Provider capacity building, and ILOS take-up are **priority areas** for Program Year 1 (i.e., calendar year 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas. Quality will emerge as a priority area for Program Year 2 (i.e., calendar year 2023).

Additional guidance on the Performance Incentive Program, as well as more details on available Projects for Assistance in Transition from Homelessness (PATH) Funding, will be added to this section as soon as it is available. This is tentatively slated for fall 2021.

Listed below are the goals and design principles of the program.

Performance Incentive Goals:

- Build appropriate and sustainable ECM and ILOS capacity.
- Drive MCP investment in necessary delivery system infrastructure.
- Incentivize MCP take-up of ILOS.
- Bridge current silos across physical and behavioral health delivery.
- Reduce health disparities and promote health equity.
- Achieve improvements in quality performance.

Performance Incentive Design Principles:

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably.
2. Set ambitious yet achievable measure targets.
3. Ensure efficient and effective use of **all** performance incentive dollars.
4. Drive significant investments in core priority areas up front.
5. Minimize administrative complexity.
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC)/Health Home Program (HHP) counties and non-WPC/HHP counties.
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates.
8. Measure and report on the impact of incentive funds.



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X. ILOS Resource Directory

ILOS Resource Directory	
Resource	Description
<u>ECM and ILOS Website</u>	Online repository for ECM and ILOS program documents and technical assistance. Future guidance will be posted here.
<u>Fact Sheet ILOS</u>	Overview of ILOS and DHCS' vision for ILOS initiative.
<u>Frequently Asked Questions Document</u>	Answers to key ILOS policy questions. Document will be updated with new questions/answers on an ad hoc basis.
<u>ECM and ILOS Change Memo</u>	Summary of key policy changes DHCS made to ECM and ILOS requirements documents based on stakeholder feedback.
<u>DHCS-MCP ECM and ILOS Contract Template</u>	ILOS contract requirements for MCPs.
<u>ECM and ILOS Standard Provider Terms and Conditions</u>	Standardized language that MCPs must include in all contracts with ILOS Providers.
<u>CalAIM ECM and ILOS Model of Care Cover Note: Instructions and Timeline</u> <u>CalAIM ECM and ILOS Model of Care Template</u>	Template for MCP to outline proposed protocols for implementation and provision of ILOS. Each MOC must be reviewed and approved by DHCS prior to ILOS implementation.



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<u>ECM and ILOS Coding Guidance</u>	Guidance on encounter data submissions for ILOS services delivered.
Non-Binding ILOS Pricing Guidance* <i>Coming Soon</i>	Non-Binding guidance on pricing for ILOS services.
ILOS Billing and Invoicing Guidance* <i>Coming Soon</i>	Guidance defining the standard, “minimum necessary” data elements MCPs will collect from ILOS Providers.
ILOS Quarterly Implementation Reporting Framework* <i>Coming Soon</i>	Guidance defining DHCS’ strategy for monitoring the implementation of ILOS.

*Check the [ECM and ILOS website](#) for the latest updates and versions of ILOS documents.



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XI. Glossary of Terms

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multiyear initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage Member risk and need through Whole Person Care Approaches and addressing social determinants of health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term services and supports to Medi-Cal beneficiaries also eligible for Medicare (“dual eligibles”). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care Providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.



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Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e., both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, by a city and a county, or by the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing states that they would phase out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020, when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the substance use disorder treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidence-based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized during the 2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive (“whole-person”) care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties that have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportionate share hospital and uncompensated care funding, where select Designated Public Hospital systems can



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achieve their “global budget” by meeting a service threshold that incentivizes movement from high-cost, avoidable services to providing higher-value, preventive services. GPP was set to expire on December 31, 2020 and sought approval under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Medi-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

Indian Health Care Providers: Health care programs operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

In Lieu of Services: Services offered by a Medi-Cal health plan that are not included in the State Plan but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan’s contract. Services are offered at the plan’s option, and a Member cannot be required to use them.

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long-Term Care: Includes skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long-Term Service and Supports: Services that include medical and nonmedical care for people with a chronic illness or disability. Long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long-Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California’s Section 1115 waiver that expired on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, and the Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.



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Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of Providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Medicaid Section 1115 Demonstration Waivers: Section 1115 waivers permit states to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an “experimental, pilot, or demonstration project” that is “likely to assist in promoting the objectives of the program.” Section 1115 waivers are generally approved for a five-year period.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing Member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all Members healthy by focusing on preventive and wellness services;
- Identify and assess Member risks and needs on an ongoing basis;
- Manage Member safety and outcomes during transitions and across delivery systems or settings through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high-quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding was authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California’s Designated Public Hospitals receive incentive



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payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value-based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net Providers' uncompensated care costs associated with Medicaid-eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Section 1915(b) “Freedom of Choice” Waivers: States generally use Section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many states originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid, and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) “Home and Community Based Services” Waivers: States generally use Section 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity: A federal opportunity for states to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the Institution for Mental Disease (IMD) exclusion (see [SMD #18-011](#)).

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, and worship, as well as their age that affect a wide range of health, functioning, and quality-of-life outcomes and risks ([Healthy People 2020](#)).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal-eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal program operated with federal and local funds. Eligible populations include:

- Children under age 21;
- Medically fragile individuals;
- Individuals at risk of institutionalization;



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- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program was authorized under the Medi-Cal 2020 demonstration and was set to expire on December 31, 2020, with approval pending to extend through calendar year 2021.