COMMUNITY SUPPORTS: SELECT SERVICE DEFINITION UPDATES

Nursing Facility Transition/Diversion to Assisted Living Facilities
Community Transition Services/Nursing Facility Transition to a Home
Asthma Remediation
Medically Tailored Meals/Medically Supportive Food

Released February 2025
Effective July 2025

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

OVERVIEW OF SERVICE DEFINITION UPDATES

In 2022, DHCS launched 14 Community Supports that may be a substitute for, and can potentially decrease utilization of, a range of covered Medi-Cal services, such as hospitalization, nursing facility care, and emergency department (ED) use. As part of its commitment to continuous improvement, DHCS has always envisioned making updates to Community Supports based on data and feedback from implementors and stakeholders. In 2023, DHCS released the ECM and Community Supports Action Plan "focused on improving the standardization of both ECM and Community Supports and increasing the number of Members who can access and receive the services they need." The Action Plan commitments[1] included clarifying and refining Community Supports service definitions to respond to feedback from those implementing the services and increase the number of Members who can access and receive the services they need.

DHCS is also focused on bridging equity gaps in health care and encouraging engagement at the local level to meet the needs of Medi-Cal Members. As outlined in the MCP Contract under Exhibit A, Attachment III; Section 4.5 Community Supports, DHCS continues to expect managed care plans (MCPs) to prioritize contracting with qualified, locally-based Community Supports Providers who are culturally responsive to their community. One way to improve networks, equity, and service uptake is to ensure that the services are understood in a clear and unified way across the state.

Beginning in 2023 and then throughout 2024, DHCS conducted extensive engagement with stakeholders on the implementation of Community Supports and how the service definitions could be improved. Engaged partners included MCPs, counties, Community Supports Providers, health care providers, and advocacy organizations. In September 2024, DHCS released proposed, draft refinements to seven service definitions and solicited feedback via a targeted comment period. The Department received approximately 100 comments from a wide range of stakeholders and, during the remainder of 2024, reviewed the feedback including with external partners.

This document provides finalized, updated service definitions for four of the 14 Community Supports, as follows:

- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Asthma Remediation

[1] The ECM and Community Supports Action Plan can be found at: ECM and Community Supports Action Plan Overview and Updates.

- Medically Tailored Meals (MTMs)/Medically Supportive Food (MSF)

The updated service definitions for these four services take effect July 1, 2025.[2]

In this document, DHCS provides for each service definition 1) a summary of the rationale for each set of refinements and 2) the finalized, updated service definition. The service definitions contained in this document supplant and take precedence over the definitions in the DHCS Medi-Cal Community Supports Policy Guide (v. July 2023). DHCS is releasing this temporary excerpt to give MCPs time to enact necessary changes ahead of the July 2025 go-live and will re-release the Community Supports Policy Guide by the end of April 2025, inclusive of the updated definitions.

A Note on Housing-Related Community Supports: Over the past year, DHCS has also engaged extensively with partners to solicit feedback on service definitions for the "Housing Trio" of Community Supports—Housing Deposits, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services—in parallel to engagement on the new Transitional Rent Benefit under Medi-Cal. In December 2024, CMS also released revised guidance on coverage of services related to Health Related Social Needs (HRSN) under Medicaid and CHIP.

This document does not contain updates to the service definitions for the Housing Trio. In order for both to take CMS' most recent guidance into account and align design decisions with the newly approved Transitional Rent Community Support service,[3]DHCS will release updates to the Housing Trio in April 2025 alongside the release of the service definition for Transitional Rent.

[2] Select updates to the Asthma Remediation service definition will go into effect on January 1, 2026, rather than July 2025. Please see the Asthma Remediation section of this document for additional details.

[3]DHCS Press Release for the BH-CONNECT DEMONSTRATION: 24-41-State Receives Federal Approval for BH-CONNECT Initiative

NURSING FACILITY TRANSITION/DIVERSION TO ASSISTED LIVING FACILITIES, SUCH AS RESIDENTIAL CARE FACILITIES FOR THE ELDERLY AND ADULT RESIDENTIAL FACILITIES

Summary of Refinements

This service aims to divert and support Members who otherwise would receive skilled nursing facility (SNF) level of care (LOC) to an assisted living facility (ALF) both by providing support during the transition and by providing ongoing assisted living services during their tenancy. For the purposes of this service, the term "ALF" includes Residential Care Facilities for the Elderly (RCFEs) and Adult Residential Facilities (ARFs).

Since the initial launch of Community Supports, stakeholders have requested that DHCS clarify several aspects of this service definition, including eligibility criteria, service components, and overlapping enrollment with other Community Supports, 1915(c) waivers, and the California Community Transitions (CCT) demonstration.

In September 2024, DHCS released for stakeholder comment a set of clarifications and updates to this service definition and received 19 comments from a range of MCPs, providers, counties, and advocacy organizations. In response to these comments and other stakeholder discussions, DHCS is finalizing the following clarifications and updates:

- **Eligibility Criteria:** DHCS proposed clarifying that Members residing in a private residence are eligible for this service as long as they are transitioning to an ALF and meet the criteria for needing a nursing facility LOC. DHCS is finalizing these clarifications. In response to feedback, DHCS is also clarifying that Members transitioning from public subsidized housing to an ALF (not just from a "private residence" to an ALF) can receive this service. Finally, in response to stakeholder feedback, DHCS is finalizing that Members currently residing in an ALF can receive the ongoing assisted living services component of this Community Support as a means of diversion from a SNF, if they meet the criteria for nursing facility LOC.
- **Service Components:** DHCS proposed clarifying that there are two distinct components of this Community Support:
    - Time-limited transition services and expenses, including one-time moving expenses such as movers/moving supplies; and

- Ongoing assisted living services for the Member after transitioning into an Assisted Living Facility (excludes room and board). This component of the Community Support does not have a time limit.

DHCS proposed clarifying that MCPs may not limit their offering of this service to only one component or the other. DHCS is finalizing this clarification.

- **Overlap Principles with Other Community Supports:** DHCS proposed clarifying that Members may receive other Community Supports (in particular, the time-limited transition services/expenses component of this service and Housing Transition Navigation) at the same time as long as the services provided are nonduplicative, distinct, and necessary. DHCS is finalizing this clarification.
- **Overlap Principles with Waivers:** DHCS proposed clarifying that while a Member may be eligible for both the Nursing Facility Transitions Community Support and the Assisted Living Waiver (ALW) or CCT, they may not receive both at the same time due to the similar services funded under each program. DHCS is finalizing this clarification.
- **Allowable Settings:** DHCS received feedback that it should consider transitions to (1) rehabilitation facilities and/or (2) public housing combined with home care as alternatives to ALFs under this service. DHCS is not expanding the scope of this service definition to these settings at this time. DHCS is aware of current pilot efforts under the ALW that combine public housing with home care as an alternative to an ALF setting and may explore expansion to this setting in future iterations of this service definition.[4]

[4] For more, please review resources on the DHCS ALW page: Assisted Living Waiver.

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

Description/Overview

This service assists individuals to live in the community and avoid institutionalization, whenever possible. The goal of the service is to facilitate nursing facility transition back into a home-like community setting, and/or to prevent skilled nursing admissions for Members living in the community with an imminent need for nursing facility LOC. This service is intended to provide Members with a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility.

For the purposes of this service definition, the term assisted living facility (ALF) includes a Residential Care Facility for the Elderly (RCFE), or Adult Residential Care Facility (ARF). This service includes two components, as follows:

1. **Time-limited transition services and expenses** to enable a person to establish a residence in an ALF. Transition services end once the Member establishes residency in the ALF.[5] The transitional period will vary in length and services provided based on a Member's unique circumstances. Allowable expenses are those necessary to enable a person to establish ALF residence (except room and board), including, but not limited to:
    a. Assessing the Member's housing needs and presenting options.
    b. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the ALF, so the Member can be safely and stably housed.
    c. Assisting in securing an ALF residence, including the completion of facility applications, and securing required documentation (e.g., Social Security card, birthcertificate, prior rental history).
    d. Moving expenses to support a Member's transition, such as movers/moving supplies and necessary private/personal articles to establish an ALF residence.
    e. Communicating with facility administration and coordinating the move.

[5] MCPs are required to provide Transitional Care Services (TCS), including transitional care management, for high and lower-risk transitioning Members, as specified in the PHM Policy Guide. Members who are eligible for this Community Supports service would receive it in addition to TCS.

f. Establishing procedures and contacts to retain housing at the ALF.

2. **Ongoing assisted living services** are provided to Members on an ongoing basis after they transition into the ALF. Members can receive these services indefinitely, as long as the Member can maintain residency in the ALF. These services include:

    a. Assistance with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs)
    b. Meal preparation
    c. Transportation
    d. Medication administration and oversight
    e. Companion services
    f. Therapeutic social and recreational programming provided in a home-like environment
    g. 24-hour direct care staff onsite at the ALF to meet unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security
    h. Care coordination services to screen for eligibility and support enrollment of Members in Enhanced Care Management (ECM) and other Community Supports

MCPs may not limit their offering of this service to only component 1 (time-limited transition services and expenses) or component 2 (ongoing assisted living services) and must offer both to the extent that they are appropriate for the Member. However, individual Members may require only one or only the other component (e.g., Members already in the ALF will require only component 2 since they are not transitioning; Members enrolled in a waiver program that covers similar wraparound services may require only component 1).

Eligibility (Population Subset)

For Nursing Facility Transition: Members residing in a nursing facility who:

1. Have resided 60+ days in a nursing facility and
2. Are willing to live in an assisted living setting as an alternative to a nursing facility; and
3. Are able to reside safely in an ALF.

For Nursing Facility Diversion: Members residing in the Community who:

1. Are interested in remaining in the community; and
2. Are willing and able to reside safely in an ALF; and

3. Meet the minimum criteria to receive nursing facility LOC[6] services and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF.

"Members residing in the community" includes Members living in a private residence or public subsidized housing and Members already residing in an ALF who are at risk of institutionalization.

Members who are receiving facility level health care services on an acute or post-acute care basis (such as a hospitalization or a short-term skilled nursing facility stay) may be eligible for this community support, provided they otherwise meet the eligibility criteria.

Crossover with the Assisted Living Waiver (ALW) in ALW Counties

A Member can be eligible for both the ALW[7] and California Community Transitions program[8] and this service; however, they cannot receive both at the same time. MCPs are encouraged to assist Members with enrollment in eligible and available waiver programs, such as the ALW, as appropriate.

MCPs must ensure coordination with ALW providers to avoid overlapping service delivery and to facilitate seamless transitions when Members move between the two programs. For example, Members transitioning out of a nursing facility who are awaiting enrollment in the ALW may utilize the time-limited transition component of this Community Support to support their transition to the ALF. Members may then utilize the ongoing assisted living services component of this Community Support to support their services received from the ALF until their enrollment in the ALW is completed. DHCS encourages MCPs to offer the Community Support to Members on the ALW waitlist.[9]

MCPs should work collaboratively with ALW Care Coordination Agencies to align care planning and ensure appropriate referrals. Additional guidance on ALW services and eligibility criteria is available on the DHCS Assisted Living Waiver website.

Restrictions/Limitations

Room and board expenses are not included in this service. Individuals may receive assistance with room and board from other sources at the same time as receiving this

---

[6] As defined in 22 CCR 51124

[7] For more information, please visit the DHCS Assisted Living Waiver webpage.

[8] For more information, please visit the DHCS California Community Transitions webpage.

[9] To determine whether a member is on the ALW waitlist, MCPs may contact DHCS directly at the email address provided on the DHCS Assisted Living Waiver webpage.

service. Additional details on how Members can obtain assistance for payment of room and board when residing in an ALF can be found on the DHCS Assisted Living Waiver website.

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

Delivery with Other Community Supports, Enhanced Care Management, Transitional Care Services, and Population Health Management

The time-limited transition services and ongoing assisted living services offered through Nursing Facility Transition/Diversion are designed to complement Enhanced Care Management (ECM).[10] The Community Support does not replace ECM services for Members who are eligible for or receiving ECM, and ECM should be used for the ongoing care management of Members receiving this Community Support.[11] For Members already enrolled in ECM during the time of transition, the MCP must ensure that the ECM Care Manager provides all necessary Transitional Care Services (TCS) and coordinates referrals to Community Supports like Nursing Facility Transition/ Diversion on the Member's behalf. Regardless of whether the Member is enrolled in ECM, Nursing Facility Transition/Diversion is not intended to replace TCS, which MCPs are required to provide for Members transitioning from one setting or level of care to another under Population Health Management.[12]

Members receiving this service may also be eligible for other Community Supports. MCPs should ensure Members are appropriately screened and referred for services for which they may be eligible. For example, Members can be connected to Housing Transition Navigation at the same time as the time-limited transition component of this service (if they meet eligibility criteria and the MCP has made them available) as long as the activities provided are distinct between the Community Supports.

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 as an

[10] Please refer to the ECM Policy Guide for additional details on scope of services available through ECM: ECM-Policy-Guide.pdf (ca.gov)
[11] Refer to the ECM Populations of Focus Spotlight for Long-Term Care POFs for additional details on integrating ECM and Community Supports for Members: ECM-POF-Spotlight-LongTermCarePopulation.pdf
[12] Refer to the Population Health Management Policy Guide: PHM-Policy-Guide.pdf (ca.gov)

example of the types of providers MCPs may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- ARF/RCFE Operators
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

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 22-013 or any subsequent APL. If there is no state-level enrollment pathway, MCPs must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Additionally, MCPs must consider factors such as the availability of clinical staff, staff training, emergency response systems and procedures, licensing, and adequate home and community-based setting characteristics within their vetting processes.

The Assisted Living Waiver, or ALW, is not considered a state-level enrollment pathway for the purpose of enrolling these operators as Medi-Cal Providers offering Community Supports. The ALW is a distinct program authorized under the 1915(c) Waiver and is available to Medi-Cal managed care Members, with restrictions as a Medi-Cal FFS benefit, and is carved out of the Medi-Cal managed care program authority. If an entity is already enrolled as an ALW provider, MCPs may consider this enrollment when vetting the Community Supports Provider and must document this consideration in their Policies and Procedures.

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

COMMUNITY TRANSITION SERVICES/NURSING FACILITY TRANSITION TO A HOME

Summary of Refinements

The Community Transition Services Community Support aims to support Members transitioning out of a skilled nursing facility back to a residence (whether a private residence or public subsidized housing). Individuals transitioning back to a home need distinct support in identifying housing and may encounter one-time costs in updating their homes to meet their clinical and mobility needs. Community Transition Services covers both the transitional care coordination and one-time costs necessary for a Member to transition to a home.

DHCS received similar feedback regarding Community Transition Services as described in Nursing Facility Transition/Diversion to Assisted Living Facilities above (including clarifications of the service components and overlapping enrollment with other Community Supports and the 1915(c) waivers/CCT).

In September 2024, DHCS released for stakeholder comment a set of clarifications and updates to this service definition and received 19 comments from a range of MCPs, providers, counties and advocacy organizations. In response to these comments and other stakeholder discussions, DHCS is finalizing the following clarifications and updates:

- **Service Components:** DHCS proposed clarifying there are two components of this Community Support available to Members:
  - Transitional coordination services to identify and support a Member in transitioning to a private residence or public subsidized housing, including efforts to assess the Member's housing needs and communicate with landlords. DHCS is clarifying that this service is not intended to duplicate or supplant MCPs' obligation to provide PHM Transitional Care Services (TCS) for Members transferring from one level of care to another, under Population Health Management.
  - One-time set-up expenses to establish or reestablish a household, such as security deposits, utility set up fees, one-time cleaning fees, and other medically necessary services. DHCS has made clarifications to the list of services in response to the December 2024 CMCS Informational Bulletin regarding the coverage of services to address Health Related Social Needs (HRSN). DHCS is also finalizing the clarification that these expenses may include Durable Medical Equipment to the extent that these services are not available to the Member from another Medi-Cal Benefit. DHCS is also finalizing the clarification that the lifetime

maximum of $7,500 that applies to this service applies only to the one-time set-up expenses, not to the cost of transitional coordination services. This interpretation of the maximum aligns with similar limits in CCT (Money Follows the Person) as was the original intent of this service.

- **Overlap Principles with Other Community Supports:** DHCS proposed clarifying that Members may receive Housing Transition Navigation, Housing Deposits, and/or Environmental Accessibility Adaptations (Home Modifications) at the same time as the Community Transition Services Community Support as long as the services provided are nonduplicative, distinct, and necessary. DHCS is finalizing this clarification.
- **Waivers:** DHCS proposed clarifying that while a Member may be eligible for both Community Transition Services and other relevant waiver/demonstration programs such as CCT and Home & Community Based Alternatives Waiver, they cannot receive both at the same time if the activities provided under each program are duplicative. DHCS is finalizing this clarification.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home (also known as "Community Transition Services") helps individuals to live in the community and avoid further institutionalization in a nursing facility.

Community Transition Services support Members in transitioning from a licensed facility to a living arrangement in a private residence or public subsidized housing where the Member is responsible for identifying funding for their living expenses. This service also covers set-up expenses necessary for a Member to establish a basic household.

This service includes two components, as follows:

1. **Time-limited transition services and expenses**[13] to enable a Member to transition from a licensed facility to a private residence or public subsidized housing. Each transitional period will vary in length and services provided based on a Member's unique circumstances. Includes services such as:
    a. Assessing the Member's housing needs and presenting options.
    b. 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).
    c. Communicating with the landlord (if applicable) and coordinating the move.
    d. Establishing procedures and contacts to retain housing.
    e. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
    f. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.
2. **Non-recurring set-up expenses** are those necessary to enable a Member to establish a basic household that does not constitute room and board and include:

[13] MCPs are required to provide Transitional Care Services (TCS),), including transitional care management, for high and lower-risk transitioning Members, as specified in the PHM Policy Guide. Members who are eligible for this Community Supports service would receive it in addition to TCS.

a. Security deposits required to obtain a lease on an apartment or home. Security deposits should be in alignment with AB12[14], enacted in 2024.
b. Set-up fees for utilities or service access and up to six months payment in utility arrears, as necessary to secure the unit;
c. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, and necessary repairs to meet Housing Choice Voucher program quality standards where those costs are not the responsibility of the landlord under applicable law;
d. Air conditioner or heater;
e. Adaptive aids designed to preserve an individual's health and safety in the home, such as hospital beds, Hoyer lifts, bedside commode, shower chair, traction, or non-skid strips, etc., that are necessary to ensure access and safety for the individual upon move-in to the home, when they are not otherwise available to the Member under Medi-Cal (e.g., State Plan, HCBS waiver, etc.).

MCPs may not limit their offering of this service to only component 1 or component 2 and must offer both to the extent that they are applicable to each Member.

Eligibility (Population Subset)

Members who:

1. Are currently receiving medically necessary nursing facility Level of Care (LOC)[15] services and in lieu of remaining in the nursing facility or Recuperative Care setting are choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
2. Have lived 60+ days in a nursing home and/or Recuperative Care setting ; and
3. Are interested in moving back to the community; and
4. Are able to reside safely in the community with appropriate and cost-effective supports and services.

A Member can be eligible for both the California Community Transitions program[16] , Home & Community Based Alternatives Waiver[17] , and/or the Multipurpose Senior Services Program and this Community Support[18] ; however, they cannot receive both at

[14] AB-12 Tenancy: Security Deposits (2023 – 2024)
[15] As defined in 22 CCR 51124.
[16] For more information, please visit the DHCS California Community Transitions webpage.
[17] For more information, please visit the DHCS Home and Community-Based Alternatives Waiver webpage.
[18] For more information, please visit the DHCS Multipurpose Senior Services Program webpage.

the same time. MCPs are encouraged to assist Members with enrollment in eligible and available waiver programs, as appropriate.

Restrictions/Limitations

- Community Transition Services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Non-recurring set-up expenses are payable up to a total lifetime maximum amount of $7,500.00. The transitional coordination cost is excluded from this total lifetime maximum. 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 or public subsidized housing through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, without which the Member would be unable to move to the private residence or public subsidized housing and would then require continued or re-institutionalization.

Community Supports shall supplement and not supplant services received by the Medi-Cal Member through other state, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. A Member can be eligible for relevant waiver/demonstration programs (e.g., CCT, Home & Community Based Alternatives, etc.) and this Community Support; however, they cannot receive both at the same time if activities provided under each program are duplicative. MCPs are encouraged to assist Members with enrollment in eligible and available waiver/demonstration programs, as appropriate.

Delivery with Other Community Supports, ECM, Transitional Care Services, and Population Health Management

Members receiving this Community Support may also be eligible for other Community Support services. MCPs should ensure Members are appropriately screened and referred for services for which they may be eligible. For example, Members can also be connected to Housing Deposits and/or Housing Transition Navigation, if eligible and available. Members can receive these Community Supports at the same time as Community Transition Services if the activities provided are distinct.

To fund home modifications, Members should first be connected to the Environmental Accessibility Adaptations (Home Modifications) Community Support if eligible and available. If a Member reaches their lifetime maximum of the Environmental Accessibility

Adaptions Community Support, funds for non-recurring set-up expenses may be used for similar modifications.

The time-limited transition services offered through Community Transition Services are designed to complement ECM.[19] The Community Support does not replace ECM services for Members who are eligible for or receiving, and ECM should be used for the ongoing care management of Members receiving this Community Support.[20]

Additionally, Community Transition Services is not intended to replace Transitional Care Services, which MCPs are required to provide for Members transitioning from one setting or LOC to another under Population Health Management.[21] For Members already enrolled in ECM during the time of transition, the MCP must ensure that the ECM Care Manager provides all necessary TCS and coordinates referrals to Community Supports like this one on the Member's behalf.

Licensing/Allowable Providers

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

- Case management agencies
- Home Health agencies
- County-operated or county-contracted behavioral health providers
- 1915c HCBA/ALW providers
- CCT/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/Recredentialing and Screening/Enrollment APL 22-013 or any subsequent APL. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may

[19] Please refer to the ECM Policy Guide for additional details on scope of services available through ECM: ECM-Policy-Guide.pdf (ca.gov)

[20] Refer to the ECM Populations of Focus Spotlight for Long-Term Care POFs for additional details on integrating ECM and Community Supports for Members: ECM-POF-Spotlight-LongTermCarePopulation.pdf

[21] Refer to the Population Health Management Policy Guide for full DHCS requirements under TCS PHM-Policy-Guide.pdf (ca.gov)

extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ASTHMA REMEDIATION

Summary of Refinements

Asthma Remediation is designed to reduce acute asthma episodes that can lead to hospitalization or emergency department use. The support covers physical modifications to a home environment and/or supplies that are necessary to ensure the health, welfare, and safety of a Member.

DHCS received feedback on several opportunities to further clarify the supplies and modifications covered under the Community Support and increase utilization by simplifying eligibility criteria and reducing documentation requirements.

In September 2024, DHCS released for stakeholder comment a set of clarifications and updates to this service definition and received seven comments from a range of MCPs, providers, counties and advocacy organizations. In response to these comments and other stakeholder discussions, DHCS is finalizing the following clarifications and updates:

- **(Effective January 2026) Phase Out of In-Home Environmental Trigger Assessments and Asthma Self-Management Education Under Asthma Remediation:** As originally launched, the Asthma Remediation Community Support included assessment, self-management education, and home remediations. DHCS launched the Asthma Preventive (APS) benefit under its State Plan in July 2022, six months after the launch of this Community Support. As a State Plan service, MCPs are required to cover this benefit. Two of the three components of APS were also included in the original Asthma Remediation service definition, namely (1) asthma self-management education and (2) in-home environmental trigger assessments. In line with the general principle that Community Supports supplement rather than supplant State Plan services, DHCS intends APS and the Asthma Remediation Community Support to be complementary and non-duplicative. Thus, DHCS' revisions clarify that these two components should be covered through the APS benefit, and these components are being removed from the Community Support definition. Given the addition of the APS benefit, DHCS' vision is that the Asthma Remediation Community Support will become a wraparound service relative to the APS, covering the supplies and physical modifications for Members' homes, based on the results of the APS in-home environmental trigger assessment, to reduce acute asthma episodes.
    - In September 2024, DHCS proposed a transition period through January 1, 2026, during which network providers will continue to be able to be reimbursed for the overlapping components under either the APS benefit or the Community Support. However, MCPs and Providers are

strongly encouraged to transition to reimbursement under the APS benefit prior to January 1, 2026. DHCS proposed a transition period because billing the APS benefit requires Medi-Cal provider enrollment. DHCS recognizes that some Community Supports providers may not be enrolled in Medi-Cal. The transition period will allow any such providers to enroll if they wish to continue providing services under the APS benefit. DHCS is finalizing the transition period for the phase-out of service components overlapping with the APS benefit in this guidance.

- **Eligibility Criteria:** DHCS received feedback that existing eligibility criteria were unintentionally leading to multiple rounds of clinician review and sign off for services covered under the Community Support. In response, in September 2024, DHCS proposed simplifying eligibility criteria for the physical modifications and supplies that will continue to be covered under the Asthma Remediation Community Support. DHCS is further clarifying documentation requirements in this final version of the service definition by stating MCPs need only to document an in-home trigger assessment was completed in the last 12 months under the APS benefit to authorize physical modifications or supplies as medically appropriate. No further documentation of medical appropriateness is required for the MCP to authorize Asthma Remediation.
- **Covered Supplies:** In response to feedback that electronic air filters rely on technology that can produce ozone or other byproducts harmful to health, DHCS proposed clarifying that the provision of air filters under this Community Support should be narrowed to mechanical air filters. DHCS is finalizing this clarification and integrating additional resources on Integrated Pest Management into the list of covered supplies.
- **Timeframe:** DHCS received stakeholder questions on whether all physical modifications and supplies needed to be delivered at the same time for a Member. DHCS is finalizing a clarification that the Asthma Remediation Community Support need not be delivered at a single point in time as long as modifications and supplies comply with the $7,500 total lifetime maximum.

Asthma Remediation

Description/Overview

Asthma Remediation can prevent acute asthma episodes that could result in the need for emergency services and hospitalization. The Asthma Remediation Community Support consists of supplies and/or physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of a Member, or to enable a Member to function in the home with reduced likelihood of experiencing acute asthma episodes.[22]

Asthma Remediation should supplement the Asthma Preventive Services (APS)[23] Medi-Cal State Plan service. APS covers clinic-based asthma self-management education, home-based asthma self-management education, and in-home environmental trigger assessments that identify physical modifications to a home or supplies that would reduce the likelihood of acute asthma episodes.

Effective January 1, 2026: Removal of In-Home Environmental Trigger Assessments and Asthma Self-Management Education from the Asthma Remediation Community Support

DHCS launched the APS benefit in July 2022, six months after the Asthma Remediation Community Support. The CalAIM Special Terms and Conditions require that Community Supports must supplement and not supplant services received by the Medi-Cal Member through other State, local, or federally funded programs. To implement this requirement, DHCS is updating Asthma Remediation Community Support effective January 1, 2026: asthma self-management education and in-home environmental trigger assessments must be covered by MCPs under the APS benefit and will no longer be covered under this Community Support.

MCPs and Community Supports Providers are strongly encouraged to implement this policy sooner than January 1, 2026, and ensure Members utilize the APS benefit for asthma self-management and in-home trigger assessments, as appropriate.

---

[22] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided, and Community Supports should be complementary. See the U.S. Department of Housing and Urban Guide to Sustaining Effective Asthma Home Intervention Programs; Appendix B

[23] For additional information, please see the Medi-Cal Provider Manual for Asthma Preventive Services.

DHCS is providing a phase-out period for asthma self-management education and in-home environmental trigger assessments from the Asthma Remediation Community Support to allow Community Supports Providers that are not currently enrolled with the Medi-Cal program to enroll and seek reimbursement under APS. Throughout 2025, MCPs may still cover asthma self-management education and in-home environmental trigger assessments under the Asthma Remediation Community Support as long as the Member meets eligibility criteria as outlined below.

Supplies and physical modifications for Asthma Remediation covered under this Community Support include, but are not limited to:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) mechanical filtered vacuums;
- Integrated Pest Management (IPM) services;[24]
- De-humidifiers;
- Mechanical air filters/air cleaners;[25]
- 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 for the management and treatment of asthma.

The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver. Services provided to a Member need not be carried out at the same time but may be spread over time, subject to lifetime maximums below.

From January 1, 2025 to December 31, 2025, MCPs should transition coverage for in-home environmental trigger assessments and asthma self-management education to the

[24] For additional information about Integrated Pest Management, visit https://www.cdpr.ca.gov/docs/pestmgt/ipminov/overview.htm

[25] Air cleaners that are listed as "Mechanical" are those that only use physical filtration, such as pleated or HEPA-style filters, and do not generate ozone or ions and are not classified as "electronic" which can generate ozone and other reactive compounds that harm health. For California Air Resources Board's list of certified air cleaners, see: https://ww2.arb.ca.gov/list-carb-certified-air-cleaning-devices. Note the list includes both mechanical and electronic cleaners; for the purposes of Asthma Remediation, only mechanical options are permitted.

APS benefit but may cover the following under the Community Support, as medically necessary, through December 31, 2025:

- In-home environmental trigger assessments are defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants. This assessment guides the supplies, home modifications, and asthma self-management education about actions to mitigate or control environmental exposures offered to the Member.
- Asthma self-management education can include, but is not limited to,
  - Teaching Members how to manage their asthma, including how to use inhalers;
  - Teaching Members how to identify environmental triggers commonly found in their own home, including allergens and irritants; and
  - Informing Members about various options for reducing environmental triggers such as using dust-proof mattresses and pillow covers, asthma-friendly cleaning products, air filters, etc.

Eligibility (Population Subset)

- Members with a completed in-home environmental trigger assessment within the last 12 months through the Asthma Preventive Services benefit that identifies medically appropriate Asthma Remediations and specifies how the interventions meet the needs of the Member. Effective January 1, 2026, MCPs must cover in-home environmental trigger assessments through the APS benefit, as described above.

When authorizing physical modifications and supplies for Asthma Remediation as a Community Support, MCPs must receive and document that an assessment is completed, as outlined above. An in-home trigger assessment within the last 12 months, assuming no change in the Member's residence, provided under the Asthma Preventive Services benefit suffices as a medical appropriateness determination for Asthma Remediation. No further documentation of medical appropriateness is required for the MCP to authorize Asthma Remediation.

- *From January 1, 2025 to December 31, 2025 only,* if the Member is receiving the in-home environmental trigger assessment or asthma self-management education through the Asthma Remediation Community Support, they must:
  - Have poorly controlled asthma (defined as an emergency department visit or hospitalization or two sick or urgent care visits due to asthma in the past 12 months, or a score of 19 or lower on the Asthma Control Test), or

otherwise have a recommendation from a licensed health care provider (e.g. physician, nurse practitioner (NP), or physician assistant (PA)) that the service will likely avoid asthma-related hospitalizations, emergency department visits, and/or other high-cost services.

Payments to Providers

MCPs and Community Supports Providers are also reminded that payments to providers for the APS benefit under managed care do not have to mirror the Fee Schedule for Fee-For-Service APS reimbursement. Network agreements with Community Supports Providers should include Community Supports Provider payment rates, which may differ from the FFS rates.

Restrictions/Limitations

- If another State Plan service beyond the APS, such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, the State Plan service should be accessed first.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.
- Asthma Remediation home modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the MCP must provide the owner and Member with written documentation that the modifications are permanent and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable

mattress and pillow dust covers; high-efficiency particulate air (HEPA) filtered vacuums; de-humidifiers; portable air filters; and asthma-friendly cleaning products and supplies.

Licensing/Allowable Providers

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

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

Physical adaptation to a residence covered by Asthma Remediation must be performed by an individual holding a California Contractor's License.

- Medi-Cal MCPs must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal MCPs shall monitor the provision of all the services included above.
- All allowable providers must be approved by the MCP 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/Recredentialing and Screening/Enrollment APL 22-013 or any subsequent APL. Asthma Remediation Providers must enroll in the Medi-Cal program to continue providing in-home trigger assessments and asthma self-management education under the APS benefit. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

MEDICALLY TAILORED MEALS/MEDICALLY SUPPORTIVE FOOD

Summary of Refinements

The Medically Tailored Meals/Medically Supportive Food (MTM/MSF) Community Support provides targeted food and nutrition services to Members with nutrition-sensitive health conditions. The meals, food, and nutrition education provided through this service are specific to the Member's eligible health conditions and are a critical part of the Member's treatment plan to improve or maintain their health status.

Since the initial launch of Community Supports, stakeholders have requested that DHCS clarify several aspects of this service definition that were leading to disparate interpretations and implementation across the state. Stakeholders requested more detailed, standardized definitions for each of the service components; clearer eligibility criteria; and more explicit DHCS expectations for how MCPs should oversee MTM/MSF providers and services.

Nationally, the integration of nutrition supports into the health care delivery system (including, but not limited to, Medicaid programs) is a rapidly evolving field. States, payers, MTM/MSF providers, and the federal government are continuing to identify and refine best practices as organizations and individuals gain more experience and evidence delivering the services. In December 2024, CMS released an updated Health Related Social Needs Framework Bulletin emphasizing that food and nutrition services delivered via Medicaid programs must meet high standards for quality and that states must establish protocols that ensure that MCPs and MTM/MSF providers are delivering high quality services that are appropriately tailored to address the nutrition-sensitive health conditions. Based on stakeholder feedback and the recent CMS guidance, this service definition update establishes more specific expectations for the quality of MTM/MSF services and MCP oversight of MTM/MSF providers.

In September 2024, DHCS released for stakeholder comment a proposed set of clarifications and updates to this service definition and received nearly 50 comments from a range of stakeholders including MCPs, MTM/MSF provider organizations, health care providers, researchers and advocates. In response to these comments and other stakeholder discussions, DHCS is finalizing the following clarifications and updates:

- **Streamlining Eligibility Criteria:** Stakeholders provided feedback that the original eligibility criteria were broad, allowing disparate interpretations. MCPs and MTM/MSF providers also reported that they found the "at risk of hospitalization or SNF placement" and "extensive care coordination needs" criteria ambiguous. In the September 2024 draft issued for stakeholder

comment, DHCS proposed to require eligible Members to have a nutrition-sensitive health condition and an additional complicating factor (e.g., at risk of hospitalization or extensive care coordination needs). Stakeholders overwhelmingly voiced that this proposal would restrict eligibility too far and be challenging to operationalize. In the finalized updates below, the eligibility criteria have been refined to focus eligibility solely on whether the Member has a nutrition-sensitive health condition appropriate for MTM/MSF services. The updates reflect stakeholder feedback to streamline the eligibility criteria, including expanding and refining the list of example health conditions. Throughout the service definition below, DHCS emphasizes that MTM/MSF services must address the Member's eligible nutrition-sensitive health condition to assist them to regain or maintain their health status related to their specific condition and that these services are not solely to address food insecurity. If Members meet the refined, more specific eligibility criteria, DHCS considers delivery of MTM/MSF services to be medically appropriate without the need for a separate step to consider medical appropriateness.

- **"Medically Tailored" and "Medically Supportive" Service Specifications:** The original service descriptions did not assert a distinction between "medically tailored" and "medically supportive" services within the definition, leading to disparate interpretations and delivery across the state. The proposed September 2024 draft for public comment sought to expand the descriptions of the allowable services. Stakeholders, including Food is Medicine experts and MCPs with implementation experience, provided valuable feedback and input informing the descriptions for each service. These updates also seek to align with evolving national best practices and service descriptions in other state Medicaid programs. Per feedback on the proposed September 2024 draft, DHCS is clarifying that MTM and MSF service packages can be designed at the service level for the identified target chronic or serious health conditions. To ensure that the interventions are provided in sufficient quantity to impact health outcomes, the proposed September 2024 refinements also specified that meals and food packages must meet two-thirds of the daily nutrient and energy needs of an average individual. Based on stakeholder feedback, the two-thirds requirement has been clarified to only apply to medically tailored meals and medically tailored groceries, and not MSF services.

  MSF services, such as medically supportive groceries or produce prescriptions, are intended to be supplemental to the Member's diet, whereas "medically tailored" interventions must be provided in specified quantities to constitute the majority of the Member's food for a period of time to have the intended impact on health outcomes. The final refinements establish clearer overall expectations for what it means for services to "medically tailored" vs.

"medically supportive" and the roles of Registered Dietician Nutritionists (RDNs) or other appropriate clinicians in their design:

- Medically tailored services must include an individual nutrition assessment conducted or overseen by an RDN to inform the development of a nutritional plan and connection to the appropriate medically tailored services for the Member. Additionally, the development of medically tailored meal or food packages must be tailored by an RDN or other appropriate clinician based on established, evidence-based nutrition guidelines for the targeted nutrition-sensitive condition.
- Medically supportive foods packages provide access to preselected whole foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the targeted health condition(s). The design or selection of foods or food options in MSF services must be overseen and signed off on by an RDN or another appropriate clinician.

» **Nutrition Education:** The updates clarify that nutrition education provided as a standalone service is not sufficient to be considered delivery of this Community Support. In the September 2024 draft for public comment, DHCS proposed that all MSF services must be paired with nutrition education. However, stakeholders provided feedback that this requirement would present an access barrier and cited literature that MTM/MSF can be evidence based even if not paired with education. As such, the service definition no longer includes the requirement that MSF services must be paired with nutrition education. MCPs and their Community Supports Providers are still strongly encouraged to offer behavioral, cooking, and/or nutrition education in parallel with MTM/MSF services and refer eligible individuals to Medi-Cal covered nutrition counseling services (e.g., diabetes self-management education, medical nutrition therapy).

» **Provider and Meal/Food Package Oversight:** As the MTM/MSF sector grows, it is more important for MCPs to provide robust oversight of providers and the food itself. In the finalized serviced definition, DHCS outlines MCP requirements for reviewing the quality and safety of MTM/MSF interventions. These requirements apply for MTM/MSF services delivered by potential and current MTM/MSF Community Supports Providers to ensure Members receive high quality meals/food tailored to their clinical needs. These strengthened requirements align closely with CMS' recent HRSN Bulletin cited above.

Medically Tailored Meals/Medically Supportive Food

Description/Overview

Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address individuals' chronic or other serious conditions that are nutrition-sensitive, leading to improved health outcomes and reduced unnecessary costs.

Medically Tailored Meals and Groceries: Medically Tailored Meals and Medically Tailored Groceries are covered by this service, defined as follows:

a. **Medically Tailored Meals (MTM):** Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.
b. **Medically Tailored Groceries (MTG):** Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

The provision of MTMs/MTGs must include an individual assessment of the Member's nutrition-sensitive condition and nutritional needs conducted or overseen by Registered Dietitian Nutritionist (RDN) to inform the development of a nutritional plan and connection to the appropriate MTM or MTG services.

The design of each of the MTM/MTG services (e.g., uncontrolled diabetes meal plan, congestive heart failure grocery plan) must be tailored by an RDN or other appropriate clinician to ensure the food provided adheres to established, evidence-based nutrition guidelines to prevent, manage, or reverse the targeted nutrition-sensitive health condition(s).

The MTM and/or MTG assistance provided (singularly or in a combination of meals and groceries) must meet at least two-thirds of the daily nutrient and energy needs of an average individual, as estimated by the RDN/clinician overseeing the design of the MTM/MTG services. "Medically tailored" interventions must be provided in specified quantities to constitute the majority of the Member's diet over the course of the intervention to have the intended impact on health outcomes. MTM/MTG must not contain ultra-processed foods nor foods with excessive sugar or salt.

Medically Supportive Food (MSF): Medically Supportive Foods are packages of foods that adhere to national nutrition guidelines to prevent, manage, or reverse nutrition-sensitive conditions of referred Members. Unlike MTM or MTG, MSF is intended to supplement, rather than replace, all or most of the Member's diet. The design or selection of foods or food options in MSF services must be overseen and signed off on by an RDN or another appropriate clinician. RDNs do not need to oversee the assembly

of each grocery box or produce prescription, but, for example, should provide or review the nutrition parameters of the types of foods to be included or approved for the food packages for the targeted conditions**.** Though MSF food packages do not need to meet minimum nutrient and energy requirements, MSF Community Supports Providers should design food packages to support participants to meet minimum recommendations for fruit, vegetable, or other targeted daily servings for nutrients. MSF must not contain ultra-processed foods nor foods with excessive sugar or salt.

Terms within the category of MSF are defined as follows:

a. **Medically Supportive Groceries:** Preselected foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the nutrition-sensitive health conditions of the recipients to whom they are prescribed.[26]
b. **Produce Prescriptions:** Fruits and vegetables, typically procured in retail settings, such as grocery stores or farmers' markets, obtained via a financial mechanism such as a physical or electronic voucher or card.
c. **Healthy Food Vouchers:** Vouchers used to procure pre-selected foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the nutrition-sensitive health conditions of the recipients, via retail settings such as grocery stores or farmers' markets.
d. **Food Pharmacy:** A model that specifically combines MSF and nutrition supports to remove barriers to healthy eating and build the knowledge and skills of participants to cook and eat foods appropriate for their nutrition-sensitive conditions.[27] Food pharmacies are often housed within (or managed by) a health care setting, providing a patient cohort with coordinated clinical, food, and nutrition education services targeted at specific nutrition-sensitive health conditions. The healthy food "prescription" includes access to a selection of specific whole foods appropriate for the specific chronic or serious health condition(s) that follow the federal Dietary Guidelines for Americans and meet recommendations for the targeted health condition(s). The food is typically paired with peer supports, nutrition education,

[26] More information on the Dietary Guidelines for Americans can be found here: https://www.dietaryguidelines.gov/

[27] Juliana A. Donohue, Tracy Severson, Lauren Park Martin, The food pharmacy: Theory, implementation, and opportunities, American Journal of Preventive Cardiology, Volume 5, 2021, 100145, ISSN 2666-6677, https://www.sciencedirect.com/science/article/pii/S2666667720301458.

counseling, and/or culinary classes to build cooking and healthy eating skills and habits.

MCPs must require and oversee that their MTM/MSF Providers produce MTM/MSF meal and food packages that follow national nutrition guidelines and that are appropriate for the nutrition-sensitive conditions identified by the MCP for MTM/MSF services. MTM/MTG and MSF service packages must be tailored or designed at the service level for the identified target chronic or serious health conditions (e.g., Medically Supportive Foods recommended and tailored for Members with chronic heart failure, or the DASH diet for Members with hypertension who may benefit from a low sodium diet). Meals, groceries, produce prescriptions, or nutritional intervention packages do not need to be individually customized for each Member, but must be appropriate based on evidence-based guidelines for the targeted nutrition-sensitive health conditions(s) for which the MTM/MSF service is intended to improve. MCPs and their MTM/MSF Community Support Providers must consider the cultural preferences/needs (e.g., halal or kosher meals) and food preparation and storage capabilities (e.g., ability to store frozen meals) of each individual Member when determining the appropriate MTM/MSF intervention for the Member.

Nutrition Education: Health coaching, counseling, classes, behavioral supports, and tools, including equipment and materials, that are based on a Member's health conditions and needs. DHCS strongly encourages, but does not require, MCPs to work with their Community Supports Providers to offer behavioral, cooking, and/or nutrition education as part of this service alongside the MTM/MSF services offered. Nutrition education provided as a standalone service is not sufficient to be considered delivery of this Community Support.

- Any nutrition education offered must adhere to nationally-established, evidence-based nutrition guidelines and be vetted by an RDN or other appropriate clinician. The education must be appropriate to the Member's chronic or serious health condition and the MTM/MSF intervention the Member is receiving. Nutrition education can be provided in an individual or group setting. Nutrition education classes do not need to be delivered by an RDN. The organization delivering the nutrition education may be the same as the organization providing the MTM/MSF but is not required to be the same organization. An MCP may choose to provide nutrition education directly.
- Nutrition education provided as part of this service does not supplant other Medi-Cal services. MCPs are encouraged to identify and refer Members who are receiving MTM/MSF Community Support services to other Medi-Cal covered

services for which they may be eligible such as Medical Nutrition Therapy and Diabetes Self-Management Education.[28]

Eligibility (Population Subset)

Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

Restrictions/Limitations

- Service covers up to two (2) meals and/or meal packages per day using a combination of Medically Tailored Meals and Medically Supportive Food interventions.
- MTM/MSF can be authorized for up to 12 weeks and may be reauthorized thereafter if medically necessary. MCPs and their MTM/MSF providers are encouraged to check in with Members who are receiving this Community Supports at a more frequent cadence to assess whether Members are obtaining and eating the foods / meals provided through this Community Support, and whether any changes need to be made to improve the effectiveness of the MTM/MSF.
- Meals, food, payments, and nutrition services that are eligible for or reimbursed by alternate programs for the Member cannot be funded or counted by MCPs as an MTM/MSF Community Support.
- Since MTM/MSF services are delivered as part of the Member's clinical care to address or mitigate nutritional needs from a chronic or serious health condition, they are not covered to respond solely to food insecurities. Given the coexistence of food and nutrition insecurity in populations afflicted by chronic and other serious health conditions, DHCS encourages screening and facilitating access to additional resources (e.g., SNAP, WIC, local food pantries) to combat food insecurity and enhance physical and mental well-being. DHCS considers food assistance benefit programs such as SNAP or WIC not to be duplicative of

[28] See the Medi-Cal Provider Manual for further information about Medical Nutrition Therapy and Diabetes Self Management Education services.

MTM/MSF services because both benefits are designed to mitigate food insecurity for a household, while MTM/MSF services are provided to the authorized Member as part of a clinical care plan to address their specific, eligible chronic or serious health condition(s).[29]

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. Types of providers Medi-Cal with whom MCPs may choose to contract include (non-exhaustive):

- MTM providers
- MSF and nutrition providers such as produce prescription services providers
- Medically tailored or supportive grocery providers (e.g., food banks)
- Home delivered meal providers
- Area Agencies on Aging
- Nutritional education providers to help sustain healthy cooking and eating habits

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 22-013 or any subsequent APL. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

[29] See the December 2024 CMCS Center Informational Bulletin on coverage of Health-Related Social Needs in Medicaid and the Children's Health Insurance Program for further information on limitation of MTM/MSF services to duplicate benefits or payments made on behalf of the beneficiary that include food. For example, medically tailored meal delivery is not available for an individual who is receiving short-term rental assistance for a stay in a facility that provides 3 meals per day included in the Medicaid payment to the facility, and pantry stocking is not available for an individual who is receiving a full board regimen of medically tailored meals.

Monitoring of MTM/MSF Community Support Providers by MCPs

MCPs are responsible for ensuring and documenting that their MTM/MSF Community Supports Providers are providing MTM/MSF services that follow this service definition, via their provider contracts and ongoing monitoring.

As part of their compliance oversight, MCPs should collect and regularly refresh information about programs and services from MTM/MSF Community Supports providers. Suggested domains to ensure compliance with the Community Support service definition include:

- Nutrition standards used by the provider, including the processes, qualifications of the clinical staff and/or RDN staff, and guidelines used to develop standards;
- Nutritional information of medically tailored meals or grocery services, including specific macro- and/or micro-nutrient thresholds utilized to ensure that the meals or food packages are tailored for the targeted chronic or serious conditions;
- Average energy content and ingredients used in the meals and food packages;
- Providers' food preparation licensure, recent inspection records, and/or food safety violations with the relevant food safety regulatory agency;
- Service locations, meal production location, and transparency in units of meals, groceries or produce distributed (e.g., # of servings provided).

In addition, MCPs should routinely audit their MTM/MSF providers including validating, through review of case files, whether each provider adheres to the criteria outlined above and demonstrates ongoing compliance. To the extent the MCP identifies concerns or violations, the MCP should take any necessary enforcement actions, including corrective action or contract terminations as needed.

Finally, to identify opportunities for ongoing quality improvement and effectiveness of this Community Support, MCPs are encouraged to routinely collect information regarding Member adherence with the MTM/MSF intervention and assessing whether Members with strong adherence had improved health outcomes and whether those Members with low adherence could have modified interventions to support MTM/MSF service adherence, and thereby improved health outcomes.