Policy Brief

California Advancing and Innovating Medi-Cal (CalAIM): Implications for the Dual Eligible Population

April 2021

I. Introduction

In October 2019, the California Department of Health Care Services (DHCS) released the proposal for California Advancing and Innovating Medi-Cal (CalAIM), a multi-year initiative to redesign the Medi-Cal program and improve the health and wellbeing of beneficiaries in the state. Ambitious and wide-ranging in scope, CalAIM proposes broad reforms in care delivery, benefit design, and financing.

Planned implementation of CalAIM was postponed from its original launch date on January 1, 2021 to January 1, 2022 due to the unforeseen impacts of the COVID-19 pandemic. In anticipation of the updated planned launch date, DHCS released a revised version of the CalAIM proposal in January 2021.

This brief will discuss policies proposed in CalAIM that will affect individuals enrolled in both Medi-Cal and Medicare. Such individuals are known as dual eligible beneficiaries, or duals.

II. Why Prioritize the Dual Eligible Population

There are 1.4 million Californians enrolled in Medicare and full-benefit Medi-Cal, accounting for nearly 20% of the nation's dual eligible population.[1] Duals tend to be among the highest-need enrollees of both the Medicare and Medi-Cal populations. This is driven in-part by disproportionately high disease burden. For example, the prevalence of diabetes and depression among duals in California is twice that of Medicare only beneficiaries in the state.[2]

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[1] Christ and Burke, "A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care."
[2] Christ and Burke.

Duals also account for disproportionately high spending. In California, duals comprise just 25% of all Medicare beneficiaries but account for 39% of Medicare spending; within Medi-Cal, duals comprise 11% of Medi-Cal beneficiaries but account for 32% of Medi-Cal spending.[3] Prior research has found long-term services and supports (LTSS), including stays in institutional care facilities such as skilled nursing facilities, to be key drivers of high-costs among the dual population.[4]

Navigating both the Medicare and the Medi-Cal systems is challenging and requires that duals overcome significant fragmentation to access care. Each system is responsible for different parts of a dual's care, increasing the potential for inefficiencies and barriers to care. For example, Medi-Cal is responsible for long-term stays in nursing facilities while Medicare is responsible for care received in the hospital, though care delivered in these two settings are intimately linked. Strengthening care coordination has long been considered to be a potential solution, facilitating seamless access to care across systems, though doing so has been difficult to implement in practice.[5]

Improving care delivery and health outcomes for duals has been a focus of the Newsom Administration and the Medi-Cal program. For example, the Administration has proposed a new Office of Medicare Innovation and Integration that would examine opportunities to improve access to care services for duals and other Medicare enrollees.[6] CalAIM's many components that affect duals signal the state's continued commitment to improving the care delivery system in California and represent a critical opportunity to improve health outcomes for this subset of the publicly insured population.

III. Policy Context and the Coordinated Care Initiative

CalAIM builds on growing public interest in improving care delivery for duals over the past decade. At the federal level, the Affordable Care Act (ACA) included a number of policies that aimed to increase care coordination, improve quality, and reduce long-term costs for duals. Notably, the ACA established the Federal Coordinated Health Care Office under the Centers for Medicare and Medicaid Services (CMS) to ensure access to care for duals and support states with resources to serve this population. Other actions included eliminating drug cost-sharing for some duals, setting quality standards for special needs plans serving duals (dual eligible SNPs or D-SNPs), providing federal support to expand programs providing health and community-based services (HCBS) and LTSS, and offering a 90% federal matching rate to implement the Health Homes Programs for high-need individuals.[7]

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[3] Christ and Burke.

[4] Coughlin, Waidmann, and Phadera, "Among Dual Eligibles, Identifying The Highest-Cost Individuals Could Help In Crafting More Targeted And Effective Responses."

[5] Bynum et al., "High-Cost Dual-Eligibles' Service Use Demonstrates Need For Supportive And Palliative Models Of Care."

[6] "Governor's Budget Summary."

[7] "Affordable Care Act Provisions Relating to the Care of Dually Eligible Medicare and Medicaid Beneficiaries."

In California, the Coordinated Care Initiative (CCI) is one key effort that aims to improve care for duals. Passed by the state legislature in 2012, CCI works toward improved overall coordination of services for duals with a focus on integrating delivery of medical, behavioral, and long-term care services and aligning incentives between the Medicare and Medi-Cal programs. CCI was implemented in 7 counties beginning in 2014: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

CCI consists of two main components:

- ***Cal MediConnect (CMC).*** CCI counties established a managed care plan that had combined responsibility for Medicare and Medi-Cal benefits with the goal of facilitating seamless care across programs. Duals could voluntarily choose to enroll in a CMC plan. 108,675 duals were enrolled in CMC plans as of May 2020.[8]

- ***Managed Medi-Cal LTSS.*** CCI requires that most duals join a Medi-Cal managed care plan (MC-MCP) in order to receive services. CCI also required MC-MCPs to take on responsibility for financing and coordinating LTSS, including care received at nursing facilities, In-Home Supportive Services (IHSS), and the Multipurpose Senior Services Program (MSSP).

CCI serves as the backbone for many of CalAIM's provisions that are designed to improve care for duals. As a result, the CCI demonstration is scheduled to conclude in December 2022, coinciding with the CalAIM's implementation of several provisions that will take the place of programs currently available through CCI. These provisions are described in greater detail in the following section.

IV. What Does CalAIM Propose for Dual Eligible Beneficiaries

This section describes the major provisions of CalAIM pertaining to duals as stated in DHCS' January 2021 proposal.

1. Nearly all Medi-Cal beneficiaries, including duals, will be enrolled in Medi-Cal managed care

CalAIM proposes that the majority of Medi-Cal beneficiaries, including duals, be mandatorily enrolled in Medi-Cal managed care. This would catalyze the ongoing growth of managed care in the Medi-Cal program, a model that already serves over 80% of all Medi-Cal beneficiaries. This transition to managed care will take place in two phases, with non-dual eligible beneficiaries (i.e. Medi-Cal beneficiaries without Medicare coverage)

[8] Christ and Burke, "A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care."

transitioning by January 2022, and duals (both full- and partial-benefit) transitioning by January 2023.

Mandatory enrollment of Medi-Cal beneficiaries into MC-MCPs aims to further standardize the way that benefits are delivered and reduce complexity in the Medi-Cal program. In addition, DHCS hopes that the transition to managed care will allow beneficiaries to benefit from care coordination, a service difficult to provide in a fee-for-service (FFS) model, improving outcomes for duals and other Medi-Cal beneficiaries.

While this provision signals an increasing shift towards managed care statewide, a limited number of populations will be mandatorily enrolled in fee-for-service in cases when managed care may not be appropriate. These groups include beneficiaries with restricted scope Medi-Cal, share of cost Medi-Cal, and those receiving services through presumptive eligibility, among others.

Table 1. Implementation Timeline for Mandatory Managed Care Enrollment

Target Date	Action	Detail
January 1, 2022	Non-dual, Medi-Cal beneficiaries are mandatorily enrolled in managed care.	This group includes the following populations currently receiving benefits through FFS: • Trafficking and Crime Victims Assistance Program (except share of cost) • Individuals participating in accelerated enrollment • Child Health and Disability Prevention infant deeming • Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present) • American Indians • Beneficiaries with other health care coverage • Beneficiaries living in rural zip codes.
January 1, 2023	Duals and Medi-Cal beneficiaries eligible for long-term care services are mandatorily enrolled in managed care.	This group includes the following populations currently receiving benefits through the FFS system (except in COHS/CCI counties): • All dual and non-dual individuals eligible for long-term care services (includes long-term care share of cost populations) • All partial and full dual aid code groups, except share of cost or restricted scope

2. Standardize the carve-in of institutional long-term care and organ transplants into Medi-Cal managed care statewide

Beginning January 2023, Medi-Cal managed care plans will be responsible for financing and coordinating institutional long-term care such as that provided in skilled nursing facilities.

While MC-MCPs in CCI counties are already responsible for long-term care, CalAIM would standardize the delivery of the benefit and MC-MCP responsibility statewide.

Unlike in CCI, the state will not pay MC-MCPs higher rates to account for the increased costs associated with an individual's stay in institutional long-term care facilities.[9] As a result, managed care plans will be incentivized to coordinate stays in institutional care facilities, reduce unnecessary admissions, and assess opportunities to safely divert some care from institutional settings to the community.

CalAIM also proposes benefit standardization of organ transplants. Currently, transplant of all major organs is only a managed care benefit in county operated health system (COHS) counties; MC-MCPs in non-COHS counties currently only cover kidney transplants.[10] CalAIM proposes that all major organ transplants be carved into managed care statewide starting January 2022.

Table 2. Implementation Timeline for Institutional Long-Term Care and Organ Transplant Carve-In

Target Date	Action
January 1, 2022	All major organ transplants, currently not within the scope of many Medi-Cal managed care plans, will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.
January 1, 2023	Institutional long-term care services (i.e. skilled nursing facilities, pediatric/adult subacute care, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, specialized rehabilitation in a skilled nursing facility or intermediate care facilities), currently not within the scope of many Medi-Cal managed care plans will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

3. DHCS will encourage aligned enrollment in Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs)

CalAIM includes a proposal that supports duals in enrolling in a MC-MCP and a D-SNP operated by the same parent company, an action that DHCS refers to as 'aligned enrollment'. The goal of aligned enrollment is to encourage coordination of care across the Medi-Cal and Medicare programs. This proposal builds and expands upon the pilot approach of the Cal MediConnect program, creating a statewide approach to coordinating benefits for duals.

[9] Resnikoff, Johnson, and Barocio, "The 2021-22 Budget: CalAIM: New Directions for Services for Seniors and Persons With Disabilities."
[10] Department of Health Care Services, "California Advancing & Innovating Medi-Cal (CalAIM) Proposal."

DHCS will require that MC-MCPs in all counties stand-up D-SNPs to allow dual beneficiaries the option to enroll in the MC-MCP and an aligned D-SNP. In a supportive policy, CMS has stated its intention to limit contracts with D-SNP 'look-alikes which are Medicare Advantage (MA) plans that offer the same cost sharing as D-SNPs but without 'integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population, such as risk assessments or care plans'.[11] This action will further support duals' enrollment into aligned plans.

DHCS has also proposed a number of integration requirements for D-SNPs. Aligned D-SNPs must coordinate care across a member's Medicare and Medi-Cal benefits to include discharge planning, disease management, and care management, have integrated member materials, include consumers in existing advisory boards, work with CMS to establish quarterly joint contract management team meetings for D-SNPs and MC-MCPs, include dementia specialists, and coordinate carved-out LTSS benefits including IHSS, MSSP, and other HCBS waiver programs.[12] Implementation of some of these requirements have already begun. Beginning in 2021, D-SNPs were required to report data to DHCS on all dual eligible member admissions to a hospital or a skilled nursing facility (SNF) for any reason.[13] More details on specific requirements are described in the D-SNP State Medicaid Agency Contract (SMAC), the contract that governs the relationship between D-SNPs and DHCS.

Through CalAIM, DHCS plans to increase availability of aligned D-SNPs and decrease enrollment in unaligned D-SNPs and D-SNP 'look-alikes'. However, beneficiary enrollment in an aligned plan is voluntary; duals will have the choice to receive their Medicare benefits through other means including Medicare FFS, non-D-SNP MA plans, or a Program of All-Inclusive Care for the Elderly (PACE) plan.[14]

Table 3. Implementation Timeline for Aligned Enrollment in D-SNPs

Target Date	Action
January 1, 2021	All existing D-SNPs must meet new regulatory integration standards.
January 1, 2022	Plans in CCI counties with existing managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans may transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP.
January 1, 2023	Aligned enrollment begins in CCI counties and managed care plans in those counties must stand up D-SNPs. All CMC members cross-walked to matching D-SNP and managed care plans, subject to CMS and state requirements.
January 1, 2025	Aligned enrollment begins in non-CCI counties; All managed care plans required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit).

[11] Department of Health Care Services.
[12] Department of Health Care Services.
[13] Department of Health Care Services, "D-SNP State Medicaid Agency Contract (SMAC) Boilerplate, CCI County - Contract Year 2021."
[14] Lightbourne, "Expanding Access to Integrated Care for Dual Eligible Californians."

4. High-need duals may receive Enhanced Care Management (ECM) and In Lieu of Services (ILOS)

Enhanced Care Management (ECM) is a new statewide benefit and a cornerstone of the CalAIM proposal. It builds on the existing Whole Person Care (WPC) pilots and Health Homes Program (HHP) and will provide comprehensive care management services to specific populations of Medi-Cal beneficiaries designated as high-need. Individuals already receiving WPC or HHP services will be transitioned to the new ECM benefit.

Given the high levels of disease burden and health care utilization among duals, there is substantial overlap between the dual population and CalAIM's proposed target populations that would be eligible for ECM benefit. Target populations likely to include significant numbers of dual eligibles include:

1. High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits;
2. Individuals at risk for institutionalization who are eligible for long-term care services; and
3. Nursing facility residents who want to transition to the community

Table 4. Implementation Timeline for Enhanced Care Management (ECM)

Target Date	Action
January 1, 2022	All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.
July 1, 2022	Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations. All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.
January 1, 2023	All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

The full list of ECM target populations is available in ***Appendix II****.*

In Lieu of Services (ILOS) is a related initiative within CalAIM that aims to better serve high-risk individuals through a set of wrap-around services. Unlike ECM, ILOS is a voluntary benefit that MC-MCPs can choose to offer. These services are designed to serve as

a substitute for other, often costlier, services such as a stay in a skilled nursing facility and often provides services that address social determinants of health. There are currently 14 ILOS options that MC-MCPs can choose to offer including supports for housing, respite services, nursing facility transition services, personal care, and medically tailored meals.

The full list of ILOS options is available in **Appendix III**.

Table 5. Implementation Timeline for In Lieu of Services (ILOS)

Target Date	Provision
January 1, 2022	Statewide implementation and inclusion of in lieu of services in Medi-Cal managed care plan contracts.

DHCS notes that plans will be provided incentives for investments in ECM and ILOS infrastructure as well as on "quality and performance improvements and reporting in areas such as LTSS and other cross-delivery system metrics".[15] According to January budget, the Governor proposes limited-term incentive payments to managed care plans totaling $750 million in General Funds ($1.5 billion in total funds) over three years. It is still unclear by what performance measures incentives will be distributed and how managed care plans will be expected to share payments with on the ground providers.

Providing duals access to care management and wraparound services as part of the ECM benefit and ILOS may serve to reduce unnecessary institutional care, reduce total costs, and improve care at the beneficiary and population level.

V. Conclusion and Overarching Themes

Overall, CalAIM takes the lessons learned from the CCI pilots to propose changes to the care delivery system with goals of improving care coordination, standardizing benefit design, and working towards a statewide system of Managed Long-Term Services and Supports.

A high-level review of CalAIM provisions relevant to duals is below.

1. **Roll out lessons learned from the CCI pilots.** A primary aim of CCI is to increase coordination between Medi-Cal and Medicare benefits for duals. However, CCI is currently limited to just 7 pilot counties. CalAIM plans to use the structure of CCI and the lessons learned from pilots to roll out a more integrated system of care delivery for duals statewide. As one example, CalAIM will leverage learnings from Cal MediConnnect to facilitate greater coordination between Medi-Cal and Medicare benefits by encouraging beneficiary enrollment into MC-MCPs and MA D-SNPs

[15] Department of Health Care Services, "California Advancing & Innovating Medi-Cal (CalAIM) Proposal."

owned by the same parent company.

2. **Improve coordination of care.** CalAIM recognizes that increased coordination can improve care for duals and other populations with complex needs who access care through multiple systems. Thus, CalAIM has a focus on strengthening care coordination and care management services to provide beneficiaries with support across all dimensions of care. Enhanced Care Management in particular is a new proposed benefit that will provide high-need duals with systematic coordination of services across both medical and non-medical needs.

3. **Standardize benefit design.** Many of CalAIM's provisions are designed to standardize benefits across beneficiary groups and geographies and reduce the complexity of the Medi-Cal program. In addition to restructuring the CCI pilots to implement a statewide system of integrated care delivery, CalAIM would facilitate a greater shift towards managed care in the Medi-Cal system through mandatory enrollment and create services such as Enhanced Care Management, a variation of a benefit currently available mainly in WPC/HHP pilot counties, as a new statewide benefit.

4. **Work towards statewide provision of Managed Long-Term Services and Supports (MLTSS) by 2027.** DHCS imagines a future in which managed care plans will be responsible for a standardized set of LTSS benefits. Working toward a goal of fully realized MLTSS by 2027, CalAIM proposes a number of enabling policies and programs to set the stage including mandatory enrollment into Medi-Cal managed care, carve-in of institutional long-term care into managed care, and aligned D-SNP enrollment.

CalAIM is an ambitious proposal that describes the future of the California Medi-Cal program. Its focus on improving care for complex, high-need populations including duals has the potential to reduce barriers to access, improve communication between systems, and allow for a whole-person approach to health and wellbeing.

Appendix I. Glossary

Acronym	Term
ACA	Affordable Care Act
CCI	Coordinated Care Initiative
CMC	Cal MediConnect
CMS	Centers for Medicare and Medicaid Services
COHS	County Organized Health Systems
DHCS	Department of Health Care Services
D-SNP	Dual Eligible Special Needs Plan
ECM	Enhanced Care Management
FFS	Fee-For-Service
HCBS	Home and Community-Based Services
HHP	Health Homes Program
IHSS	In-Home Supportive Services
ILOS	In Lieu of Services
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MC-MCP	Medi-Cal Managed Care Plan
MLTSS	Managed Long-Term Services and Supports
MSSP	Multipurpose Senior Services Program
PACE	Program of All-Inclusive Care for the Elderly
SMAC	State Medicaid Agency Contract
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
WPC	Whole Person Care

Appendix II. Enhanced Care Management (ECM) Target Populations Descriptions

The CalAIM proposal provides descriptions of target populations for enhanced care management. These include:

- **Children & Youth:** Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- **Homeless:** Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless**.**
- **High Utilizers:** High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- **Risk for Institutionalization:** Individuals at risk for institutionalization who are eligible for long-term care services.
- **Nursing Facility Transition to Community:** Nursing facility residents who want to transition to the community.
- **Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and Substance Use Disorder (SUD) at Risk for Institutionalization:** Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and SMI (adults), SED (children), or SUD.
- **Individuals Transitioning from Incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.**

Appendix III. Menu of In Lieu of Service (ILOS) Options

The following is high-level overview of the proposed menu of in lieu of services that would be covered under CalAIM. (See Appendix J of the DHCS proposal for a complete description of these services, including eligibility, restrictions and limitations, licensing/allowable providers, and state plan services to be avoided.)

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

Each set of services is described in detail below:

- **Housing Transition Navigation Services.** Description: assist beneficiaries with obtaining housing. Examples include: conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy; developing an individualized housing support searching for housing and presenting options; assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history); assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process; identifying and securing available resources to assist with subsidizing rent (such as Section 8 or Section 202, etc.); identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses; communicating and advocating on behalf of the client.

  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 clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

  Eligibility: Highly vulnerable individuals with multiple chronic conditions and/or serious mental illness and/or serious substance use disorder. Also, individuals who meet the Housing and Urban Development (HUD) definition of homeless (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental

health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals. Also, individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

- **Housing Deposits.** Description: 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. Examples: Security deposits required to obtain a lease on an apartment or home; set-up fees/deposits for utilities or service access; first month coverage of utilities, including but not limited to telephone, gas, electricity, heating and water; first and last month's rent as required by landlord for occupancy. Eligibility: Same as for Housing Transition Navigation Services.

- **Housing Tenancy and Sustaining Services**. Description: provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Examples include: early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations; education and training on the role, rights and responsibilities of the tenant and landlord; coaching on developing and maintaining key relationships with landlords/property managers; assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction; providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

- **Short-term Post-Hospitalization Housing.** Description: provides beneficiaries who are homeless 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), substance abuse or mental health treatment facility, custody facility, or recuperative care.

- **Recuperative Care (Medical Respite).** Description: 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. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food and housing. Examples:

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). Also, limited or short-term assistance with activities of daily living; coordination of transportation to post-discharge appointments; connection to any other on-going services an individual may require including mental health and substance use disorder services.

- **Respite.** Description: services provided by the hour on an episodic basis or by the day or overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

- **Day Habilitation Programs.** Description: programs designed to assist the participant in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in the person's natural environment. Examples of training include: use of public transportation; personal skills development in conflict resolution; community participation; developing and maintaining interpersonal relationships; daily living skills (cooking, cleaning, shopping, money management).

- **Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF).** Description: facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care.

- **Nursing Facility Transition to a Home.** Description: assists individuals to live in the community and avoid further institutionalization. Examples: non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or 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 such as assessing the participant's housing needs and presenting options; 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); communicating with landlord, if applicable and coordinating the move; identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one- time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as

hospital beds, Hoyer lifts, etc. to ensure access.

- **Personal Care (beyond In-Home Services and Supports) and Homemaker Services**. Description: assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management. Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, 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. Note: these are services 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.

- **Environmental Accessibility Adaptations (Home Modifications).** Description: physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home, without which the participant would require institutionalization. Examples: ramps and grab-bars to assist beneficiaries in accessing the home; doorway widening for beneficiaries who require a wheelchair; stair lifts; making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).

- **Meals/Medically Tailored Meals.** Description: meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission. Also, meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.

- **Sobering Centers.** Description: alternative destinations for individuals who are found to be publicly intoxicated (alcohol and/or drug) 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 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, and homeless care support services. Services can also include 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. Best practices suggested for clients who are homeless and who have complex health and/or

behavioral health conditions include Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

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

- **Asthma Remediation.** Description: physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. Examples include allergen-impermeable mattress and pillow dustcovers, HEPA filtered vacuums, air filters, integrated pest management services, minor mold removal services, and ventilation improvements.

  The eligible population is comprised of 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). A home visit must be conducted to determine the suitability of any requested remediation. Asthma remediations are payable up to a total lifetime maximum of $5,000, barring significant changes in the beneficiary's condition.

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