CalOptima Health
CalAIM Community Supports
Clinical Tip Sheets

April 2023

CalAIM Community Supports Clinical Tip Sheets

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Community Supports:
Housing Transition Navigation Services

Definition of Service:

Housing transition services assist members with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the member's preferences and barriers related to a successful tenancy. The assessment may include collecting information on the member's housing needs, potential housing transition barriers and identification of housing retention barriers.
2. Developing an Individualized Housing Support Plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member's approach to meeting goals, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet goals.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate and prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process.
6. Identifying and securing available resources to assist with subsidizing rent (such as the U.S. Department of Housing and Urban Development's Housing Choice Voucher Program [Section 8] or state and local assistance programs) and matching available rental subsidy resources to members.
7. Identifying and securing resources to cover expenses, such as security deposits, moving costs, adaptive aids, environmental modifications and other one-time expenses.
8. Assisting with requests for reasonable accommodation, if necessary.

9. Arranging landlord education and engagement.
10. Ensuring the living environment is safe and ready.
11. Communicating and advocating on behalf of the member with landlords.
12. Assisting in arranging and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
14. Identifying, coordinating, securing or funding non-emergency and non-medical transportation to assist members' mobility and to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
15. Identifying, coordinating, securing or funding environmental modifications to install necessary accommodations for accessibility (see environmental accessibility adaptations Community Support). The services provided should be based on an individualized assessment of needs and documented in the Individualized Housing Support Plan.

Eligibility:

- Member is homeless
- Member is at risk of homelessness **and** meets one of the following criteria:
    - Has one or more serious chronic conditions
    - Has a serious mental illness
    - Is at risk of institutionalization
    - Is at risk of overdose
    - Is requiring residential services because of a substance use disorder (SUD)
    - Has a serious emotional disturbance
    - Is receiving Enhanced Care Management (ECM)
    - Is a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, a serious mental illness, serious emotional disturbance, and/or the youth has been the victim of trafficking or domestic violence.
- Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System

Ineligible (Denial):

Restrictions and limitations for housing transition/navigation services must be identified as reasonable and necessary in the member's Individualized Housing Support Plan.

Healthcare Common Procedural Coding System (HCPCS) Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
Housing Navigation			
H0043U6	Supported housing	1 unit = per diem	**Place of Service Code reference listing
H2016U6	Comprehensive community supports services	1 unit = per diem	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for social determinants of health (SDOH) from the Department of Health Care Services (DHCS) All-Plan Letter (APL) 21-009.

Length of Authorization:

Six months

How it Works:

- CalOptima Health will receive the referral form.
    - Paper referral form is faxed to CalOptima Health.
    - Electronic referral submitted via CalOptima Health (SafetyNet) Connect.
        - All referrals will be routed to housing shelter.
- Long-Term Support Services (LTSS) CalAIM team will review referrals as they arrive and assign to Community Supports providers based on the client capacity listed in CalOptima Health (SafetyNet) Connect.
    - This will queue up a wait list as needed if there are no Community Supports providers who have listed available capacity.
- Provider will accept the referral via CalOptima Health (SafetyNet) Connect.
- Provider submits the authorization request for six months.
- LTSS CalAIM team will approve authorization within CalOptima Health (SafetyNet) Connect.
- If the request is for reauthorization, the provider will ensure the member's tenant screening, housing assessment and Individualized Housing Support Plan are uploaded into CalOptima Health (SafetyNet) Connect.
    - These documents will be reviewed by the LTSS CalAIM team when approving the reauthorization.

Number of Units to Authorize:

9,999 units = Six months

Additional Tools and Documentation Needed:

The Community Supports provider is responsible for creating three documents for the member, including:

1. Tenant screening
2. Housing assessment
3. Individualized Housing Support Plan

FAQ:

1. **Can this service help pay for room and board?**
   Services do not include the provision of room and board or payment of rental costs.

2. **How many times can this service be reauthorized?**
   Initial and reauthorizations are done every six months, however, there is no limit on how many reauthorizations can be processed for each member. The service duration can be as long as necessary.

3. **Are there CalOptima Health standardized forms for the tenant screening, housing assessment and Individualized Housing Support Plan?**
   At this time, there are no standardized forms being used for this service. As the program matures, potential changes to the process will be discussed with providers prior to implementation.

4. **When would this authorization end?**
   The Community Supports provider will request to end the authorization within CalOptima Health (SafetyNet) Connect once a member has completed the service.

5. **How would a Community Supports provider submit a self-referral for this service?**
   As of January 1, 2023, all housing transition navigation referrals will be automatically directed to CalOptima Health within the CalOptima Health (SafetyNet) Connect portal. If the Community Supports housing provider is submitting this referral with the intent for the referral to be assigned to themselves, please indicate that this is a self-referral in the comments section. CalOptima Health staff will then assign that referral back to the requesting provider.

Community Supports: Housing Deposits

Definition of Service:

Housing deposits assist with identifying, coordinating, securing or funding one-time services and modifications necessary to enable a person to establish a basic household but do not constitute room and board. The services provided should be based on an individualized assessment of needs and documented in the Individualized Housing Support Plan. Individuals may require and access only a subset of the services listed above.

Housing deposits have a lifetime maximum of $5,000.

Covered Services:

Appliances
Application fee(s)
First/last month's rent and security deposit
Furnishings
Furniture
Household items: Goods such as an air conditioner or heater. Other medically necessary adaptive aids and services designed to preserve an individual's health and safety in the home upon move-in, such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies
Housing deposit
Moving expenses
Professional services such as pest eradication and one-time cleaning prior to occupancy
Utilities/deposits (first month and setup fees)

Eligibility:

- Member is homeless or at risk of homelessness
- Member is receiving housing transition navigation services
- Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System

Ineligible (Denial):

Members who have already received housing deposits (service may be reauthorized if total funds are not spent within the authorization period).

Individuals must also receive housing transition navigation services (at a minimum, the associated tenant screening, housing assessment and Individualized Housing Support Plan) in conjunction with this service.

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
Housing Deposit			
H0044U2	Supported housing deposit	1 unit = lifetime max	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

Six months

How it Works:

- CalOptima Health will receive the referral form.
  - Paper referral form is faxed to CalOptima Health.
  - Electronic referral submitted via CalOptima Health (SafetyNet) Connect.
- LTSS CalAIM team will review referrals as they arrive and assign to the Community Supports provider based on the client capacity listed in CalOptima Health (SafetyNet) Connect.
  - This will queue up a wait list as needed if there are no Community Supports providers with listed available capacity.
- Provider will accept the referral via CalOptima Health (SafetyNet) Connect.
- Community Supports provider submits the authorization request for six months.
- LTSS CalAIM team will approve authorization within CalOptima Health (SafetyNet) Connect.
- If the request is for reauthorization, the provider will ensure the member's tenant screening, housing assessment and Individualized Housing Support Plan, as well as all receipts for money already spent, are uploaded into CalOptima Health (SafetyNet) Connect.

    - Provider must have also completed an up-to-date invoice tracker within CalOptima Health (SafetyNet) Connect to track money spent.
- These documents will be reviewed by the LTSS CalAIM team when approving the reauthorization.

Number of Units to Authorize:

5,000 units = Six months

Additional Tools and Documentation Needed:

- Housing navigation authorization within CalOptima Health (SafetyNet) Connect
- Tenant screening
- Housing assessment
- Individualized Housing Support Plan
- All receipts of money spent (if request is for a reauthorization)

FAQ:

1. **Are there any circumstances in which CalOptima Health will authorize a second housing deposit for a member?**
   CalOptima Health may approve a second authorization for housing deposits if:
   - Member is in the process of moving into permanent supportive housing and was unable to spend the entire deposit amount within the authorized six-month period.
   - Member has documentation as to what conditions have changed to demonstrate why providing housing deposits would be more successful on the second attempt.

2. **Can this service be authorized if member did not participate in housing transition navigation services?**
   If the member did not participate in the housing transition navigation services, CalOptima Health will review the authorization on a case-by-case basis. There may be instances where a member may get approved if they have a tenant screening, housing assessment and Individualized Housing Support Plan completed in conjunction with this service.

3. **When would this authorization end?**
   The Community Supports provider will request to end the authorization within CalOptima Health (SafetyNet) Connect once a member has completed the service.

4. **Does this service cover room and board?**
   Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage, as noted above.

Community Supports:
Housing Tenancy and Sustainability

Definition of Service:

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

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payments, hoarding, substance use and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with the goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse actions, including developing a repayment plan or identifying funding in situations in which the member owes back rent or payment for damage to the unit.
6. Advocacy and connection with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).
13. Providing education on independent living and life skills, including assistance with and training on budgeting, financial literacy and connection to community resources. Services do not include the provision of room and board or payment of rental costs.

Eligibility:

- Member is homeless or at risk for homelessness
- Member has received housing transition navigation services
- Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System

Ineligible (Denial):

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed.

They are only available for a single duration in the individual's lifetime.

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
Housing Tenancy			
T2040U6	Financial management self-directed	1 unit = 15 minutes	**Place of Service Code reference listing
T2041U6	Support brokerage self-directed	1 unit = 15 minutes	**Place of Service Code reference listing
T2050	Financial management self-directed	1 unit = per diem	**Place of Service Code reference listing
T2051	Supported brokerage self-directed	1 unit = per diem	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

Six months

How it Works:

- CalOptima Health will receive the referral form.
    - Paper referral form is faxed to CalOptima Health
    - Electronic referral submitted via CalOptima Health (SafetyNet) Connect.
- Community Supports provider will accept the referral via CalOptima Health (SafetyNet) Connect.
- Provider submits the authorization request for six months.
- LTSS CalAIM team will approve authorization within CalOptima Health (SafetyNet) Connect.
- If the request is for reauthorization, the provider will ensure the member's tenant screening, housing assessment and Individualized Housing Support Plan are uploaded into CalOptima Health (SafetyNet) Connect.
    - These documents will be reviewed by the LTSS CalAIM team when approving the reauthorization.

Number of Units to Authorize:

9,999 Units

Additional Tools and Documentation Needed:

- Housing navigation authorization within CalOptima Health (Safety) Connect
- Tenant screening
- Housing assessment
- Individualized Housing Support Plan

FAQ:

1. **Can members receive this service more than once in their life?**
   Housing tenancy and sustaining services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing this support would be more successful on the second attempt.

2. **Can members who did not receive housing navigation receive this service?**
   A member is eligible for this service if they did not receive housing navigation, but the provider will need to complete a tenant screening, housing assessment and Individualized Housing Support Plan and upload them into CalOptima Health (SafetyNet) Connect before this service can be authorized.

3. **Can this service be reauthorized?**
   Yes, this service is reauthorized every six months as long as the member is benefiting from the service. If there is a break in services, then it would be considered a second request and will need to be reviewed on a case-by-case basis by CalOptima Health.

4. **When would this authorization end?**

The Community Supports provider will request to end the authorization within CalOptima Health (SafetyNet) Connect once a member has completed the service.

Community Supports: Recuperative Care

Definition of Service:

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.

At a minimum, the service will include interim housing with a bed, meals, transportation and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring).

Based on individual needs, the service may also include:

1. Limited or short-term assistance with instrumental activities of daily living (ADLs) and/or independent activities of daily living (iADLs).
2. Coordination of transportation to post-discharge appointments.
3. Connection to any other ongoing services an individual may require, including mental health and substance use disorder services.
4. Support in accessing benefits and housing.
5. Gaining stability with case management.

Eligibility:

- Member is homeless or at risk of homelessness
- Member is at risk of hospitalization or is post-hospitalization

- Member lives alone with no formal supports

Ineligible (Denial):

A member cannot use more than 90 consecutive days of recuperative care

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
Recuperative Care			
T2033U3	Residential care not otherwise specified	1 unit = per diem	**Place of Service Code reference listing
T2033U3	Residential care not otherwise specified	1 unit = per diem	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

Presumptive 14 days

Continued — Not to exceed 90 days (including the 14 presumptive)

How it Works:

- Member must have the Recuperative Care/Short-Term Post-Hospitalization Housing (STPHH) Referral Form completed. This is typically completed by the staff at the hospital, the street medicine team or primary care provider (PCP), however, anyone can complete the form.
- Once the form is completed, it will be faxed to one of the contracted recuperative care facilities (facilities and fax numbers are listed on the Recuperative Care/STPHH Referral Form [see example below]).

Community Supports Contact Information

Name	Phone Number	Fax Number	Email Address
Recuperative Care			
Blue Sky Manor Inc.	714-844-2667	714-844-2668	referral@blueskymanorcare.com
Harbor Care Center	818-925-1451	818-350-4105	info@harborcares.org
Horizon Recuperative Care	323-676-1000 ext. 1	323-676-2000	admissions@horizoncenters.org

Recuperative Care and Short-Term Post-Hospitalization Housing			
Mom's Retreat	714-904-1668	888-459-2407	referral@blueskymanorcare.com
Illumination Foundation	949-273-0555	888-517-7123	RECUP@ifhomeless.org

- The recuperative care provider will review the clinical information provided on the form and determine if they are able to accept the member.
    - If the provider cannot accept the member, they need to complete Step 5 and return the form to CalOptima Health.
    - If they can accept the member, they will complete the form and submit to CalOptima Health.
- The provider will log onto CalOptima Health (SafetyNet) Connect, complete the electronic referral form and submit (assign to self) and accept the referral.
- The provider will submit the authorization request via CalOptima Health (SafetyNet) Connect for the 14-day presumptive approval.
- The LTSS CalAIM team will complete the auto-approval for the presumptive 14 days.
- The provider will need to complete the second electronic self-referral for recuperative care days 15–90.
- The provider will submit the authorization request for the ongoing recuperative care services.
    - The provider should upload the plan of care, including discharge planning notes, into CalOptima Health (SafetyNet) Connect.
- The LTSS CalAIM team will approve the authorization within CalOptima Health (SafetyNet) Connect.

Number of Units to Authorize:

14 Units — Presumptive

76 Units — Regular

Additional Tools and Documentation Needed:

- Recuperative Care/STPHH Referral Form
- Care plan uploaded into CalOptima Health (SafetyNet) Connect

FAQ:

1. **Can a member stay longer than 90 days?**
   Members are only allowed to stay 90 consecutive days in the recuperative care setting.

2. **What happens if the member returns to the hospital within the 90 days? Does their presumptive or complete authorization start again?**
   Yes. If the member is readmitted to the hospital for an overnight stay, then they would be processed through the CalAIM recuperative care Community Support like they are a new admission. They will begin with the 14-day presumptive and progress to the max of 90 days.

3. **Can a member be enrolled into housing navigation while they are enrolled in recuperative care?**
   Yes. A member can be enrolled into housing navigation while they are enrolled in recuperative care. They simply cannot receive duplicative services from both programs.

4. **What happens if a member is not accepted at any of the CalOptima Health-contracted recuperative care facilities?**
   CalOptima Health is willing to work with non-contracted recuperative care entities to ensure our members' needs are met. If the member is accepted at a non-contracted facility, the LTSS CalAIM team will work with our contracting department to facilitate a Letter of Agreement for the services. The same time frames and presumptive eligibility will apply.

5. **Since meals are included with the recuperative care service, what happens if the member needs a specialized diet (i.e. a pureed diet) while at the recuperative care facility?**
   CalOptima Health will work with the recuperative care facility on a case-by-case basis to determine if an additional authorization for medically tailored meals is appropriate for the member. If they are appropriate, the LTSS CalAIM team can process the additional referral on the member's behalf.

6. **When would this authorization end?**
   The Community Supports provider will request to end the authorization within CalOptima Health (SafetyNet) Connect once a member has been discharged from the facility.

Community Supports:
Personal Care/Homemaker Services

Definition of Service:

Provide members who need help with ADLs with personal care and homemaker services.

Eligibility:

- At risk for hospitalization or institutionalization in a nursing facility
- Has functional deficit and no support system
- Has either approved In-Home Supportive Services (IHSS) **or** an application submitted pending social worker assessment and determination of hours

Ineligible (Denial):

- Members living in facilities such as board and care, assisted living facility (ALF) or nursing facility
- Members who have not applied for IHSS
- Member who has access to reliable caregiver support from family or friends

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
PERSONAL CARE/HOMEMAKER SERVICES			
S5130U6	Homemaker services per 15 minutes	1 unit = per 15 minutes	**Place of Service Code reference listing

T1019U6	Personal care services per 15 minutes	1 unit = per 15 minutes	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

Six months

How it Works:

The number of units authorized will depend on the member's "rank," based on their personal care homemaker assessment. This assessment is modeled after the IHSS assessment and is intended to match the number of hours authorized to the average of what someone receiving IHSS will be authorized for.

Below are two tables. The first table is for members who have their IHSS application in "pending" status. Due to the member not currently having any IHSS caregiver hours, the member will be awarded a higher number of hours. The second table is for those who already have IHSS, but the number of hours is not adequate for them to remain safely in their home. These services are intended to be authorized until an IHSS reassessment is completed and the member has been awarded a higher number of hours.

The charts are set up with the following columns: Ranking, Weekly Hours, Monthly Hours, Hours in Six Months and Units. Because this service is billed in 15-minute increments, the number of units approved is the most important part of this chart and what you will enter in your authorization to ensure that your billing and claims match.

Anyone with a rank of "1" does not qualify for personal care/homemaker services and would not be authorized for any hours.

The ranks are determined based on the number of times a ranking score was chosen. In the 14-question assessment, the average rank is determined by what the majority count is. For example, if there are two 1s, two 2s, seven 3s, one 4 and two 5s, the majority is the "3s" and the member will be Rank 3, qualifying them for 2,688 units if IHSS is pending OR 1,800 units if they already have IHSS in a six-month period. You may notice that the IHSS pending authorizes double the number of units than the IHSS approved authorizes, which is by design and carries though all rankings.

Number of Units to Authorize:

**IHSS Pending — Authorize this number of units				
	Weekly Hours	**Monthly Hours**	**Six Months Hours**	**Weekly hours x 4 units per hour x 4 weeks in a month x 6 months in an authorization**
Average Rank 1	0	0	0	**0**
Average Rank 2	23.5	94	564	**23.5 x 4 x 4 x 6= 2,256**
Average Rank 3	28	112	672	**28 x 4 x 4 x 6= 2,688**

Average Rank 4	37.25	149	894	**37.5 x 4 x 4x 6= 3,600**
Average Rank 5	45.25	181	1086	**45.25 x 4 x 4 x 6= 4,344**

	Weekly Hours	**Monthly Hours**	**Six Months Hours**	**Weekly hours x 4 units per hour x 4 weeks in a month x 6 months in an authorization**
Average Rank 1	0	0	0	**0**
Average Rank 2	11.75	47	282	**11.75 x 4 x 4 x 6= 1,128**
Average Rank 3	14	56	336	**14 x 4 x 4 x 6= 1,344**
Average Rank 4	18.75	75	450	**18.75 x 4 x 4 x 6= 1,800**
Average Rank 5	22.75	91	546	**22.75 x 4 x 4 x 6= 2,184**

Additional Tools and Documentation Needed:

CalOptima Health has created a personal care/homemaker assessment tool and built it into CalOptima Health (SafetyNet) Connect. The member or the member's representative and the health network (HN) or Community Supports provider representative will complete this questionnaire. This assessment cannot be completed by the personal care/homemaker company representative. The questionnaire has 14 questions that rank a member's ability to perform ADLs and iADLs. A score of 1 in a category indicates a member is independent in completing that activity, whereas a 5 indicates a member is unable to perform the activity even with assistance.

FAQ:

1. **How do you define a support system?**
   A support system should be defined as someone being available to ensure that a member is able to safely perform ADLs and iADLs. This may be a family member or friend. It may be continuous or intermittent, but if this support did not exist the member would need to be institutionalized in a nursing facility or hospital.

2. **How does the member apply for IHSS?**
   Here is the link to complete the IHSS application. Additional information about IHSS can also be found on the California Department of Social Services website.

3. **Does IHSS have other qualifications other than those for CalAIM?**
   Yes, IHSS has its own qualifications. Eligibility criteria for all IHSS applicants and recipients are:

   - You must physically reside in the United States.
   - You must be a California resident.
   - You must have a Medi-Cal eligibility determination.
   - You must live at home or an abode of your own choosing. Acute care hospitals, long-term care facilities and licensed community care facilities are not considered your own home.
   - You must submit a completed Health Care Certification form.

4. **Does this mean if someone does not qualify for IHSS they do not qualify for CalAIM personal care and homemaker services?**
   DHCS requires that a member has a pending or active IHSS application to qualify for this service, however if there is a member who does not meet IHSS criteria CalOptima Health may review the request and determine if there is an urgent need for services without which the member would be at risk for institutionalization or hospitalization.

5. **How does CalOptima Health know when to end the authorization?**
   The service will end once the member has adequate IHSS hours approved and a caregiver in place. CalOptima Health has access to a report that indicates which members are active with IHSS. This report can be used to match to active authorizations. Once the IHSS service begins, the personal care and homemaker service provider will be notified to request discharge from the service that will trigger CalOptima Health staff to close out the authorization.

6. **What if my six-month authorization is about to expire and the member still is not showing on the approved IHSS list? Can CalOptima Health issue another authorization?**
   Yes, but we recommend you also have the member or the member representative follow up with IHSS to see why the service has not been initiated.

7. **Will I need to do a Notice of Action (NOA)?**
   A NOA is required for one of two reasons: a member does not meet eligibility criteria or the member has been unable to be contacted after a minimum of three outreach attempts. If the member receives a rank of "1" and will not be authorized for any hours because they do not qualify for personal care or homemaker services per the CalOptima Health guidelines, CalOptima Health will issue an NOA denial to the member.

8. **If the member switches providers, do I need to complete another personal care and homemaker assessment?**
   No, that assessment is valid for six months, unless the member has a change in condition, and can be used in the event there is a new provider requested.

9. **What if IHSS does not approve the initial hours or the increase in hours?**
   Once a determination is made by IHSS, this CalAIM service will be terminated 10 days after the date listed on the notification from IHSS.

10. **Why are the hours listed with decimals?**
    The 0.25 equals a 15-minute increment to match the billing codes. These are averages of the IHSS model of hours authorized and that is why some are 0.25, 0.5 or 0.75.

11. **Can this service be used when the member has IHSS, but they can't obtain an IHSS caregiver due to low staffing issues, language barriers, caregiver promised and not showing up?**
    CalAIM personal care and homemaker services should be used as secondary to IHSS. However, if they have approved IHSS hours but the issue is related to staffing and not a request for an increase in hours due to a change in condition, the member may still be eligible for this service, but providers should reach out to assist the member in getting an IHSS caregiver.

Community Supports: Medically Tailored Meals (MTM)

Definition of Service:

Provide members with medically tailored meals at home after discharge from a hospital or nursing home.

How it Works:

There are three components of MTM:

1. The registered dietician/registered dietician nutritionist (RD[N]) assessment
2. Home-delivered meals
3. Medically tailored grocery boxes

All members receiving this service will need an RD(N) assessment completed by the meals provider to be eligible for any deliveries. From the assessment, a recommendation will be made to either authorize the ready-made meals or the grocery boxes.

The information given to the authorizer will be the RD(N) assessment along with the recommendation for the type of meals, diet restrictions, consistency, grocery box type, quantity and duration. All these options will be selected in the authorization request by the MTM provider. The first 12 weeks of MTM will be auto approved within the CalOptima Health (SafetyNet) Connect site.

If this is an ongoing need for MTM that extends beyond the initial 12 weeks, a second request for an RD(N) assessment will be completed prior to MTM authorization. As the authorizer, CalOptima Health will compare the new assessment to the recommendation and authorize as appropriate. These authorizations are intended to be for up to 12 weeks.

Meals	Diet Restrictions	Consistency	Grocery Box	Quantity/Volume	Duration
Low Sodium	Gluten allergy	Regular	Low sodium	2 meals per day	1 week – 7 days
Diabetes Friendly/Low Carb	Peanut	Pureed	Diabetes friendly/low carb	1 meal per day	2 weeks – 14 days
Cardiac/Heart Friendly	Lactose		Cardiac/heart friendly	1 grocery box per week	3 weeks – 21 days
Renal Friendly	Kosher		Renal friendly		4 weeks – 28 days
Cancer Supports Calories	No Pork		Cancer supports calories		5 weeks – 35 days
Vegetarian	Other: (Fillable)				6 weeks – 42 days
					7 weeks – 49 days
					8 weeks – 56 days
					9 weeks – 63 days
					10 weeks – 70 days
					11 weeks – 77 days
					12 weeks – 84 days

Eligibility:

- Has a qualifying medical condition, such as, but not limited to, diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders
- Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement
- Individuals with extensive care coordination needs

Ineligible (denial):

- Members who do not have access to a refrigerator
- Members who are receiving food delivered to their home through another program

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
MEDICALLY- SUPPORTIVE FOOD/MEDICALLY TAILORED MEALS			
S5170U6	Home-delivered prepared meal	1 unit = 1 meal	**Place of Service Code reference listing
S9470U6	Nutritional counseling, diet	1 unit per consultation	**Place of Service Code reference listing

S9977U6	Meals: per diem, not otherwise specified, aka grocery box	1 unit = 1 day (per service date)	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

12 weeks (may be extended beyond 12 weeks but will need a new RD(N) assessment and documentation). Any duration less than 12 weeks can also be authorized depending on the member's need.

Number of Units to Authorize:

An RD(N) assessment will be auto authorized through CalOptima Health (SafetyNet) Connect, but in the event manual authorization is needed, the authorization will be for one unit.

When authorizing a grocery box, you would choose seven units multiplied by the duration in weeks. Example: One box per week x 12 weeks = 7 x 12 = 84 units.

When authorizing meals, CalOptima Health can authorize up to two meals per day x seven days per week x 12 weeks, which equals a maximum of 168 units. However, it can be less than that depending on the frequency and duration requested by the Community Supports provider. The first 12 weeks of MTM will be auto-authorized, but subsequent requests will require LTSS nurse review for ongoing medical necessity.

Additional Tools and Documentation Needed:

The MTM vendors each have their own paper or PDF assessment. They will upload the completed assessment form as an attachment to the authorization request in CalOptima Health (SafetyNet) Connect.

FAQ:

1. **What if a member needs more than one type of meal (example: low salt and low carb)?**
   The authorization request form within CalOptima Health (SafetyNet) Connect was built to accommodate multiple options, so there should be no problems choosing multiple needs.

2. **What happens when a member can't receive their meals (i.e. they are hospitalized)? Do we need to end the authorization?**
   No. CalOptima Health will be able to communicate directly with the meals provider in CalOptima Health (SafetyNet) Connect via the inbox service about holding versus ending the service.

3. **What happens if a member doesn't like their food?**
   Members have the option to change meals providers or work with the current meals provider to make any adaptations if they still follow their prescribed diets.

4. **How does the member change providers?**

The CalOptima Health authorizer would end the current authorization and refer the member to another meals provider. If it is within 12 weeks of the RD(N) assessment, and there has been no change in condition, there is no need to redo the assessment. The original can be used for the authorization.

5. **How does CalOptima's Health Coaching program fit into this?**
   Members receiving MTM are still eligible for CalOptima's Health Coaching and registered dietician programs. The CalOptima Health team will access the RD(N) assessment via CalOptima Health (SafetyNet) Connect and will continue to provide ongoing services to the member.

6. **Is a NOA needed if the member chooses to end the service before the end date of the authorization?**
   If a member chooses to voluntarily end the services, then the Community Supports provider will submit a discharge request within the CalOptima Health (SafetyNet) Connect portal and no NOA is needed. The CalOptima Health staff will then end date the authorization. If the services are being ended due to "Unable to Contact" then yes, CalOptima Health would issue a NOA to the member.

7. **Can a member who is homeless have this service?**
   Not necessarily. If the member meets eligibility criteria for being homeless, they may still qualify. The most important factor is whether they have access to a refrigerator. Someone on the streets would not, however, someone staying with friends or at risk of homelessness can be eligible for services.

8. **Can members have both CalAIM MTM and CalFresh?**
   Yes, Cal Fresh is a program intended to address food insecurity as an SDOH. CalAIM meals are not intended to be used solely as a resource for food insecurity. We highly recommend that all members eligible for CalFresh be referred to that program. Find out more on the CalFresh website.

9. **Can a member get this service if they are in recuperative care**?
   Meals are included in the payment in the recuperative care authorization and thus this would be a duplication of services. CalOptima Health may review certain requests for specific diets that a recuperative care provider may not be able to provide, however this will be reviewed on a case-by-case basis.

Community Supports: Sobering Centers

Definition of Service:

Support for intoxicated individuals who would otherwise be transported to the emergency department or a jail, or who presented at an emergency department and are appropriate to be diverted to a sobering center.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

How it Works:

These will be auto authorized via CalOptima Health (SafetyNet) Connect. There are no limitations to the number of times a member can be authorized for this service. However, CalOptima Health (SafetyNet) Connect will run a weekly report and give it to CalOptima Health showing the members who have utilized this service three or more times in a rolling 30 calendar days. HNs should reach out to members on this report offering additional resources for alcohol dependency.

Eligibility:

- 18 years of age or older
- Intoxicated
- Conscious
- Cooperative
- Able to walk

- Non-violent
- Free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms)
- Agreeable to obtain services

Ineligible (Denial):

- Under 18 years of age
- Medically unstable to remain in this setting

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
SOBERING CENTERS			
H0014U6	Alcohol and/or drug services; ambulatory detoxification	1 unit = 1 day (per service date)	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

These services are authorized for less than 24 hours

Number of Units to Authorize:

Auto-authorization of one unit

Additional Tools and Documentation Needed:

None. This entire process is through CalOptima Health (SafetyNet) Connect. An additional outreach process will be developed by your internal HN.

FAQ:

1. **As the authorizer, do I have to do anything to authorize this service?**
   No, this is all done between the sobering center provider and CalOptima Health (SafetyNet) Connect.

2. **What additional resources can I offer if the member has had three or more visits?**
   - Inpatient detox centers
   - Outpatient mental health (MH) and SUD clinic locations
   - Outpatient substance abuse services
   - Residential treatment
   - Sober living referrals
   - Substance abuse detox and treatment

3. **Can members be transferred from a hospital/emergency room (ER) to a sobering center?**

Yes. A goal of this program is to reduce ER visits solely due to intoxication. However, there will be some members referred into a sobering center from the hospital/ER.

4. **How does the member get to the sobering center?**
   Typically, this is a collaboration between law enforcement, hospitals/ERs and street medicine outreach programs. It is common that the member is brought into the center by law enforcement or others with available transportation.

5. **What happens when the member leaves the sobering center?**
   Throughout the member's stay, they are working with staff to develop a discharge plan into either other in-house programs, county programs or alternative discharge dispositions.

6. **Is there a referral form for this service?**
   This is the only community support that does not have a referral form. The rationale for this is that the service is considered presumptive if the member meets the eligibility criteria. Additionally, based on the mechanism of bringing the member, having to wait for a referral form to be processed by CalOptima Health would prolong the access to the care during a critical period, therefore the decision was to not have this service dependent on a referral form.

Community Supports:
Short-Term Post-Hospitalization Housing

Definition of Service:

Assists with short-term housing for members with high medical or behavioral health needs after leaving the hospital, recovery facility, recuperative care or other qualified facility.

How it Works:

Members transitioning from one of the above locations can be placed into a short-term post-hospitalization program once in their lifetime. The maximum length of stay is six months (180 days). The goal is for members in this setting to be stable enough to not need to transition back and forth from the hospital during their admission. On-site staff and visiting licensed staff are available to assist members in fulfilling their needs, including, but not limited to, behavioral health needs. This service is provided in various settings including shelters, congregate homes, etc.

Members will typically be referred to this Community Support by members and health care workers in the community.

Like recuperative care, this service requires acceptance by a facility before an authorization can be requested. To have a member accepted, the referrer will complete the Recuperative Care/STPHH referral form and fax it to one of the contracted STPHH vendors listed on the form. The STPHH will then review and, once they have accepted the member, they will complete the referral and the authorization request within the CalOptima Health (SafetyNet) Connect portal.

Eligibility:

- Member is exiting recuperative care, inpatient hospital, residential substance uses disorder treatment facility, residential mental health treatment facility, correctional facility or nursing facility

- Member is homeless or at risk of homelessness

Ineligible (Denial):

This is a once-in-a-lifetime benefit. There are rare instances when it can be authorized more than once, but documentation must be provided to justify why a second visit is needed.

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
SHORT-TERM POST-HOSPITALIZATION HOUSING			
H0043U3	Supported housing, per diem. Modifier used to differentiate Short-term post-hospitalization housing from housing transition/navigation services	1 unit = 1 day (per service date)	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

Maximum six months (180 days). CalOptima Health recommends authorizing the 180 days from the start if the authorizer feels it to be medically necessary. Shorter authorizations can be made; however, it may limit members' ability to use the complete service.

Number of Units to Authorize:

Calculation based on dates authorized

Additional Tools and Documentation Needed:

Review member's medical records in your electronic health record (EHR) to determine eligibility based on high medical or behavioral health needs.

FAQ:

1. **Can a member come and go within the 180 days?**
   Yes, this is at the discretion of CalOptima Health. The intent is to serve members engaged in this process, and gaps in service bring added challenges. Please work with the community supports provider to determine ongoing eligibility for members leaving the site.

2. **What if the service authorized is supposed to be in a shelter but there are residency restrictions that don't allow member to stay there?**
   This is something we are still working on solving. However, for now, the accepting service provider must be able to accommodate the member in the location of service that meets the member's needs.

3. **Can a member discharge directly from a hospital into this program?**
   Yes, this program can be part of the member's discharge plan.

Community Supports: Day Habilitation

Definition of Service:

Programs designed to assist the member in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in their natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision.

How it Works:

Members will receive day habilitation services in either group or one-on-one settings. The service provider will complete an assessment and make a recommendation as to how many days they feel the member would benefit from receiving these services. For example, higher acuity equals more days authorized.

The service provider submits documentation, including an assessment, to determine what skills members would benefit from receiving classes or coaching on. Members will be ranked from beginning through proficient. Since this is an ongoing service, the provider will need to complete this assessment every six month for reauthorization.

The authorization request will be received via CalOptima Health (SafetyNet) Connect, and CalOptima Health LTSS staff will compare this assessment (which will be uploaded as an attachment) to determine if this is an appropriate service to request.

Eligibility:

- Member is homeless
- Member is at risk of homelessness or institutionalization
- Member left homelessness and entered housing in the past 24 months

Ineligible (denial):

Members matching proficient in all categories will be ineligible for this service. There may be instances where the authorization processor does not agree with the recommended number of days. In this case, the authorization processor will issue a modification and authorize the appropriate service days.

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
DAY HABILITATION PROGRAMS			
T2012U6	Habilitation, educational; per diem	1 unit = 1 day (per service date)	**Place of Service Code reference listing
T2014U6	Habilitation, prevocational; per diem	1 unit = 1 day (per service date)	**Place of Service Code reference listing
T2108U6	Habilitation, supported employment; per diem	1 unit = 1 day (per service date)	**Place of Service Code reference listing
T2020U6	Day habilitation; per diem	1 unit = 1 day (per service date)	**Place of Service Code reference listing
H2014U6	Skills training and development; per 15 minutes	1 unit = per 15 minutes	**Place of Service Code reference listing
H2038U6	Skills training and development; per diem	1 unit = 1 day (per service date)	**Place of Service Code reference listing
H2024U6	Supported employment; per diem	1 unit = 1 day (per service date)	**Place of Service Code reference listing
H2026U6	Ongoing support to maintain employment; per diem	1 unit = 1 day (per service date)	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

Up to six months. May extend beyond the six months with new assessment completed by the service provider with proof of ongoing need.

Number of Units to Authorize:

9,999 units

Additional Tools and Documentation Needed:

The service provider will complete an assessment tool and upload into CalOptima Health (SafetyNet) Connect. On this form, there is a section to measure the member's skills with a ranking from beginning through proficient. The number of days authorized will depend on this assessment.

FAQ:

1. **Can members get this service while they are getting other housing support services (i.e., housing tenancy)?**
   Yes. There is no restriction on having overlapping services. The service providers have been educated to bill to the appropriate authorization for the services.

2. **Is there an end date (i.e., one or two years)?**
   No, this service is available to the members if they need it and are benefitting from it.

Community Supports: Nursing Facility Transition to Home

Definition of Service:

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. This authorization covers the coordination and funds ($7,500 lifetime maximum) needed to establish a basic household, but does not constitute room and board.

In essence, this service is a combination of several other CalAIM Community Supports. This service includes components taken from:

- Nursing facility transition: Coordination to identify a home and complete the required documentation
- Deposits: To set up first and/or last month security fees, cleaning or pest fees, and turning on utilities
- Home modifications: To allow for safe access

Eligibility:

- Currently receiving medically necessary nursing facility level of care (LOC)
- Has lived 60-plus days in a nursing home and/or medical respite setting
- Interested and agreeable to move back to the community
- Able to reside safely in the community with appropriate and cost-effective supports and services

Ineligible (Denial):

Those needing monthly rental or mortgage expenses paid or who cannot pay their ongoing monthly expenditures, such as food and utilities.

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
NURSING FACILITY TO HOME			
T2038U5	Lifetime max $7,500	1 unit per service	**Place of Service Code reference listing
	Monthly care coordination rate	Include only in the invoice tracker in the portal	

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes SDOH from DHCS APL 21-009

Length of Authorization:

One year

How it Works:

- CalOptima Health will receive the referral form.
    - For members residing in long-term care, CalOptima Health LTSS staff will upload the following documents into CalOptima Health (SafetyNet) Connect:
        - History and Physical Examination (H&P) form for long-term care facility
        - Social worker's (SW's) notes from the long-term care facility (including any financial documentation available)
        - Care plan
- Provider will accept the referral via CalOptima Health (SafetyNet) Connect.
- Provider will contact member and establish rapport.
    - Provider will decide if member is appropriate for the CalAIM Community Support or if member will be better served using an alternative program (California Community Transitions [CCT]/Home- and Community-Based Alternatives [HCBA] waiver, etc.) based on the provider's initiate screening process.
    - Depending on provider, the process will be to either:
        - Refer to CCT or other appropriate waiver programs
        - Submit the authorization request to begin services
- Provider will assess housing needs and begin searching for and securing housing.
- Provider will complete housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
- Provider will coordinate transportation needed for member prior to move-in day.
- Provider will communicate with landlord (if applicable) and coordinate the move.
  Provider will complete the Home Assessment Tool.
- If there are home modifications that are needed to be completed prior to move in the provider will coordinate the following process:
    - Provider will fax a copy of the Home Assessment Tool to **714-481-6516** if the anticipated modification will exceed $2,500.

- CalOptima Health physical therapist will review the tool and determine if a home visit (in-person or virtual) is required.
- If a home visit is required, the CalOptima Health physical therapist will provide dates and times they are available to complete the assessment to the provider, and the provider will coordinate and schedule the assessment directly with the member.
- CalOptima Health physical therapist will complete the Letter of Recommendation (LOR) Form.
- CalOptima Health physical therapist will complete the assessment in the CalOptima Health electronic medical record (EMR) system and send a PDF to the provider for review.
- The provider must give the member and landlord a copy of the Approval of Permanent Modification for CalAIM Community Supports Home Modification/Asthma Remediation Repairs for all proposed permanent modifications to the home.
  - Provider will complete a portion of the document on behalf of the member.
  - The homeowner will need to sign the document.
  - The signed document will be returned to the provider.
- Provider then uploads the following documents into CalOptima Health Connect (SafetyNet) along with the authorization request:
  - Signed copy of the Approval of Permanent Modification for CalAIM Community Supports Home Modification/Asthma Remediation Repairs (if service is permanent).
  - Any required bids that the provider obtained for the completion of the work (two bids required for work that costs more than $2,500).
- Provider submits authorization request into CalOptima Health (SafetyNet) Connect.
- LTSS CalAIM team will review the documentation and approve authorization in CalOptima Health (SafetyNet) Connect.
- Provider can commence remediations to the member's home.
- Provider will upload all receipts and complete the invoice tracker within CalOptima Health (SafetyNet) Connect.
- Once all remediations are complete:
  - Provider completes a Notice of Completion of CalAIM Community Supports Home Modification/Asthma Remediation Repairs and obtains a signature from the homeowner.
  - Provider uploads signed Notice of Completion of CalAIM Community Supports Home Modification/Asthma Remediation Repairs into CalOptima Health (Safety Net) Connect.
  - Provider sends a copy to member's PCP.

- For members who need to utilize the deposit component, the provider will upload all receipts and use the invoice tracker in CalOptima Health (SafetyNet) Connect to track all expenditures. The total cost, including all components of the Community Support, will not exceed $7,500.

Covered Services:

Item
ADA-accessible bathroom remodel (e.g., constructing a roll-in shower)
Air conditioner
Application fees
Chair lifts

Doorway widening for members who require a wheelchair
Drywall and painting to return the home to a habitable condition, but does not include aesthetic embellishments
Grab bars
Furnishings
Furniture
Heater
Hospital bed
Household items
Hoyer lift
Installation of specialized electric systems that are necessary to accommodate the medical equipment and supplies of the member
Installation of specialized plumbing systems that are necessary to accommodate the medical equipment and supplies of the member
Moving expenses
Professional services (one-time cleaning/pest eradication)
Ramps
Security deposit (first/last month)
Stair lifts
Utility deposits (including first month)
Other (justify in notes section)

Number of Units to Authorize:

9,999 units (requires billed amounts to be reported)

Additional Tools and Documentation Needed:

- CalOptima Health will upload any relevant documents, including H&P, SW notes, financial information and care plan, so they are available to the provider to review upon acceptance of the initial referral
- Invoice Tracker Tool used within CalOptima Health (SafetyNet) Connect
- Receipts uploaded of all purchases including deposits, home modifications and moving expenses
- Two bids (if required)
- Home Assessment Tool
- Approval of Permanent Modifications for CalAIM Community Supports Home Modification/Asthma Remediation Repairs
- Notice of Completion of CalAIM Community Supports Home Modification/Asthma Remediation Repairs
- Copy of LOR Form completed by CalOptima Health physical therapy staff (if applicable)

FAQ:

1. **Are there any instances in which a member can exceed the $7,500 maximum?**
   Per the DHCS Policy Guide, if the member is compelled by circumstances beyond their control to move from a provider-operated living arrangement to a living arrangement in a private residence, then the limit will be reviewed on a case-by-case basis.

2. **Can the member utilize the CalAIM home modifications as well as this service?**
   The member should utilize the full $7,500 balance of this service before utilizing any additional CalAIM Community Supports concurrently. CalOptima Health will evaluate requests on a case-by-case basis.

3. **Can the member get an IHSS caregiver to help me after I move in?**
   Yes, part of this service coordination should include collaboration and applications to programs that will ensure success after move-in, including referrals to MTM, personal care/homemaker services and ECM.

4. **What happens if the member is admitted to the hospital or is unable to successfully stay in their new environment and needs to be readmitted to a long-term care facility?**
   As with all CalOptima Health beneficiaries, if a member meets the criteria to stay in a long-term care setting those nursing facility services will be coordinated and authorized by the CalOptima Health LTSS department.

5. **What if it takes longer than the one-year authorization time to get these services coordinated?**
   Our hope is that it will not, however, CalOptima Health will review any requests for reauthorization of continued services on a case-by-case basis.

Community Supports: Asthma Remediation

Definition of Service:

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

Asthma remediation includes providing information to members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and asthma-related hospitalizations.

Covered Services:

Advanced insulation techniques and air tightness
Allergen-impermeable mattress and pillow dustcovers
Asthma-friendly cleaning products and supplies
Dehumidifiers
Drywall repair
Energy-efficient and sealed combustion appliances
Energy-efficient high-performance windows
High-efficiency air filtration and ventilation improvements
High-efficiency particulate air (HEPA) filtered vacuums
Integrated pest management (IPM) services
Labor costs
Minor mold removal and remediation services
Moisture-controlling interventions: Foundation waterproofing and moisture control, insulated basement, walls and slab floor
Paint

Portable air filters
Radon control
Other (justify in notes)

Eligibility:

Individuals with poorly controlled asthma as determined by one of the following:

- An emergency department visit or hospitalization
- Two sick or urgent care visits in the past 12 months
- A score of 19 or lower on the Asthma Control Test

Ineligible (Denial):

Member is participating in another state plan that would accomplish the same goals of preventing asthma emergencies or hospitalizations.

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
ASTHMA REMEDIATION			
T1028U5	Asthma assessment	1 unit = per service	**Place of Service Code reference listing POS 12 (Home) is only acceptable
S5165U5	Asthma remediation — $7,500 lifetime maximum	1 unit = per service	**Place of Service Code reference listing POS 12 (Home) is only acceptable

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

Assessment authorization — 90 days

Remediation — One year

How it Works:

- LTSS CalAIM team will send a referral to the Community Supports provider for the asthma assessment.
- The provider will request the authorization via CalOptima Health (SafetyNet) Connect for the asthma assessment (this will be auto-approved as long as member meets eligibility criteria).
- Provider conducts in-home assessment and completes the following documentation:
    - Centers for Disease Control and Prevention (CDC) Home Assessment Checklist

- The provider will outreach to the member's PCP and send the Asthma Remediation Program Attestation Form to be signed by the PCP.
- The PCP will sign the form and fax it back to the Community Supports provider.
- For all proposed permanent modifications to the home, the provider must give the member and landlord a copy of the Approval of Permanent Modification for CalAIM Community Supports Home Modification/Asthma Remediation Repairs.
    - Provider will complete a portion of the document on behalf of the member.
    - The homeowner will need to sign the document.
    - Provider then uploads the following documents into CalOptima Health (SafetyNet) Connect along with the authorization request for the Asthma Remediation Service (S5165U5 code):
        - Signed copy of the Asthmas Remediation Program Attestation Form
        - CDC Home Assessment
        - Signed copy of the Approval of Permanent Modification for CalAIM Community Supports Home Modification/Asthma Remediation Repairs (if service is permanent)
- Provider submits authorization request into CalOptima Health (SafetyNet) Connect.
    - LTSS CalAIM team will review the documentation and approve the authorization in CalOptima Health (SafetyNet) Connect.
- CalAIM provider can commence remediations to the member's home.
- Once all remediations are complete:
    - Provider completes a Notice of Completion of CalAIM Community Supports Home Modification/Asthma Remediation Repairs and obtains a signature from the homeowner.
    - Provider uploads signed Notice of Completion of CalAIM Community Supports Home Modification/Asthma Remediation Repairs into CalOptima Health (SafetyNet) Connect.
    - Provider sends copy to member's PCP.

Number of Units to Authorize:

9,999 units for the assessment

9,999 units for the remediation service

Additional Tools and Documentation needed:

- CDC Home Assessment Checklist
- Asthma Remediation Program Attestation Form
- Approval of Permanent Modification for CalAIM Community Supports Home Modification/Asthma Remediation Repairs
- Notice of Completion of CalAIM Community Supports Home Modification/ Asthma Remediation Repairs

FAQ:

1. **Are there any exceptions to the $7,500 lifetime maximum?**
   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.

2. **If the member only rents, can they still use this service?**
   The services are available in a home that is owned, rented, leased or occupied by the member or their caregiver.

3. **What happens if the item that is modified breaks? Will CalOptima Health replace it?**
   CalOptima Health and the state are not responsible for the maintenance or repair of any modification, nor for removal of any modification if the member ceases to reside at the residence. We have the property owner sign the Notice to Property Owner of Permanent Modification Form to ensure there is documentation that the member and the property owner are both aware of this prior to the remediations being performed. This document is kept in the CalOptima Health EHRs.

4. **What if the landlord refuses to sign the Approval of Permanent Modification for CalAIM Community Supports Home Modification/Asthma Remediation Repairs?**
   Unfortunately, if the landlord is not agreeable to the modification, CalOptima Health and the provider are unable to complete the remediation.

5. **What if the doctor is unwilling to sign the Asthma Remediation Program Attestation?**
   CalOptima Health and the provider can work with a member's specialists (i.e. a pulmonologist) to obtain this signature. If there are still no willing providers, a CalOptima Health medical director may be asked to review the medical records and sign on behalf of the member, if needed.

Community Supports:
Nursing Facility Transition/Diversion to Assisted Living Facility (ALF) or Residential Care Facility for the Elderly (RCFE)

Definition of Service:

To facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for members with an imminent need for nursing facility LOC.

Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements. Care provided in an ALF include assisting with ADLs, iADLs, meals, transportation and medication administration, as needed.

For individuals transitioning from a licensed health care facility to a living arrangement in a residential care facility for the elderly (RCFE) and adult residential facilities (ARF) the Community Supports provider is responsible for:

- Assessing the member's housing needs and presenting options.
- Assessing the service needs of the member to determine if the member needs enhanced onsite services at the RCFE or ARF so the member can be safely and stably housed in an RCFE or ARF.
- Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
- Communicating with facility administration and coordinating the move.
- Establishing procedures and contacts to retain facility housing.
- Coordinating with the Medi-Cal managed care plan to ensure that members who need enhanced services to be safely and stably housed in RCFE or ARF settings have Community Supports and/or ECM services to provide those services.

Eligibility:

A. For Nursing Facility Transition:	B. For Nursing Facility Diversion:
1. Has resided 60-plus days in a nursing facility 2. Willing to live in an assisted living setting as an alternative to a nursing facility 3. Able to reside safely in an ALF with appropriate and cost-effective supports	1. Interested in remaining in the community 2. Willing and able to reside safely in an ALF with appropriate and cost-effective supports and services 3. Must be currently receiving medically necessary nursing facility LOC, or meet the minimum criteria to receive nursing facility LOC services, and, in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF

***Members must be agreeable to moving out of the nursing facility

Ineligible (Denial):

Individuals are directly responsible for paying their own living expenses. Community Supports will supplement, but not supplant services received by the Medi-Cal beneficiary through other state, local or federally funded programs, in accordance with CalAIM Special Terms and Conditions (STCs) and federal and DHCS guidance.

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
Nursing Facility TRANSITION/ DIVERSION			
T2038U4	Community transition	1 unit per service	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

One year

How it Works:

- CalOptima Health will receive the referral form.
    - For member's residing in long-term care, CalOptima Health LTSS staff will upload the following documents into CalOptima Health (SafetyNet) Connect:
        - H&P form for long-term care facility
        - SW's notes from the long-term care facility (including any financial documentation available)
        - Care plan
- Provider will accept the referral via CalOptima Health (SafetyNet) Connect.
- Provider will contact member and establish rapport.

    - Provider will decide if member is appropriate for the CalAIM Community Support or if member will be better served using an alternative program (such as CCT/HCBA waiver) based on the provider's initiated screening process.
    - Depending on provider, the process will be to either:
        - Refer member to CCT or other appropriate waiver programs
        - Submit the authorization request to begin services
- When/if the provider submits the authorization request:
    - LTSS CalAIM team will approve authorization within CalOptima Health (SafetyNet) Connect.

Number of Units to Authorize:

Request 9,999 unit in the authorization

Billed amounts should be reported on each encounter. Multiple encounters may be submitted for a single transition if different services are involved. A transition can also be indicated on a single encounter with a begin and end date.

Additional Tools and Documentation Needed:

None.

FAQ:

1. **Is CalOptima Health offering the wrap-around supports listed in the DHCS Policy Guide?**
   At this time CalOptima Health is not offering the wrap-around services listed in the DHCS Policy Guide, such as assistance with ADLs and iADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment that includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

Community Supports: Environmental Accessibility Adaptations (EAA) (Home Modification)

Definition of Service:

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 and without which the member would require institutionalization.

The services are available in a home that is owned, rented, leased or occupied by the member.

EAAs are payable up to a total lifetime maximum of $7,500.

Covered Services:

Item
ADA-accessible bathroom remodel (e.g., constructing a roll-in shower)
Chair lifts
Doorway widening for members who require a wheelchair
Drywall and painting to return the home to a habitable condition, but do not include aesthetic embellishments
Installation of specialized electric systems necessary to accommodate the medical equipment and supplies of the member
Installation of specialized plumbing systems that are necessary to accommodate the medical equipment and supplies of the member
Grab bars
Labor
Ramps (permanent)
Stair lifts

Other (justify in notes section)

Eligibility:

Individuals at risk for institutionalization in a nursing facility

Ineligible (Denial):

Service does not allow for additions to the home to add square footage.

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS			
T1028U6	Assessment	1 unit = per service	**Place of Service Code reference listing POS 12 (Home) is only acceptable
S5165U6	Modification	1 unit = per service	**Place of Service Code reference listing POS 12 (Home) is only acceptable

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

Assessment = 90 days

Modification = One year

How it Works:

- CalOptima Health will receive the referral form and sends to Community Supports provider via CalOptima Health (SafetyNet) Connect.
- Provider will accept the referral via CalOptima Health (SafetyNet) Connect.
- Provider will submit authorization request for the Home Modification Assessment (T1028U6).
- CalOptima Health will approve the assessment authorization. In the future, this will be automatically approved by CalOptima Health within CalOptima Health (SafetyNet) Connect. For now, this will require a manual approval by the LTSS CalAIM team.
- Provider will contact member and establish rapport.
    - Provider will decide if member is appropriate for the CalAIM Community Support or if member will be better served using an alternative program.
    - Provider will complete the Screening Tool.
    - Depending on provider, the process will be to either:
        - Refer to CCT or other appropriate waiver programs
        - Continue process for CalAIM Community Supports services

- Provider will complete the Home Assessment Tool.
- If there are home modifications that are needed to be completed prior to move-in, the provider will coordinate the following process:
    - Provider will fax a copy of the Home Assessment Tool to **714-481-6516** if the anticipated modification will exceed $2,500.
    - CalOptima Health physical therapist will review the tool and determine if a home visit (in-person or virtual) is required.
    - If a home visit is required, the CalOptima Health physical therapist will provide dates and times to the provider when they are available to complete the assessment and the provider will coordinate and schedule the assessment directly with the member.
    - CalOptima Health physical therapist will complete the Approved LOR Form.
    - CalOptima Health physical therapist will complete the assessment in the CalOptima Health EMR system and fax a PDF to the provider for review.
    - For all proposed permanent modifications to the home, the provider must give the member and landlord a copy of the Approval of Permanent Modification for CalAIM Community Supports Home Modification/Asthma Remediation Repairs.
        - Provider will complete a portion of the document on behalf of the member.
        - The homeowner will need to sign the document.
        - The signed document will be returned to the provider.
    - Provider then uploads the following documents into CalOptima Health (SafetyNet) Connect along with the Authorization Request:
        - Signed copy of the Approval of Permanent Modification for CalAIM Community Supports Home Modification/Asthma Remediation Repairs (if service is permanent)
        - Any required bids that the provider obtained for the completion of the work (two bids are required for work that costs less than $2,500)
    - Provider submits authorization request into CalOptima Health (Safety Net) Connect.
    - LTSS CalAIM team will review the documentation and approve the authorization in CalOptima Health (SafetyNet) Connect.
    - Provider can commence remediations to the member's home.
    - Provider will upload all receipts and complete the invoice tracker within the CalOptima Health (SafetyNet) Connect System.
    - Once all remediations are complete:
        - Provider completes a Notice of Completion of CalAIM Community Supports Home Modification/Asthma Remediation Repairs and obtains a signature from the homeowner.
        - Provider uploads signed Notice of Completion of CalAIM Community Supports Home Modification/Asthma Remediation Repairs into CalOptima Health (SafetyNet) Connect.
- Provider sends a copy to member's PCP.

Number of Units to Authorize:

9,999 units assessment

9,999 units modification

Requires all billed amounts to be reported

Additional Tools and Documentation Needed:

- Invoice Tracker Tool used within CalOptima Health (SafetyNet) Connect

- Receipts uploaded of all purchases including deposits, home modifications and moving expenses
- Two bids (if required)
- Home Assessment Tool
- Approval of Permanent Modification for CalAIM Community Supports Home Modification/Asthma Remediation Repairs
- Notice of Completion of CalAIM Community Supports Home Modification/Asthma Remediation Repairs
- Copy of LOR Form completed by CalOptima Health physical therapy staff (if applicable)

FAQ:

1. **Are there any exceptions to the $7,500 lifetime maximum?**
   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.

2. **If the member only rents, can they still use this service?**
   The services are available in a home that is owned, rented, leased or occupied by the member or their caregiver.

3. **What happens if the item that is modified breaks? Will CalOptima Health replace it?**
   CalOptima Health and the state are not responsible for maintenance or repair of any modification, nor for removal of any modification if the member ceases to reside at the residence. We have the property owner sign the Notice to Property Owner of Permanent Modification Form to ensure there is documentation that the member and the property owner are both aware prior to the remediations being performed. This document is kept in CalOptima Health EHRs.

4. **What if the landlord refuses to sign the Notice to Property Owner of Permanent Modification Form?**
   Unfortunately, if the landlord is not agreeable to the modification, CalOptima Health and the Community Supports provider are unable to complete the remediation.

5. **Can a member use this service at the same time as another state program?**
   If another state plan-funded program is available and would accomplish the same goals of independence and avoidance of institutional placement, that program should be utilized in lieu of this service.

6. **Do these modifications need to have permits and abide by building codes?**
   EAAs must be conducted in accordance with applicable state and local building codes.

7. **If there are multiple members in the same home that will benefit from these modifications, can they each qualify for the $7,500?**
   Each eligible member can be referred to this service. CalOptima Health will review each request on a case-by-case basis, but if the determination is made that both members need the service, then both will receive authorization approval.

8. **If this Community Support is being used to supplement funding from an alternative program or waiver, do they need to repeat the bids and all documents?**

Per DHCS guidelines, the assessment and authorization for EAAs must take place within a 90-day time frame. The Community Supports provider may use the same assessments if they are within the required timeframe, following CalOptima Health requirements.

Community Supports: Personal Emergency Response System (PERS)

Definition of Service:

PERSs are for members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision. This service falls under the EAA (Home Modifications) Community Support and thus the monthly service costs and any instillation are deducted from the total EAA lifetime maximum of $7,500.

As defined in the DHCS Policy Guide, EAAs are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home and without which the member would require institutionalization.

Eligibility:

Individuals at risk for institutionalization in a nursing facility

Ineligible (Denial):

Individuals who are not at risk for institutionalization in a nursing facility

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**

PERS			
S5165U6	Modification	1 unit = 1 month of service	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

Refer to diagnosis codes for SDOH from DHCS APL 21-009

Length of Authorization:

One year

How it Works:

- CalOptima Health will receive the referral form and sends to Community Supports provider via CalOptima Health (SafetyNet) Connect.
- Provider will accept the referral via CalOptima Health (SafetyNet) Connect.
- Provider will submit an Authorization Request into CalOptima Health (SafetyNet) Connect.
- LTSS CalAIM team will approve the Authorization Request within CalOptima Health (SafetyNet) Connect.
- Provider will initiate services directly with the member for any installation.
- Provider will generate an invoice in CalOptima Health (SafetyNet) Connect on a monthly basis.
- CalOptima Health (SafetyNet) Connect generates an invoice which is sent to CalOptima Health for Community Supports claims.

Number of Units to Authorize:

Authorize 9,999 units

All billed amounts must be reported

Additional Tools and Documentation Needed:

None

FAQ:

1. **Can more than one person in the home have a PERS?**
   The PERS authorization will be given to each unique member within the household who qualifies for the service individually.

2. **The monthly cost of PERS is constant. Does this come out of the same lifetime maximum as EAA? Will there be any exceptions for members who would benefit from both EAA home modification and PERS?**
   CalOptima Health will review any authorization requests for both EAA and PERS separately.

3. **What happens when the authorization expires after one year? Can it be renewed?**
   If the member needs ongoing PERS, the Community Supports provider is responsible to complete the referral (to self) and then submit the authorization request. The LTSS CalAIM team will approve the reauthorization following the steps above.

Community Supports: Respite

Definition of Service:

Provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis due to the absence or need for relief of those persons who normally care for and/or supervise the member and are non-medical in nature.

1. Services provided by the hour on an episodic basis due to the absence of or need for relief for those normally providing care to the member.

2. Services provided by day/overnight on a short-term basis due to the absence of or need for relief for those normally providing care to the member.

3. Services attend to the member's basic self-help needs and other ADLs, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Home respite services are provided to the member in his or her own home or another location being used as the home.

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.

- Members who receive caregiver benefits from other entities (IHSS, Community-Based Adult Services or a private caregiver) would have those hours subtracted from their total daily authorized respite hours.

Service limit is up to 336 hours per calendar year (24 hours x 7 days x 2 weeks= 336 hours).

Eligibility:

Individuals who live in the community and are compromised in their ADLs and therefore dependent upon a qualified caregiver who provides most of their support and who require caregiver relief to avoid institutional placement.

Ineligible (Denial):

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

HCPCS Codes:

COMMUNITY SUPPORTS CODING AND BILLING OPTIONS			
HCPCS LEVEL II CODE/MODIFIER	**HCPCS Description**	**Units of Service**	**Place of Service**
RESPITE SERVICES			
S5151U6	Hourly rate	1 unit = 1 hour and only one DOS per claim line	**Place of Service Code reference listing

Diagnosis Codes/SDOH Codes:

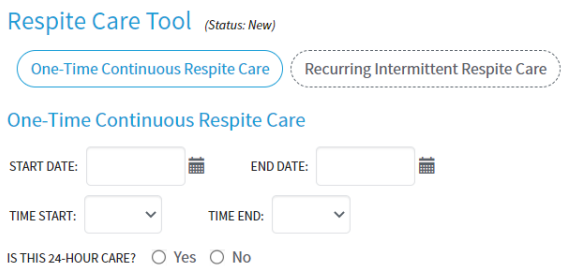
Refer to diagnosis codes for SDOH from DHCS APL 21-009

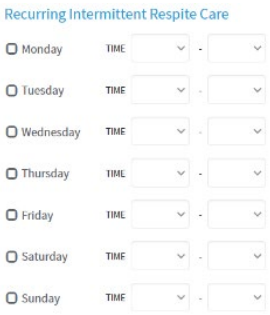
Length of Authorization:

One year

How it works:

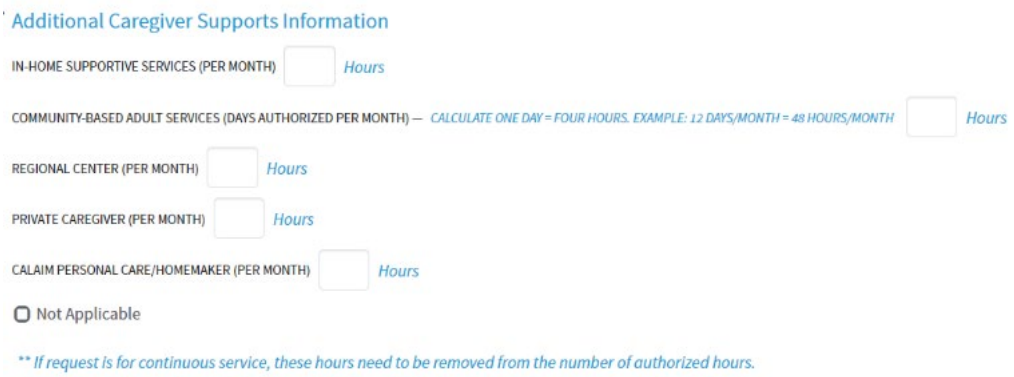
- CalOptima Health will receive a referral request
- LTSS CalAIM team will call and complete the respite questionnaire built into CalOptima Health (SafetyNet) Connect.
- The questionnaire will answer the following questions:
    - Dates and times respite is being request, split between continuous and intermittent requests





    - If this request is for around-the-clock care, we ask the caregiver or member and/or run reports to determine hours received from other programs including IHSS, Orange County Regional Center, etc.

- These hours will then be subtracted from the approved hours so as not to exceed 24 hours of combined care within a 24-hour timeframe (Only applicable to continuous respite care requests).



- There are six questions that rank the member's ability to perform ADLs/iADLs and a question related to dementia, based on the FAST scale. There is also an optional free text area to describe any known behaviors.

- Once the LTSS CalAIM team have completed the questionnaire, they will contact providers who show available capacity in CalOptima Health (SafetyNet) Connect via a telephone call or via the CalOptima Health (SafetyNet) Connect inbox messaging portal, depending on the urgency of the request.
- The LTSS CalAIM team will provide details about the dates and times being requested and how many hours will be approved for the member.
- The provider can verbally accept the referral based on the conversation.
- The LTSS CalAIM team obtains the verbal acceptance and will send the formal referral through CalOptima Health (SafetyNet) Connect.
- The provider will be able to access the member's questionnaire and make a final determination of whether they are able to accept the member and staff the case.
- If the provider decides they cannot meet the member's needs, they can decline the referral within CalOptima Health (SafetyNet) Connect.
- Once the provider accepts the member, they will submit an authorization request for the number of hours (336, unless otherwise specified within the questionnaire).
- LTSS CalAIM team will approve the authorization request and the provider can initiate services.

Number of Units to Authorize:

The Respite Questionnaire completed by CalOptima Health staff will indicate any hours that need to be subtracted from the 336 hours. The number of approved hours will be communicated to the provider when the referral/communication occurs.

Additional Tools and Documentation Needed:

CalOptima Health has created a Respite Questionnaire and built it into CalOptima Health (SafetyNet) Connect. This questionnaire will be completed by the member or member representative and the HN or community support provider representative. This assessment cannot be completed by the respite company representative.

FAQ:

1. **How do you define a caregiver?**
   A caregiver is someone who assists the member with their basic self-help needs and other ADLs, including interaction, socialization and continuation of usual daily routines.

2. **Are children eligible?**
   Children who previously were covered for respite services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, members enrolled in either California Children's Services or the Genetically Handicapped Persons Program (GHPP) and members with complex care needs are eligible.

3. **Are there any exceptions to the 336 hours?**
   Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization.

4. **What if the IHSS hours is 10 per week, how do we subtract the daily?**
   For continuous hours these will be automatically subtracted in CalOptima Health (SafetyNet) Connect. For intermittent requests there is no need to subtract those hours.

5. **What is the average number of hours per week if a member wanted to utilize the service only one day per week?**
   Maximum annual approved is 336 hours per year (if request is spread over one year) with a recommendation of 6.46 hours per week. CalOptima Health recommends that members work directly with their respite provider to ensure that the member's needs are met.

6. **When should this authorization be ended?**
   This authorization is given for dates of service of one year from the original date. As soon as the member utilizes the full amount of the approved hours, the respite provider will request a discharge within the CalOptima Health (SafetyNet) Connect system. This will trigger CalOptima Health to end the authorization.