PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="5">Policy/Procedure Number: MCUP3142</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="5">Policy/Procedure Title: CalAIM Community Supports (CS)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/09/2022
Effective Date: 01/01/2022 vs. DHCS</td><td colspan="5">Next Review Date: 01/10/2025
Last Review Date: 01/10/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="4">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td colspan="2">☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="4">Approval Date: 01/10/2024</td></tr>
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I. RELATED POLICIES:

A. MCCP2032 – CalAIM Enhanced Care Management (ECM)
B. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
C. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
E. MCUP3103 – Coordination of Care for Members in Foster Care
F. MPCR100 – Credential and Re-credential Decision Making Process
G. MPPR200 – PHC Provider Contracts

II. IMPACTED DEPTS:

A. Health Services
B. Care Coordination
C. Claims
D. Finance
E. Member Services
F. Provider Relations
G. Administration

III. DEFINITIONS:

A. Community-Based Organizations (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.
B. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).
C. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
D. Community Supports (CS) Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports
E. In Home Supportive Services (IHSS) Program: The In-Home Supportive Services (IHSS) program is a Medi-Cal program funded by federal, state, and county dollars to provide in-home assistance to eligible aged (over the age of 65), blind and disabled individuals as an alternative to out-of-home care.

F. Whole Person Care (WPC): A five-year pilot program under California's 1115 Medicaid waiver to service high-risk populations using a collaborative approach across public and private entities to integrate and coordinate health, behavioral health, and social services. PHC counties participating in the WPC pilot program include Marin, Mendocino, Napa, Shasta, and Sonoma.

IV. ATTACHMENTS:

A. Community Supports Criteria Matrix and Community Supports HCPCS Code Chart

V. PURPOSE:

To describe how Partnership HealthPlan of California (PHC) administers Community Supports (CS) for PHC Medi-Cal eligible beneficiaries and to outline the collaboration between members, PHC, providers, county agencies, community resources, and Community Based Organizations (CBOs). Pursuant to the Department of Health Care Services (DHCS) All Plan Letter (APL) 21-017 *Revised*, Community Support services are not plan benefits, but are instead optional services that PHC may authorize for members to save health care costs while promoting better health outcomes for the member. Community Supports builds upon the design and learning from California's Whole Person Care (WPC) and Health Homes Program (HHP) and are a part of DHCS' waiver under CalAIM. The goals of Community Supports are:

A. To place members in the least restrictive setting possible and keep them in the community.
B. Focus largely on Social Determinants of Health (SDOH) such as housing/shelter, food instability, transportation and community resources to improve medical health outcomes and healthcare costs.

VI. POLICY / PROCEDURE:

A. PHC ADMINISTRATION OF COMMUNITY SUPPORTS
   1. Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).
   2. Effective January 1, 2022, PHC offers the following DHCS approved CS services:
      a. Housing Transition Navigation Services
      b. Housing Deposits
      c. Housing Tenancy and Sustaining Services
      d. Short-Term Post-Hospitalization Housing
      e. Recuperative Care (Medical Respite)
      f. Meals/Medically Tailored Meals.
   3. Effective January 1, 2023, PHC offers the additional DHCS approved CS services:
      a. Respite Services
      b. Personal Care and Homemaker Services
   4. Upon approval by DHCS, PHC may elect to add additional CS services to their network every six (6) months.

B. COMMUNITY SUPPORTS ELIGIBIILTY CRITERIA:
   1. To be eligible to receive a CS service, the member and/or CS provider must demonstrate that the service will result in:
      a. A decrease in utilization and/or cost for a subsequent Medi-Cal benefit. Examples include, but are not limited to:
         1) Hospitalization (Medical or Behavioral Health conditions)
         2) Nursing Facility care
         3) Emergency Department use
   2. CS services must be reviewed and pre-authorized as per policy MCUP3143 Service Authorization

Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

3. CS services are optional services that PHC may offer and services that a member can decline or end at any time.
    a. The CS service provider is responsible for obtaining the member's consent for service and data sharing (when required by federal law) and remitting the consents to PHC along with other documents pursuant to policy MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
4. Please see Attachment A for PHC's methodology to ensure an appropriate, equitable, and non-discriminatory approach when reviewing and authorizing CS services.
    a. In the event PHC identifies the CS service authorization has an inappropriate, inequitable, and/or discriminatory effect, PHC will take immediate action and set a Correction Action Plan (CAP), one-on-one meetings, and follow-ups to guarantee CS services providers and/or delegates adhere and align to PHC policies and procedure; if a provider fails to adhere to the Corrective Action Plan, it may be decided to terminate the provider's contract.

C. MEMBER IDENTIFICATION AND REFERRAL FOR COMMUNITY SUPPORT SERVICES

1. PHC shall utilize a variety of methods to identify members who may benefit from CS, including:
    a. Working with ECM Providers to identify members receiving ECM who could benefit from CS
    b. Proactively identifying members who may benefit from the PHC's CS services, through the use of information such as:
        1) Enrollment data
        2) Utilization/claims data
        3) Screening or assessment data, when available (ex: HRA, IHA, HIF, ACEs, etc.)
        4) Clinical information on physical and/or behavioral health
        5) Severe Mental Illness (SMI)/Substance Use Disorder (SUD) data, when available
        6) Risk stratification information for children in PHC's Whole Child Model (WCM)
        7) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other relevant information
    c. Identification and referral by internal PHC departments (ex: Care Coordination, Claims, Utilization Management, Quality, Member Services, Population Health Management, etc.)
2. PHC encourages direct referrals for members to access CS services. These direct referrals can come from a multitude of sources, including but not limited to:
    a. PCPs, specialists, ECM providers, and/or CBOs via phone, mail, or fax.
    b. Members and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) via phone, mail, or PHC member portal.
3. Upon internal identification or direct referral for a member who may potentially benefit and/or be eligible for a CS service, a referral shall be sent to PHC's Care Coordination department. The staff in the Care Coordination department shall attempt to contact the member, CS provider, and/or the member's caregiver, AR, or Lead Care Manager to refer the member to the CS service within ten (10) Business Days. Once a member is referred to a CS provider, the CS provider has two (2) business days to:
    a. Notify PHC that they received and accept the referral, and
    b. Attempt to contact the member or their representative to begin services, or
    c. Notify PHC that the CS provider is at full capacity pursuant to their contract with PHC so that the member can be re-referred to an alternative provider
4. PHC's Care Coordination department shall document and track the CS referral in the appropriate system.
    a. If the member is receiving ECM, their Lead Care Manager shall document, coordinate and ensure closed-loop referrals and service delivery of the CS service(s) per the member's Individualized Care Plan. For more information, see MCCP2032 CalAIM Enhanced Care

Management (ECM).

5. Members may be referred more than once for CS Services; members must engage with PHC and/or CS providers to qualify for services.
   a. Members who do not engage or are unresponsive to the CS Provider and/or PHC may not be authorized for CS Services again until the member is willing to engage and maintain communication.
   b. The member is responsible for a means to communicate with the CS Provider and/or PHC.
6. If referral lacks required information, PHC will make one (1) attempt to contact the referring party (e.g. case worker, lead care manager, etc.) or member to gather more information, however, member will be responsible to continue communication with PHC and/or CS provider to prevent cancelation of services.

D. DISCONTINUATION OF COMMUNITY SUPPORT SERVICES
1. The CS provider shall notify PHC, and the inter-disciplinary care team (ex. PCP, Lead Care Manager, etc.) when a member discontinues CS services. Examples of discontinuation include, but are not limited to:
   a. The member has met their goals for the service and/or their service limitations pursuant the approved CS Treatment Authorization Request (TAR)
   b. The member expresses that he/she no longer wishes to receive the CS service
   c. The member is unresponsive or unwilling to engage with the CS provider and/or attempts from an ECM provider or Lead Care Manager (when applicable). Providers must make a minimum of three (3) outreach attempts. If no response, the CS provider must contact PHC immediately for further direction.
   d. The member is deceased
   e. The member loses PHC Medi-Cal eligibility
   f. The member moves out of PHC's service area
   g. The member becomes incarcerated for more than 30 days
   h. The CS provider can no longer provide services (e.g.: patient behavior, unsafe environment, etc.)
2. The CS provider may submit other reasons to request that the member discontinue services, for which PHC will review on a case-by-case consideration.

E. COMMUNITY SUPPORTS PROVIDERS
1. PHC shall contract with both traditional and/or non-traditional providers for the provision of CS services. CS Providers can include, but are not limited to, those listed in the Medi-Cal Community Supports, or In Lieu of Services (ILOS) Policy Guide – under "Licensing/Allowable Providers."
2. Providers must communicate with PHC and provide weekly updates through email, phone calls, meetings, etc. until the member is engaged and participating. When the member is engaged, a TAR should be submitted to authorize services for a specified period of time, which will allow the provider to submit claims for their services.
3. All CS providers must have experience and expertise with the services they provide. To demonstrate such, all CS providers must complete PHC's CS Provider "Readiness Assessment" prior to contracting.
4. All CS providers must have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition.
5. All CS providers shall prioritize referrals for PHC members in a non-discriminatory manner and shall not, without the expressed consent of PHC, keep or maintain "waitlists" for members referred or approved for a CS service.
   a. To the extent possible, PHC shall prioritize the member's preference for a CS provider.
6. Pursuant to their contracts, CS providers must maintain their stated capacity/volume levels for the provision of the CS service. CS providers must communicate to PHC within five (5) business days if

they have changes to their organization's capacity or staffing levels.

7. All CS providers must be enrolled with Medi-Cal pursuant to relevant DHCS APLs including APL 19-004 Provider Credentialing/Recredentialing and Screening/Enrollment.
    a. For providers that do not have a pathway to state-level enrollment, PHC requires that they meet and adhere to PHC's contract standards. See policies MPPR200 PHC Provider Contracts and MPCR100 Credential and Re-credential Decision Making Process.

F. COMMUNITY SUPPORTS CORE SERVICE COMPONENTS:
The following CS services shall be offered pursuant to the definitions and standards set forth by DHCS in the CalAIM Waiver and per the DHCS contract for the following PHC approved CS services:

1. Housing Transition Navigation Services:
    a. Conducting tenant screening(s) and/or assessment(s) to identify the member's preferences and barriers related to a successful tenancy
    b. Development of an individualized housing support plan that contains both short-term and long-term goals, as well as a housing support crisis plan
    c. Searching for housing, presenting options, and assisting with requests for reasonable accommodations if necessary
    d. Assistance in securing housing via direct support with applications, documentation requirements, advocacy, etc.
    e. Landlord education and engagement including advocacy on behalf of a member when necessary
    f. Identification and coordination of benefits and resources to secure costs such as security deposits, moving costs, adaptive aids, environmental modifications, and/or other one-time expenses. These services do not assist members with ongoing rental costs.
    g. Identification, coordination, and/or securing non-emergency, non-medical transportation (NMT)
2. Housing Deposits:
    a. Housing deposits may be approved based on the individualized assessment of need and documented in the member's individual housing support plan.
        1) The housing deposit may be used to secure a one-time service/funding to enable a person to establish a basic household that does not constitute room and board or ongoing rental cost.
            a) Housing Deposits can only be approved one additional time with documentation demonstrating what has changed and how this service would be more successful on the second attempt.
        2) Member must have been enrolled in Housing Transition Navigation Services for a minimum of 30 to 60 days and have a housing support plan.
        3) If approved, members may use the one-time benefit for a subset of the services below:
            a) Security deposits required to obtain a lease on an apartment or home
            b) Set-up fees/deposits for utilities or service access and utility arrearages
            c) First month coverage of utilities (e.g.: telephone, gas, electricity, heating, and water).
            d) First month's and last month's rent as required by landlord for occupancy
            e) Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy
3. Housing Tenancy and Sustaining Services
    a. Tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include, but are limited to:
        1) Early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations
        2) Education and training on the role, rights, and responsibilities of the tenant and landlord
        3) Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy
        4) Coordination with landlord and/or case management provider(s)

5) Development of a plan to mitigate risk to housing such as assistance in resolving disputes with landlords/neighbors, repayment plans for damage to unit or back rent, etc.
6) Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process
7) Assistance with the annual housing recertification process
8) Health and safety visits, including unit habitability inspections
9) Providing independent living and life skills including assistance with and training on budgeting, financial literacy, and connection to community resources

b. This service is available only for a single duration in a member's lifetime.
   1) Housing Tenancy and Sustaining Services may be approved for one additional time with documentation demonstrating what has changed and how this service would be more successful on the second attempt.

4. Short-Term Post-Hospitalization Housing
   a. For members exiting an inpatient hospital setting such as:
      1) An acute or psychiatric or Chemical Dependency and Recovery hospital
      2) Residential substance use disorder treatment or recovery facility
      3) Residential mental health treatment facility
      4) Correctional facility, or
      5) Nursing facility
   b. These services are intended to provide on-going support necessary for recuperation and recovery (e.g. gaining or re-gaining the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management, and beginning to access other housing supports such as Housing Transition Navigation, etc.)
5. Recuperative Care (Medical Respite)
   a. At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring, etc.).
   b. Based on individual needs, the service may also include:
      1) Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
      2) Coordination of transportation to post-discharge appointments
      3) Connection to any other on-going services an individual may require including mental health and substance use disorder services
      4) Support in accessing benefits and housing
      5) Gaining stability with case management relationships and programs
6. Meals/Medically Tailored Meals.
   a. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission
   b. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases
   c. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes
      1) Chronic conditions such as, but not limited to, Diabetes, Cardiovascular Disorders, Congestive Heart Failure, Stroke, Chronic Lung Disorders, Human Immunodeficiency Virus (HIV), Cancer, and chronic or disabling mental/behavioral health disorder.
7. Respite Services (Effective January 1, 2023)

a. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals. Services are provided in the member's own home or in an approved out-of-home location.
b. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
c. Services cannot be provided virtually, or via telehealth.
d. Services that attend to the participant's basic self-help needs and other activities of daily living.
e. Hours approved by the plan will be based on the individual's assessment of needs.
f. Service limit is up to 336 hours per calendar year.
g. Subsets may include children who were previously covered under:
    1) Pediatric Palliative Care
    2) Foster Care Programs
    3) California Children's Services (CCS)
    4) Generally Handicapped Persons Program (GHPP)
    5) Clients with complex care needs

8. Personal Care and Homemaker Services (Effective January 1, 2023)
    a. Above and beyond any approved county In-Home Supportive Services (IHSS) hours, when additional hours are required and if IHSS benefits are exhausted; and
    b. As authorized during any IHSS waiting period (member must be already referred to IHSS); this approval time period includes services prior to and up through the IHSS application date.
    c. For members not eligible to receive IHSS, to help avoid a short-term stay in a skill nursing facility (not to exceed 60 days).
    d. Services can only be utilized if appropriate and if additional hours/supports are not authorized by IHSS.
    e. Total number of awarded IHSS hours for the member will be requested to ensure adequate hours for the individual's needs.
    f. Services cannot be utilized in lieu of referring to the IHSS Program.
    g. Personal Care and Homemaker Services are only allowed four (4) hours a day for up-to 20 hours a week, or as determined by the intake assessment.

G. CONTINUITY OF CARE
1. Effective January 1, 2022, for members who were enrolled in a Whole Person Care Pilot program, and identified by the WPC Lead entity as in receipt of a corresponding CS that PHC intends to offer, PHC automatically authorized CS services for six (6) months pursuant to DHCS implementation schedule.
    a. PHC notified all members transitioning from WPC who were receiving PHC CS service of the transition of their services 30 days prior to their transition date.
    b. CS providers submitted a Treatment Authorization Request (TAR) to PHC within six (6) months of the member's transition. PHC reviewed the authorization using the CS criteria set forth in policy MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).
2. In HHP and WPC Pilot Counties, PHC contracted with WPC Lead Entities and HHP CB-CMEs as CS Providers unless PHC received prior written approval from DHCS.
3. Members transitioning to PHC from another managed care plan and /or fee-for-service Medi-Cal who are currently receiving a Community Support that is currently being offered by PHC, shall automatically be authorized for CS services. For these members:
    a. PHC shall use available utilization data to proactively identify any new members who are in receipt of a Community Support service within the previous 90 days of their assignment to PHC, and initiate continued Community Support authorization.
    b. Newly assigned PHC members or their AR may contact PHC directly to request continued

Community Support Services, and PHC shall expedite this request.

c. PHC is not obligated under DHCS continuity of care requirements to keep the member assigned to the same CS provider, however, whenever possible PHC shall make a good faith effort to keep the member's CS provider the same.
d. PHC shall contact and work with the member's previous health plan and/or CS provider to obtain access to the Member's ICP and ensure services are connected appropriately.
e. PHC intends to adhere to Continuity of Care guidelines for transitioning members receiving CS services not offered by PHC but offered by a previous MCP. Members who have an active prior authorization for services not offered by PHC at the time of the transition will be authorized for a six-month span of the service. Requests for additional date spans will be reviewed on a case-by-case basis.

H. DATA SHARING TO SUPPORT COMMUNITY SUPPORTS
1. PHC shall support CS providers to access systems and processes allowing the CS provider to obtain and document Member information including eligibility, CS authorization status, Member authorization for data sharing (to the extent required by federal law), and other relevant demographic and administrative information, and to support notification to the member's PCP and/or interdisciplinary care team when a referral has been fulfilled. Examples include but are not limited to:
   a. Encounter / claims data
   b. Physical, behavioral, administrative, and SDOH data (e.g., HMIS data).
   c. Quality Reports
2. PHC has an IT and data analytic infrastructure to support the delivery of the CS services. Key features of PHC's systems include, but are not limited to:
   a. Securely share data between, PHC, the CS provider, the member, and other providers in support of the CS service
   b. The ability to receive, process, and send encounters from CS providers to DHCS
   c. The ability to receive and process supplemental reports from CS providers
   d. The ability to receive and process electronic claims and/or invoices from an CS provider
   e. The ability to track CS grievances and appeals for PHC
   f. PHC will support CS Provider access to systems and processes allowing them to track and manage referrals for CS and Member information.
3. PHC will use defined Federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with CS Providers and with DHCS, to the extent practicable.
4. Effective September 1st, 2023, PHC will follow guidance provided by DHCS in the most current version of the document "CalAIM Data Guidance: Community Supports Member Information Sharing."
   a. PHC will share the required CS Authorization Status File (CS-ASF) data elements with contracted providers monthly using a Secure File Transfer Portal (s-FTP)
   b. CS contracted Providers will share the required CS Provider Return Transmission File (CS-RTF) data elements with PHC monthly using a Secure File Transfer Portal (s-FTP)

I. COMMUNITY SUPPORTS PROVIDER OVERSIGHT & QUALITY MONITORING
1. PHC will perform oversight of CS providers, holding them accountable to all applicable requirements contained in the DHCS Contract amendment and DHCS APL 21-017 *Revised*.
   a. PHC will perform quarterly audits, or more frequently as needed, to evaluate CS provider performance and compliance to ensure State, Federal, and contractual requirements are met. At a minimum, the following will be reviewed:
      1) PHC internal monitoring reports
         a) Utilization Reports
         b) Cost Reports

c) Referral Reports

2) Quality reports (e.g. Member Experience surveys)

3) CS TARs to ensure they are equitable and non-discriminatory and have not had an inequitable effect

b. Data and outcomes concerning CS services will be aggregated quarterly and reported at PHC's Over/Under Utilization Review Committee and/or other Committees deemed appropriate.

2. PHC has developed its CS provider contracts using the DHCS ILOS Provider Standard Terms and Conditions and incorporated all of its CS provider requirements, including all monitoring and reporting expectations and criteria.
3. CS providers are responsible for timely and accurate submission of data to PHC for the purposes of reporting to DHCS.
4. PHC shall provide and make available CS training and technical assistance to CS providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in PHC's contract with DHCS in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

J. PAYMENT TO COMMUNITY SUPPORTS PROVIDER

1. To the extent possible, PHC encourages all of its CS providers to submit electronic claims to PHC for payment.
   a. When a CS provider does not have the ability to submit a claim electronically, PHC shall accept an invoice via mail.
      1) CS providers shall make a good faith attempt when remitting invoices to PHC for the purposes of reimbursement of approved CS services to use the necessary billing and member-specific encounter information for DHCS PHC validation and DHCS reporting purposes.
      2) Invoices sent via mail shall be processed in the same time frames as electronic claims.
      3) In the event of a request for expedited claim payment, the plan will review the request on a case-by-case basis.
      4) For more information on how to submit claims, refer to PHC's Provider Manual, Section 3: Claims at http://www.partnershiphp.org/Providers/Policies/Pages/Section3.aspx

K. DHCS COMMUNITY SUPPORTS REPORTING

1. PHC will submit the following data and reports to DHCS to support DHCS' oversight of CS:
   a. Encounter data
      1) PHC shall submit all CS encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
      2) PHC shall be responsible for submitting to DHCS all CS encounter data, including encounter data for CS generated under subcontracting arrangements.
      3) In the event the CS Provider is unable to submit CS encounters to PHC using the national standard specifications and code sets to be defined by DHCS, PHC shall be responsible for converting CS Providers' invoice data into the national standard specifications and code sets for submission to DHCS.
   b. Supplemental reporting
      1) Contractor shall submit supplemental reports on a schedule and in a format to be defined by DHCS.
   c. In the event of underperformance by PHC in relation to its administration of CS, DHCS may administer sanctions as set out in the DHCS Contract Exhibit E, Attachment 2, Provision 16, Sanctions.

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) 438.3(e)(2)

B. DHCS All Plan Letter (APL) 21-017 Community Supports Requirements (*Revised* 03/01/2022)
C. DHCS Contract Exhibit A, Attachment 5 Utilization Management; Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition; Exhibit A, Attachment 7, Provision 5, Network Provider Training
D. DHCS Contract Exhibit E, Attachment 2, Provision 16, Sanctions.
E. DHCS Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide (July 2023)
F. CalAIM Data Guidance - Community Supports Member Information Sharing (April 2023)
G. DHCS APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements (09/14/2023)

VIII. DISTRIBUTION:
A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 01/11/23; 06/14/23; 01/10/24

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual needs and the benefits covered under PHC.

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.