PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

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<tr><td colspan="5">Policy/Procedure Number: MPAP7003 (previously MCUP3142)</td><td colspan="3">Lead Department: Health Services
Business Unit: EHS</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 (MCUP3142)
Effective Date: 01/01/2022 (MCUP3142)</td><td colspan="5">Next Review Date: 02/11/2027
Last Review Date: 02/11/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="4">☒ Partnership Advantage</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="5">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 02/11/2026</td></tr>
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I. RELATED POLICIES:

A. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
B. MCAP7002 – CalAIM Enhanced Care Management (ECM)
C. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
E. MCBP8015 Coordination of Care for Child Welfare-Involved Members
F. MPUG3011 – Criteria for Home Health Services
G. MPCR100 – Credential and Re-credential Decision Making Process
H. MPPR200 – Partnership Provider Contracts
I. CMP36 – Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Health Services
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. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV

E. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and/or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

F. Community Supports (CS) Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports

G. Global Cap: Recuperative Care and Short-Term Post Hospitalization Housing (STPHH) cannot exceed a duration of six months (182 days) per rolling 12-month period and is subject to the six-month global cap on room and board services. This means a member may not receive more than a combined six months of STPHH and Recuperative Care services during any rolling 12-month period.

H. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (DSNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual-Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

I. Registered Dietician (RD) or Registered Dietician Nutritionist (RDN): An individual who has met current minimum (Baccalaureate) academic requirements with successful completion of both specified didactic education and supervised-practice experiences through programs accredited by The Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics and who has successfully completed the Registration Examination for Dietitians. To maintain the RD credential, the RD must comply with the Professional Development Portfolio (PDP) recertification requirements (accrue 75 units of approved continuing professional education every five years.)

J. 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.

K. Transitional Rent: Effective January 1, 2026, Partnership will add a DHCS mandatory Community Supports Service for members meeting the Behavioral Health Population of Focus (PoF) within the overall eligible population. To be eligible for Transitional Rent, members must meet at least one requirement in each of the three domains: Clinical, Social, and Transitioning Risk Factors.

L. 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. Partnership counties participating in the WPC pilot program include Marin, Mendocino, Napa, Shasta, and Sonoma.

IV. ATTACHMENTS:

A. Community Supports Criteria
B. Community Supports (CS) Release of Information (ROI)

V. PURPOSE:

To describe how Partnership HealthPlan of California administers Community Supports (CS) for Partnership members and to outline the collaboration between members, Partnership, 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 Partnership 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. PARTNERSHIP 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, Partnership 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)
   3. Medically Tailored Meals/Groceries Effective January 1, 2023, Partnership offers the additional DHCS approved CS services:
      a. Respite Services
      b. Personal Care and Homemaker Services
   4. Effective January 1, 2025, Partnership offers the additional DHCS approved CS Services:
      a. Day Habilitation Program
      b. Sobering Centers
   5. Effective January 1, 2026, Partnership offers the additional DHCS approved CS Services:
      a. Asthma Remediation
      b. Transitional Rent
   6. Upon approval by DHCS, Partnership 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 MCAP7001 Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
   3. CS services are optional services that Partnership 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 Partnership along with other documents pursuant to policy MCAP7001 CalAIM Service Authorization Process for

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

4. Please see Attachment A for Partnership's methodology to ensure an appropriate, equitable, and non-discriminatory approach when reviewing and authorizing CS services. This includes eligibility requirements as outlined by DHCS.
   a. In the event Partnership identifies the CS service authorization has an inappropriate, inequitable, and/or discriminatory effect, Partnership 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 Partnership 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. Partnership 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 Partnership'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 Partnership'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 Partnership departments (ex: Care Coordination, Claims, Utilization Management, Quality, Member Services, Population Health Management, etc.)
2. Partnership 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, secure electronic mail, 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 Partnership 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 Partnership's Enhanced Health Services (EHS) department. The staff in the EHS department shall review the referral for criteria and 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 Partnership that they received and accept the referral, and
   b. Attempt to contact the member or their representative to begin services, or
   c. Notify Partnership that the CS provider is at full capacity pursuant to their contract with Partnership so that the member can be re-referred to an alternative provider
4. Partnership's EHS 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 MCAP7002 CalAIM Enhanced Care Management (ECM).
5. Members may be referred more than once for CS Services; members must engage with Partnership and/or CS providers to qualify for services.
   a. Members who do not engage or are unresponsive to the CS Provider and/or Partnership 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 Partnership.

6. If referral lacks required information, Partnership 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 and referring party will be responsible to continue communication with Partnership and/or CS provider to prevent cancelation of services.
7. Partnership will track and monitor all referrals to ensure complete and necessary information is shared securely and efficiently.
8. Partnership will maintain timely data on referral status and intervene in support of individual referrals to improve member connections to services.
9. Partnership will collect the data on a monthly basis from the service providers.

D. DISCONTINUATION OF COMMUNITY SUPPORT SERVICES:
1. The CS provider shall notify Partnership, and the inter-disciplinary care team (e.g.,. 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 they no longer wish 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 Partnership immediately for further direction.
   d. The member is deceased
   e. The member loses Partnership Medi-Cal eligibility
   f. The member moves out of Partnership'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 Partnership will review on a case-by-case consideration.
3. If a member was not informed at the beginning of the service delivery via the provider, portal or Treatment Authorization Request (TAR), Partnership will send a Notice of Action (NOA) letter to inform a member when the CS service is ending or discontinuing. NOAs are not required if the member has opted out of the CS service.

E. COMMUNITY SUPPORTS PROVIDERS:
1. Partnership 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 Partnership 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 Partnership'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. Partnership will ensure members receive CS services within a timely manner. All CS providers shall prioritize referrals for Partnership members in a non-discriminatory manner and shall not, without

the expressed consent of Partnership, keep or maintain “waitlists” for members referred or approved for a CS service.

a. To the extent possible, Partnership 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 Partnership within five (5) business days if they have changes to their organization’s capacity or staffing levels. All CS providers must be enrolled with Medi-Cal pursuant to relevant DHCS APLs including APL 22-013 Revised Provider Credentialing/Recredentialing and Screening/Enrollment.
   a. For providers that do not have a pathway to state-level enrollment, Partnership requires that they meet and adhere to Partnership’s contract standards. See policies MPPR200 Partnership 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 Partnership approved CS services:

1. Housing Transition Navigation Services (HTNS)
   a. Services include:
      1) Conducting tenant screening(s) and/or assessment(s) to identify the member’s preferences and barriers related to a successful tenancy.
      2) Development of an individualized housing support plan that contains both short-term and long-term goals, as well as a housing support crisis plan that includes how the member will sustain housing.
      3) Assist searching for housing, presenting options, and assisting with requests for reasonable accommodations if necessary.
      4) Assistance in securing housing via direct support with applications, documentation requirements, advocacy, etc.
      5) Landlord education and engagement including advocacy on behalf of a member when necessary.
      6) Ensuring that the living environment is safe and ready for move-in.
      7) Assisting in, arranging for and supporting the details of the move.
      8) 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.
      9) Identification, coordination, and/or securing non-emergency, non-medical transportation (NMT).
      10) Members that are referred for HTNS should be offered enrollment in ECM, if not already enrolled.
      11) A member cannot receive HTNS and Housing Tenancy and Sustaining Services (HTSS) at the same time.
   b. Eligibility for HTNS:
      1) Social Risk Factor Requirement: Experiencing or at risk of homelessness based on HUD’s definition of homelessness AND
      2) Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors:
         a) Meets the access criteria for SMHS;
         b) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
         c) One or more serious chronic physical health conditions;
         d) One or more physical, intellectual, or developmental disabilities; or
         e) Individuals who are pregnant up through 12-months postpartum **OR**

3) Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTNS **OR**
4) Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.

2. Housing Deposits:
   a. Eligibility for Housing Deposits:
      1) Social Risk Factor Requirement: Experiencing or at risk of homelessness based on HUD's definition of homelessness AND
      2) Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors:
         a) Meets the access criteria for SMHS;
         b) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
         c) One or more serious chronic physical health conditions;
         d) One or more physical, intellectual, or developmental disabilities; or
         e) Individuals who are pregnant up through 12-months postpartum **OR**
      3) Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for Housing Deposits **OR**
      4) Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.
   b. Housing deposits may be approved based on the individualized assessment of need and documented in the member's individual housing support plan. Deposit TARs must be accompanied by a Housing Support Plan, a lease agreement or similar document and in the Housing Deposit Services Request for Funds form.
      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) If approved, members may use the one-time benefit, per waiver period, for a subset of the services below:
         a) Security deposits required to obtain a lease on an apartment or home in alignment with California Civil Code section 1950.5.
         b) Set-up fees/deposits for utilities or service access and utility arrears.
         c) First month coverage of utilities (e.g.: telephone, gas, electricity, heating, and water).
         d) Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
         e) Application fees to cover the cost of the lease application.
         f) Household items that a person needs to establish a basic household that do not constitute room and board as outlined in the Housing Deposit Services Request for Funds form.

3. Housing Tenancy and Sustaining Services (HTSS)
   a. Eligibility for HTSS:
      1) Social Risk Factor Requirement: Experiencing or at risk of homelessness based on HUD's definition of homelessness AND
      2) Clinical Risk Factor Requirement: Must have one or more of the following qualifying clinical risk factors:
         a) Meets the access criteria for SMHS;
         b) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
         c) One or more serious chronic physical health conditions;
         d) One or more physical, intellectual, or developmental disabilities; or
         e) Individuals who are pregnant up through 12-months postpartum **OR**
      3) Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTSS **OR**
      4) Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.
   b. Tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include, but are not 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.
      10) Education about Fair Housing and anti-discriminatory practices, including making requests for reasonable accommodation if necessary.
4. Short-Term Post-Hospitalization Housing (STPHH – Room and Board Service):
   a. Members are eligible if they meet all of the following criteria:
      1) Exiting an inpatient hospital setting such as:
         a) An acute or psychiatric or Chemical Dependency and Recovery hospital
         b) Residential substance use disorder treatment or recovery facility
         c) Residential mental health treatment facility
         d) Correctional facility, or
         e) Nursing facility AND
      2). Experiencing or at risk of homelessness AND
      3). Meeting one of the following criteria:

a) Are receiving ECM
b) Have one or more serious chronic conditions
c) Have a serious mental illness, or
d) Are at risk of institutionalization or requiring residential services as a result of a substance use disorder AND4). Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not in receipt of STPHH.

b. These services are intended to provide ongoing 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.).
c. STPHH cannot exceed a duration of six months (182 days) per rolling 12-month period and is subject to the six-month global cap on room and board services including Recuperative Care and Transitional Rent.

5. Recuperative Care (Medical Respite – Room and Board Service):
   a. Members are eligible for Recuperative Care if they meet **both** of the following criteria:
      1) Individuals requiring recovery in order to heal from an injury or illness AND
      2) Experiencing or at risk of homelessness
   b. 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.).
   c. An individual need not be exiting an institution to qualify but must have been determined by a contracted network provider or a clinical provider at Partnership to have medical needs significant enough to result in ED visits, hospital administration or other institutional care.
   d. Recuperative Care cannot exceed a duration of six months (182 days) per rolling 12-month period and is subject to the six-month global cap on room and board services including STPHH and Transitional Rent.
   e. Based on individual needs, the service may also include:
      1) Limited or short-term assistance with Instrumental Activities of Daily Living and/or Activities of Daily Living (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. Medically Tailored Meals/Groceries (MTM/G)
   a. Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders
   b. MTM/G may only be reimbursable when provided by an MTM/G vendor contracted and in good standing with Partnership.
   c. MTM/Gs must include an individual assessment of the member’s condition and nutritional needs conducted or overseen by a Registration Dietitian Nutritionist (RDN).
   d. Each MTM/G must be tailored by a RDN or appropriate clinician to ensure the food provided adheres to established, evidence-based nutrition guidelines to prevent, manage or reverse the

targeted health condition.

e. MTM/Gs must meet at least two-thirds of the daily nutrient and energy needs of an average individual.
f. Members receive no more than two meals a day for MTM and no more than one delivery per week for MTG.
g. Members should receive no less than one documented nutritional education session from a RDN within the first 30 days and a total of three (3) other touches from program staff within the 12-week period.
h. Per DHCS, MTM/G is not covered to respond to or address food insecurities and/or food disparities. Members experiencing food insecurities, shortages or disparities shall be referred to the appropriate community program. (ex-CalFresh, Meals on Wheels, etc.)
i. For members meeting criteria, MTM/G may be authorized for up to 12 weeks. Providers can request additional services via a new authorization. Additional services will require a report from the nutritionist or registered dietician outlining:
   1) The educational interventions to date identifying any member improvements to date,
   2) An explanation of why the member could not achieve stated goals during the initial authorization period,
   3) Any changes of medical condition(s) the member may have as documented by a medical provider if applicable, and
   4) How additional services would likely lead to member success and/or completion of goals.
j. Request for additional services beyond the 12-week period will not be approved if one or more of the following apply:
   1) The member and/or the member's authorized representative was unable or unwilling to engage with the MTM/G staff and/or RDN,
   2) No progress towards document goals,
   3) Meals and/or groceries are not being consumed by the member,
   4) As applicable, referrals to appropriate community programs for food insecurity or disparity are not made, and/or
   5) Other requirements of the program pursuant ot DHCS Community Support policy guidance are not being met in the initial period.
k. MTM/Gs are tailored to the medical needs of the member by a RDN 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:

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) Genetically Handicapped Persons Program (GHPP)

5) Clients with complex care needs
6) Individuals who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement

h. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
   1) Providers of Community Supports (including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs) must complete a self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator.
   2) Please refer to Policy MPUG3011 Criteria for Home Health Services for further information on EVV requirements.

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). Authorization should include information and the need for short term stay in a skilled nursing facility in the absence of PCHS being available.
   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. Member must be referred to the IHSS program when they meet referral criteria.
   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.
   h. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
      1) Providers of Community Supports (including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs) must complete a self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator.
      2) Please refer to Policy MPUG3011 Home Health Services for further information on EVV requirements.

9. Sobering Centers (Effective July 1, 2024)
   a. Will 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 counselling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.
   b. CS provider is required to provide direct coordination with the county behavioral health agency and warm hand-offs for additional behavioral health services are strongly encouraged.
   c. Service will also include screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options where applicable.
   d. CS providers will be required to partner with law enforcement, emergency personnel,

and outreach teams to identify and divert individuals to Sobering Centers.

e. CS providers must be prepared to identify members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.

f. CS providers will utilize best practices for members who are experiencing homelessness and who have complex health and/or behavioral health conditions including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma-informed care.

g. Eligible members are 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a sobering center.

h. Service is covered for a duration of less than 24 hours.

10. Day Habilitation Program (Effective January 1, 2025)

a. Provide in a member's home or an out-of-home, non-facility setting training on:
   1) The use of public transportation
   2) Personal skills development in conflict resolution
   3) Community participation
   4) Developing and maintaining interpersonal relationships
   5) Daily living skills (cooking, cleaning, shopping, money management
   6) Community resource awareness such as police, fire, or local services to support independence in the community.

b. Programs may include assistance with, but not limited to:
   1) Selecting and moving into a home
   2) Locating and choosing suitable housemates
   3) Locating household furnishings
   4) Settling disputes with landlords
   5) Managing personal financial affairs
   6) Recruiting, screening, hiring, training, supervising, and dismissing personal attendants
   7) Dealing with and responding appropriately to governmental agencies and personnel
   8) Asserting civil and statutory rights through self-advocacy
   9) Building and maintaining interpersonal relationships, including a circle of support
   10) Coordination with Partnership to link member to any CS or ECM for which the member may be eligible
   11) Referral to non-CS housing resources if member does not meet HTNS, HD, HTSS, or Transitional Rent eligibility criteria
   12) Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if member is not receiving these services through CS or ECM
   13) Coordination with Partnership to link member to health care, mental health services, and substance use disorder services based on the individual needs of the member for members who are not receiving this linkage through CS or ECM

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

d. Members eligible are individuals who are experiencing homelessness, who exited

homelessness and entered housing within the last 24 months, and those at risk of homelessness or institutionalization while housing stability could be improved through participation in a day habilitation program.

e. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
   1) Providers of Community Supports (including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs) must complete a self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator.
   2) Please refer to Policy MPUG3011 Criteria for Home Health Services for further information on EVV requirements.

11. Asthma Remediation (Effective January 1, 2026)
   a. Provide interventions to help manage acute asthma episodes which consist of supplies and/or physical modifications to a home environment that are necessary to ensure health, welfare, and safety of a member, or to enable a member to function in the home with reduced likelihood of experiencing acute asthma episodes.
   b. Supplies and/or physical modifications included but not limited to:
      1) High-Efficiency Particulate Air (HEPA) filtered vacuums
      2) Allergen-impermeable mattress and pillow dustcovers
      3) Integrated Pest Management (IPM) services
      4) De-humidifiers
      5) Mechanical air filters/air cleaners
      6) Other moisture-controlling interventions
      7) Minor mold removal and remediation services
      8) Ventilation improvements
      9) Asthma-friendly cleaning products and supplies
      10) Other interventions identified to be medically appropriate for the management and treatment of asthma.
   c. Asthma Remediation home modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments
   d. When authorizing physical modifications and supplies for Asthma Remediation as a Community Support, Partnership must receive and document that an assessment is completed.
   e. Asthma Remediation will supplement the Asthma Prevention Servies (APS) benefit. If another State Plan service beyond the APS, such as Durable Medical Equipment (DME), is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, the State Plan service should be accessed first.
   f. The services are available in a home that is owned, rented, leased, or occupied by the member or their caregiver.
   g. Services provided to a member need not be carried out at the same time but maybe spread over time, subject to lifetime total maximum of $7,500.
   h. Member must have poorly controlled asthma and criteria is as follows:
      1) An emergency department visit or hospitalization or two sick or urgent care visits due to asthma in the past 12 months **OR**
      2) Asthma Control Test score of 19 or lower **OR**
      3) Recommendation from a licensed health care provider

i. Documentation required:
   1) An emergency department visit or hospitalization or two sick or urgent care visits due to asthma in the past 12 months **OR**
   2) Asthma Control Test score of 19 or lower **OR**
   3) Recommendation from a licensed health care provider

j. Along with an in-home environmental trigger assessment performed within the last 12 months, the following information is required:
   1) Date of Home Visit
   2) Date of Scheduled Home Visit

k. An in-home environmental trigger assessment is defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants within the last 12 months. This assessment identifies medically appropriate Asthma Remediation such as the supplies, home modifications, and/or asthma self-management education about actions to mitigate or control environmental exposures offered to the member.

l. Asthma remediations must be conducted in accordance with applicable State and local building codes.

m. Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, Partnership must provide the owner and member with written documentation that the modifications are permanent and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable mattress and pillow dust covers, high-efficiency particulate air (HEPA) filtered vacuum, de-humidifiers, portable air filters, and asthma-friendly cleaning products and supplies.

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

o. Partnership shall monitor the provision of all the Asthma Remediation services.

p. All allowable providers must be approved by Partnership to ensure adequate experience and appropriate quality of care standards are maintained

q. Asthma Remediation Providers must enroll in the Medi-Cal program to continue providing in-home trigger assessments and asthma self-management education under the APS benefit.

G. CONTINUITY OF CARE

1. Members transitioning to Partnership from another managed care plan and /or fee-for-service Medi-Cal who are currently receiving a CS service that is currently being offered by Partnership, shall automatically be authorized for CS services. For these members:

a. Partnership shall use available utilization data to proactively identify any new members who are in receipt of a CS service within the previous 90 days of their assignment to Partnership and initiate continued CS authorization.

b. Newly assigned Partnership members or their AR may contact Partnership directly to request continued CS Services, and Partnership shall expedite this request.

c. Partnership is not obligated under DHCS continuity of care requirements to keep the member assigned to the same CS provider, however, whenever possible Partnership shall make a good faith effort to keep the member's CS provider the same.

d. Partnership 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. Partnership intends to adhere to Continuity of Care guidelines for transitioning members receiving CS services not offered by Partnership but offered by a previous MCP. Members who have an active prior authorization for services not offered by Partnership 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. Partnership 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. Partnership has an IT and data analytic infrastructure to support the delivery of CS services. Key features of Partnership's systems include, but are not limited to:
   a. Securely share data between Partnership, 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 a CS provider
   e. The ability to track CS grievances and appeals for Partnership
   f. Partnership will support CS Provider access to systems and processes allowing them to track and manage referrals for CS and member information.
3. Partnership 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, Partnership will follow guidance provided by DHCS in the most current version of the document "CalAIM Data Guidance: Community Supports Member Information Sharing."
   a. Partnership 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 Partnership monthly using a Secure File Transfer Portal (s-FTP)

I. COMMUNITY SUPPORTS PROVIDER OVERSIGHT AND QUALITY MONITORING

1. Partnership 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. Partnership 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) Partnership 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
      4) Required documentation such as member file, a Housing Support Plan, updated notes on

services and member encounters, etc.

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

2. Partnership 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 Partnership for the purposes of reporting to DHCS.
4. Partnership 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 Partnership'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, Partnership encourages all of its CS providers to submit electronic claims to Partnership for payment.
   a. When a CS provider does not have the ability to submit a claim electronically, Partnership shall accept an invoice via mail.
      1) CS providers shall make a good faith attempt when remitting invoices to Partnership for the purposes of reimbursement of approved CS services to use the necessary billing and member-specific encounter information for DHCS Partnership 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 Partnership's Provider Manual, Section 3: Claims at http://www.partnershiphp.org/Providers/Policies/Pages/Section3.aspx

K. DHCS COMMUNITY SUPPORTS REPORTING

1. Partnership will submit the following data and reports to DHCS to support DHCS' oversight of CS:
   a. Encounter data
      1) Partnership shall submit all CS encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
      2) Partnership 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 Partnership using the national standard specifications and code sets to be defined by DHCS, Partnership 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 Partnership in relation to its administration of CS, DHCS may administer sanctions as set out in the DHCS Contract Exhibit E, Provision 1.1.19, 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 III, 2.3 Utilization Management; 4.5 Community Supports

D. DHCS Contract Exhibit E, Provision 1.1.19, Sanctions.
E. DHCS Medi-Cal Community Supports Policy Guide, Volume 1 ~~and Volume 2~~ (April 2025)
F. DHCS Medi-Cal Community Supports Policy Guide, Volume 2 – Community Supports to Support Members Experiencing or At Risk of Homelessness (April 2025)
G. CalAIM Data Guidance - Community Supports Member Information Sharing (December 2024)
H. DHCS APL 22-013 Provider Credentialing/Re-credentialing and Screening/Enrollment (07/19/2022)
I. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)
J. DHCS APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements (09/14/2023)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer, Director of Enhanced Health Services

X. REVISION DATES:
Medi-Cal
MPAP7003 (02/12/2025)
11/12/25, ~~02/10/2026~~ 2/11/26

Partnership Advantage (Effective Jan. 1, 2027)
N/A

PREVIOUSLY APPLIED TO:
MCUP3142 (Archived 02/12/2025)
01/11/23; 06/14/23; 01/10/24

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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 Partnership 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 Partnership.

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