PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPAP7004 (previously MCCP2033)</td><td colspan="2">Lead Department: Health Services
Business Unit: EHS</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Community Health Worker (CHW) Services Benefit</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 02/08/2023 (MCCP2033)
Effective Date: 07/01/2022 vs. DHCS</td><td colspan="3">Next Review Date: 06/10/2026
Last Review Date: 06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 06/11/2025</td></tr>
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I. RELATED POLICIES:

A. MCND9001 – Population Health Management Strategy & Program Description
B. MCCP2032 – CalAIM Enhanced Care Management (ECM)
C. MCAP7003 – CalAIM Community Supports (CS)
D. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
E. MCUP3041 – Treatment Authorization Request (TAR) Review Process
F. MCUP3113 – Telehealth Services
G. MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers
H. MPAP7005 – Street Medicine

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Provider Relations
D. Member Services

III. DEFINITIONS:

A. California Integrated Care Management (CICM): California-specific requirements for integrated care coordination for specific vulnerable populations covered by Dual-Eligible Special Needs Plans (D-SNPs) as determined by the State.
B. 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.
C. Community-Based Organization (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.
D. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who

help address chronic conditions, preventive health care needs, and health related social needs within their communities.

E. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

F. 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.51532).

G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

H. Licensed Practitioner of the Healing Arts (LPHA): For the purposes of this policy, an individual who, within the scope of State law, has the ability and appropriate state licensure to independently make a clinical assessment, certify a diagnosis and recommend treatment.

I. Managed Care Plan (MCP): Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP).

J. 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 (D-SNP) 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.

K. Street Medicine: Refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment.

L. Supervising Providers: The organizations with which Partnership HealthPlan of California (Partnership) contracts that employ or otherwise oversee the CHWs. The Supervising Provider must be a licensed provider, a hospital including the Emergency Department (ED), outpatient clinic, local health jurisdiction (LHJ), or community-based organization (CBO). The Supervising Provider ensures that CHWs meet Department of Health Care Services (DHCS) qualifications as listed in APL 24-006, oversees CHWs and the services delivered to Partnership Members, and submits claims for services provided by CHWs.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the Community Health Worker (CHW) Medi-Cal benefit (effective July 1, 2022), including categories of service and pathways to CHW certification.

VI. POLICY / PROCEDURE:

A. Partnership recognizes the CHW benefit as a means to ensure that members have improved access to culturally competent services that link health and social resources with the intent to improve the overall

quality of health and wellbeing of the member population. CHW services may be provided through multiple entities including contracted primary care providers (PCPs), community-based organizations (CBOs), as well as via health plan staff trained to perform services normally provided by CHWs

B. CHW Qualifications
   1. Per APL 24-006 Community Health Worker Services Benefit, CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.
   2. CHWs must demonstrate, and Supervising providers must maintain evidence of, minimum qualifications that may be met through one of the following means:
      a. Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:
         1) CHW Certificate: A CHW Certificate allows a CHW to provide all covered CHW services including violence prevention services. It must be a valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas as determined by the Supervising Provider:
            a) communication
            b) interpersonal and relationship building
            c) service coordination and navigation
            d) capacity building
            e) advocacy
            f) education and facilitation
            g) individual and community assessment
            h) professional skills and conduct
            i) outreach
            j) evaluation and research, and
            k) basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider.
            l) Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in APL 24-006, including violence prevention services.
         2) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute.
            a) A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or completion of a general CHW Certificate.
      b. Work Experience Pathway: Individuals having at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and who demonstrate skills and practical training in the areas described above (as determined and validated by the Supervising Provider) may provide CHW services without a certificate for a maximum period of 18 months.
         1) A CHW who does not have CHW certification must earn certification, as described above, within 18 months of the first CHW visit provided to a Member.

   3. Supervising Providers will maintain evidence of CHWs completing a minimum of six hours of additional relevant training annually, which can be in core competencies or a specialty area.

C. Supervising Provider Responsibilities
   1. The Supervising Provider ensures that CHWs meet all required qualifications, maintains evidence of the CHW's experience (as mentioned in section VI.B.2.) and training, and oversees CHWs and the services delivered to Partnership Members.
   2. The Supervising Provider does not need to be the same entity as the Provider who made the referral for CHW services, nor do they need to have a licensed provider on staff in order to contract with Partnership to provide CHW services.
   3. Supervising Providers do not need to be physically present at the location when CHWs provide services to Members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider. However, the Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.
   4. Supervising Providers must provide direct or indirect oversight to CHWs.
      a. Supervising providers (or their Subcontractors contracting with or employing CHWs to provide covered CHW services to the MCP's Members) must ensure CHWs have adequate supervision and training.
      b. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of the care plan, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.
      c. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.
   5. See policy MPCR11 Credentialing of Community Health Worker (CHW) Supervising Providers for further information on credentialing requirements for Supervising Providers.

D. Partnership CHW Workforce Initiative
   1. Partnership actively supports local partnerships and CHW training across our network, including funding by the Health Resources and Services Administration (HRSA).
   2. Partnership encourages providers to integrate CHWs into basic Population Health Management (PHM) and preventive care, and to give anticipatory guidance in support of the primary care team, Enhanced Care Management (ECM) teams, and perinatal care teams.
   3. Partnership surveys our provider network periodically to get an understanding of how many CHWs are providing services, what area of focus/training the CHWs have, and if they have capacity for referrals from outside agencies.
   4. Partnership is actively building a mechanism for Partnership staff and outside providers to search for organizations with CHW capacity for outside referrals, so they can make referrals to CHWs matched to the needs of individual members.

E. Informing providers about the CHW benefit
   1. Partnership publicizes our current understanding of the regulatory framework for CHWs with our provider network and community-based organizations in community meetings, provider meetings, and in provider newsletters.
   2. Partnership's Provider Relations department educates providers on CHW services through the Medical Director's newsletter, Provider quarterly newsletters, bulletins, and other mechanisms of education to ensure providers know how to leverage this benefit on behalf of their members.

F. Informing members about the CHW benefit
   1. Partnership's Health Education team crafts communications that are culturally and linguistically appropriate and explain CHW services to our members. Details of the CHW benefit and services are outlined in Partnership's Evidence of Coverage (EOC), which is distributed annually to Partnership members by Member Services.

2. Partnership's Health Education team and Communications department collaborate to ensure there are written notices in the member newsletter and that the Partnership webpage is updated with these new services.
3. CHW can provide qualifying members with specific support and offer tailored communication about how these services can support their health and wellbeing. Members referred to these services can be provided with materials explaining the services and are given the option to opt out of CHW services.

G. Member Eligibility for CHW services

   a. Members who meet the eligibility criteria for receiving CHW services have a standing recommendation issued by DHCS. For CHW services rendered in the ED, the treating Provider may document the recommendation in the Member's medical record of the ED visit.

2. CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services. The recommending Provider, whom does not need to be Medi-Cal enrolled, must determine whether a Member meets eligibility criteria based on the presence of one or more of the following before recommending CHW services:
   a. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
   b. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
   c. Any stressful life event presented via the Adverse Childhood Events (ACEs) screening.
   d. Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
   e. Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
   f. One or more visits to a hospital emergency department (ED) within the previous six months.
   g. One or more hospital visits or hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
   h. One or more stays at a detox facility within the previous year.
   i. Two or more missed medical appointments within the previous six months.
   j. Member expressed need for support in health system navigation or resource coordination services.
   k. Need for recommended preventive services, including updated immunizations, annual dental visit, and well-child care visits for children.
3. CHW violence prevention services are specific to community violence (e.g. gang violence) and are available to Members who meet any of the following circumstances as determined by a licensed practitioner:
   a. The Member has been violently injured as a result of community violence.
   b. The Member is at significant risk of experiencing violent injury as a result of community violence.
   c. The Member has experienced chronic exposure to community violence.
4. CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

H. Assessing and Identifying Member Needs for CHW Services

1. In addition to recommending that Providers identify member needs for CHW services, Partnership also assesses member needs for services and determines priority populations using a data driven approach. Partnership attempts outreach to identified members and their Providers and offers to

connect the qualifying Members to needed CHW services. Data sources may include, but are not limited to, using past and current Member utilization/encounters, Partnership's proprietary risk score model, risk stratification and segmentation methodology, utilization reports showing member hospitalizations and ED visits, data on health risks and clinical core gaps, demographic and SDOH data, referrals from the community (including Provider referrals) for services, member self-referral to identify members who may benefit from CHW services, and needs assessments.

2. Populations of special focus include:
   a. Children who need preventive care
   b. Members who under-utilize primary care
   c. Pregnant or newly delivered members
   d. Members who have behavioral health needs, substance use disorders (SUD), or conditions requiring integration of physical and behavioral health.
   e. Members newly released from incarceration.

I. Documentation Requirements
1. CHWs are required to document the dates and time/duration of services provided to Members, which should also reflect information on the nature of the service provided and support the length of time spent with the patient that day.
2. Documentation must be accessible to the Supervising Provider upon their request.
3. Documentation should be integrated into the Member's medical record and available for encounter data reporting.

J. Authorization for CHW Services and Care Plans
1. Partnership does not require prior authorization for CHW services as preventive care for the first 12 units with a limit of four (4) units a day.
2. For Members who need multiple CHW services or continued CHW services in excess of 12 units, a prior authorization request (TAR) is required (see Partnership Policy MCUP3041 Treatment Authorization Request (TAR) Review Process for requirements and procedures).
   a. Documentation to be provided with the TAR includes a written care plan that must be written by one or more individual licensed providers (with the exception of services provided in the ED) which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.
      1) The care plan must state the following:
         a) Specify the condition that the service is being ordered for and be relevant to the condition
         b) Include a list of other health care professionals providing treatment for the condition or barrier
         c) Contain written objectives that specifically address the recipient's condition or barrier affecting their health
         d) List the specific services required for meeting the written objectives
         e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives
      2) The Provider submitting the care plan does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services.
      3) CHWs may participate in the development of the care plan and may take a lead role in drafting the care plan if done in collaboration with the Member's care team and/or other Providers.
      4) The plan of care may not exceed a period of one year.
      5) The care plan must state the following:
         a) Specify the condition that the service is being ordered for and be relevant to the condition

b) Include a list of other health care professionals providing treatment for the condition or barrier
c) Contain written objectives that specifically address the recipient's condition or barrier affecting their health
d) List the specific services required for meeting the written objectives; and
e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives.

6) A licensed Provider must review the member's care plan at least every six months from the effective date of the initial care plan. The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary.
   a) TARs will be authorized for 6 months and reauthorization will be contingent upon submission of a reviewed/updated care plan.
   b) If there is a significant change in the member's condition, Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

K. Partnership's CHW Program Standards
1. Partnership will not establish unreasonable or arbitrary barriers for accessing coverage.
2. Partnership complies with all reporting and oversight requirements including monitoring for fraud, waste and abuse of CHW services through committees that review for over and under-utilization of services.
3. Partnership uses CHWs to help address basic population health management, improve engagement, quality and health equity, and to improve efficiencies.
4. Partnership encourages providers to integrate CHWs into basic population health management and preventive care activities. This may include:
   a. Referrals for families with children requiring preventive care
   b. Referrals for vulnerable pregnant members who may benefit from added support through pregnancy and the first year of a child's life
   c. Referrals for members with Limited English Proficiency (LEP) or members who are not familiar with Medi-Cal benefits.
5. Partnership will encourage recruitment of CHWs who have lived experience with incarceration, behavioral health concerns, homelessness, and other vulnerable populations to provide CHW services to members facing these challenges.
6. Partnership will track quality indicators for those members who use CHW services compared to a matched sample of members who do not agree to CHW services. For example:
   a. HEDIS compliance with well-child visits for families requiring preventive care
   b. HEDIS compliance with prenatal, post-partum, and well-baby visits for pregnant mothers
   c. Member satisfaction post benefit-utilization for a representative sample of those using the CHW benefit.
7. Partnership will assess the CHW workforce through several means:
   a. Surveying providers known to be using CHWs to determine the number of CHWs engaged by provider, the particular population of focus for each CHW, and a percentage of population covered calculated by provider and by county.
   b. Tracking utilization rates using the DHCS-designated CPT/HCPCS billing codes for CHW services that are not billed under global services (such as ECM or perinatal services).

L. CHW Services Provided
1. CHW services can be provided as individual or group sessions and can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. Services may also be provided via telehealth (see policy MCUP3113 Telehealth Services). There are no service location limits.

2. Services may be provided to a parent or legal guardian of Members under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider. Services for the direct benefit of the Member must be billed under the Member's Medi-Cal ID. If the parent or legal guardian of the Member is not enrolled in Medi-Cal or Partnership Advantage, the Member must be present during the session. Covered services do not require a license.
3. CHWs may render street medicine, and the Supervising Provider would bill Partnership for any appropriate and applicable services within the scope of the CHW benefit. (Street Medicine services are defined by DHCS in APL 24-001 *Street Medicine Provider: Definitions and Participation In Managed Care* dated 01/12/2024)
4. Covered CHW services do not include any service that requires a license.
5. CHW Services include:
   a. Health Education: Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
   b. Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care, including, and communicating cultural and language preferences to providers. Health navigation includes connecting Members to community resources necessary to promote health; addressing barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
      1) Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team;
      2) Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
      3) Help a Member enroll or maintain enrollment in government or other assistance programs related to improving their health, if such navigation services are provided pursuant to a plan of care.
   c. Screening and Assessment: Providing screening and assessment services that do not require a license and assisting Members with connecting to appropriate services to improve their health, including connecting individuals and families with community-based resources.
   d. Individual Support or Advocacy: Assisting Members in preventing the onset or exacerbation of a health condition, or preventing injury or violence. This includes peer support as well if not duplicative or other covered benefits.

M. Non-Covered CHW Services
   1. Non-covered CHW services include, but are not limited to:
      a. Clinical case management/care management that requires a license
      b. Child care
      c. Chore services, including shopping and cooking meals
      d. Companion services
      e. Employment services
      f. Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
      g. Delivery of medication, medical equipment, or medical supply
      h. Personal care services/Homemaker services
      i. Respite care
      j. Services that duplicate another covered Medi-Cal service already being provided to a Member
      k. Socialization

l. Transporting members
m. Services provided to individuals not enrolled in Medi-Cal, except as noted above
n. Services that require a license
o. Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. (CHW services are distinct and separate from Peer Support Services.)

N. Partnership is actively working towards establishing closed loop referrals for services provided by CHWs, peer counselors (peer support not duplicative of other covered Medi-Cal or Medicare D-SNP benefits), and local community organizations, as defined at III.B. above. Closed loop referrals are currently accomplished through:
1. Tracking member referrals through Partnership's case management system and sharing access to this system with providers.
2. Leveraging Community Information Exchanges (CIEs) to allow community-based organizations and their staff to have insight into services and referrals made on behalf of shared members/clients.
3. Establishing protocols for documenting and sharing referral data in shared systems.

O. Billing, Claims, and Payments
1. CHW services will be reimbursed through a CHW Supervising Provider in accordance with its Provider contract.
2. Claims processes must adhere to contractual requirements related to claims processing and encounter data submissions including use of approved codes pursuant to the Medi-Cal Provider Manual for CHW Preventive Services.
3. Claims for CHW services will be submitted by the Supervising Provider with allowable current procedural terminology (CPT) codes as outlined in the Medi-Cal Provider Manual at Community Health Worker (CHW) Preventive Services (*chw prev*).
4. Partnership does not require prior authorization for CHW services; however, quantity limits can be applied based on goals detailed in the care plan as described in section VI.J.2.
5. Encounter data:
   a. Partnership shall submit all CHW encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
   b. Partnership shall be responsible for submitting to DHCS all CHW encounter data, including encounter data for CHW generated under subcontracting arrangements.
6. Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM or CICM, which is inclusive of the services within the CHW benefit. Through Partnership's Claims process, Partnership shall ensure that members shall not receive duplicative services through CHW and/or ECM or CICM. Please see Partnership policies MCCP2032 CalAIM Enhanced Care Management and MCAP7001CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).
7. Tribal clinics may bill Partnership for CHW services at the Fee-for-Service rates using the CPT codes as outlined in the Medi-Cal Provider Manual

For purposes of the services rendered by CHWs, FQHC and Rural Health Clinic (RHC) providers are not authorized as supervising providers in the Medi-Cal State Plan. Although FQHC and RHC providers may use CHWs to provide covered CHW preventive services, CHWs are not considered to be FQHC and RHC billable providers.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006 Community Health Worker Services Benefit (05/13/2024) supersedes APL 22-016
B. State Plan Amendment (SPA) 22-0001
C. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)

D. Welfare and Institutions Code (WIC) 14087.325(d)
E. Medi-Cal Provider Manual/ Guidelines: Community Health Worker (CHW) Preventive Services (*chw prev*)
F. DHCS APL 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024) supersedes APL 22-023
G. DHCS Standing Order

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

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

X. REVISION DATES:
MPAP7004:
06/11/25

PREVIOUSLY APPLIED TO:
Medi-Cal MCCP2033:
02/14/24; 10/09/24; ARCHIVED 06/11/25

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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 need 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.