POLICY AND PROCEDURE	
Policy # and TITLE: Community Supports	
Primary Policy owner: Utilization Management	**POLICY #:** UM50
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☐Behavioral Health (BH) 3) ☐Benefits Administration (BA) 4) ☐Care Management (CM) 5) ☐Claims (CLMS) 6) ☒Community Marketplace & Member Engagement (MAR) 7) ☐Compliance (CMP/HPA) 8) ☐Configuration (CFG) 9) ☐Provider Contracting (CONT) 10) ☐Cultural & Linguistics (CL) 11) ☒Customer Service (CS)	12) ☐Facilities (FAC) 13) ☐Finance (FIN) 14) ☐Human Resources (HR) 15) ☐Information Technology / Core Systems (IT) 16) ☐Pharmacy (PH) 17) ☒Provider Networks (PRO) 18) ☒QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☒ Utilization Management (UM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** N/A

I. PURPOSE

This policy is intended to outline the guidelines for the provision of Community Supports to San Joaquin County Health Commission ("Commission"), operating and doing business as Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan")'s members

transitioning from the Whole Person Care Program to Community Supports and new Health Plan members eligible for Community Supports.

II. POLICY

A. In compliance with CalAIM initiatives and starting on 01/01/22 for San Joaquin County, 07/01/22 for Stanislaus County, and 01/01/23 for Alpine and El Dorado counties, the Health Plan offers community supports to eligible populations of focus in a phased in implementation based on dates as determined by DHCS.

B. In managing community support services, the Health Plan selects service offerings from the list of pre-approved community supports by DHCS as medically appropriate and cost-effective substitutes for covered services or settings under the state plan. The Health Plan may add or remove community supports at defined intervals: every six (6) months for an addition and annually for removal of a previously offered community support service. The Health Plan submits any requests for community support changes to DHCS for approval.

C. The Health Plan ensures continuous evaluation of community support needs for the Health Plan's members by referring to the Health Plan's Population Needs Assessments, County Public Health Assessments, and prior experience and information from the Whole Person Care pilot.

D. The Health Plan arranges for and coordinate community supports to address the physical and behavioral health, social, functional, cultural, and environmental factors affecting health by providing seven DHCS pre-approved community supports core services as of 1/1/2022: housing transition navigation services, housing deposits, housing tenancy and sustaining services, short term post hospitalization housing, recuperative care, meals and medically tailored meals, and sobering centers. The Health Plan may add or reduce community supports core services.

E. The Health Plan ensures an adequate network of contracted community providers with expertise and experience in providing community supports to members of San Joaquin, Stanislaus, Alpine and El Dorado counties. The Health Plan shall ensure providers possess capabilities and standards including but not limited to experience, Medi-Cal enrollment (if applicable), credentialing or vetting by plan, cultural/linguistics, staffing, provider capacity, data sharing and oversight responsibilities.

F. The Health Plan provides an adequate network of community support providers to deliver all selected community supports. The Health Plan

ensures community providers have sufficient capacity to receive referrals for community supports and provide agreed upon volume for community supports.

G. The Health Plan develops a framework and plan for community supports and submit model of care for review and approval as specified by DHCS.
H. The Health Plan makes best efforts to offer community supports to Whole Person Care Pilot participants who are being provided similar services through the Whole Person Care pilot to provide continuity of the services being delivered through the WPC program.
I. The Health Plan informs members and providers regarding the transition to community supports and provide member informing materials regarding community supports to all eligible members.
J. The Health Plan identifies individuals who may benefit from community supports and for whom community supports will be a medically appropriate and cost-effective substitute for state plan covered services and accept requests for community supports from members and on behalf of members from providers and organizations that serve them, including community-based organizations.
K. The Health Plan utilizes DHCS community supports service definitions which contain specific eligibility criteria, restrictions/limitations, and allowable providers as listed in the CalAIM Proposal Appendix J and DHCS Community Supports Policy Guide.
L. The Health Plan authorizes community supports for the Health Plan's members deemed eligible for community supports.
    1. The Health Plan processes the following time sensitive Community Supports referrals as expedited in accordance with the Health Plan's policy UM01 Authorization and Referral Review:
        a. Recuperative Care
        b. Short Term Post Hospitalization Housing
        c. Sobering Centers, and
        d. Medically Tailored Meals offered post-acute care.
    2. Should a request for one of the expedited services identified above be submitted outside of normal business hours, the Health Plan will deem approved until the next business day.
M. The Health Plan reimburses contracted community support providers for the provision of authorized community supports to members in accordance with contractual obligations and the Health Plan's claims processing policies.

N. The Health Plan utilizes systems and processes capable of tracking community supports referrals, access to community supports, and grievances and appeals to the Health Plan.
O. The Health Plan also ensures community support providers have access to required data and information to effectively provide community support services. The Health Plan uses defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with community support providers and with DHCS, to the extent practicable.
P. The Health Plan performs oversight of community supports providers in accordance with all requirements as specified in the DHCS/MCP contract, provider terms and conditions, model of care, and associated guidance for community supports.
Q. When contracting with other entities such as delegates and subcontractors to administer community supports, The Health Plan is responsible for oversight of compliance will all contracted provisions and covered services.
R. The Health Plan coordinates with the Medicare Advantage Plan in the provision of community supports for members dually eligible for Medicare and Medi-Cal when the member is enrolled in a Medicare Advantage Plan, including a Dual Eligible Special Needs Plan.
S. The Health Plan submits required data and supplemental reports to DHCS to support DHCS' oversight of community supports.
T. The Health Plan meets all quality management and quality improvement requirements as set forth in its DHCS contract and any additional quality requirements as set forth in associated guidance from DHCS for community supports.
U. The Health Plan participates in the CalAIM Incentive Payment Program (IPP) related to adoption and expansion of Community Supports, building infrastructure and provider capacity, delivery system infrastructure, bridge current silos across physical and behavioral health care service delivery, reduce health disparities and promote health equity, achieve improvements in quality performance and/or performance milestones in accordance with the definitions and requirements set forth in DHCS APL 21-016, including any future revised or superseding versions of the APL and in any forthcoming guidance as provided by DHCS.
V. The incentive program is expected to be effective from January 1,2022 to June 30, 2024, the program period will be split between three distinct Program Years (PY):

1. PY 1 (January 1,2022 to December 31, 2022)
2. PY 2 (January 1,2023 to December 31, 2023)
3. PY 3 (January 1,2024 to June 30, 2024)

W. IPP incentive payments from DHCS to the Health Plan will be in addition to the Health Plan's actuarially sound capitation rates.
   1. DHCS determines the maximum amount of incentive payments that each Managed Care Plan is eligible to earn based on factors established by DHCS.
   2. The Health Plan must comply with the policy requirements outlined in Appendix A for PY 1 and in Appendix B for PYs 2 and 3 of the incentive program to earn CalAIM incentive payments for the applicable payment year.

X. Payment to T=the Health Plan is based on successful completion of measures outlined in the IPP reporting template. The Health Plan is required to submit information pertaining to mandatory measures and can select among additional optional measures to earn up to the full payment allocation. DHCS shall evaluate the Health Plan's submissions and make incentive payments proportional to the number of points earned per measure. DHCS will also monitor the timeliness and content of the Health Plan's submissions and request revisions for incomplete submissions as needed during the review timeframe.

Y. Each measure in the reporting template is assigned to a program priority area. The maximum amount of incentive payments that the Health Plan is eligible to earn is initially allocated as follows through actual earnings may differ:
   1. Minimum of 20% is tied to Delivery System Infrastructure (Priority Area 1) measures.
   2. Minimum of 20% is tied to ECM Provider Capacity Building (Priority Area 2) measures, and.
   3. Minimum of 30% is tied to Community Supports(CS) Provider Capacity Building and Take-Up (Priority Area 3) measures. The remaining 30% is allocated according to the Health Plan's selection, subject to approval by DHCS, and as indicated in the Health Plan's submitted gap filling plan (detailed below) of one or more program priority area. DHCS will evaluate the Health Plan on its submission for all measures in the selected program priority area and award the remaining 30% of the payment accordingly. DHCS may, at its sole discretion, consider granting exceptions in limited cases where the Health Plan makes compelling requests to DHCS to allocate more than 30% to the Health Plan J's selected

program priority area (i.e. by allocating dollars from another priority area). The Health Plan will be required to submit this request with the reporting template, and DHCS has the discretion to approve or disapprove the proposed approach by the Health Plan upon review of the reporting template.

Z. As part of IPP, the Health Plan is expected to work closely will all applicable local partners including, but not limited to county social services, county behavioral health, public healthcare systems, county/local public health jurisdictions, community-based organizations (CBOs), correctional partners, housing continuum and others, in their efforts to achieve the measures.

AA. If the Health Plan fails to demonstrate a minimum level of effort, as determined by DHCS using a standard set of parameters, the Health Plan must work with DHCS on a corrective action plan (CAP) aimed at improving results and performance on the process measures. DHCS will consider the extent of investments made by the Health Plan in ECM and Community Supports provider capacity and infrastructure in accordance with their gap filling plan when determining whether the plan has demonstrated a minimum level of effort. DHCS may, at its sole discretion require that if the Health Plan fails to follow the CAP and meet the minimum level of effort return to DHCS a portion of all of Payment 1, in an amount determined by DHCS. The portion of funds to be returned by the Health Plan is determined based on the level of effort (below the required minimum) demonstrated by the Health Plan, as determined by DHCS using a standard set of parameters across all managed care plans. DHCS may offset the amount the Health Plan is required to return against capitation payments.

BB. For payment 2, the Health Plan must meet subsequent submission requirements using the reporting template in the Fall of 2022 to demonstrate overall progress and performance against target linked to achievement of the gap filling plan. Targets will either be individualized, pay for reporting. or noted with specific evaluation criteria in the reporting template, in accordance with the specified measures. Each measure will either be earned in full, or not earned. For measures with individualized targets, a minimum target will be set for the Health Plan based on the information provided by the Health Plan in the needs assessment and gap filling plan. The targets must be reviewed and approved by DHCS. The achievement of these targets will result in Payment 2.

CC. The reporting template will specify the requirements for the Health Plan reporting. For managed care plans operating in more than one county, the Health Plan must submit data pertaining to the quantitative measures for each county in which it operates and elects to participate in the incentive program. The Health Plan may submit one narrative for their needs assessment and gap filling plan that pertains to all counties in which they operate; however, the needs assessment and gap filling plan must address gaps, need, and strategies for each county individually. The data sources specified in the reporting template must be used for collecting and reporting data. The reporting template must be submitted by the Health Plan to CalAIMECMILOS@dhcs.ca.gov.

III. PROCEDURE

A. The Health Plan will provide services from the DHCS pre-approved community support services list to qualifying members in San Joaquin, Stanislaus, Alpine and El Dorado Counties via contracted providers. In providing community supports, the Health Plan utilizes community supports service definitions which contain specific eligibility criteria, restrictions/limitations, and allowable providers as listed in the CalAIM Proposal Appendix J and DHCS Community Supports Policy Guide. the Health Plan service and delivery descriptions are included below:

1. Housing Transition Navigation Services: Services will assist members with obtaining housing and include tenant screening, developing individual housing support plans, searching for housing, advocating for the member to potential landlords, and assisting with any needs a tenant may have to secure housing the Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Providers will have demonstrated experience with providing housing related services and support. Services are housing authorities, low-income housing community-based organizations, and shelters.
2. Housing Deposits: Services will assist with identifying, coordinating, securing, or funding start up services and modifications necessary to enable a person to establish a basic household that does not constitute room and board. May include security deposits, utility deposits, one time house cleaning or pest control upon move in, and any medically necessary adaptive aids that would ensure member health and safety, such as air conditioner or heater. This

service is available once in a lifetime and the individual must also receive Housing Transition Navigation Services in conjunction with this service. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Providers will have demonstrated or verifiable experience with providing housing related services and supports. Services providers are housing authorities, low-income housing community-based organizations, and shelters.

3. Housing Tenancy Sustaining Services: Services to ensure ongoing safe and stable tenancy and prevent eviction once housing is secured. Services may include maintaining relationships with landlords, identification and intervention in member behaviors that may jeopardize housing such as late rent payments, hoarding, failure to maintain the property, substance use disorders, and other lease violations. This service is available for a single duration in the individual's lifetime. Can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing this service would be more successful on the second attempt. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Providers will have demonstrated experience with providing housing related services and supports. Services providers are housing authorities, low-income housing community-based organizations, and shelters.
4. Short Term Post Stabilization Housing: Service provides members who do not have housing but are being discharged from an inpatient hospital/facility and who have high medical, behavioral, and/or substance use disorder treatment needs with the opportunity to continue their medical, psychiatric, substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care. This service is available once in an individual's lifetime and are not to exceed a duration of 6 months per episode. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01

Authorization and Referral Review. Providers will have demonstrated experience and expertise in housing related services and supports and may include a variety of providers including supportive housing providers and service providers for individuals experiencing homelessness. Services providers are community-based organizations which currently provides these services.

5. Recuperative Care: Service includes care coordination and interim housing with a bed and meals and ongoing monitoring of the member's ongoing medical or behavioral condition. Members must no longer require hospitalization, but still need to heal from any injury or illness (including physical, behavioral, and substance use recovery) and whose condition would be exacerbated by an unstable living environment. Care coordination services include transportation to appointments, referral and connection to needed ongoing services, support in accessing benefits and housing, and ensuring stability through case management relationships. This service is for not more than 90 days in continuous duration. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Providers will have demonstrated experience in providing these unique services and may include interim housing facilities or shelter beds. Service providers are community-based organization which currently provides these services.
6. Meals and Medically Tailored Meals: Service provides an intervention to poor nutrition and prolonged healing or at risk for hospital readmission in members who are being discharged from an inpatient facility. Services include delivery of up to three meals a day for a limited time, a tailored diet based on a chronic disease, and medically tailored meals approved by a Registered Dietician that reflect the appropriate dietary therapy based on evidence-based nutrition practice guidelines to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure optimal nutritional related health outcomes. This service is for up to three medically- tailored meals per day and/or medically- supportive food and nutrition services for up to 12 weeks, or longer if medically necessary. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with

UM01 Authorization and Referral Review. Providers will have demonstrated experience in providing these unique services and may include home delivered meal providers, nutritional education services of health cooking and eating habits, and meals on wheels providers. The service provider is a contracted meal vendor.

7. Sobering Centers: Sobering centers are short-term alternative destinations for members who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Includes screening and linkage to ongoing supportive services such as follow up mental health and substance use disorder treatment and housing options. This service is covered for a duration of less than 24 hours. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Sobering centers are the only Community Supports service that shall have presumptive authorization. Providers will have demonstrated experience in providing these unique services and may include sobering centers or other appropriate and allowable substance use disorder providers. Service providers are federally qualified health centers and others with experience in sobering centers.

As of July 1, 2022

A. Asthma Remediation: Environmental trigger remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety to the individual or to enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. This service is available to individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care Provider has documented that the service will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services). Asthma remediations are payable up to a total lifetime maximum. The only exception to the total maximum is if the member's

condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the member or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Providers will have demonstrated experience in providing these unique services and may include but not limited to area agencies on aging (AAA), local health departments, and community-based providers and organizations.

B. Environmental Accessibility Adaptations (Home Modifications): Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual or to enable the individual to function with greater independence in the home, without which the member would require institutionalization. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. This service is available to individuals at risk for institutionalization in a nursing facility. This service is available up to a total lifetime maximum. The only exceptions to the total maximum are if the member's place of residence changes or if the member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the member or to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization. Providers will have demonstrated experience in providing these unique services and may include but not limited to lung health organizations, healthy housing organizations, local health departments, and community-based providers and organizations.

As of January 1, 2023

A. Day Habilitation Programs: Provided in a member's home or an out-of-home, non-facility setting. The programs are designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Individuals who are experiencing homelessness, individuals who exited

homelessness and entered housing in the last 24 months, and individuals at risk of homelessness and institutionalization whose housing stability could be improved may be eligible for participating in day habilitation programs. This service is available to members as determined when medically appropriate. Providers will have demonstrated experience in providing these unique services and may include but not limited to mental health or substance use disorder treatment providers, licensed psychologists, licensed certified social workers, registered nurses, home health agencies, professional fiduciary, and vocational skills agencies.

B. Personal Care and Homemaker Services: Services provided to individuals who need assistance with activities of daily living such as bathing, dressing, toileting, ambulation, or feeding. Services can also include assistance with instrumental activities of daily living (IADLs) such as meal preparation, grocery shopping, and money management. Eligible individuals may include individuals at risk for hospitalization or institutionalization in a nursing facility, individuals with functional deficits and no other adequate support system, individuals approved for In Home Supportive Services. The service is available to members as determined when medically appropriate. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Providers will have demonstrated experience in providing these unique services and may include but not limited to home health agencies, county agencies, personal care agencies, and AAA (area agencies on aging).

C. Respite Services: Provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are nonmedical in nature. These services are distinct from medical respite/recuperative care and provide rest for the caregiver only. In the in-home setting these services in combination with any direct care services the member is receiving, can be provided up to 24 hours per day of care. The service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the limit of 336 hours per calendar year can be made, with Medi-Cal plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided

during these episodes can be excluded from the 336-hour annual limit. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Providers will have demonstrated experience in providing these unique services and may include but not limited to home health and respite agencies to provide services in private residence, residential facility such as congregate living health facilities, and providers contracted by county behavioral health. Other community setting that are not a private residence such as adult family home/family teaching home, certified family homes for children, county agencies, residential care facility for the elderly and respite facilities.

As of July 1, 2023

A. Nursing Facility Transition/Diversion to Assisted Living Facilities: Nursing facility transition/diversion services help individuals live in the community and/or avoid institutionalization when possible. Members may receive services as determined medically appropriate. Members are directly responsible for paying their own living expenses. The Health Plan will authorize community supports for eligible members in a medically appropriate and equitable manner in accordance with UM01 Authorization and Referral Review. Providers will have demonstrated experience in providing these unique services and may include but not limited to case management agencies, home health agencies, and AFR/RCFE operators.
B. Community Transition Services/Nursing Facility Transition to a Home: Community transition services/nursing facility transition to a home helps individuals live in the community and avoid further institutionalization. Community transition services do not include monthly rental or mortgage expense, food, regular utility changes, and/or household appliances or items that are intended for purely diversionary/recreational purposes. Community transition services are payable up to a total lifetime maximum amount. The only exception to the total maximum is if the member is compelled to move from a provider operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control. Members may receive services as medically appropriate. Providers will have demonstrated experience in providing these unique services and may include but not limited to case management agencies, home health agencies, county mental health providers, 1915c Home and

Community Based Alternatives/Assisted Living Waiver providers, California Community Transitions/Money Follows the Person Providers.

C. The Health Plan's community supports provider network consists of long-standing community providers from San Joaquin, Stanislaus, Alpine and El Dorado counties with current expertise and experience in providing the Health Plan's selected community supports. Community support providers must undergo the Health Plan's assessment and training to meet the following capabilities and standards:
    1. Community Support providers must be Medi-Cal enrolled providers, as is required by DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
        a. If APL 19-004 does not apply to the community support provider, the community support provider must comply with the Health Plan's vetting process which may extend to individual's employed by or delivering services on behalf of the community supports provider, to ensure it can meet the capabilities and standards required to be a community supports provider.
    2. Community support provider must have sufficient experience and expertise in the provision of the community support being offered.
    3. Have capacity to provide community supports in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training, or other factors as identified by the Health Plan.
    4. If the community support provider subcontracts with other entities to administer functions of the community support, the community support provider must ensure agreements with such subcontractors for the provision of community supports bind all subcontractors to the terms and conditions enumerated here.
    5. Meet all delivery of community supports requirements as per DHCS Community Supports Provider Terms and Conditions and Community Supports Policy Guide.
    6. Community Support Provider shall:
        a. Accept and act upon member referrals from MCP for authorized community supports unless the community support provider is at pre-determined capacity.
        b. Conduct outreach to the referred member for authorized community supports as soon as possible, including by making

best efforts to conduct initial outreach within 24 hours of assignment if applicable.

c. Be responsive to incoming calls or other outreach from members including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week.
d. Coordinate with other providers in the member's care team, including ECM providers, other community support providers, and the MCP.
e. Comply with cultural competency and linguistic requirements required by federal, State and local laws, and in contract(s) with the MCP; and
f. Comply with non-discrimination requirements set forth in State and Federal law and contract with MCP.

7. When federal law requires authorization for data sharing, community support provider shall obtain and/or document such authorization from each assigned member, including sharing of protected health information (PHI) and shall confirm it has obtained such authorization to the MCP.
   a. Member authorization for community supports-related data sharing is not required for the community supports Provider to initiate delivery of community supports unless such authorization is required by federal law.
   b. Community support providers will be reimbursed only for services that are authorized by MCP.
      i. In the event of a Member requesting services not yet authorized by MCP, Community Support Provider shall send prior authorization request(s) to MCP, unless a different agreement is in place (e.g., if the MCP has given the Community Support Provider authority to authorize Community Support directly).
8. If a community support is discontinued for any reason, community support provider shall support transition planning for the member into other programs or services that meet their needs.
9. Community support provider is encouraged to identify additional community supports the member may benefit from and send any additional request(s) for community supports to MCP for authorization.

D. Community support providers with a pathway to Medi-Cal enrollment will be expected to obtain such certification. However, many community support providers will not have a pathway to Medi-Cal

enrollment. The Health Plan elected community support services and providers have all been determined not to have a pathway for Medi-Cal Enrollment.

1. For housing transition navigation services, housing deposits, housing tenancy and sustaining services, short term post hospitalization housing, recuperative care, meals and medically tailored meals, and sobering centers the Health Plan utilizes a set of minimum DHCS standard qualifications and criteria to be used for vetting by the Health Plan's Credentialing and Compliance teams.
2. The Health Plan will vet the organization and may require the organization to provide a roster of staff or individual providers as well for review.
3. Additionally, the Health Plan conducts a pre-contractual assessment to ensure community support providers adhere to regulatory, contractual, and operational requirements to provide community supports.
4. Community support providers may also be subject to a pre-contractual assessment process consisting of policies and procedures and supporting documentation as requested by the Health Plan as part of the contracting process.
5. Additionally, all providers will be expected to adhere to the requirements and guidelines contained in the Health Plan's Provider Manual.

E. D. The onboarding of community support providers will be accomplished through a team of the Health Plan's subject matter experts from Contracting, Compliance, and Medical Management teams including Credentialing, Utilization Management and Case Management.
   1. Compliance and Contracting will take the lead in providing onboarding of community support providers.

F. Designated the Health Plan staff have been trained in accordance with DHCS regulations and are able to provide detailed information about the Health Plan's benefits, the Health Plan's programs, and managed care concepts to the new community support providers and serve as the resource for the new providers to obtain information about the Health Plan's programs, DHCS, CMS and other regulatory issues, as applicable.

G. On an initial, periodic and provider requested basis, the Health Plan provides training to the community support providers and their staff covering an array of topics, including but not limited to:
   1. Prior Authorization Process and Requests
   2. Member Eligibility
   3. Resources and Tools:
   4. Electronic Referrals
   5. Care Plans
   6. Member Health Records
   7. Online formulary search
   8. The Health Plan's Guidelines for Care Management
   9. Compliance Training and Fraud, Waste and Abuse (FWA)
   10. Provider Orders for Life-Sustaining Treatment (POLST)
   11. Claim Submission and Status Checks
   12. Clean Claim requirements, including coding requirements
   13. Provider Dispute Resolution (PDR) Process
   14. Review of blast faxes sent in previous quarter
   15. Sensitivity Training
   16. Cultural and Linguistic requirements and resources such as Case Management, Disease Management, Behavioral Health and Social Work programs

H. When contracting with other entities such as delegates and subcontractors to administer community supports, the Health Plan shall be responsible for oversight of compliance will all contracted provisions and covered services.
   1. The Health Plan is responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
   2. The Health Plan is responsible for evaluating the prospective Subcontractor's ability to perform services;
   3. Community Supports services to the health Plan's Kaiser members shall be provided in accordance with Kaiser policy Community Supports, NCAL Region.
   4. The Health Plan remains responsible for ensuring the Subcontractor's community supports provider capacity is sufficient to serve eligible Members; MCPs will report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided and identify the county or counties in which Members are served;
   5. The Health Plan makes all Subcontractor agreements available to DHCS upon request. Such agreements must contain the minimum

required information specified by DHCS, including method and amount of compensation.

6. The Health Plan ensures their agreements with any Subcontractor mirror the requirements set forth in ECM and Community Supports Contract Template, and the ECM and Community Supports Provider Standard Terms and Conditions.

I. The Health Plan provides an adequate network of community support providers to deliver all selected community supports by contracting with multiple skilled providers for the elected services in proportion to estimated membership to meet the Health Plan's member's needs and volume by 01/01/22 for San Joaquin County, and similarly by 07/01/22 for Stanislaus County, and 01/01/24 for Alpine and El Dorado Counties, and subsequent dates.

J. If a community supports provider is unable to meet the agreed upon volume, the Health Plan shall be notified and address via letters of agreement on a case-by-case basis as per the Health Plan's policy CONT05 Network Deficiency.

K. The Health Plan does not intend to restrict community support services but will offer an enhanced array of 14 community supports to augment currently available services and may add or remove some of the community support services in the future.

L. The Health Plan offers community supports countywide within its respective covered counties.

M. Kaiser will maintain responsibility for community supports of Housing Transition Navigation Services and Housing Tenancy and Sustaining Services for members delegated to Kaiser.

N. For members delegated to Kaiser who wish to receive other community supports offered by the Health Plan and not offered by Kaiser; they may access by choosing reassignment to the plan via the Health Plan's standard PCP assignment process as noted in policies CS05 Primary Care Provider Assignment and PRO11 PCP Assignment.

O. Kaiser will continue to monitor community supports experience and may continue to add community supports incrementally.

P. If for any reason, the Health Plan is unable to offer its elected community supports (CS), the Health Plan leverages its policies and procedures CONT05 Network Deficiency and UM01 Authorization and Referral Review to prioritize equitable delivery of community supports via letters of agreement (LOA)and address contracting needs as the community supports network continues to grow and is expanded.

1. The Health Plan has a vast array of provider for each CS service, in the event a CS provider is at capacity, the Health Plan will:
    1. Outreach to each CS provider who provides the requested service,
    2. Determine the urgency of the service by contacting the referral source,
    3. Determine providers capacity, if capacity available, members will be assigned based on urgency, or the date of CS referral receipt,
    4. Determine if there are non-contracted providers who can provide the CS through an LOA,
    5. If the request is urgent and there are no other providers are available, the Health Plan will discuss with the medical provider to determine if there is a similar Medi-Cal services that can address the members needs until CS provider capacity is available,
    6. Identify any community resources, such as shelters or through the county of member residence, that can provide services to meet the members needs until CS provider capacity is such that the member can receive the requested service.

Q. The Health Plan continues to assess long term provider capacity building and community engagement (including delegates and subcontractors).

R. The Health Plan submits required information as requested by DHCS including but not limited to a three-year plan to DHCS detailing how it will build network capacity over time and update the plan annually; and participate in regular meetings with DHCS or other stakeholder to review progress towards expanding community support network capacity.

S. Transition of Whole Person Care to Community Supports: The Health Plan will leverage the foundation of the Whole Person Care Program (WPC) and improve care through community supports.
    1. For the transition, the Health Plan will review existing members and services being currently provided. The Health Plan's medical management and care management to ensure that members have access to and are authorized, as appropriate, for community supports as per UM01 Authorization and Referral Review.

T. Member Information and Engagement: The Health Plan will inform members and/or the member's Authorized Representative (AR), e.g.,

family member(s), caregiver, or guardian, about community supports through the following methods:

1. A joint letter will be sent on behalf of Health Plan of San Joaquin and the Whole Person Care (WPC) program for members transitioning from WPC receiving enhanced care management (ECM) or community support like services.
2. When the member calls into the Health Plan's Member Services inquiring about community supports, Customer Service will be educated about and have a call script/job aid to assist in explaining community supports and how to warm transfer the member for additional information.
3. Posting on the Health Plan secure member portal
4. Posting on the Health Plan website
5. Inclusion in the Health Plan's EOC/ Member Handbooks;
6. Alternative formats for members who cannot access written material (e.g., Braille, large print, and audio formats); and
7. Communication via TTY, Video Remote Interpreting service and Video Phone are available for members who are deaf or hard of hearing.
8. All Medical Management staff will be trained in ECM and community supports and to refer members that require the service.

U. While members eligible for community supports have, by definition, had interactions with the health care system, those interactions may not have led to improved health outcomes due to SDOH barriers. Thus, the goal of community supports must be not only the provision of needed services, but also to potentially engage the member in Care Management, as appropriate. The Health Plan will require community supports to assume responsibility for obtaining and documenting members' consent, consistent with the Health Plan's policies and procedures and DHCS guidelines.

V. Community supports providers are expected to engage with members and encourage participation in Care Management programs, the Health Plan's CM programs or ECM, as evidence demonstrates that a whole person-centered approach to engagement, which is based on the member's strengths, needs, values, and preferences, leads to trusting relationships, member's confidence to manage their own health, improved health outcomes, and decreased dependence on episodic care.

W. Member Eligibility In general, the populations eligible for community supports include DHCS identified populations of focus with the most complex challenges affecting health such as homelessness, unstable housing, food insecurity, and/or other social needs. Enrollment in ECM is not a requirement for access to community supports. The Health Plan utilizes DHCS community supports service definitions which contain specific populations of focus and eligibility criteria as listed in the CalAIM Proposal Appendix J and DHCS Community Supports Policy Guide.

X. Member Identification For member identification, the Health Plan utilizes a variety of methods to identify members who may benefit from community supports, including, but not limited to the following:
   1. Working with ECM providers to identify members receiving ECM who could benefit from community supports;
   2. Proactively identify members who may benefit from community supports through clinical analytics, utilization and care management data and workflows, including evidence-based risk assessment tools based in the CM system (Essette);
   3. Accepting requests from providers and other community-based entities;
   4. Accepting member and/or their family member(s), guardian, authorized representatives (AR), caregivers, and/or authorized support person(s) requests; and
   5. Identifying during UM, CM, Population Health and SW activities

Y. For any members who are not currently enrolled in ECM, the Medical Management staff will assess the member for ECM and refer as appropriate. Members will also be evaluated for Care Management programs such as Complex Care Management, Palliative Care, etc.

Z. For members who do not meet criteria for ECM, opt out of ECM, or need to transition to a lower level of service, such as general care management, referrals will be made to CM for assessment for Complex Case Management, Basic Case Management, or Care Coordination.

AA. The Health Plan obtains data from multiple sources to assist in identifying members for whom the community supports program will be a medically appropriate and cost-effective alternative to a State Plan service or setting. The Health Plan adheres to a no “wrong-door” policy by accepting requests for community supports from members and/or their authorized representatives (ARs), medical as well as behavioral health providers, county program staff, and community-based entities.

BB. Providers referenced above will be educated on community supports through means such as contact with the Provider Services Department via office brochures/promotional material, faxes, and the Health Plan Website and via regular joint operations meetings (JOMs).

CC. Members receiving CS through their previous MCP can be identified by a member, family or Authorized Representative requesting CS with The Health Plan. These requests can come in via calls, fax, correspondence, or some other means of communication.

DD. Members can also be identified by analyzing the Plan Data Feed, sent by DHCS to the Health Plan. The Health Plan reviews historical encounters for CS related encounter data in the past 90 days.

EE. These members will be referred to the Health Plan's CS provider for CS services provided by the Health Plan. CS providers will outreach to the member, previous MCP and/or previous CS provider to mitigate any gaps in care and assess the member's current situation for CS. CS providers will submit a prior authorization for CS.

FF. In addition, the Health Plan's Team Members from multiple departments/units such as CM, Customer Services, Community Health, Health Education, and Utilization Management (UM), have opportunity to inform members about community supports through direct telephonic and/or face-to-face contact.

GG. The Health Plan adheres to a no "wrong door" policy for accepting community supports referrals. Members can be referred for community supports through a variety of means including, but not limited to:

1. A member and/or the member's AR, e.g., family member(s), caregiver, or guardian, may request community supports by calling the Health Plan's Customer Services, who will provide information about community supports by following a dedicated call script.
2. PCP or specialist referral
3. Health information line referrals (e.g., Nurse Advice Line)
4. CM, DM, BH and SW Care Teams
5. Health Risk Assessment (HRA) findings
6. Health Information Form (HIF)
7. UM Inpatient Discharge Nurses (prior auth nurses and TOC (transitions of care) nurses)
8. ECM Care Managers
9. Delegated IPAs
10. Health Education/disease management programs.

HH. Referrals may come from providers or clinical staff and will follow standard referral submissions methods such as provider portal or phone for authorization in accordance with the Health Plan's policy UM 01 Authorizations and Referrals.

II. Other referrals such as those from a member, family member, caregiver, or guardian may come directly to the Health Plan:
    1. For community supports requests that come in through Customer Services or Provider Services, the Health Plan's Customer Services will: refer the member to their ECM provider or transfer the member to the Health Plan's Medical Management team.

JJ. IECM Provider will:
    1. Verify in the Automated Eligibility Verification System (AEVS) that the member has active enrollment status.
    2. Review to determine the member's eligibility for community supports.
    3. If Member meets Community Supports criteria, ECM provider submits prior authorization to the Health Plan.
    4. The Health Plan will follow authorization of Community Supports as outlined in section K below.
    5. If authorization approved, ECM Provider will refer Member to Community Supports Provider.

KK. The Health Plan's Medical Management team will:
    1. Internal departments will refer Member for community supports by creating a program referral for Medical Management in the medical management system (Essette).
    2. Provide centralized support for community supports referral management and assignment to Care Coordinators or Care Managers, depending on the need.
    3. Verify in the AEVS that the member has active enrollment status.
    4. Review to determine the member's eligibility for community supports.
    5. Make three (3) attempts to contact member (2 telephonic attempts followed by 1 "Unable to Contact "letter).
    6. If Member is successfully reached, CM will notify the member of community supports referral and gather additional information to assist in determining Member need and if services requested qualify under community supports.
    7. If member meets community supports criteria, Medical Management will create prior authorization and refer member to community supports provider.

LL. In order to initiate community supports for each qualifying member, it must be determined that the member meets community supports criteria. The member must then give verbal or written consent to both receipt of community supports and related data sharing, in accordance with Federal, State, and local laws.

MM. UM Criteria for Community Supports Community supports are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. Community supports can only be covered if: 1) the State determines they are medically appropriate and a cost-effective substitute or setting for the State plan service; 2) members are not required to use community supports; and 3) community supports is authorized and identified in the Health Plan contracts. Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

NN. The Health Plan uses written criteria based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria to ensure they are equitable and non-discriminatory. The Health Plan applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

OO. Once received from either entry points (provider or directly to the Health Plan from other sources) the Health Plan will authorize community supports for eligible members in a medically appropriate, equitable, and non-discriminatory manner in accordance with the Health Plan's policy UM01 Authorizations and Referral Review. The Health Plan will monitor and evaluate community supports authorizations to ensure they are equitable and non-discriminatory minimally at least annually. Corrective action will be implemented if evaluation findings identify instances where service authorizations have been inequitable or discriminatory.

1. Authorization timeframes for community supports will be consistent with regulatory requirements for all UM decisions.
    1. For routine referrals received by the Health Plan, a decision will be made within five (5) business days of receiving the necessary information to make a final determination.
    2. For expedited referrals received by the Health Plan, a decision will be made within 72 hours of the referral receipt.

2. There are certain services which may require an authorization decision in real time to avoid a hospital emergency room visit or inpatient admission. An example might be a potential Sobering Center admission in lieu of an emergency room visit after normal business hours.
3. If a community supports provider believes that the Health Plan's member meets eligibility criteria for community supports such as a Sobering Center, and the need for the service occurs outside of normal business hours, the referring provider can notify the Health Plan the next business day. The referring provider will consider the member pre-authorized for community supports and commence connecting the member with the community supports needed.
4. If approved, member will be referred to the community supports provider to render services. The community supports provider will engage the member and document member consent. The community supports provider will provide community supports and monitor and track members for closed looped referrals
5. For routine member notification of an authorization decision, written notification will be sent to the member within two (2) business days from the date the decision has been made.
6. Member notification of an expedited authorization decision will result in written notification sent to the member within 72 hours from the date of receipt of the request.
    1. This is in alignment with the Health Plan's policies and procedures regarding member notification timeliness.
7. UM criteria will be applied in an equitable and non-discriminatory manner for authorization decisions. Even though services provided through community supports are not health plan benefits, the Health Plan follows the current appeals process per the appeals policy for members to appeal community supports authorization denials.
8. In cases when a member appeals an authorization decision, the case will be reviewed by the Health Plan's Medical Director to ensure UM criteria was applied correctly, gathering more clinical information as needed to assist in making the decision to uphold or overturn the denial.
    1. Members will be notified by mail dependent on how the appeal was classified, either standard or expedited. For standard requests, a letter will be sent to the member within two business days of the decision date. For expedited

requests, a letter will be sent to the member within 72 hours of the decision date.

9. For members who either no longer qualify for or require Community Supports services, HSPJ is responsible to notify the member of the discontinuation and ensure the member is informed of their right to appeal and the appeals process by way of the Notice of Action (NOA) process.
10. The Health Plan will ensure payment to Community Supports Providers is in accordance with regulatory timeframes and policy CLMS13 Reimbursement of Services Claims.
    1. As stated in the Health Plan's Provider Contracts, the Health Plan pays 90% of all clean claims and invoices within 30 days of receipt and 99% of clean claims and invoices within 90 days of receipt.
    2. The date of receipt shall be the date the Health Plan receives the claim, as indicated by its date stamp on the claim.
    3. The date of payment shall be the date on the check or other form of payment.
    4. The Health Plan provides expedited payments for urgent CS, such as recuperative care, pursuant to its Contract with DHCS and any other related DHCS guidance.
11. For community supports providers who have a National Provider Identifier (NPI) number, the preferred route for claims submittal will be the EDI 837 process.
    1. For community supports providers that do not have an NPI number, the Health Plan provides resources for the provider to obtain an NPI number for claims submittal.
    2. The Health Plan works with providers to ensure they provide NPI, taxonomy and data elements required in DHCS billing guidance.
12. The Health Plan submits encounter data for community supports provided through the existing encounter data reporting mechanisms for all covered services for which the organization incurs any financial liability, whether directly or through subcontracts or other arrangements, using federal and state standards. Community supports providers will receive training on the set of HCPCS codes and modifiers that will be used to bill community supports and will become effective January 1, 2022.
13. The Health Plan shares the following data elements, as necessary, with community supports providers in a manner most conducive

to protecting member personal information, such as the Health Plan's Provider Portal or a secure file transfer protocol (SFTP):

1. Member assignment files via provider portal or secure file transfer protocol
2. Encounter and claims data via provider portal or secure file transfer
3. Physical, behavioral, administrative and SDOH data Physical, behavioral, and administrative data will be shared between the ECM Team, the CM Team, ECM and community support Providers via a common care management software or SDOH platform.
4. Reports of performance on quality measures/metrics from the Health Plan's HEDIS team.
5. For community supports referrals, a closed-loop referral pathway will be achieved via the utilization management and care management modules of the Health Plan's medical management system.

14. The Health Plan monitors Member access to care through access studies, review of grievances, and other methods. Access to community supports will comply with regulatory timely access standards. The Health Plan monitors community supports engagement, and utilization data according to the following methods:
    1. Number of members receiving community supports, access, and utilization metrics will be reported on a regular basis with guidance to improve adverse findings per committee direction.
    2. Eligible members identified through the Health Plan's reports, consultation, authorizations, and encounter and claims data will be tracked to ensure access community supports is compliant with regulatory standards.
        1. Authorization files, with at least 18 months of historical data, will be sent to providers monthly, as agreed upon.
        2. Data will be submitted via the Health Plan's web-based portal.
    3. Utilization analysis will include monitoring inpatient admissions and emergency room visits with the purpose of identifying effectiveness of the services being utilized.

4. On a quarterly basis, the Health Plan requires all contracted community supports providers to submit member-level as well as community supports utilization data to be included in the transition and implementation monitoring reports submitted to DHCS.
5. Annually, a total cost of care analysis is performed for members prior to community supports as compared to period in which community supports was received.

PP. The Health Plan produces an annual evaluation for internal and external stakeholders which summarizes the progress, achievements, and opportunities for growth of the Health Plan's community supports. The Health Plan utilizes the annual Population Health Needs Assessment, which may assist in driving which community supports the Health Plan provides.

QQ. At least annually, or more frequently as needed, the Health Plan conducts an onsite / virtual chart audit of all contracted community supports providers, including county and any subcontractors, to ensure that Quality of Care standards and contractual obligations are being met. In addition, data such as community supports utilization, encounters and claims, and member grievances and appeals, will be used to ensure community supports provider contract compliance.

RR. Audit scope will include, but not be limited to:
1. Requirements under the current All Plan Letter
2. Quality of Care Standards
3. Contractual obligations

SS. Lack of compliance on the prioritized measures may result in any of the following interventions, depending on the severity of the performance or compliance gap.
1. Additional training by the Health Plan on key topics.
2. Enhanced practice coaching or Manager support.
3. Conference between community supports provider leadership and the Health Plan's leadership to discuss barriers to improvement and compliance with minimum standards.

TT. The community supports care management system chart audit supplements the quantitative data elements listed above by providing the Health Plan with data on the quality and completeness of documentation of community supports outreach, engagement, and authorization. Audit elements are aligned with community supports provider contract requirements as well as community supports quality metrics.

1. Cases are selected using systematic random sampling to ensure cases are selected across all community supports Providers.
2. Selected charts are reviewed by an internal auditor.
3. Findings are analyzed to identify learnings about the efficacy and quality of collective community supports and by community supports provider.
4. The audit is performed at least annually.

UU. The Health Plan's elected community supports from pre-approved menu as these were services that were initially determined to be cost-effective alternatives to state plan services by DHCS. Additionally, the Health Plan vetted the selected community supports and assessed that services represent medically appropriate and cost-effective substitute services and could greatly impact health outcomes and inappropriate utilization for members of our membership as a whole. In making such a determination, the Health Plan evaluated cost-effectiveness at an aggregate level for potentially eligible members by reviewing community supports estimates and focusing of member needs and utilized services.

VV. The Health Plan monitors cost-effectiveness of the selected community supports services by evaluating projections and provider contracts. The Health Plan utilizes monthly reviews and financial tracking mechanisms for a comprehensive view of community supports performance. Annually, a total cost of care analysis will be performed for members prior to community supports as compared to period in which community supports was received.

WW. To assist in evaluating community supports effectiveness and opportunities for quality improvement, various data sources will be analyzed, including encounter and claims data, utilization data (i.e. inpatient stays, readmissions, ED visits, and PCP visits), HEDIS/MCAS measure data, as well as rates of institutionalization among members utilizing community supports.

XX. The Health Plan monitors the utilization and/or outcomes resulting from the provisions of community supports at least quarterly and report to the QMUM Committee. Additionally, the Health Plan annually evaluates performance of the Community Supports Program to determine if the selected community supports is a cost-effective, high quality alternative to traditional Medi-Cal covered services or settings. Criteria that may be monitored may include:
1. Emergency Department utilization
2. Inpatient length of stay

3. Readmission rates
4. Member satisfaction
5. Appeals and Grievances
6. Provider Capacity
7. MCAS and/or HEDIS quality metrics

YY. The Health Plan collects and measures quality metrics for each community supports including but not limited to:
1. Housing Transition Navigation Services
    a. Reduction in ED visits
    b. Reduction in IP stays
    c. Increase in PCP utilization
2. Housing Deposits
    a. Reduction in ED visits
    b. Reduction in IP stays
    c. Increase in PCP utilization
3. Housing Tenancy and Sustaining Services
    a. Reduction in ED visits
    b. Reduction in IP stays
    c. Increase in PCP utilization
4. Short-Term Post-Hospitalization Housing
    a. Reduction in ED visits
    b. Reduction in IP stays (including readmission rates)
    c. Post-Discharge Follow Up
5. Recuperative Care (Medical Respite)
    a. Reduction in ED visits
    b. Reduction in IP stays(including readmission rates)
    c. Post-Discharge Follow Up
6. Meals and Medically Tailored Meals
    a. Reduction in ED visits
    b. Reduction in IP stays
    c. Increase in PCP utilization
    d. HbA1c reduction over time for members with Diabetes
7. Sobering Center
    a. # Sobering center visits vs. inpatient/ER visits
    b. Sobering center cost vs. ER cost
8. The Health Plan provides the required monitoring reports to DHCS in a file, format and frequency as specified by DHCS.

ZZ. The Health Plan participates in the CalAIM Incentive Payment Program (IPP) the Health Plan participates in the CalAIM Incentive Payment Program (IPP) related to adoption of CS, building infrastructure and

provider capacity, health care quality and outcomes, and/or performance milestones as in accordance with the definitions and requirements set forth in DHCS APL 21-016, including any future revised or superseding versions of the APL and in any forthcoming guidance as provided by DHCS. The Health Plan participates in the CalAIM IPP to meet the following objectives:

1. Build appropriate and sustainable ECM and Community Supports capacity.
2. Drive MCP investment in necessary delivery system infrastructure.
3. Incentivize MCP take-up of community supports.
4. Improve related health care quality and outcomes.
5. Bridge current community supports across physical and behavioral health delivery.
6. Reduce health disparities and promote health equity.
7. Achieve improvements in quality performance.

IV. ATTACHMENT(S)

A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
B. Glossary of Terms Link
C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

A. Code of Federal Regulations (CFR) 42 438.3(e)(2) Standard contract requirements
B. Department of Health Care Services (DHCS) Community Supports, or In Lieu of Services (ILOS), Policy Guide
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-012: Provider Credentialing/Recredentialing and Screening/Enrollment
D. DHCS APL 21-017: Community Supports Requirements
E. DHCS APL 23-003: California Advancing and Innovating Medi-Cal Incentive Payment Program (Supersedes APL 21 – 016)
F. DHCS Primary Operations Contract Exhibit A, Attachment III, Section 4.5

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date

000	4/23, 6/23, 7/23	N/A
001	Moved UM50 to new template	12/22/2023
Initial Effective Date: 1/1/2022		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	001	12/7/2023
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review	001	11/15/2023
Quality and Utilization Management	001	7/19/2023
• Quality Operations Committee		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manager	001	10/27/2023
Department of Managed Care (DMHC)	N/A	N/A	N/A

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy