

POLICY AND PROCEDURE	
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) <input type="checkbox"/> All Departments 2) <input checked="" type="checkbox"/> Behavioral Health & Social Services (BH/SS) 3) <input type="checkbox"/> Benefits Administration (BA) 4) <input checked="" type="checkbox"/> Case Management (CM) 5) <input type="checkbox"/> Claims (CLMS) 6) <input checked="" type="checkbox"/> Community Marketplace & Member Engagement (MAR) 7) <input type="checkbox"/> Compliance (CMP/HPA) 8) <input type="checkbox"/> Configuration (CFG) 9) <input type="checkbox"/> Provider Contracting (CONT) 10) <input type="checkbox"/> Cultural & Linguistics (CL) 11) <input checked="" type="checkbox"/> Customer Service (CS)	12) <input type="checkbox"/> Facilities (FAC) 13) <input type="checkbox"/> Finance (FIN) 14) <input type="checkbox"/> Human Resources (HR) 15) <input type="checkbox"/> Information Technology / Core Systems (IT) 16) <input type="checkbox"/> Pharmacy (PH) 17) <input checked="" type="checkbox"/> Provider Networks (PRO) 18) <input checked="" type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) <input checked="" type="checkbox"/> Utilization Management (UM) 20) <input type="checkbox"/> Procurement (PRM) 21) <input type="checkbox"/> Administration (SAF/BC/EM) 22) <input type="checkbox"/> Medical Management (MM)
Product Type: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> D-SNP	Supersedes Policy Number: N/A

I. PURPOSE

This policy is intended to outline the guidelines for the provision of Community Supports to Health Plan of San Joaquin and Mountain Valley

Health Plan ("Health Plan")s eligible members who can benefit from these services.

II. POLICY

- A. Health Plan offers 14 community supports to eligible populations as outlined in Department of Health Care Services (DHCS) Community Supports Policy Guide Volume 1 & 2.
 - 1. The first mandatory community support, Transitional Rent, will be implemented January 1, 2026. Please refer to Health Plan Policy UM 93 Transitional Rent.
- B. Should Health Plan find it necessary to remove community support, Health plan will:
 - 1. Remove any offered community supports annually.
 - 2. Health Plan submits any requests for community support changes to DHCS for approval.
- C. Health Plan ensures continuous evaluation of community support needs for members by referring to Health Plan's Population Needs Assessments, County Public Health Assessments, and prior experience and information from the Whole Person Care pilot.
- D. Health Plan arranges for and coordinates community supports to address the physical and behavioral health, social, functional, cultural, and environmental factors affecting member health.
- E. Health Plan ensures an adequate network of contracted community providers with expertise and experience in providing community support to members in Health Plan's service area in accordance with Health Plan Policy CONT 001 Provider Contracting: Review and Execution of Provider Contracts.
 - 1. For providers who do not have a state enrollment pathway, Health Plan will have a process for vetting these providers as outlined in Health Plan Policy QM 47 Initial Assessment, Verification, and Ongoing Monitoring of Facility and Ancillary and Organizational Providers.
- F. Health Plan provides an adequate network of community support providers to deliver all selected community supports.
 - 1. Health Plan ensures community providers have sufficient capacity to receive referrals for community supports and provide agreed upon volume for community supports.

- G. Health Plan has developed a framework and plan for community supports and submit the model of care for review and approval as specified by DHCS, at specified intervals.
- H. Health Plan informs members and providers regarding community supports, including the process to request these services, and provide member informing materials regarding community supports to all eligible members.
 - 1. This is accomplished through regular provider trainings, member and provider newsletters, bi-monthly Enhanced Care Management (ECM)/Community Supports provider meetings, provider alerts and website content for both members and providers.
- I. 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 through multiple channels.
 - 1. Members currently receiving ECM and community supports, drawing on the experience to date managing these members,
 - 2. Members that are homeless or at risk of becoming homeless,
 - 3. Health Plan programs such as Case Management, Transitions of Care, Behavioral Health and Social Services, community providers,
 - 4. County Behavioral Health, Homeless shelters, data from DHCS and review of Health Plan data identifying potential members.
 - 5. Focus on hard-to-reach populations and those identified with significant mental health needs.
- J. Requests for community supports may come from members and on behalf of members from providers and organizations that serve them, including community-based organizations.
- K. Health Plan utilizes DHCS community supports service definitions which contain specific eligibility criteria, restrictions/limitations, and allowable providers as listed in the CalAIM Community Supports Policy Guide Volumes 1 and 2.
- L. Health Plan authorizes community supports for its members deemed eligible for community supports.
 - 1. Health Plan processes the following time sensitive Community Supports referrals as expedited in accordance with Health Plan's policy UM01 Authorization and Referral Review:
 - a. Recuperative Care, and

b. Short Term Post Hospitalization Housing

- M. Should a request for one of the expedited services identified above be submitted outside of normal business hours, Health Plan will deem approved until the next business day.
- N. Health Plan reimburses contracted community support providers for the provision of authorized community supports to members in accordance with contractual obligations and Health Plan's claims processing policies.
- O. Health Plan utilizes systems and processes capable of tracking community supports referrals, access to community supports, and grievances and appeals to Health Plan.
- P. Health Plan also ensures community support providers have access to required data and information to effectively provide community support services.
 - 1. 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.
- Q. 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.
- R. When contracting with other entities such as delegates and subcontractors to administer community supports, Health Plan is responsible for oversight of compliance with all contracted provisions and covered services.
- S. 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.
 - 1. Effective January 1, 2026, Health Plan will implement a Medi-Medi Dual Special Needs Plan (D SNP).
- T. Health Plan submits required data and supplemental reports to DHCS to support DHCS' oversight of community supports.
- U. 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.

III. PROCEDURE

- A. Health Plan provides community support services to qualifying members in San Joaquin, Stanislaus, Alpine and El Dorado Counties via contracted providers.
1. In providing community supports, 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 Volumes 1 & 2.
 2. Health Plan provides the following community support services:
 - a. Housing Transition Navigation Services (HTNS)
 - b. Housing Deposits
 - c. Housing Tenancy Sustaining Services (HTSS)
 - d. Day Habilitation Programs
 - e. Recuperative Care
 - f. Short Term Post Stabilization Housing (STPHH)
 - g. Transitional Rent – Effective January 1, 2026
 - h. Medically Tailored Meals(MTMs)/Medically Supportive Food (MSF)
 - i. Sobering Centers
 - j. Asthma Remediation
 - k. Environmental Accessibility Adaptations (Home Modifications)
 - l. Personal Care and Homemaker Services (PCHS)
 - m. Respite Services
 - n. Assisted Living Facility (ALF) Transitions
 - o. Community or Home Transition Services
- B. Enhanced Case Management (ECM) should be offered to most members receiving community supports and may qualify for other community supports, as long as there is no duplication of services.
- C. 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 Health Plan's selected community supports. Community support providers must undergo 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/Rec credentialing and Screening/Enrollment APL 22-013.

- a. If APL 22-013 does not apply to the community support provider, the community support provider must comply with 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 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 support binds 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:
 - a. Accepts and acts upon member referrals from Health Plan and all sources that are able to refer a member identified as needing such services, for authorized community supports unless the community support provider is at pre-determined capacity.
 - b. Conducts outreach to the referred member for authorized community support as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment if applicable.
 - c. Obtains confirmation that Health Plan member is willing to accept the community support service.
 - d. Submits authorization requests to Health Plan with all information confirming the member meets eligibility requirements for the community support.

- D. Community support providers with a pathway to Medi-Cal enrollment are expected to obtain such certification. However, many community support providers will not have a pathway to Medi-Cal enrollment. 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, transitional rent, short term post hospitalization housing, recuperative care, meals and medically tailored meals, and sobering centers Health Plan utilizes a set of minimum DHCS standard qualifications and criteria to be used for vetting by Health Plan's Credentialing and Compliance teams.
 2. Health Plan vets the organization and may require the organization to provide a roster of staff or individual providers as well for review.
 3. Additionally, 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 Health Plan as part of the contracting process.
 5. Additionally, all providers are expected to adhere to the requirements and guidelines contained in Health Plan's Provider Manual.
- E. The onboarding of community support providers is accomplished through a team of Health Plan's subject matter experts from Contracting, Compliance, and Medical Management teams including Credentialing, Provider Services, Utilization Management and Case Management.
1. Compliance and Contracting take the lead in providing onboarding of community support providers.
- F. Designated Health Plan staff have been trained in accordance with DHCS regulations and are able to provide detailed information about Health Plan's benefits, 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 Health Plan's programs, DHCS, CMS and other regulatory issues, as applicable.

- G. On an initial, periodic and provider requested basis, 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. 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, Health Plan is responsible for oversight of compliance with all contracted provisions and covered services.
1. Health Plan is responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
 2. Health Plan is responsible for evaluating the prospective Subcontractor's ability to perform services;
- I. 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 Health Plan's member's needs and volume for San Joaquin County, Stanislaus County, Alpine and El Dorado Counties.
- J. If a community supports provider is unable to meet the agreed upon volume, Health Plan is be notified and address via letters of agreement on a case-by-case basis as per Health Plan's policy CONT05 Network Deficiency.

- K. Health Plan does not intend to restrict community support services but offers 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. Health Plan offers community supports countywide within its respective covered counties.
- M. If for any reason, Health Plan is unable to offer its elected community supports (CS), 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.
- N. Health Plan has a vast array of provider for each CS service, in the event a CS provider is at capacity, Health Plan:
 - 1. Outreaches 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 are 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 available, Health Plan discusses 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.
- O. Health Plan continues to assess long term provider capacity building and community engagement (including delegates and subcontractors).
- P. 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.

- Q. Member Information and Engagement: Health Plan informs 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 is sent on behalf of Health Plan 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 Health Plan's Member Services inquiring about community supports, Customer Service is 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 Health Plan secure member portal
 4. Posting on Health Plan website
 5. Inclusion in 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 is trained in ECM and community supports and to refer members that require the service.
- R. 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. Health Plan requires community supports to assume responsibility for obtaining and documenting members' consent, consistent with Health Plan's policies and procedures and DHCS guidelines.
- S. Community supports providers are expected to engage with members and encourage participation in Care Management programs, 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.

- T. 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. 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.
- U. Member Identification For member identification, 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
- V. For any members who are not currently enrolled in ECM, the Medical Management staff assesses the member for ECM and refer as appropriate. Members are also evaluated for Care Management programs such as Complex Care Management, Palliative Care, etc.
- W. 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 are made to CM for assessment for Complex Case Management, Basic Case Management, or Care Coordination.
- X. Health Plan obtains data from multiple sources to assist in identifying members for whom the community supports program is medically appropriate and cost-effective alternative to a State Plan service or setting. 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.

- Y. Providers referenced above are educated on community supports through means such as contact with the Provider Services Department via office brochures/promotional material, faxes, and Health Plan Website and via regular joint operations meetings (JOMs).
- Z. Members receiving CS through their previous MCP can be identified by a member, family or Authorized Representative requesting CS with Health Plan. These requests can come in via calls, fax, correspondence, or some other means of communication.
- AA. Members can also be identified by analyzing the Plan Data Feed, sent by DHCS to Health Plan. Health Plan reviews historical encounters for CS related encounter data in the past 90 days.
- BB. These members are referred to Health Plan's CS provider for CS services provided by Health Plan. CS providers 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 submit a prior authorization for CS.
- CC. In addition, 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.
- DD. 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 Health Plan's Customer Services, who 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.
- EE. Referrals may come from providers or clinical staff and follow standard referral submissions methods such as provider portal or phone for

- authorization in accordance with Health Plan's policy UM 01 Authorizations and Referrals.
- FF. Other referrals such as those from a member, family member, caregiver, or guardian may come directly to Health Plan:
1. For community supports requests that come in through Customer Services or Provider Services, Health Plan's Customer Services transfers the member to Health Plan Case Management to refer the member to the appropriate community support provider, or transfer the provider to Health Plan's Medical Management team.
- GG. IECM Provider:
1. Verifies in the Automated Eligibility Verification System (AEVS) that the member has active enrollment status.
 2. Reviews to determine the member's eligibility for community supports.
 3. If Member meets Community Supports criteria, ECM provider submits prior authorization to Health Plan.
 4. Health Plan follows authorization of Community Supports as outlined in section K below.
 5. If authorization approved, ECM Provider refers Member to Community Supports Provider.
- HH. Health Plan's Medical Management team:
1. Internal departments, such as Transitions of Care, Case Management, Social Services refers the Member for community supports by creating a program referral to the appropriate community support provider.
 2. Provide centralized support for community supports referral management and assignment to Care Coordinators or Care Managers, depending on the need.
 - a. When a Health Plan member is referred to the community support provider, the provider determines the eligibility for the community support and submit an authorization request to Health Plan with supporting documentation.
 3. Verify in the AEVS that the member has active enrollment status.
 4. If member meets community supports criteria, Medical Management creates prior authorization and refer member to community supports provider.
- II. Health Plan applies criterion outlined in the DHCS Community Supports Policy Guide Volumes 1 & 2 in to process any authorization requests for the specific service.

1. Health Plan applies such objective and evidence-based criteria and the local delivery system into account when determining the medical appropriateness of health care services.
- JJ. Health Plan authorizes community supports for eligible members in a medically appropriate, equitable, and non-discriminatory manner in accordance with Health Plan's policy UM01 Authorizations and Referral Review.
- KK. Health Plan monitors and evaluates community supports authorizations to ensure they are equitable and non-discriminatory minimally at least annually. Corrective action are implemented if evaluation findings identify instances where service authorizations have been inequitable or discriminatory.
1. Authorization timeframes for community supports are consistent with regulatory requirements for all UM decisions.
 - a. For routine referrals received by Health Plan, a decision is made within five (5) business days of receiving the necessary information to make a final determination and not to exceed 14 calendar days from receipt of the request.
 - b. For expedited referrals received by Health Plan, a decision is 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. When the authorization is approved, member are referred to the community supports provider to render services.
 - a. The community supports provider engages the member and document member consent to receive services.
 4. Health Plan monitors community supports through Closed Loop Referral as outlined in the DHCS Addendum to the PHM Policy Guide: Closed-Loop Referral Implementation Guidance.
 5. For routine member notification of an authorization decision, written notification is 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 results in written notification sent to the member within 72 hours from the date of receipt of the request.
 - a. This is in alignment with Health Plan's policies and procedures regarding member notification timeliness.

7. UM criteria is applied in an equitable and non-discriminatory manner for authorization decisions. Even though services provided through community supports are not health plan benefits, 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 is reviewed by 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.
 - a. Members are notified by mail dependent on how the appeal was classified, either standard or expedited. For standard requests, a letter is sent to the member within two business days of the decision date. For expedited requests, a letter is 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, Health Plan 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 in accordance with Health Plan Policy UM 07 Notice of Action for Delayed, Denied, Modified, or Terminated Services
10. Health Plan ensures payment to Community Supports Providers is in accordance with regulatory timeframes and Health Plan Policy CLMS13 Reimbursement of Services Claims.
 - a. As stated in Health Plan's Provider Contracts, 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.
 - b. The date of receipt is the date Health Plan receives the claim, as indicated by its date stamp on the claim.
 - c. The date of payment is the date on the check or other form of payment.
 - d. 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 is the EDI 837 process.

- a. For community supports providers that do not have an NPI number, Health Plan provides resources for the provider to obtain an NPI number for claims submittal.
 - b. Health Plan works with providers to ensure they provide NPI, taxonomy and data elements required in DHCS billing guidance.
12. 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.
13. 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 Health Plan's Provider Portal or a secure file transfer protocol (SFTP):
 - a. Member assignment files via provider portal or secure file transfer protocol
 - b. Encounter and claims data via provider portal or secure file transfer
 - c. Physical, behavioral, administrative and SDOH data
Physical, behavioral, and administrative data is shared between the ECM Team, the CM Team, ECM and community support Providers via a common care management software or SDOH platform.
 - d. Reports of performance on quality measures/metrics from Health Plan's HEDIS team.
 - e. For community supports referrals, a closed-loop referral pathway is achieved via the utilization management and care management modules of Health Plan's medical management system.
14. Health Plan monitors Member access to care through access studies, review of grievances, and other methods. Access to community supports complies with regulatory timely access standards. Health Plan monitors community supports engagement, and utilization data according to the following methods:
 - a. Number of members receiving community supports, access, and utilization metrics are reported on a regular basis with

- guidance to improve adverse findings per committee direction.
- b. Eligible members identified through Health Plan's reports, consultation, authorizations, and encounter and claims data are tracked to ensure access community supports is compliant with regulatory standards.
 - i. Authorization files, with at least 18 months of historical data, is sent to providers monthly, as agreed upon.
 - ii. Data is submitted via Health Plan's web-based portal.
 - c. Utilization analysis includes monitoring inpatient admissions and emergency room visits with the purpose of identifying effectiveness of the services being utilized.
 - d. On a quarterly basis, 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.
 - e. 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.
- LL. Health Plan produces an annual evaluation for internal and external stakeholders which summarizes the progress, achievements, and opportunities for growth of Health Plan's community supports. Health Plan utilizes the annual Population Health Needs Assessment, which may assist in driving which community supports Health Plan provides.
- MM. At least annually, or more frequently as needed, 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, are used to ensure community supports provider contract compliance.
- NN. Audit scope includes, but not be limited to:
- 1. Requirements under the current All Plan Letter
 - 2. Quality of Care Standards
 - 3. Contractual obligations
- OO. 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 Health Plan on key topics.

2. Enhanced practice coaching or Manager support.
 3. Conference between community supports provider leadership and Health Plan's leadership to discuss barriers to improvement and compliance with minimum standards.
- PP. The community supports care management system chart audit supplements the quantitative data elements listed above by providing 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.
- QQ. Health Plan monitors cost-effectiveness of the selected community supports services by evaluating projections and provider contracts. Health Plan utilizes monthly reviews and financial tracking mechanisms for a comprehensive view of community supports performance. 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.
- RR. To assist in evaluating community supports effectiveness and opportunities for quality improvement, various data sources are 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.
- SS. Health Plan monitors the utilization and/or outcomes resulting from the provisions of community supports at least quarterly and report to the Quality Improvement Health Equity Committee (QIHEC). Additionally, 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
- TT. 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. Number of Sobering center visits vs. inpatient/ER visits
 - b. Sobering center cost vs. ER cost
 8. Health Plan provides the required monitoring reports to DHCS in a file, format and frequency as specified by DHCS.

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, Policy Guide Volume 1 & 2
- C. Department of Health Care Services (DHCS) Addendum to the PHM Policy Guide: Closed-Loop Referral Implementation Guidance
- D. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013 Provider Credentialing/ Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004)
- E. DHCS APL 21-017: Community Supports Requirements
- F. DHCS APL 23-003: California Advancing and Innovating Medi-Cal Incentive Payment Program (Supersedes APL 21 – 016)
- G. DHCS Contract Exhibit A, Attachment III, Section 4.5
- H. Health Plan Policy CLMS13 Reimbursement of Services Claims
- I. Health Plan Policy CM 73 Enhanced Care Management
- J. Health Plan policy CONT 001 Provider Contracting: Review and Execution of Provider Contracts
- K. Health Plan Policy CONT05 Provider Recruitment
- L. Health Plan Policy QM 47 Initial Assessment, Verification, and Ongoing Monitoring of Facility, Ancillary and Organizational Providers
- M. Health Plan Policy UM 01 Authorization and Referral Review
- N. Health Plan Policy UM 07 Notice of Action for Delayed, Denied, Modified, or Terminated Services
- O. Health Plan Policy UM 093 Transitional Rent

VI. REVISION HISTORY

Version*	Revision Summary	Date
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000	4/23, 6/23, 7/23	N/A
001	Moved UM50 to new template	12/22/2023
002	Update to reflect updated community supports definition and processes, as well as other requirement change. Clean up formatting and firm up language	8/7/2025
Initial Effective Date: 1/1/2022		
Published Date: 02/03/2026		

VII. Committee Review and Approval to be Completed by Compliance

Committee Name	Version	Date
Compliance Committee (CC)	002	02/02/2026
<ul style="list-style-type: none"> Privacy & Security Oversight Committee (PSOC) 		
<ul style="list-style-type: none"> Program Integrity Committee (PIC) 		
<ul style="list-style-type: none"> Audits & Oversight Committee (AOC) 		
<ul style="list-style-type: none"> Policy Review Committee (PRC) 	001	11/15/2023
Quality Improvement Health Equity Committee (QIHEC)	001	7/19/2023
<ul style="list-style-type: none"> Quality Operations Committee (QOC) 		
<ul style="list-style-type: none"> Grievance Committee (GC) 		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
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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