



Policy and Procedure No: UM 60.7	Revision No: 7
Division: Care Management	
Department: Utilization Management	
Title: PHC-CA CalAIM Community Supports Referral and Authorization	
Effective Date: 1/1/2022	
Supersedes Policy No: UM 60.0, UM 60.1, UM 60.2, UM 60.3, UM 60.4, UM 60.5, UM 60.6	
Reviewed/Revised by: Adam Villalpando	Review/Revision Date: 10/8/2025
Approving Committee: Utilization Management Committee	Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

The purpose of this policy is to describe the referral and authorization process for Community Supports requests.

Policy:

1. The Health Plan makes Community Supports benefits available through its referral and authorization process to all enrollees upon request.
2. The Health Plan accepts Community Supports requests from providers, community-based entities, enrollees and their families, guardians, authorized representatives, and caregivers. The plan follows DHCS guidance concerning closed loop referrals as described in PHC California Policy and Procedure CM 23, CalAIM Closed Loop Referrals for Community Supports and Enhanced Care Management.
3. The Health Plan directly authorizes the following Community Supports:
 - a. Medically Tailored Meals/Medically Supportive Food
 - b. Personal Care and Homemaker Services
 - c. Housing Tenancy and Sustaining Services
 - d. Housing Deposits
 - e. Housing Transition Navigation Services
 - f. Transitional Rent, effective January 1, 2026
 - g. Environmental Accessibility Adaptations (Home Modifications)
 - h. Community or Home Transition Services
 - i. Assisted Living Facility (ALF) Transitions
 - j. Recuperative care (medical respite)

4. The Health Plan does not place restrictions, including geographical restrictions, on the availability of Community Supports beyond the eligibility criteria described in this policy and procedure.
5. The Health Plan deauthorizes Community Supports for enrollees who no longer qualify for, no longer require, or no longer want to receive Community Supports services.
6. Should the Health Plan encounter Community Supports provider shortages or lack of provider capacity to serve enrollees within its contracted network, the plan will negotiate letters of agreement (LOA) with other providers with the necessary capacity.
7. The Health Plan strives to ensure timely provision of Community Supports services without resorting to waitlists should it encounter provider shortages or lack of provider capacity within its contracted network.

Procedure:

Coverage and Coordination

1. Medically Tailored Meals/Medically Supportive Food
 - a. Member has an authorization request approved for MTM/MSF
 - b. The Health Risk Assessment, Social Determinants of Health Survey (SDOH) and/or Plan of Care indicates food scarcity/insecurity.
 - c. Transition of Care (TOC) post-discharge MTM/MSF indicates food scarcity/insecurity or needed support with meal services.
 - d. Members are eligible for up to two (2) meals per day.
 - e. Enhanced Care Management (ECM) Care Manager will perform initial assessment of member to determine need for services. ECM staff will obtain verbal consent from member and document such consent in the care management system session notes.
 - f. ECM staff will re-evaluate member every four (4) weeks to identify if members has a continued need for services.
 - g. The ECM staff shall notify the Utilization Management department if a member has a change in status that would necessitate cancellation of meal delivery, such as an inpatient admission.
 - h. ECM Care Manager will obtain verbal consent from member for meal delivery service and document consent in the Health Plan's care management medical record.
2. Personal Care and Homemaker Services
 - a. This benefit is available to members based on patient's Health Risk Assessment, Social Determinants of Health Survey (SDOH) and/or Plan of Care indicates that the enrollee needs assistance with activities of daily living (ADLs)
 - b. ECM Care Manager will obtain verbal consent from member for services and document

consent in the Health Plan's care management medical record.

c. Members are assessed yearly and as needed based on change in health condition.

3. Housing Tenancy and Sustaining Services

a. This benefit is available to members who meet the following eligibility:

- i. Any individual who received Housing Transition/Navigation Services Community Supports in counties that offer Housing Transition/Navigation Services.
- ii. Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization, or requiring residential services as a result of a substance use disorder, and/or exiting incarceration; or
- iii. Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, Institutions for Mental Diseases, and State Hospitals; or
- iv. Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
 - (1) An individual or family who:
 - Has an annual income below thirty (30%) percent of median family income for the area, as determined by HUD;
 - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
 - Meets one of the following conditions:
 - Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance.
 - Is living in the home of another because of economic hardship.

- Has been notified in writing that their right to occupy their current housing or living situation will be terminated within twenty-one (21) days after the date of application for assistance.
 - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals.
 - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau.
 - Is exiting a publicly funded institution or system of care (such as a health care facility, mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan
- v. Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining Services if they have significant barriers to housing stability and meet at least one of the following:
 - Have one or more serious chronic conditions;
 - Have a serious mental illness.
 - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents)
 - Are receiving Enhanced Care Management
- b. This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:
 - i. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
 - ii. Education and training on the roles, rights, and responsibilities of the tenant and landlord.
 - iii. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
 - iv. Coordination with the landlord and case management Provider to address identified issues that could impact housing stability.

- v. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the member owes back rent or payment for damage to the unit.
- vi. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
- vii. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skill set. 8. Assistance with the annual housing recertification process.
- viii. Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
- ix. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
- x. Health and safety visits, including unit habitability inspections (does not include housing quality inspection).
- xi. Other prevention and early intervention services identified in the crisis are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).
- xii. Providing independent living and life skills, including assistance with and training on budgeting, including financial literacy and connection to community resources.

c. The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan and the Plan care management system. Individuals may require and access only a subset of the services listed above.

d. Enhanced Care Management (ECM) team member will perform the initial assessment of member to determine the need for services. ECM staff will obtain verbal consent from the member. The consent will be documented in the Health Plan's care management medical record.

e. Members are assessed yearly and as needed based on changes in health condition and/or housing status.

4. Housing Deposits

This Community Support assists with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household.

The ECM Program Manager is responsible for assessing homeless enrollees and those at risk of becoming homeless for eligibility for housing deposits. Should an enrollee be eligible for any of the services available under this community support, the ECM Program Manager determines which

services are necessary and refers the request to the Health Plan Administrator to order/obtain the services necessary (with the exception of DME orders).

a. Eligibility:

- i. Individuals who received Housing Transition Navigation Services.
- ii. Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration; or
- iii. Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder.

b. Services Available:

- i. Security deposits required to obtain a lease on an apartment or home.
- ii. Setup fees/deposits for utilities or service access and utility arrearages
- iii. First-month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
- iv. Application fees to cover the cost of the lease application.
- v. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
- vi. Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services designed to preserve an individual's health and safety in the home, such as hospital beds, Hoyer lifts, air filters, and specialized cleaning or pest control supplies etc.
- vii. Total lifetime maximum: \$6,000

c. Required Documentation:

- i. Assessment of members' housing needs with pertinent details regarding need for support. This may include:
 - Pending lease document
 - Medi-Cal durable medical equipment (DME) denial letter

- Invoice for cleaning/pest service.
- Other documents as needed to verify review of service needs.

- d. The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access only a subset of the services listed above.
- e. Enhanced Care Management (ECM) team member will perform an initial assessment of the member to determine the need for services. ECM staff will obtain verbal consent from the member for services and document consent in the Health Plan’s care management medical record.
- f. Enrollees are assessed yearly and as needed based on a change in health condition and/or housing status.

5. Housing Transition Navigation Services

a. Eligibility:

- i. Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness or institutionalization or requiring residential services as a result of a substance use disorder and/or exiting incarceration; or
- ii. Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, Institutions for Mental Diseases, and state hospitals; or
- iii. Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
 - An individual or family who:
 - Has an annual income below thirty (30%) percent of median family income for the area, as determined by HUD;
 - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
 - Meets one of the following conditions:



- Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance.
 - Is living in the home of another because of economic hardship.
 - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within twenty-one (21) days after the date of application for assistance.
 - Lives in a hotel or motel and the cost of the hotel or motel 9 stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals.
 - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau.
 - Is exiting a publicly funded institution or system of care (such as a health care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.
- iv. Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
- Have one or more serious chronic conditions.
 - Have a serious mental illness.
 - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents);
 - Are receiving Enhanced Care Management
- b. Housing Transition/Navigation Services must be identified as reasonable and necessary in the individual's individualized housing support plan. Service duration can be as long as necessary.
- c. Individuals may not be receiving duplicative support from other State or local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- d. Housing Transition Navigation Services assist members with obtaining housing and include:
- i. Conducting a tenant screening and housing assessment that identifies the member's

preferences and barriers related to successful tenancy. The assessment may include collecting information on the member's housing needs and on potential housing transition barriers, as well as identification of housing retention barriers.

- ii. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member's approach to meeting the goal, and identifies when other Providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
- iii. Searching for housing and presenting options.
- iv. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
- v. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skill set.
- vi. Identifying and securing available resources to assist with subsidizing rent (such as U.S. Department of Housing and Urban Development's Housing Choice Voucher Program (Section 8) or state and local assistance programs) and matching available rental subsidy resources to members.
- vii. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
- viii. Assisting with requests for reasonable accommodation, if necessary. (This is related to expenses incurred by the housing navigator supporting the member moving into the home.
- ix. Educating and engaging with landlords.
- x. Ensuring that the living environment is safe and ready for move-in.
- xi. Communicating and advocating on behalf of the member with landlords.
- xii. Assisting with arranging for and supporting the details of the move.
- xiii. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
- xiv. Identifying, coordinating, securing, or funding non-emergency, nonmedical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

e. The services provided should be based on individualized assessment of needs and documented

in the individualized housing support plan. members may require and access only a subset of the services listed above.

- f. Enhanced Care Management (ECM) team member will perform an initial assessment of the enrollee to determine the need for services. ECM staff will obtain verbal consent from the enrollee for services and document consent in the Health Plan's care management medical record.
 - g. Enrollees are assessed yearly and as needed based on a change in health condition and/or housing status.
6. Transitional Rent, effective January 1, 2026 – provides up to six months of rental assistance in interim and permanent settings to members who are experiencing or at risk of homelessness and meet other criteria listed below.
- a. Eligibility: must meet i, ii, and iii.
 - b. Clinical Risk Factor Requirement including one or more serious chronic physical health conditions. The Health Plan's enrollees fall into this category as all have an HIV/AIDS diagnosis.
 - c. Social Risk Requirement: Experiencing or at risk of homelessness.
 - d. Enrollee must meet one of the following requirements:
 - i. Transitioning Population Requirement: Either transitioning out of an institutional or congregate residential setting, transitioning out of a carceral setting, transitioning out of interim housing, transitioning out of recuperative care or short-term posthospitalization housing, transitioning out of foster care. Excluding transitioning out of foster care, an enrollee must receive authorization for Transitional Rent within six months (i.e., within 182 days) of the transition event (e.g., date of discharge, date of release). For six months from the date of authorization, the member may use the Transitional Rent benefit without a redetermination of eligibility.
 - ii. Experiencing Unsheltered Homelessness. Enrollees experiencing unsheltered homelessness, assuming satisfaction of the clinical risk factor eligibility requirement, may be authorized at any time. For six months from the date of authorization, the enrollee may use the Transitional Rent benefit without a redetermination of eligibility.
 - iii. Eligible for Full-Service Partnership (FSP). Enrollees eligible for FSP, assuming satisfaction of the social risk factor eligibility requirement (experiencing or at risk of homelessness), may be authorized at any time. For six months from the date of authorization, the enrollee may use the Transitional Rent benefit without a redetermination of eligibility.
 - e. Services available - Transitional Rent provides up to six months of rental assistance (in allowable settings) and rent and housing fees per demonstration, subject to the six-month global cap on Room and Board services within a rolling 12-month period. The six months of Transitional Rent are not required to be continuous. The Housing Deposits Community Support

may be deployed for coverage of additional expenses not provided under Transitional Rent.

- e. Allowable Settings include permanent settings in which there is a renewable lease agreement with a term of at least one month, such as single and multifamily homes, apartments, ADUs, shared housing, SRO units, tiny homes, recovery housing, and license-exempt room and board. Allowable settings also include interim settings in which there is no lease agreement, or the lease term is not renewable, such as SRO units, tiny homes, hotels/motels when serving as the member's primary residence, settings with a small number of individuals per room, and transitional and recovery housing with no lease agreement.
- f. Habitability Requirements – to follow DHCS requirement that allowable settings be compliant with applicable HUD quality standards or habitable as defined by state law, an attestation of compliance will be completed.
- g. Transitional Rent, Housing Transition Navigation Services (HTNS), and Housing Tenancy and Sustainment Services (HTTS) collaboration – the Health Plan expects that members eligible for Transitional Rent will have already been authorized for ECM and HTNS. The HTNS provider is responsible for assisting the enrollee in finding suitable housing in an allowable setting. The ECM Program Manager is responsible for assessing homeless enrollees and those at risk of becoming homeless for eligibility for Transitional Rent. Should an enrollee be eligible, the ECM Program Manager collaborates with the HTNS provider and determines whether transitional rent is necessary and refers the request to the Health Plan Administrator to order/obtain the services necessary. The enrollee will also be authorized automatically for Housing Tenancy and Sustainment Services if Transitional Rent is authorized.
- i. Transitional Rent with Housing Deposits – an enrollee may be eligible to receive both Housing Deposits and Transitional Rent in support of the same housing placement. As described in Procedure 4, Housing Deposits can cover the security deposits required to obtain a lease on housing but cannot cover room and board, including rent. Transitional Rent may therefore cover rent, including first and last month (previously covered by Housing Deposits). If an enrollee receives both Housing Deposits and Transitional Rent, the maximum amount of rental assistance they will be able to receive is six months through Transitional Rent (including first and last month's rent), with Housing Deposits covering the security deposit and other one-time services and modifications necessary to enable a person to establish a basic household.
- j. Transitional Rent Authorization Requirements – as a condition for authorization for Transitional Rent, the ECM Program Manager will determine 1) the enrollee is eligible for Transitional Rent and 2) ensure the Member has a housing support plan in place.
 - i. Permanent Settings – the ECM Program Manager, in collaboration with the HTNS/HTTS provider, will ensure that a comprehensive housing support plan has been developed, including identifying the payment source(s) and mechanism(s) to maintain housing.
 - ii. Interim Settings – beginning January 1, 2026, the Health Plan will be required to cover Transitional Rent for the Behavioral Health Population of Focus. Should the enrollee not be eligible for housing subsidies or vouchers to transition to at the end of the coverage

under Transitional Rent, the ECM Program Manager, in collaboration with the HTNS/HTTS provider, will coordinate with the County Department of Mental Health (DMH) and will confirm that the member is Behavioral Health Services Act (BHSA)-eligible, and will be able to transition to BHSA Housing Interventions at the expiration of Transitional Rent. The ECM Program Manager will also ensure that a housing support plan is in place prior to authorization for Transitional Rent.

7. Environment Accessibility Adaptations (EAA)

a. Eligibility

- i. Enrollees who are at risk for institutionalization in a nursing home are eligible for EAAs.
- ii. Clinical Documentation from the enrollee's current primary care physician or other health professional specifying the requested equipment or service;
- iii. Documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the member, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the member describing how and why the equipment or service meets the needs of the member will still be necessary.
- iv. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This evaluation should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
 - An evaluation of the member and the current equipment needs specific to the member, describing how/why the current equipment does not meet the needs of the member;
 - An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the member and reduces the risk of institutionalization. This should also include information on the ability of the member and/or the primary caregiver to learn about and appropriately use any requested item, and
 - A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the member and a description of the inadequacy.
 - If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and
 - That a home visit has been conducted to determine the suitability of any requested equipment or service.

b. EAAs include:

- i. Ramps and grab-bars to assist members in accessing the home;
- ii. Stair lifts;
- iii. Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- iv. Door widening for members who require a wheelchair;
- v. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the member; and
- vi. Installation and testing of a Personal Emergency Response System (PERS) for members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

c. The ECM Program Manager obtains verbal consent from member for EAA services and document consent in the Health Plan's care management medical record.

d. The services are available in a home that is owned, rented, leased, or occupied by the member. For a home that is not owned by the member, the member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.). This consent will be saved in the Health Plan's care management medical record.

8. Community or Home Transition Services

a. Covered Services

- i. Nonrecurring setup expenses for members who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.
- ii. Allowable Expenses (those necessary to enable a person to establish a community facility residence (except room and board) include but not limited to:
 - Assessing the member's housing needs and presenting options.
 - Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
 - Communicating with the landlord (if applicable) and coordinating the move.
 - Establishing procedures and contacts to retain housing.
 - Identifying, coordinating, securing, or funding non-emergency, nonmedical transportation to assist members' mobility to ensure reasonable accommodations

and access to housing options prior to transition and on move-in day.

- Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.
- Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household (funding that does not constitute room and board).

b. An initial assessment is required and to be loaded by the Director of Care Coordination or his or her designee.

c. Eligibility

- Currently receiving medically necessary nursing facility level of care (LOC) services and in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
- Has lived sixty (60) or more days in a nursing home and/or Medical Respite setting; and
- Interested in moving back to the community; and
- Able to reside safely in the community with appropriate/cost-effective supports services.

d. Restrictions

- Enrollee is participating in duplicative state, local, or federally funded programs.
 - Service does not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
 - Service must be necessary to ensure the health, welfare, and safety of the member, and without which the member would be unable to move to the private residence and would then require continued or re-institutionalization.
 - State Plan services to be avoided include, but are not limited to, skilled nursing facility services.
- e. Total lifetime maximum expense for this Community Support is \$7,500. However, to the limit of \$7,500 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 their control.
- f. Billing code for this Community Support is T2035 (community transition waiver) with modifier U5.
- g. Initial authorization period varies based on enrollee's needs. Reauthorization varies based on enrollee's needs.

9. Assisted Living Facility (ALF) Transitions

a. Covered Services

This Community Support assists enrollees live in the community and/or avoid institutionalization. The service is for enrollees who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facility for the Elderly (RCFE) or an Adult Residential Facility (ARF).

Services include:

- i. Assistance with bathing, dressing, grooming, ambulating/transferring
 - ii. Meals/snacks
 - iii. Housekeeping and Laundry
 - iv. Transportation
 - v. Activities
 - vi. Assistance with Medication
 - vii. Supervision/Preventing Wandering
- b. An initial assessment is required and to be loaded by the Director of Care Coordination or his or her designee.
- c. Eligibility

For Nursing Facility Transition:

- i. Enrolled in full scope Medi-Cal with Health Net with zero (0) share of cost;
- ii. Meets the level of care provided in a nursing facility due to their medical needs;
- iii. Has resided sixty (60) or more days in a nursing facility;
- iv. Is willing to live in an assisted living setting as an alternative to a nursing facility, that is part of the Assisted Living Waiver (ALW) program; and
- v. Can reside safely in an assisted living facility with appropriate and cost-effective supports.

For Nursing Facility Diversion:

- i. Is interested in remaining in the community;
- ii. Is willing and able to reside safely in an assisted living facility, that is part of the ALW program, with appropriate and cost-effective supports and services; and

- iii. Must be currently receiving medically necessary nursing facility level of care (LOC) or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an assisted living facility.

d. Authorization Requirements

Initial authorization will be issued for up to 6 months following receipt of all supporting documentation including the following:

- i. Admission face sheet
- ii. Individual plan of care
- iii. Copy of ALW application
- iv. ALW assessment

Reauthorization will be issued if enrollee needs additional time in an assisted living facility, a new referral form must be submitted and include the following:

- i. Reason for authorization extension
- ii. Individual care plan
- iii. Status of ALW application

- e. Billing code for this Community Support is T2038 (community transition) with modifier U4. H2022 (community wraparound services) with modifier U5.

f. Restrictions

- i. Enrollee is participating in duplicative state, local, or federally funded programs.
- ii. Enrollees who are directly responsible for paying their own living expenses.
- iii. State Plan services to be avoided include, but are not limited to, skilled nursing facility services, inpatient hospital services, and psychiatric inpatient stays.

g. Allowable expenses include but are not limited to:

- i. Assessing the member's housing needs and presenting options.
- ii. Assessing the service needs of the member to determine whether the member needs enhanced on-site services at the RCFE/ARF.
- iii. Assisting in securing a facility residence, including the completion of facility applications, and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
- iv. Communicating with facility administration and coordinating the move.

- v. Establishing procedures and contacts to retain facility housing.
- vi. Coordination to ensure that the needs of members who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports and/or enhanced care management services.

10. Recuperative Care (Medical Respite)

a. Covered Services

Members with unstable housing who no longer require hospitalization but still need to heal from an injury or illness, receive short-term residential care. The residential care includes housing, meals, ongoing monitoring of the member's condition, and other services like coordination of transportation to appointments.

Services include:

- i. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
- ii. Coordination of transportation to post-discharge appointments
- iii. Connection to any other on-going services an individual may require including mental health and substance use disorder services
- iv. Support in accessing benefits and housing
- v. Gaining stability with case management relationships and programs

b. Eligibility

- i. Individuals who are at risk of hospitalization or are post-hospitalization
- ii. Individuals who live alone with no formal supports
- iii. Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification
- iv. Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals. If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless to thirty (30) days.

a) Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

1. An individual or family who:
 2. Has an annual income below thirty (30) percent of median family income for the area, as determined by HUD;
 3. Does not have sufficient resources or support networks, e.g., family friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
- Meets one of the following conditions:
 - Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance;
 - Is living in the home of another because of economic hardship; o Has been notified in writing that their right to occupy their current housing or living situation will be terminated within thirty (30) days after the date of application for assistance;
 - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
 - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
 - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Recuperative Care services if they have significant barriers to housing stability and meet at least one of the following:

- i. Have one or more serious chronic conditions;
- ii. Have a Serious Mental Illness;

- iii. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or Have a Serious Emotional Disturbance (children and adolescents);
 - iv. Are receiving Enhanced Care Management;
 - v. Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence;
 - vi. Able to transition out of inpatient facility care, skilled nursing facility care, or other health care facility, and Recuperative Care is medically appropriate and cost-effective.
- c. Authorization Requirements
- Initial authorization will be issued within seventy-two (72) hours and be effective for up to ninety (90) days in continuous duration.
- d. Billing code for this Community Support is T2033 (Residential care, not otherwise specified (NOS), waiver; per diem) with modifier U6.
- e. Restrictions
- i. Recuperative care/medical respite is an allowable Community Supports service if it is necessary to achieve or maintain medical stability and prevent hospital admission or re admission, which may require behavioral health interventions
 - ii. Will be no more than 90 days in continuous duration
 - iii. Does not include funding for building modification or building rehabilitation.
- f. Licensing/Allowable Providers:
- i. Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.
 - Interim housing facilities with additional on-site support
 - Shelter beds with additional on-site support
 - Converted homes with additional on-site support
 - County directly operated or contracted recuperative care facilities

Referral and Authorization Process

1. Requests for Community Supports requiring prior authorization from the Health Plan are to be submitted to the Utilization Management Department by phone, fax, portal, email or mail. Decisions and Notifications are made by the UM Department based on the type of request (Urgent Pre-Service, Non-Urgent Pre-Service) and are detailed in the guidelines set forth in: Attachment A "Utilization Management Timeliness Standards." The Plan authorizes Community Supports in an equitable and non-discriminatory manner.
2. The Health Plan automatically authorizes member-initiated requests that the Health Plan receives directly from the member, family, or authorized representative (AR) for those newly enrolled members who were receiving Community Supports through their previous Medi-Cal managed care plan.
 - a. The Health Plan makes a good faith effort to request records from the prior managed care plan once the member has initiated the Community Supports enrollment request.
 - b. The Health Plan utilizes the data from the DHCS Plan Data Feed to review the historical utilization data using a ninety (90) day look-back period to identify members who have received Community Supports. Therefore, members, family or authorized representatives do not need to make a direct request for continuity of Community Supports (ILOS) received through their previous Medi-Cal managed care plan.
 - c. When the Health Plan receives enrollment for a new member previously enrolled in another Medi-Cal managed care plan, the Health Plan contacts the member or AR to complete an assessment and confirm whether the member was receiving Community Supports through their previous Medi-Cal managed care plan. The Health Plan also outreaches the Community Supports Provider. The Health Plan makes a good faith effort to mitigate any gaps in care for the member.
3. Once a request is received an authorization number is assigned through the Health Plan's Care Management and Utilization Review System.
 1. The Health Plan does not pend authorization requests for reasons other than missing documentation. Referral and authorization requests, if pending for missing data, are subject to the UM Timeliness Standards contained in PHC California Policy and Procedure UM 22, Authorization Referral Process. Following DHCS Community Supports Policy Guide, Volume 1, Updated April 2025, the Health Plan recognizes that supporting documentation is not required to authorize Community Supports. The Health Plan uses data already available to the Plan including care management records, claims history, prior authorizations, etc. If clinical eligibility cannot be verified, the Health Plan may arrange additional assessments including records from the member's primary care provider.
 2. Notifications to members completed via telephone and to Providers in writing via fax, within the timeframes specified in PHC California Policy and Procedure UM 22, Authorization Referral Process. Adverse determinations are determined by the Plan Medical Director/physician designee and require written notification per guidelines on adverse determinations. Only a physician holding an active, unencumbered state license may render an adverse determination regarding a service.
 3. Prompt phone notification of the authorization of services is provided to the member by the authorization coordinator. Timeframes for notifications are listed in PHC California Policy and Procedure UM 22, Authorization Referral Process.
 4. .

5. Members always retain the right to file appeals and/or grievances if they request one (1) or more Community Supports offered by the Plan but were not authorized to receive the requested Community Support because of a determination that it was not medically appropriate or cost effective.
6. Members are not required to utilize Community Support. Members always retain their right to receive the Medicaid state plan covered service on the same terms as would apply if a Community Support was not an option in accordance with regulatory requirements.
7. When federal law requires authorization for data sharing, the Health Plan shall support Community Supports Providers with obtaining and/or documenting such authorization from each assigned member, including sharing of protected health information (PHI). 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. Community Supports Provider will be reimbursed only for services that are authorized by the Health Plan.

Medical Necessity

1. Authorizations or adverse determination of service requests that are based on medical necessity, are treated as follows:
 - a. Review of supportive clinical information received with requests for authorization of service
 - b. Additional documentation may be requested if deemed necessary by the reviewer or Plan Medical Director, i.e., test results, labs, images, physician findings
2. Upon request to the Member Services Department, a member or provider may obtain a description of the process used to determine whether health care services are medically necessary, including the source of any third party criteria that were referenced in the decision.
3. The member and provider are issued a written notification of adverse determinations issued by on the basis of medical necessity with a full description of the reason for the determination. Results of notification will be distributed within two (2) working days.
4. Any change in the Plan's definition of "medically necessary", "medical necessity" or the process used to determine medical necessity shall be reported to the appropriate state regulator immediately by the Plan's Medical Director or his/her designee.

Discontinuation/Deauthorization of Community Supports

1. In the event an enrollee no longer qualifies for, no longer requires, or no longer wants to receive Community Supports services:
 - a. The ECM Care Manager notifies the Community Supports provider of the services to be discontinued and the date of discontinuation.

- b. The Utilization Management Department sends a Notice of Action (NOA) to the enrollee informing the enrollee when the Community Support service is ending.
 - i. A NOAs is not needed if the enrollee was informed at the beginning of service delivery (i.e., when a Medically Tailored Meal service is authorized for three months, the Member is informed at the beginning of the authorized period of service).
 - ii. A NOA is not necessary if the Member has opted out of the Community Support service.
2. The Health Plan determines that an enrollee no longer qualifies for or no longer requires services by:
 - a. Receiving notification that the enrollee has disenrolled from PHC (either voluntarily or through lapsed Medi-Cal benefits).
 - b. Receiving new information from the enrollee during ECM outreaches and assessments that would make member ineligible for the Community Support authorized (i.e., when an enrollee is newly approved for county-provided IHSS and no longer requires or is eligible for Personal Care and Homemaker Services).
 - c. Receiving information from Community Supports Providers during ICT meetings that indicates the enrollee has met previously set goals (i.e., enrollee authorized for Housing Sustainment and Tenancy and has successfully remained housed more than 12 months).
 - d. The enrollee requests a Community Supports service be terminated.

Provider Capacity/Shortages

1. In the event the ECM Care Manager encounters a contracted Community Supports capacity issue or shortage of a provider of the service needed, he or she submits an LOA request to the Contracting and Provider Relations team so it can look for a provider to take on any affected members.
2. The Contracting and Provider Relations team will establish an LOA with the needed Community Supports provider who is willing to take on affected members.
3. Should the Health Plan encounter a situation where a provider shortage or capacity limitation affects multiple members, the ECM Care Manager will review affected members' clinical information to determine priority for service. Because Health Plan will not create member waitlists for services, the Health Plan will actively work to find alternative providers to serve enrollees.

Definitions:

1. "Medically necessary" or "medical necessity" - medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice

parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature.

2. Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit. The Health Plan's Care Management Department serves as the ECM Provider.
3. "Food Insecurity" or "Food insecurities": The disruption of food intake or eating patterns because of lack of money and other resources.
4. Community Supports/In Lieu of Services: Pursuant to 42 CFR 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. Community Supports are optional for both the Health Plan and the enrollee and must be approved by DHCS. DHCS already has authorized the list of Community Supports included in Section 2: DHCS-Approved services.
5. Care Manager: A enrollee's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with the Health Plan, as described in the DHCS-MCP ECM and ILOS Contract, Section 4: ECM Provider Capacity). The Care Manager operates as part of the enrollee's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Supports. The Care Manager is responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services.
6. "Urgent pre-service" or "Expedited pre-service": When the service requested is required to prevent serious deterioration in the patient's health or could jeopardize the patient's ability to regain maximum function.

Monitoring:

Quality Management Committee: Utilization Management submits reports of UM activities to include breakdown and analysis reports on the number and types of appeals, denials, deferrals, and modifications, as well as timeliness reports of referrals and authorizations to the appropriate QIS to be reviewed on a quarterly basis.

Additionally, the Plan also develops, analyzes and reviews reports in an effort to make Community Supports more equitable by addressing barriers in several domains: access to health care; health care quality; patient education and empowerment. Any Community Supports referrals not fully authorized will be reviewed to ensure service was not denied inequitably. If services are found to be denied in a discriminatory or inequitable manner, services will be authorized within one (1) business day of review, and a Corrective Action Plan (CAP) will be implemented.

This policy will be reviewed and revised, as necessary and approved annually by the Utilization Management Committee.

Reference(s):

4. DHCS Contract 23-30211, Subsection 4.4.7, Authorizing Members for Enhanced Care Management.
5. **Attachment A:** UM Timeliness Standards
6. DHCS Community Supports Policy Guide, Volume 1, Updated April 2025
7. DHCS Community Supports Policy Guide, Volume 2, Updated April 2025
8. PHC California Policy and Procedure CM 21, CalAIM Community Supports Enrollee Identification
9. PHC California Policy and Procedure CM 23, CalAIM Closed Loop Referrals for Community Supports and Enhanced Care Management.
10. PHC California Policy and Procedure UM 22, Authorization Referral Process.

Regulatory Agency Approvals:

Date	Version	Agency	Purpose	Response
	60.5	Dept. of Health Care Services (DHCS)	January 2025 Community Supports Model of Care, updated August 2024	Approved
10/7/2025	60.6	DHCS	January 2026 Community Supports Model of Care	Returned with inquiry
TBD	60.7	DHCS	January 2026 Community Supports Model of Care	Pending