



Policy and Procedure No: CM 20.2		Revision No: 2
Division: Care Management		
Department: Care Management		
Title: PHC- CA CalAIM Health Plan Responsibility for Administration of Community Supports)		
Effective Date:1/1/2022		
Supersedes Policy No: CM 20.0, CM 21.1		
Reviewed/Revised by: Tiffany Jarrett		Review/Revision Date: 6/19/2025
Approving Committee: Utilization Management Committee		Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025		

Purpose:

To define PHC California’s (the Health Plan) responsibility for administration of the CalAIM Community Supports (ILOS) program.

Policy:

1. The Health Plan participates in the CalAIM Community Supports (ILOS) program.
2. The Health Plan is approved by Department of Health Care Services (DHCS) to offer its enrollees one (1) or more of the following Community Supports:
 - a. Housing Transition Navigation Services
 - b. Housing Deposits
 - c. Housing Tenancy and Sustaining Services
 - d. Recuperative Care (Medical Respite)
 - e. Assisted Living Facility (ALF) Transitions
 - f. Community or Home Transition Services
 - g. Personal Care and Homemaker Services
 - h. Environmental Accessibility Adaptations (Home Modifications)
 - i. Medically Tailored Meals/Medically Supportive Food
 - j. Transitional Rent, effective July 1, 2026
3. The Health Plan adheres to DHCS guidance on eligible populations, code sets, potential Community Supports providers, and parameters for each Community Support the Health Plan chooses to provide.
4. The Health Plan makes best efforts to maintain a robust network of providers to deliver all elected Community Supports.

5. In the event the Health Plan requests an alternate approach involving narrowing eligible populations, including specifying such limitations in the Member Services Guide/EOC and on the Health Plan's website, the Health Plan provides public notice in addition to receiving DHCS' written approval.
6. The Health Plan documents its process for determining documentation to ensure appropriate clinical support for the medical appropriateness of Community Supports. This process details that provision of the Community Support, recommended by a provider at the plan or network level using their professional judgment, is likely to reduce or prevent the need for acute care of other Medicaid services, including but not limited to inpatient hospitalizations, skilled nursing facility stays, or emergency department visits.
7. The Health Plan ensures that the Community Supports services supplement and not supplant services received by the enrollee through other State, local, or federally funded programs, in accordance with federal and state guidance.

Procedure:

1. The Health Plan's Care Management Department identifies individuals who may benefit from Community Supports and for whom Community Supports may be a medically appropriate and cost-effective substitute for State Plan Covered Services (see Policy No. CM 21). The UM Department authorizes Community Supports for enrollees deemed eligible.
2. The Utilization Management (UM) Department, in consultation with the Enhanced Care Management (ECM) Program Manager, determines the frequency of services based on medical appropriateness.
3. The Utilization Management Department authorizes a duration of services valid for ninety (90) days, at which time the department conducts a reevaluation of the medical appropriateness. Changes in the plan of care may trigger a reevaluation sooner than ninety (90) days.
4. The ECM Program Manager completes documentation of the need for Community Supports services and includes this in a care plan developed for the enrollee.
5. As needed, the Health Plan Administrator submits requests to DHCS to offer pre-approved Community Supports not previously offered, or new supports in addition to DHCS' pre-approved Community Supports.
6. The Utilization Management Department ensures the underlying State Plan services are made available to the enrollee if medically necessary, or if the enrollee declines Community Supports.
7. The Health Plan's Utilization Management Department accepts referrals for Community Supports from enrollees and on behalf of enrollees from providers and community-based organizations:
 - a. The Health Plan reviews relevant policies and procedures regarding Community Supports Provider background checks on all providers who are seeing enrollees. The Health Plan will maintain roster lists of all Community Supports staff that are seeing Members. Community Supports Provider shall have policies and procedures to verify the professional requirements and participation status ("Participation Status") of its Participating Physicians and its Subcontractor and/or agents (collectively "agents"). Community Supports Providers shall



meet Health Plan’s Participation Status requirements during the term of Provider’s contract with Plan. Community Supports Providers shall immediately disclose to Health Plan any pending investigation of itself or its Participating Physicians or agents involving the suspension, exclusion or debarment of Community Supports Providers or agents occurring or discovered during the term of this Agreement. Community Supports Providers shall take immediate action to remove any agent that does not meet Participation Status requirements from furnishing items or services related to Provider’s contract with Plan (whether medical or administrative) to Members.

8. The Medical Director Is responsible for Concurrent Review decisions resulting in a denial, deferral or a modification, which includes termination, reduction or suspension of an existing service, as well as the denial, in whole or in part, of an initial request for service, based on medical necessity. Adverse decisions pertaining to care that is underway shall be communicated to the enrollee's treating provider within twenty-four (24) hours. Care is not discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the enrollee.

Definitions:

1. Community Supports/In Lieu of Services (ILOS): Community Supports/In Lieu of Services (ILOS): Pursuant to 42 CFR 438.3(e)(2), Community Supports (ILOS) 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 (ILOS) are optional for both Contractor and the Member and must be approved by DHCS. DHCS already has authorized the list of Community Supports (ILOS) included in Section 2: DHCS-Approved Community Supports (ILOS) (“pre-approved Community Supports (ILOS)”) services [See ILOS Section 2: DHCS Pre-Approved ILOS].

Monitoring:

The Utilization Management Committee reviews this policy and procedure annually and updates it accordingly.

Reference(s):

1. DHCS Community Supports Policy Guide, Volume 1, Updated April 2025
2. DHCS Community Supports Policy Guide, Volume 2, Updated April 2025
3. DHCS Contract 23-30211, Exhibit A, Attachment III, Section 4.5 Community Supports.

Regulatory Agency Approval(s):

Date	Version	Regulatory Agency	Purpose	Response
Not avail.	20.1	Department of Health Care Services (DHCS)	January 2025 Community Supports Model of Care	Approved
TBD	20.2	DHCS	January 2026 Community Supports Model of Care	Pending

