California | Anthem Blue Cross | Medi-Cal Managed Care

Community Supports Provider Guide

Version 1.2

CABC-CD-072747-24 March 2025

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Introduction to Community Supports

California Advancing & Innovating Medical (CalAIM) was launched January 1, 2022, by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal Managed Care (Medi-Cal) beneficiaries by implementing a broad delivery system, programmatic and payment system reforms. A key feature of CalAIM is the introduction of a new menu of Community Supports (CS), which, at the option of Anthem, a member can substitute for covered Medi-Cal services as cost-effective alternatives. Anthem is responsible for administering CS to their members. For more information about CalAIM, see DHCS' **Community Supports Policy Guide** released in July 2023.

Community Supports are an important part of the care delivery for members enrolled in Enhanced Care Management (ECM), another CalAIM initiative that addresses the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services and comprehensive care management. Members are not required to be enrolled in ECM to receive CS. The benefit and services built on the former Health Home Program (HHP) and Whole Person Care (WPC) Pilots and transitioned those services and Members to the ECM and CS statewide managed care benefit to provide a broader platform to build on positive outcomes from these programs. The overall goal of these new benefits and services under CalAIM is to provide comprehensive care and achieve better outcomes for the highest-need beneficiaries in Medi-Cal.

CS are voluntary, flexible wrap-around services or settings provided by Anthem and integrated into its population health management programs. CS are medically appropriate and cost- effective alternatives to services covered under the State Plan. The services are provided as a substitute for utilization of other services or settings such as a hospital or skilled nursing facility admissions. CS can effectively prevent discharge delays or deter emergency department use. CS will be integrated with care management for Members at medium to high levels of risk and fill gaps in state plan benefits to address medical or other needs that may arise from social determinants of health.

Effective January 1, 2022, Anthem voluntarily launched Medi-Cal CS services designed by the Department of Health Care Services (DHCS) and authorized by the Centers for Medicare and Medicaid Services (CMS). CS are optional for Members and include the following distinct services or settings:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transitions Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals/Medically Supportive Food
- Sobering Centers
- Asthma Remediation

Anthem has a county-specific approach for the implementation of CS based upon our DHCS Model of Care (MOC) submissions. Anthem has committed to standing up all 14 services in all active Counties by January 2025.

This CS Provider Guide outlines the requirements and expectations for CS providers contracted with Anthem. Anthem may provide updated versions of this CS Provider Guide in the future.

By entering into a CS agreement (contract) with Anthem, the CS provider agrees to follow the program requirements as established under Law, regulation, and through any service agreements between the Plan and DHCS, including Member Materials applicable to the Program. The CS provider will provide the CS services in accordance with all applicable Federal and State laws and regulatory guidance as outlined in the signed contract.

Getting Ready for CS: The CS provider

CS Providers are mostly local community-based entities with experience and/or training providing one or more of the CS approved by DHCS. CS providers do not have to have a history of serving
Medi-Cal Members. To contract with Anthem and before providing CS services, the CS Provider must meet several requirements.

Provider Experience and Qualifications

To become a CS provider, the CS provider will have demonstrated verifiable experience in providing these unique services. The CS provider will be able to communicate and offer services in a culturally and linguistically appropriate and accessible manner. The CS provider will have the capacity to provide timely services in some instances.

The CS provider will use a documentation care management system or process that supports the documentation of data and integration of information from other entities to support the management and maintenance of the CS services. Documentation systems may include Certified Electronic Health Record Technology or other documentation tools that can:

- Document and retain a Member's authorization for CS services.
- Support Member care coordination needs (in other words, allow for documenting close-looped referrals to ensure the follow-up with the Member is tracked and completed).
- Gather information from other sources (i.e., HMIS for housing providers).
- Support care team coordination and communication
- Support notifications regarding Member health status and transitions of care
- Support and track the CS services provided to the Member to enable CS providers to appropriately submit claims to Anthem.

Additionally, the CS providers must comply with all applicable state and federal laws/regulations and all CS program requirements in the DHCS-Anthem CS contract and associated guidance.

For providers who are interested in being contracted for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Day Habilitation, or Short-Term Post-Hospitalization Housing, Anthem strongly encourages all ECM and CS providers serving individuals experiencing homelessness to participate in their local Continuum of Care (CoC) **Homeless Management Information System (HMIS)** databases and has released the following **HMIS Guidance.** The Department of Health Care Services (DHCS) is also encouraging HMIS use and has identified it within the **DHCS ECM Policy Guide**, and highlighted HMIS-related systems such as the Coordinated Entry System (CES) within the **DHCS CS Policy Guide**. Anthem is also heavily encouraging the use of CES among providers in the following CES Guidance. For more information, see the Housing and Homeless Services Provider section.

Provider certification

The purpose of the CS provider certification process is to certify organizations that are qualified to serve as a CS provider. Certification is the process used by Anthem to evaluate and verify the potential CS provider's ability to comply with CS requirements as outlined by DHCS, including the ability to submit data files and claims.

To become a CS provider, organizations must meet the criteria described in the **CalAIM guidance** documents. Submitting a Letter of Interest (LOI) to Anthem is the first step to becoming a CS provider. Anthem will invite select organizations to submit the CS provider certification application with accompanying documentation supportive of their application and work with Anthem to establish an understanding of the CS requirements such as services offered, populations served, staffing, and system readiness as they relate to the prospective CS provider. Together the prospective CS provider and Anthem will determine where additional effort(s) will be necessary to meet the contracted CS provider requirements.

Anthem and the prospective CS Provider discuss, document, and agree on a Readiness and Gap Closure Plan to ensure the CS Provider's readiness prior to the go-live date. Key areas of focus for the Readiness and Gap Closure Plan include the domains outlined in the CS certification document:

#	Domain
1	CS Provider Current Service Overview and Provisions
2	CS Provider Proposed Service Provision, Staffing, Capacity, Operations and Cultural Competency
3	CS Outreach, Engagement, and Care Coordination
4	CS Data Collection, Exchange, Reporting, Consent, Billing
5	CS Infrastructure Needs
6	CS Provider Oversight and Monitoring
7	CS Service-Specific Eligibility Criteria and Service Provisions

Anthem and the prospective CS provider connect regularly to evaluate progress made toward closing the gaps documented in the plan. If the CS provider is unable to show that it meets the CS requirements and/or does not work to meet CS requirements, the CS provider cannot be certified by Anthem, and therefore cannot provide CS services. Anthem may request an on-site visit with the prospective CS provider during the certification process and or/program administration period.

Medicaid Enrollment/Vetting for CS Providers

Pursuant to relevant DHCS APLs including provider credentialing, recredentialing, and screening/enrollment ***APL 22-013 and APL 22-013 FAQ***, if a state-level enrollment pathway exists, the CS provider will enroll as a Medi-Cal provider. If APL 22-013 does not apply to a CS provider, the CS provider must comply with Anthem's process for vetting the CS provider, which may extend to individuals employed by or delivering services on behalf of the CS provider, to ensure it can meet the capabilities and standards required to be a CS provider. Anthem will request information from the CS provider to fulfill this requirement:

Experience and training in the elected CS:

- The CS provider must have experience and/or training in the provision of the community support(s) being offered.
- The CS provider must have the capacity to provide the community support(s) in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training, or other factors identified by the MCP.

If the CS provider subcontracts with other entities to administer its functions of CS, the CS provider must ensure agreements with each entity bind each entity to applicable terms and conditions set forth here.

In preparation for the contracting and to determine if a state-level pathway exists, the following must be completed:

- **Provider Application and Validation for Enrollment (PAVE)** — All CS providers must attempt to enroll as a Medi-Cal provider through the DHCS Enrollment Division's Provider Application and Validation for Enrollment (PAVE) system. At the end of the process, DHCS will issue you a 9- digit Medi-Cal provider numbers. Anthem must record this number in the contract and report this number to the State. Some non-traditional Medi-Cal providers (in other words housing agency) may not be able to enroll through PAVE. In this case, please alert your Anthem contracting points of contact as PAVE will be extended at the individual level.
    1. **National provider identifier (DHCS NPI Application Guidance)** — An CS provider must have at least one 10-digit organization-level Type 2 NPI number in order complete the contracting process. CS provider will submit claims at the NPI level. The State requires an NPI to enroll as a Medi-Cal provider. Anthem's member assignment algorithm considers a member's geographic proximity to providers. Providers serving multiple counties or working from multiple locations are encouraged to register multiple NPIs. If an organization already has an NPI, it can use that NPI for CS.
    2. **NPI taxonomy** — All providers must check the taxonomy codes listed in the organization's NPI profile are current and reflect the licenses and services that will be provided as part of its participation in the CS. If you need to add a code to reflect CS, please consider Taxonomy Code: 171M00000X-Case Manager/Care Coordinator. Taxonomy is used to process claims and to properly place your organization in Anthem's provider directory. For more information on Taxonomy please visit DHCS' NPI Application Guidance.

Contracting

In addition to the CS Certification application process, CS providers will work with Anthem to establish a contract and prepare to provide CS services by the agreed-upon start date.

The contracting process starts once the application review committee completes the pre-contracting certification process. and hands the applicant off to the Contracting department. Contracting has several required components, which may include:

- Scope of Work (DHCS Finalized ECM and CS Provider Standard Terms and Conditions)
- Provider agreement
- Disclosure of ownership
- *W-9 Form*
- Proof of insurance (professional, general, commercial auto)
- Business ASSOCIATES AGREEMENT
- Roster
- Rates

The contracting process involves an organization-level administrative certification process, which is separate from, and in addition to, the certification application process.

- **Credentialing** — Pursuant to *APL 22-013* licensed staff members who will be working on CS must submit their credentials to Anthem. Anthem requests that credentialed staff members enroll and submit their credentials via the Council of Affordable Quality Healthcare, Inc. (CAQH). This requirement extends to the licensed staff of any CS subcontractors if applicable.

Provider capacity & training

CS provider staffing and capacity

At all times, the CS provider must maintain staffing that allows for timely, high-quality service delivery of the CS that is consistent with the DHCS ECM and CS provider standard terms and conditions, the DHCS-Anthem CS contract, and any other DHCS guidance.

CS providers must accept and act upon Member referrals from Anthem for the authorized CS unless the provider is at a pre-determined capacity. CS providers must submit ongoing capacity progress reports as requested by Anthem at a minimum on a quarterly basis. Provider must also render an agreed-upon volume of community supports to members who are authorized for such services for the duration of the approved authorization and as long as the Member is enrolled with the health plan.

If at any time a CS provider has reached their maximum capacity and cannot accept additional member referrals for a period of time, the provider is required to notify the Anthem CS Service Coordination Team immediately via email.

Training

CS providers are expected to participate in all mandatory, provider-focused CS training and technical assistance provided by Anthem, including in-person sessions, webinars, and/or calls, as necessary.

CS providers are required to undergo new provider orientation training within 10 working days of when Anthem places a newly contracted CS provider on active status. The new provider orientation training in select Medi-Cal provider training areas including but not limited to cultural competency, policies and procedures, member rights and responsibilities, as outlined in all Medi-Cal Managed Care boilerplate contracts and other trainings specific to CS providers as outlined in the DHCS– MCP ECM and Community Supports Contract Template Provisions.

CS service providers may also have additional Anthem required training. Please refer to the specific CS section for any additional Anthem training requirements.

Conflict Free Care Management

Anthem recognizes that many CS providers may also provide CalAIM Enhanced Care Management (ECM). Best practice is that providers should maintain a separation between care management programs to reduce the risk of duplication of services, and to avoid decisions that are not in the best interest of the client. Anthem will allow ECM providers to also provide CS. However, Anthem's policy is that the ECM Lead Care Manager cannot also be a CS provider.

Anthem CS service coordination

Anthem's CS Service Coordination Team oversees referrals and authorization processes, in addition to working with CS Providers, ECM Providers, and Members to ensure service delivery. The Anthem CS Service Coordination Team reviews all referrals for eligibility determination and authorizes services as appropriate. For members not engaged in ECM, the CS Service Coordinator engages in service coordination, monitoring, and oversight for the duration of the services as needed. Anthem CS Coordinators are members of the Special Programs team and include LTSS RN Coordinators, LTSS Clinician Coordinators, LTSS non-Clinician Coordinators, Community Health Workers, and/or Housing Specialists. CS Service Coordinators are responsible for assessing members for CS needs, reviewing and approving CS referrals/requests; and coordination of services between the member/family, the CS provider, and the broader care team.

Identification of Members for CS

This section provides information on Anthem's responsibility for vetting of CS referrals, eligibility, and data sharing. Anthem will proactively identify members for CS eligibility through the use of our proprietary risk stratification and identification algorithm, which considers a variety of data sources and elements such as enrollment, claims, pharmacy, SDOH, HMIS, IHSS, and others as available. Upon identification through this method, information is posted in the case management platform that can be utilized across the MCP to identify Community Support needs during member outreach. If the Member participates in ECM, notification of authorized services for one or more CS will be sent to the ECM Provider via email or designated platform. If after review of the Member's care plan and goals, the ECM provider, and the Member wish to pursue a CS, the ECM provider will submit a referral for the CS through the provider website, along with any documentation required to substantiate the member's eligibility for the service(s).

CS referrals

Referrals for all CS services will be accepted from CS providers, ECM providers, community-based providers, primary care providers, other providers engaged in the member's care, and health professionals, at the request of the member or their representative.

Anthem will take a "No Wrong Door" approach to accepting referrals from an ECM provider, or other providers and entities supporting the member. Anthem will accept referrals electronically through the provider website, via phone, fax, or email. The provider website has a referral link to allow providers to complete a referral that is sent directly to the CS referrals intake queue for review. Referrals will be assigned a tracking number upon entering in the system and display the status of the referral, as well as any authorization and status, associated with the referral.

Providers may also access and find additional resources for Members and Caregivers through **The Community Resource Link by findhelp - Search and Connect to Social Care** on the Provider Website, as well as on Provider and public websites.

Similar to the Provider referral process, Anthem is taking a No Wrong Door Approach to accepting Member initiated referrals. Members may call the Anthem Customer Care Center toll free at **800-407-4627** (TTY **711**), or **888-285-7801** (TTY **711**) for members in Los Angeles. Referrals may be made by Members, their representative, family members, or others involved in the Member's life through phone, fax, or email.

How to submit a CS referral

CS providers should make referrals via the provider website whenever possible. This is a dedicated referral process for CS and ECM providers. Providers can view Member's associated CS attributes in the Provider Website. Providers may submit a referral for the CS through the Provider Website, along with any documentation required to substantiate the Member's eligibility for the service(s), as necessary. Other acceptable referral pathways include a fax or secure email (CalAIMReferrals@anthem.com). Providers are to complete the CS referral form (see Appendix A) and all supporting documentation as outlined on the referral form.

Referral Procedure

All referrals received for CS will be processed by Community Supports Service Coordinators or delegated team members, and the outcome of the referral will be shared with the referent by their preferred method of communication.

Referrals from ECM and CS Providers are accepted with or without documentation to support Member eligibility for the service. The Community Supports Service Coordinator may accept the elements on the referral form as true and to the best of the referral source's knowledge.

The CS Service Coordinator will initiate contact with the Member within 3 business days of receipt of the referral and include 3 attempts within 10 business days to assess for appropriateness and initiating the CS outlined below. The CS Service Coordinator may accept the referral sources noting member is aware of referral on the referral form as consent to having service authorized. If CS Service Coordinator can validate all criteria is met in Anthem systems or on referral form, no outreach is completed at time of the referral. If additional information is required, the CS Service Coordinator, or delegated team member, will outreach to Member and or Provider. The Anthem CS Service Coordinator will initiate requests for required documentation from the PCP or health professional within 3-5 business days. The assigned Provider obtains consent for services once they outreach and engage the Member.

For Members enrolled in ECM, the ECM Provider will be required to verify delivery of services by 10 business days and any subsequent follow-up deemed necessary.

If a Member, during initial outreach, cannot be reached within the specified timeframe, CS Service Coordinator will mail an unable to reach letter to the address on file. If a response is not received within 14 calendar days of the notification, a denial will be completed, the referral will be closed to outreach and the referring entity will be notified.

If services have been authorized and the Member is not responding to outreach, CS Service Coordinator will mail an unable to reach letter within the specified timeframe. Anthem will determine if a Notice of Action (NOA) will be initiated due to failure to respond to the notice within 30 days of the notification.

A review of accepted referrals will be completed within 5 business days after the receipt of the completed documentation. Standard CS Referral turnaround time is five business days. Urgent CS Referral turnaround time is 1 to 3 business days.

Best practices for urgent or expedited referrals are to mitigate any delays in the consent, review of eligibility, authorization, and placement processes. This includes immediate contact with the ECM and/or CS Provider to initiate the review of requested CS Services.

If after the review of the accepted referral, the Member is not eligible for the CS service, the CS Service Coordinator will identify if other applicable CS services are available. Additionally, the referral source will be notified that the Member is not eligible and provide additional updated services information.

If after review of the accepted referral, the Member is eligible for the CS service, the CS Service Coordinator will determine, based on Member's area of residence and Provider availability, which CS Provider has capacity to accept the Member. The CS Service Coordinator then authorizes services, and the assigned provider can view authorization and member details in the Provider website.

Whether the accepted referral is eligible or not eligible for the selected CS, the CS Service Coordinator will review and confirm ECM eligibility and assess Members interest, if not already engaged. If there is no need for Member outreach, the CS Service Coordinator will inform the assigned provider, and or referring part of the Member ECM benefit. When the CS Service Coordinator does contact the Member and they want to participate in ECM, the CS Service Coordinator will inform the Member of the ECM benefits and send a referral to the Anthem ECM team. The CS Service Coordinator will review for other CS services and recommend which services the Member appears eligible for and make referrals as appropriate. Members have the right to decline any and all CS services regardless of eligibility.

Population Health Management

Population Health Management (PHM) is an initiative of CalAIM that identifies and manages member risk and need through whole person care approaches while focusing on and addressing SDOH. To support PHM and overcome the challenges of collecting SDOH data, Anthem collects and analyzes data from health plan, State, County, and other public and proprietary sources.

CS Eligibility Criteria and Duplication of Services

Medi-Cal Managed Care Members are eligible to opt-in for the CS service if they meet certain eligibility criteria pertaining to the CS, considering geographically located Providers and capacity. Members may be eligible for one or more CS services simultaneously.

Community Supports shall supplement and not supplant services received by the Member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance. Examples may include services provided under a Medicare Advantage product, Multipurpose Senior Service Program or PACE program. If a Member is receiving duplication of services from other sources, CS Providers are expected to alert Anthem to ensure non-duplication of services. CS Providers are expected to follow Anthem's instruction and participate in efforts to ensure CS services are not duplicative.

Given the number of care management and care coordination programs, initiatives, or waivers in existence today, duplicative program exclusion criteria are intended to ensure that the most appropriate Members that would benefit from CS can participate.

The Member's right to choose between the CS services and other duplicative programs must always be maintained.

Anthem's Role in Member Outreach

For all referrals, prior to authorization or initiation of any CS, member outreach may occur to determine if the Member wants the CS service. If the member is enrolled in ECM, and the referral is not submitted by the ECM Provider, Anthem encourages the ECM Provider to check the Provider website to see approved CS services to ensure care coordination. If the Member is not assigned an ECM provider, the CS Service Coordinator may request that the assigned CS Provider follow-up with the Member during their contact to assess members interest in ECM. Members will be contacted within 3 business days for urgent referrals and 5 business days for standard referrals. Anthem or the CS Provider will provide education to the Member or Representative, regarding guidelines of the CS, including but not limited to eligibility requirements, restrictions, and program limitations.

During initial engagement, Anthem or the CS Provider are expected to identify, to the best of their ability if the Member meets any exclusion criteria or are enrolled in any duplicative care coordination programs as outlined in DHCS Community Supports Policy Guide.

Anthem or CS Provider shall communicate with the Member about other CS services or programs that may be available to the Member, as applicable, and complete referrals as needed.

It is important for Anthem, or the CS Provider to get the Member to authorize participation in CS services to ensure the Member is aware of the CS Provider's expectations of them and the Member's expectations for their service from the CS Provider. CS is an opt-in service.

There are no formal requirements for the CS Provider or Anthem to document a Member's consent before beginning to provide services.

DHCS has removed documentation requirements to streamline and simplify implementation

of the service. However, an individual may decline or discontinue CS at any time.

Anthem's Roles in Data Sharing

Obtaining, documenting, and managing Member authorization to share CS-related data and Personally Identifiable Information between Anthem, ECM, CS, other Providers and Personal representatives involved in the Member's care, when required by federal law, may be obtained by the ECM Provider, the CS Provider, the Anthem CS Service Coordinator or Anthem Care Manager. They will ensure Member understanding of their authorization to share information, including what information will be shared and with whom the information will be shared.

This authorization may be obtained and documented verbally and/or in writing based upon the requirements by Federal Law. Any limitations on the sharing of information that the Member requests must be documented and followed. Anthem will maintain this documentation in an area accessible to any staff who is authorized to engage in the Member's care. Also, upon obtaining this authorization, Providers may upload documentation of the authorization to the Member's electronic case file, viewable to Providers through the Provider website in the Member's information section. If Providers are unable to upload the documentation through the Provider website, Anthem will accept a secure communication from the Provider notifying Anthem an authorization has been obtained. Anthem will manually upload the documents into the secure Provider Website to ensure that information is current and up to date.

At a minimum, a CS Provider must be able to:

- Accept and integrate CS authorized members and their CS-specific and social needs data into processes to engage, assess, provide CS services, and coordinate care.
- Submit claims/encounters through Anthem's secure web-based website or through other method of providers choice using *CMS1500* or another approved invoice template.
- Gather and share member assessments, care plans, discharge summaries or any other documents as applicable for each contracted CS service.
- Report updates to members' status, services rendered, and additional care coordination and population identification data to CS Clinical Team when requested.
- Submit provider staffing, capacity, reporting and other administrative data as requested by Anthem if applicable.

CS Member Information Sharing

DHCS released the CS Member Information Sharing Guidance in April 2023. This guidance includes new standards for data exchange between managed care plans and CS providers. MCPs are required to utilize the minimum necessary specific data elements, as well as file formats, transmission methods and transmission frequencies, to initiate and track the progress of CS service delivery. Anthem implemented the two-way Member Information Sharing Process in September 2023 of the Authorization Status File and the Return Transmission File.

Authorization Status File

Each contracted CS Provider will receive a cumulative list of both Members who have been assigned to the Provider and Members referred to Anthem for authorization 18 months prior to the reporting dates. In addition, the file includes Member-level information that will also be shared. Anthem will share the ASF file biweekly, unless another mutually agreed-upon cadence for updates is established between Anthem and the CS Provider. Anthem will provide the ASF using an upload/download function in Availity.

Return Transmission File

The purpose of the CS Provider Return Transmission File is to allow CS Providers to share timely updates about service delivery with Anthem. Each contracted CS Provider will send back to the plan any Member-level information about the status of Member engagement and CS service delivery (to include Housing Status as of August 2024) for all Members who have been authorized to receive CS services during the most recent calendar month. The Return Transmission File (RTF) is to be submitted to Anthem monthly by date requested unless another mutually agreed-upon cadence for updates is established between Anthem and the CS Provider.

CS Authorization and CS Provider Outreach

CS Authorization Assignment

CS Providers can access the secure Provider website for the list of Members authorized for CS services including details on the duration and frequency of services.

Authorization reviews will be completed within 5 business days of receipt of completed documentation (3 business days for urgent/expedited). Authorizations will be sent to the CS Provider via fax, or email within 1 business day of the decision as well as viewable on the Provider Website. If Recuperative Care or Short-term Post Hospitalization CS are required after hours, and a delay could result in seriously jeopardizing the life or health of a Member or Member's ability to regain maximum function, the CS Provider may submit an authorization request by no later than 3:00 pm the next business day. Requests for Sobering Centers do not require an authorization.

Upon engagement with Members for the initiation of services, the CS Provider should provide education on guidelines of the service, including but not limited to eligibility requirements, restrictions, and program limitations.

Anthem may request supporting documentation from referring entities (ECM and CS providers, members, other organizations) to assist in the eligibility determination for members who are identified as potentially eligible for CS. Once Anthem makes a final determination regarding the member's eligibility, Anthem will notify the CS Provider. If the member is found to be ineligible for CS, Anthem will send a notification via fax, email, mail, or phone call regarding the ineligibility for CS services to the member and referring entity. If the referring entity is an Anthem provider, information is also available in the Provider Website.

Anthem will share documents, data and authorizations in the Provider website or secure email at the time of authorization/assignment necessary for the provision of CS services.

Obtaining, documenting, and managing Member authorization to share CS-related data and Personally Identifiable Information between Anthem, ECM, CS, other Providers, and Personal representatives involved in the Member's care, when required by federal law, may be obtained by the ECM Provider, the CS Provider, the Anthem CS Service Coordinator or Anthem Care Manager. They will ensure Member understanding of their authorization to share information, including what information will be shared and with whom the information will be shared. This authorization may be obtained and documented verbally and/or in writing based upon the requirements by Federal Law. Any limitations on the sharing of information that the Member requests must be documented and followed. Providers may upload any limitations during submission of a referral or through secure communication. Anthem will maintain this documentation in an area accessible to any staff who is authorized to engage in the Member's care.

Provision of Data from Anthem to the CS Provider

The CS Provider can utilize the Provider website to upload and download documentation to support the delivery and coordination of CS services. Providers can view necessary Member level data to address and utilize the physical, behavioral, social service, and administrative data and information from other entities – including Anthem, CS Providers, CS, and other county and community-based Providers – to support the management, maintenance, and sharing of a Member care plan and/or CS service provisions that can be shared with other Providers and organizations involved in each Member's care when this data is available.

Providers can view Member's associated CS attributes in the Provider Website. CS attributes are considered potential CS eligibility. Providers may submit additional referrals for any CS through the Provider Website, along with any documentation to substantiate the Member's eligibility for the service(s), as necessary.

CS Provider Member Outreach

Engagement of CS-eligible Members is critical for the program's success. CS Providers are responsible for conducting outreach to each authorized Member within 24 hours following notification.

CS Providers may be expected to conduct outreach through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community, depending on the specific service. This is especially critical for CS services such as Housing Transition Navigation, where in-person services are the expectation. The CS Provider may also utilize secure teleconferencing and telehealth, where appropriate and with the Member's consent.

Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week.

The CS Provider will provide culturally and linguistically appropriate and timely CS services to all authorized members in compliance with federal, State, and local laws, and in contracts with Anthem.

The CS Provider must comply with non-discrimination requirements set forth in State and Federal law and the Contract with Anthem.

Member Exit/Disenrollment Process

The following are examples of when Members may no longer be eligible for CS services:

- Service completion
- Does not meet medical necessity or services not found to be cost-effective.
- Member no longer wishes to receive CS services or is unresponsive or unwilling to engage.
- Other reasons a Member might disenroll include the following, but are not limited to:
  - Unsafe behavior
  - Enrolled in a duplicative program.
  - Medi-Cal termed or Member deceased
  - Switched to another health plan

The CS Provider must notify Anthem for any of the above disenrollment reasons as soon as possible.

If Member has an unplanned exit, ECM Provider or CS Service Coordinator will:

- Conduct immediate outreach to assess Member's status and needs.
- Coordinate as needed with Special Programs for additional services that may be necessary.

- CS Service Coordinator will end authorization for the date of exit, if applicable.
- CS Service Coordinator will send an NOA to Member using the address on file, if applicable.

Member Initiated Disenrollment

A Member can contact Anthem Customer Care or their CS Provider to request to disenroll or exit from CS services at any time if they no longer wish to receive the CS service. The Member may communicate directly with the ECM Provider, CS Provider, the assigned CS Service Coordinator or Anthem's Customer Care. ECM and CS Providers are responsible for relaying any and all requests for discontinuation, as soon as notified, to Anthem's CS Team. CS Service Coordinator will send a Notice of Action (NOA) to Member using the address on file, as applicable.

Anthem Initiated Disenrollment

Anthem will notify CS Providers, via the regular Member eligibility and authorization data in the Provider website of Members who no longer qualify for the CS service. If Anthem determines the Member is no longer eligible for CS, the CS Provider will be notified through the Provider Website and via email within one (1) business day of the determination being made.

Notice of Action (NOA)

When a CS service is discontinued, or will be discontinued for the Member, Anthem is responsible for sending an NOA notifying the Member of the discontinuation of the CS service and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA. Anthem must ensure authorization or a decision not to authorize CS services occurs in accordance with federal and existing state regulations for processing Grievances and Appeals.

The Medi-Cal NOA is a written notice that explains a Member's eligibility for Medi-Cal coverage or services. The NOA includes the eligibility decision and effective date of coverage, as well as any changes made in a Member's eligibility status or level of services. The NOA includes information about how a Member may appeal a decision if the Member disagrees with the eligibility determination.

Complaints, Grievances and Appeals

Member grievance and appeals

The standard grievance and appeals processes apply to CS for all members. If a member has concerns or complaints, the member can contact Anthem's Member Services. If the member feels that she has been wrongfully denied service authorization, or wrongfully disenrolled from CS, the member can initiate an appeal via Anthem's complaints, grievances and appeals and process by calling the Anthem Customer Care Center Monday to Friday, 7 a.m. to 7 p.m. toll free at **800-407-4627** (TTY **711**) for non-LA members, or **888-285-7801** (TTY **711**) for members in Los Angeles. A member grievance must be filed within 60 calendar days from the date of the letter notifying the member of a denial, deferral, or modification of a request for services.

A CS Provider may assist a Member to file complaints, grievances, and appeals, or may file a complaint, grievance, or appeal on behalf of a Member.

Provider grievance, appeals, disputes

Providers may also submit complaints, grievances, and appeals. See, ***Anthem Blue Cross Provider Manual*** **Grievance, Appeals, Disputes** section. Provider grievances and appeals are classified into the following two categories:

- Grievances relating to the operation of the plan including benefit interpretation, claim processing and reimbursement.
- Provider appeals of claim determinations including medical reviews related to adverse benefits determinations.

Claims Submission and Payments

Claims

In accordance with DHCS CalAIM Proposal dated, January 8, 2021, Anthem began providing payments to providers for whom CS have been authorized as medically appropriate and cost-effective alternatives to a State Plan service or setting in select counties as approved by DHCS in Anthem's CS Program. It is imperative that the procedure code-modifier code combinations represent the services that are being performed and modifiers are in the appropriate position. Providers must bill the amount they expect to get paid. Providers who bill less than their expected payment, will receive an amount up to their billed charge. The CS Provider is required to submit claims and encounter data for the provision of CS services to Anthem using the national standard specifications and code sets as defined by DHCS. Please see **ECM and Community Supports HCPCS Coding Options** for more information. This ensures that Anthem can effectively monitor the volume and frequency of CS service provision and shows the true cost of providing CS services to Anthem and DHCS. Anthem shall adjudicate 90 percent of all clean claims from Providers within 45 calendar days of date of receipt.

Anthem pathways for claims submission (in order or preference):

- Provider Website
- Electronic Data Exchange (EDI)
- Manual Invoice (via secure email):
  - To request the template and for invoice submission, send an email to CalAIMInvoices@anthem.com
- Paper Submission (CMS Form 1500 for Professional Claims)

For additional guidance, see **Anthem Medi-Cal Managed Care (Medi-Cal) Provider Manual, Claims and Encounters section.**

EAE DSNP Claims

The **Anthem MediBlue Full Dual Advantage plan** is an exclusively aligned enrollment dual special needs program (EAE-DSNP) that integrates the members Medicare Advantage and Medi-Cal care coordination, benefits, and services under one plan. This plan is currently in Santa Clara, Los Angeles Fresno, Kings, Sacramento, Madera, and Tulare starting in January of 2024.

Under this plan, Anthem issues members one ID card for Medicare and Medi-Cal services. The County Medi-Cal offices are also issuing a copy of their Medi-Cal card or Benefits Identification (BIC) card. **The member ID on the Anthem issued card is necessary to file your CS claims.** Utilizing the Medi- Cal or original Medicare ID will result in claims being rejected.

Please ensure that the member ID listed on the claim matches the member ID on the approved authorization for services:

- Anthem MediBlue Full Dual Advantage members:
  - Use member's unique ID (Ex. MNL123W12345) which can be found on the Member insurance card

If further assistance is required, Provider can contact EAE (Exclusively Aligned Enrollment) DSNP (Anthem MediBlue Full Dual Advantage) Customer service **833-707-3129** or find more

information at this link: https://providers.anthem.com/california-provider/resources/learn-about-availty.

Customer Care Centers:

- CA EAE DSNP (Dual Special Needs Plan) Plan: **833-707-3129**
- Medi-Cal Managed Care (outside L.A. County): **800-407-4627**
- Medi-Cal Managed Care (inside L.A. County): **888-285-7801**

Anthem MediBlue Full Dual Advantage plan information and documents

Invoices

In the event the CS Provider is unable to submit claims via Provider Website or EDI, the CS Provider can submit an invoice to Anthem with a minimum set of data elements necessary for Anthem to convert the invoice to an encounter for submission to DHCS. DHCS has developed guidance that describes the minimum set of data elements required to be included in an invoice. See Appendix C: Invoice Template and Guidance

Per DHCS **CalAIM Data Guidance: Billing and Invoicing between ECM/CS Providers and MCPs, updated April 2023,** Anthem will allow single invoice submissions to include multiple ECM or CS Provider services rendered on a single day by a single Provider for a single Member.

Quality, Monitoring and Oversight

Anthem will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Anthem will regularly monitor CS Provider performance and compliance with CS requirements using a variety of methods which may include monitoring calls, on-site and/or virtual visits, and/or audits, as needed. Corrective action could be imposed if deficiencies are identified.

The Special Programs team will continue to monitor the CS Provider from a program level and an administrative level. Anthem will collect and track required data from CS Providers, in order to manage and evaluate the effectiveness of services provided. CS providers will receive Performance Reports that provide the basis for addressing opportunities for improvement. Data collected may include but is not limited to:

- *Demographic data*
- *Processes, including outreach and engagement, delivery of services, and services provided.*
- *Tracking health outcomes including utilization and HEDIS® quality measures*
- *Member and provider satisfaction scores*
- *Social determinants of health impact, including food insecurity and housing flex dollars*
- *Financial measures*
- *Other measures and outcome data to be reported for the State's evaluation process.*
- *Reporting on core service metrics healthcare quality measures established by CMS.*

The Special Programs team will utilize information obtained to define and drive improvement through interventions and education with targeted providers who have unique or outlying issues or identified trends for multiple provider groups.

The CS Provider acknowledges that Anthem will conduct oversight of its participation in CS services to ensure the quality of CS services and ongoing compliance with program requirements, which may include audits and/or corrective actions. The CS Provider must respond to all Anthem requests for information and documentation in a timely manner to

permit ongoing monitoring of CS services. The Special Programs team will provide a feedback report to the CS Provider team highlighting the positive trends as well as identifying opportunities for improvement.
Program level monitoring may encompass the following areas:

- Individual case audits to ensure compliance with CS Core Services
- Performance reviews of quality and performance metrics, including, but not limited to:
  - Timeliness of services
  - Number of members in each status (pended, approved, denied, declined)

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Administrative monitoring may encompass the following areas:

- Timely claims/invoice submission
- Required reporting timeliness and accuracy for both Anthem and DHCS reports.
- Network Adequacy
- Other contractual obligations

Anthem's provider contracting and monitoring process lends itself to natural integration points for providing training and technical assistance. Just as CS is geared toward person centered planning, our philosophy for supporting providers is very provider centric. The Special Programs team assigned to each CS provider engages in the following activities:

- Assessment: ongoing process of data collection aimed at identifying a provider's strengths and opportunities for improvement
- Guidance and support: ongoing provision of information, expertise, recommendations, encouragement and transparent communication that support successful implementation and sustainment of the CS program.
- Training and education: ongoing assessment of knowledge gaps and determine the optimal training modality, which can be delivered either in-person or virtual classrooms. Each CS provider is also provided with access to a learning management system which houses an extensive library of self- paced modules that are focused on topics such as social drivers of health (SDoH), special populations, health literacy, information sharing, motivational interviewing, and trauma-informed care.
- Innovation: creative problem solving that can lead to work processes, systems and solutions that support the success of the program
- Collaboration: engaging productively and efficiently to work toward a specific outcome or work product that supports the success of the program
- Program Oversight: ongoing assessment of program level requirements which examines and evaluates the ongoing efficacy of the CS program.

Each CS service may have additional specific monitoring and oversight requirements. Please see specific CS service information below for more information.

Electronic Visit Verification

In accordance with APL 22-014 Electronic Visit Verification Implementation Requirements, Anthem will apply minimum standards to ensure that PCS and HHCS providers are compliant. Anthem will regularly monitor CS Provider performance and compliance with EVV requirements using a variety of methods which includes monitoring registration, training, audits, and/or corrective actions, as needed.

Anthem will communicate EVV requirements to all Network Providers required to comply with EVV requirements by January 1, 2023.

Anthem will utilize and encourage subcontractors and Network Providers to utilize the state-sponsored EVV system, Sandata Technologies, LLC (Sandata). Sandata's EVV system has the ability to capture data elements during the visit, data websites to allow providers to view and report on visit activity, and an EVV Aggregator to provide EVV program oversight and analytics. The EVV Aggregator also has the ability to receive data from providers that choose to use their existing EVV system. Anthem will not require additional expenditures or efforts by Members, should an alternate EVV system be utilized.

In the event Anthem decides not to utilize the state-sponsored EVV vendor, Anthem will file an administrative service agreement with the Department of Managed Health Care (DMHC). All Medi-Cal PCS and HHCS providers must capture and transmit the following six mandatory data components:

- The type of service performed.
- The individual receiving the service.
- The date of the service.
- The location of the service.
- The individual providing the service; and
- The time the services begins and ends.

All Network Providers are required to comply with the EVV requirements when rendering PCS and HHCS, subject to federal EVV requirements. Anthem will:

- Monitor Provider compliance with EVV requirements and EVV Information Notice(s) and notify DHCS with any compliance issues
- Supply providers with technical assistance and training on EVV compliance
- Require Providers to comply with an approved corrective action plan
- Deny payment if the Provider is not complying with EVV requirements and arrange for Members to receive services from a Provider who does comply
- If a Network Provider is identified as non-compliant with EVV requirements, Anthem will not authorize the Network Provider to perform services and/or withhold payment.

EVV Registration and Training

Alternate EVV systems must comply with all the business requirements and technical specifications, including the ability to capture and transmit the required data elements to the EVV Aggregator. Network Providers who choose to use an alternative system are required to register in the EVV self-registration website and must participate in the state-sponsored training.

Anthem will require providers of CS, including Personal Care and Homemaker Services, Respite Services, and Day Habilitation programs to register in the online self-registration website, trained on how to operate the solution and capture the six data elements with each in-home visit by October 19, 2022.

EVV Compliance

Anthem provides EVV training to all providers who are required to submit EVV data with their claims.

Monitoring and Oversight

Anthem will monitor providers submitting claims for any service that requires an accompanying EVV visit for compliance with following:

- Being registered with Sandata or an Alternate EVV system
- Submitting claims with an EVV code, but did not include an accompanying EVV visit

- Submitting claims with an EVV code, but the accompanying EVV visit is missing any of the six mandatory data components

Outreach to providers for Additional Support and Training

For providers who are not yet registered with Sandata or an Alternate EVV System — Anthem's Special Programs Team will partner with Anthem's Provider Relations team to communicate the EVV registration requirements.

For registered providers — If Anthem's EVV monitoring identifies any provider non-compliance, Anthem's Special Programs Team will reach out to the provider to provide additional support and/or training on the non-compliant requirement. Continued non-compliance will necessitate continued training up to and including Corrective Action. If instructed by DHCS, claims will be held until proof of compliance is provided.

Housing and Homeless Services Providers

Many of the CS services are focused on supporting members experiencing or at-risk of homelessness. CS services provide an opportunity to bring new resources to local communities to address homelessness and significantly expand services within the homeless response system.

In alignment with DHCS policy guidelines, Anthem expects CS providers offering the different housing services to ensure the use of best practices including Housing First Harm Reduction, Motivational Interviewing, and Trauma Informed Care. In addition to these, Anthem expects services to be delivered using culturally appropriate practices and providers should seek to incorporate people with lived experience into their models and have opportunities for input from members being served. When providing services to members experiencing homelessness it is critical that services are delivered in person as much as possible including locations where members are including on the streets, in encampments, in vehicles, in shelters, or in other housing settings. There needs to be a focus on continued outreach using assertive engagement techniques centered around building relationships.

In addition to using best practice service provision models, strengthening, and building partnerships with homeless system partners is critical. Anthem expects that CS providers serving members experiencing homelessness develop partnerships with their local homeless Continuum's of Care (CoC's). For more information on how to get involved with your local CoC, please contact your local County.

This includes gaining knowledge of the various partners and services available in communities and seeking to integrate CalAIM services within the larger local homeless system, rather than CS services be a siloed intervention. Anthem expects that CS providers gain access to the local **Homeless Management Information System (HMIS)** and enter data in HMIS on members receiving services in alignment with Anthems HMIS Guidance. Anthem also expects CS providers to connect with their local CoC Coordinated Entry System (CES) to aid members with accessing different housing resources including permanent and temporary housing through the CoC.

Anthem is committed to supporting CS providers with addressing members experiencing homelessness. Anthem has a dedicated housing and homeless strategy team with local housing managers supporting different regions in California available to help with best practice implementation, connection to CoC partners, and aligning programs with Anthem guidance. Annually, Anthem develops an internal housing and homeless strategy with key activities that include increasing utilization of CS housing services and effectively delivering services focused on core outcomes including helping members access permanent housing

and ensuring long-term housing stability.

CS Specific Service Overview

The information below is subject to change per DHCS guidance and Anthem program updates.

Community Supports Services:

1. Housing Transition Navigation Services: Provider Reference Information
2. Housing Deposits: Provider Reference Information
3. Housing Tenancy and Sustaining Services: Provider Reference Information
4. Short-term Post Hospitalization Housing: Provider Reference Information
5. Recuperative Care (Medical Respite): Provider Reference Information
6. Respite Services: Provider Reference Information
7. Day Habilitation Services: Provider Reference Information
8. Nursing Facility Transition/Diversion to Assisted Living Facilities: Provider Reference Information
9. Community Transitions Services/Nursing Facility Transition to a Home: Provider Reference Information
10. Personal Care and Homemaker Services: Provider Reference Information
11. Environmental Accessibility Adaptations (Home Modifications): Provider Reference Information
12. Medically Supportive Food/Meals/Medically Tailored Meals: Provider Reference Information
13. Sobering Centers: Provider Reference Information
14. Asthma Remediation: Provider Reference Information

Housing Transition Navigation Services: Provider Reference Information

Back to Overview

Claims/ Billing and Payment

H0043 Supported Housing with U6 Modifier
H2016 Comprehensive community support services with U6 Modifier

Bundled PMPM = One flat rate per month for both codes.
Encounters are reported Per Diem

T1016 U8 Community Supports In-Person Outreach
T1016 U8, GQ Community Supports Telephonic/Electronic Outreach

Per 15 min for Housing Transition and Navigation, Housing Deposits and Housing Tenancy and Sustaining Services (for tracking purposes only, no rates attached at this time)

See Anthem CS Provider Guide Section 7 Claims for more information

Service Description and Expectations

Housing Transition Navigation Services include:

1. Conducting a tenant screening and housing assessment that identifies the Member's needs, preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. 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.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (i.e., Social Security card, birth certificate, prior rental history).
5. 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 skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8 state and local assistance programs, etc.) and matching available rental subsidy resources to Members.
7. If included in the housing support plan, identifying, and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
8. Assisting with requests for reasonable accommodation, if necessary.
9. Landlord education and engagement.
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the Member with landlords.
12. Assisting in arranging for and supporting the details of the move
13. 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.
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members who have issues with their mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
15. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided:
- Are 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 based on need.
- Utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Frequency and Duration of Service - New Authorizations

Initial approval for up to one year (12 months). Member must maintain eligibility.

Service Eligibility Criteria and Restrictions

ELIGIBILITY
In order to be eligible for Housing Transition Navigation services, a Member must meet at least one of the following:

Be 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 Members with disabilities and/or 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 and/or is exiting incarceration.

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, nursing facilities, transitional recovery housing, Institutes for Mental Disease and State Hospitals.

Meet the definition of an individual experiencing Chronic Homelessness, either as defined by:
- In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or more or had at least four episodes of

homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

- By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as a "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
  - Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
  - Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or
  - An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
  - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or
  - Members 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 30 percent of median family income for the area, as determined by HUD.
    - Does not have sufficient resources or support networks (such as 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 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 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 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, 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.
- A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a (3)), section 637(11) of the Head Start Act (42
- U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a (2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Members 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.
    - Have a Serious Emotional Disturbance (children and adolescents).
    - Are receiving Enhanced Care Management; or
    - 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

- Members who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Anthem will accept an attestation of the need for housing to satisfy any documentation requirements regarding the Member's housing status.

Restrictions/Limitations

Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and CS are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Services do not include the provision of room and board or payment of rental costs.

Housing Transition Navigation services must be identified as reasonable and necessary in the Member's individualized housing support plan.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance. Members that switch to Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on initial CS criteria.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section 3 CS Referrals. Extensions may be requested via provider website. If a Member has concluded Housing Transition Navigation Services and wishes to reengage, additional documentation will be required as to the circumstances to support the subsequent request.

If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Service Coordination Team within 2 business days of any staffing and capacity changes that affect their ability to accept new authorizations.

Additional Information and Documentation

CS Providers are responsible for conducting outreach to each authorized Member within 24 hours following notification from Anthem of authorization. Initiate outreach within 3 business days of receiving an approved referral, and schedule first Member meeting.

If after 3 outreach attempts in 14 calendar days the Member is unable to be contacted, the Provider will notify Special Programs for direction or assistance to reach out to the referral source for any updated contact information and send an unable to reach notice if necessary. If no response received within 30 calendar days, the case will be closed. If a new referral is received, the case may be reopened, and outreach attempts will begin again.

Provider to request for an extension of services if continued need demonstrated.

Housing needs assessment and individualized housing support plan is to be initiated by CS provider during successful outreach.

Assessment and housing support plan update is to be uploaded to Provider Website if an extension is being requested.

Upon securing housing, the Housing Transition Navigator may:

- Assist Member to identify need for Environmental Accessibility Adaptation CS or Asthma Remediation CS.
- Assist Member in facilitating move in.
- As necessary, coordinate with other CS Providers and ECM Provider to ensure continuity of care.
- Update housing support plan.
- Facilitate Member exiting services including updating case in designated platform.

Provider to notify Anthem of disenrollment reason at time of discharge/services ending.

CS providers must collaborate with ECM Lead Care Manager if the member is receiving ECM, and CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment. Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.

If Member wants to move outside of local housing navigation area,

	coordinate with Housing Transition Navigator in desired location.
Service Reporting	Providers are requested to complete a CS Staffing and Capacity Report (SCR), update the Housing Status upon exit on the Return Transmission File (RTF) and provide additional data per Anthem's request. Providers are strongly encouraged to utilize the Homeless Management Information System (HMIS) for CS Housing Navigation Services as outlined in the HMIS Guidance (see Appendix).
Oversight/ Monitoring Processes and Activities	Subject to Anthem's quality oversight and auditing. Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Housing Deposits: Provider Reference Information Back to Overview

Claims/ Billing and Payment

H0044 with U2 modifier – Supported housing, per month. Requires deposit amounts to be reported on the encounter.
All claims and service encounters must be submitted timely.

T1016 U8 Community Supports In-Person Outreach
T1016 U8, GQ Community Supports Telephonic/Electronic Outreach

Per 15 min for Housing Transition and Navigation, Housing Deposits and Housing Tenancy and Sustaining Services (for tracking purposes only, no rates attached at this time)

Service Description and Expectations

See Anthem CS Provider Guide Section 7 Claims for more information
Housing Deposits includes identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a Member to establish a basic household at "move-in" This includes funding to support:

- Security deposits required to obtain a lease on an apartment or home.
- Set-up fees/deposits for utilities or service access and utility arrears (limited to 3 months).
- First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
- First months and last month's rents required by landlord for occupancy.
- Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services, designed to preserve a Members' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.
- Services necessary for the Member's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
- Basic Household items to include the following (this is not an exhaustive list): Effective 6/24/2024:
  - Kitchen items: bowls, can opener, cleaning supplies, cutlery, cutting board, dining table and chairs, dish drying rack, dish towels, kitchen utensils, microwave, plates, pots and pans, refrigerator, stove
  - Bedroom: air conditioner, bedding, bedframe, clothing hangers, heater, infant furniture, mattress, nightstand
  - Bathroom: cleaning supplies, shower/bath curtain, toiletries, towels, trash can
  - Living room: couch, coffee/end table, lamps/lighting, TV

Frequency and Duration of Service - New Authorizations

Housing Deposits are available once in a Member's lifetime. A CS Service Coordinator will complete a review of information available to determine if the Member has previously received services. This may include records of prior authorizations from Anthem or outside sources and review of any assessment questions that may elicit information.

Subject to Member eligibility.

Service Eligibility Criteria and Restrictions

Eligibility
Any Member who has a housing support plan regardless of if receiving CS Housing Transition Navigation Services or ECM, received/receiving Housing Transition Navigation Services or is enrolled in Enhanced Care Management may be eligible for Housing Deposits.

Members 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 Members 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 is exiting incarceration; or

Members 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, Institutes for Mental Disease and State Hospitals.

Anthem will accept an attestation of the need for housing to satisfy any documentation requirements regarding the Member's housing status.

Restrictions/Limitations
Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. CS can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

The need for services must be identified in the Member's individualized housing support plan, must meet cost guidelines that are reasonable and necessary, and are available only when the enrollee is unable to meet such expense. The Member requesting funds should make

reasonable attempts to establish need through statements of why they are requesting services. Examples include temporary loss of income due to illness, lay off, etc. In addition, through the housing assessment process, assessment questions may elicit additional information.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as previously noted above.
Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transport services, and skilled nursing facility services.

Community supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section on CS Referrals.

If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Service Coordination Team within 2 business days of any staffing and capacity changes that affect their ability to accept new authorizations.

Additional Information and Documentation

Assessing for appropriateness and Initiating Housing Deposits
The ECM Provider, Housing Transition Navigator or CS Service Coordinator will:

- Provide education to Member or representative regarding guidelines of Housing Deposits, including but not limited to eligibility requirements, restrictions, and program limitations.
- Gather documentation to support the Members need for a housing deposit in the housing support plan and the inability to meet these expenses independently and without duplication of service.
- Gather documentation to support the expenses. Examples may include the lease agreement with fees noted, utility company bill, and/or cost estimate for the goods and services necessary for the Members health and safety.
- Utilize a contracted Provider/Provider services with pre-negotiated rates upon notification of the referral being accepted, if required
- Outreach to the Housing Deposit Provider to ensure services being initiated.

The Housing Deposit Provider, upon receipt of approved request, will:

- Acknowledge the receipt of Housing Deposit request the day it is received by communicating with Housing Transition Navigator.
- Initiate payment to identified parties within 2 business days of receiving a completed request, or as soon as possible.

- Submit notification to Member, Housing Transition Navigator, and/or CS Service Coordinator that a payment has been made through the delegated platform to substantiate reimbursement.
- Update case within 10 business days after the initial referral to ensure receipt of services.
- Utilize any payment method that is traceable and in a timely manner.
- Keep record of all payments made.
- **Never provide payment directly to the Member.**

CS providers must collaborate with ECM Lead Care Manager if member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services) as applicable. CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on the assessment.

Service Reporting

Providers are requested to complete a CS Staffing and Capacity Report (SCR), update the Housing Status upon exit on the Return Transmission File (RTF) and provide additional data per Anthem's request.

Providers are strongly encouraged to utilize the Homeless Management Information System (HMIS) for CS Housing Navigation Services as outlined in the HMIS Guidance (see Appendix).

Oversight/ Monitoring Processes or Activities

Subject to Anthem's quality oversight and auditing.
Anthem may conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Housing Tenancy and Sustaining Services: Provider Reference Information Back to Overview

Claims/ Billing and Payment

T2040 Financial management, self-directed with U6 Modifier
T2050 Financial management, self-directed with U6 Modifier
T2041 Support brokerage, self-directed with U6 Modifier
T2051 Support brokerage, self-directed with U6 Modifier

Bundled PMPM = one flat rate per month for all codes Encounters are reported Per Diem
All claims and service encounters must be submitted timely.

T1016 U8 Community Supports In-Person Outreach
T1016 U8, GQ Community Supports Telephonic/Electronic Outreach

Per 15 min for Housing Transition and Navigation, Housing Deposits and Housing Tenancy and Sustaining Services (for tracking purposes only, no rates attached at this time)

Service Description and Expectations

Housing Tenancy and Sustaining Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, poor follow-up with physical health, mental health or substance use-related treatment needs, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management Provider to address identified issues that could impact housing stability.
5. 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 client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. 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 skillset.
8. Assistance with the annual housing recertification process.

9. 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.

10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.

11. Health and safety visits, including unit habitability inspections.

12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (in other words., assisting with reasonable accommodation requests that were not initially required upon move-in).

13. Identifying and coordinating the need for independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided will be based on individualized assessment of needs and documented in the individualized housing support plan created by the Housing Transition Navigator, ECM Provider or CS Service Coordinator. Members may require and access only a subset of the services listed above based on individual need.

The services provided will utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the Member has access to supports needed to maintain successful tenancy, as necessary.

Tenancy and Sustaining services do not include the provision of room and board or
payment of rental costs.

If Member is housed and receiving Housing and Tenancy services, and violates their lease, the Member may involuntarily be removed from Housing Sustaining and Tenancy Services.

Frequency and Duration of Service-New Authorizations

Initial approval for up to 12 months subject to Member eligibility with health plan.

Service Eligibility Criteria and Restrictions

Eligibility

- Any Member who receives Housing Transition Navigation Services CS in counties that offer Housing Transition and Navigation Services.
- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System (CES) or similar system designed to use information to identify highly vulnerable Members 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 is exiting incarceration, OR
- Members 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, Institutes for Mental Disease and State Hospitals, OR-
- Members who meet the definition of an individual experiencing Chronic Homelessness, either as defined:
  - 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.
- Members 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 30 percent of median family income for the area, as determined by HUD.
    - Does not have sufficient resources or support networks, in other words, 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 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 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 resides 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.

– A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a (3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42U.S.C 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
– A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney- Vento Homeless Assistance Act (42 U.S.C. 11434a (2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
– Members 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:
  - One or more serious chronic conditions
  - A Serious Mental Illness
  - At risk of institutionalization or overdose or are requiring residential services because of a substance use disorder.
  - Have a Serious Emotional Disturbance (children and adolescents)
  - Are receiving Enhanced Care Management
  - 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.

Note: Anthem will accept an attestation of the need for housing to satisfy any documentation requirements regarding the Member's housing status.

Restrictions/limitations
Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the Member's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Authorizing the services for a second time needs to be approved by the Director of Special Programs or their designee.

These services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the Member is unable to successfully maintain longer-term housing without such assistance.

Many Members will also receive Housing Transition and Navigation services in conjunction with this service, but it is not a requirement.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

Examples of State Plan services to be avoided include but are not limited to:

- Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transport services, and skilled nursing facility services.
- Members that switch to Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on initial CS
- criteria.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section on CS Referrals. Referrals for a Housing Tenancy and Sustaining services will be redirected to Housing Transition Navigation if a housing care plan is not in place. Authorization of services for a second time requires approval of the Director of Special Programs or their designee.

If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.

Additional Information and Documentation

Provider to request for extension of services if continued need demonstrated. The Housing Tenancy and Sustaining Services (HTSS) Provider will:

- Initiate outreach within 3 business days of receiving an approved referral, and schedule first visit with Member, at time and placement of Member preference, if applicable.
- If after 3 outreach attempts in 10 days, the Member is unable to be contacted, the Provider will notify an CS Service Coordinator for direction or assistance. The CS Service Coordinator may send an unable to contact letter to the Member requesting a call back. If no response is received within 30 calendar days, the case for Tenancy and Sustaining services will be closed. If a new referral were to be received, the case may be reopened, and outreach attempts will begin again.
- During the first meeting and upon completion of the housing support plan, the HTSS Provider will complete the following activities during successful outreach:
  - Obtain Release of Information (ROI), as needed.
  - Discuss current housing status.
  - Review housing support plan and update goals and barriers as needed.
  - Discuss options for overcoming barriers including connections to services, community resources, etc.
  - Discuss ongoing visit meeting schedule.
  - At least monthly, engage with the Member to evaluate efficacy of the housing support plan, keep plan current, and monitor Member progress toward goals for purposes of graduating Member from HTSS.
  - When the Member and HTSS Provider determines there is no further need for the service, the HTSS provider will coordinate with the ECM Lead Care Manager, Housing Transition Navigator or Service Coordinator that the service is complete.

If Member chooses to exit Housing Tenancy and Sustaining Services before the end of the authorization or before housing stabilization has been achieved the Provider must:

- Notify the CS Service Coordinator within 3 business days or as soon as possible regardless of if voluntary or involuntary.
- Conduct immediate outreach to assess Member's status and needs.
- Coordinate as needed with CS Service Coordinator for additional services that may be necessary.
- Educate the Member that they will forfeit this once in a lifetime benefit for future HTSS unless the Member is able to prove their

circumstances have changed substantially which would make HTSS more successful:
  - Examples demonstrating substantial change in their circumstance include, and are not limited to, recommendation from an AA sponsor, Behavioral/Physical Health or other Provider showing stabilization of condition, or recommendation from a community-based organization.
- CS Service Coordinator will:
  - End authorization for the date of exit, if applicable.
  - Send an NOA to Member using the address on file, if applicable

CS providers must collaborate with ECM Lead Care Manager for Members that are receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services). CS providers are encouraged to refer Member for any additional CS services or ECM if they find member is eligible based on their assessment.

Provider will have access to send referrals to Anthem via provider website, phone,
fax or email.

Service Reporting

Providers are requested to complete a CS Staffing and Capacity Report (SCR), update the Housing Status upon exit on the Return Transmission File (RTF) and provide additional data per Anthem's request.

Providers are strongly encouraged to utilize the Homeless Management Information System (HMIS) for CS Housing Navigation Services as outlined in the HMIS Guidance (see Appendix).

Oversight/Monitoring Processes or Activities

Subject to Anthem's quality oversight and auditing.

Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Short-term Post Hospitalization Housing: Provider Reference Information

Back to Overview

Claims/ Billing and Payment	**H0044 Supported Housing with U3 Modifier - Unit of service is per diem.** **H0043 Supported Housing with U3 Modifier -** **Refer to CS Provider Guide Claims Section for more information.** All claims and service encounters must be submitted timely
Service Expectations	Short-Term Post-Hospitalization Housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute, psychiatric or Chemical Dependency and Recovery hospital), residential Alcohol or Drug Abuse Recovery or Treatment facility, residential mental health treatment facility, correctional facility, nursing facility or recuperative care. This setting provides Members with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing support such as Housing Transition Navigation. This setting may include an individual or shared interim housing setting, where Members receive the services described above. Members must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of an individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post Hospitalization Housing. Contracted Providers will utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive engagement, Motivational Interviewing, and Trauma Informed Care. Use of Coordinated Entry System (CES) to support housing exit is expected and encouraged. Please see Housing and Homeless Services Provider section for more information. Services do not include the provision of room and board or payment of rental costs.
Unit, Frequency, and/or Duration of Service (as applicable) – New Authorizations	Short-Term Post-Hospitalization Housing Services are available once per lifetime and are not to exceed a duration of six (6) months (may be authorized for a shorter period based on Member needs). Unit of service is per diem.
Service Eligibility	**Eligibility**

Criteria

- In order to be eligible for Short-term Post-hospitalization Housing, Members must reside in one of the covered service areas and:
  - Be exiting recuperative care.
  - Be exiting an inpatient hospital stay (either acute, psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, or nursing facility and who meet any of the following criteria:
    - 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, nursing facilities, transitional recovery housing, Institutes for Mental Disease and State Hospitals.
    - Meet the definition of an individual experiencing Chronic Homelessness, either as defined by:
      - In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
      - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
          - Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
          - Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a

break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or
- Members 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 30 percent of median family income for the area, as determined by HUD.
    - Does not have sufficient resources or support networks, in other words, 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 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 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, 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.
- A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a (3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a (2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Members who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization Housing 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.
    - Have a Serious Emotional Disturbance (children and adolescents).
    - Are receiving Enhanced Care Management; or
    - 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
    - Members who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with

significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

- In addition to meeting one of these criteria at a minimum, Members must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re- hospitalization, or institutional readmission.

NOTE: Anthem will accept an attestation of the need for housing to satisfy any documentation requirements regarding the Member's housing status.

Restrictions/Limitations
Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Community supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section on CS Referrals

In the event that STPH is required after hours, and a delay could result in seriously jeopardizing the life or health of a Member or Member's ability to regain maximum function, the CS Provider may submit an authorization request by no later than 3:00 pm the next business day.

In the event the Member is discharged to an IP facility before the 6-month stay has expired, the remaining days of the STPHH services will be considered if the following conditions are met:

- The length of time between discharge and readmission does not exceed 30 days.
- The member meets the admission requirement for the facility.
- Best practice includes returning the Member to the same facility.

If a provider is at capacity and unable to accept new referrals and

authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.

Additional Information and Documentation

Anthem CS clinician and team will follow up 30 days prior to authorization expiration.

ECM Provider, CS Provider or Anthem CS Service Coordinator will:

- Provide education to Member or representative regarding guidelines of STPH including but not limited to eligibility requirements, restrictions, and program limitations.
- Ensure all required documentation received to support STPH request including and not limited to the consent and release of information and assessment of Member's needs.
- Ensure all documentation is uploaded into designated platform.
- Review the request within established timeframes.
- Upon notification of the referral being accepted, Anthem has the right to utilize a contracted Provider with pre-negotiated rates.
- If Member is eligible for STPH, Anthem CS Service Coordinator will notify the ECM Provider, Member, and CS STPH Provider/agency that authorization has been approved.
- Ensure Member referral to CS for Housing Transition Navigation:
  - If STPH CS provider is also a Housing Transition Navigation CS Provider, STPH Provider will connect the Member to Housing Transition Navigator within the organization.
  - If STPH Provider is not a Housing Transition Navigation Provider, the STPH Provider will present Member with contracted Housing Transition Navigation Provider options.
  - STPH Provider will send Housing Transition Navigation referral to CS.
  - Service Coordinator for approval with Housing Transition Navigation Provider identified. Refer to Policy and Procedure for Housing Transition Navigation CS for requirements.
  - If the Member is expected to stay at a higher level of care for more than 30 days, Housing Transition Navigation will pause, and Members can return to STPH with continued access to the remaining benefit days not utilized.
- Follow-up activities to be completed with initial status of follow-up by 10 business days and within 30 days of the authorization expiration.
- CS Providers are responsible for conducting outreach as necessary to each authorized Member within 24 hours following authorization assignment notification.

STPH CS Provider to ensure:

- All member health needs are being supported including, but not limited to:
  - Coordination of and transportation to medical and behavioral health appointments.
  - Providing rehabilitation services as needed.
  - Support Housing Transition Navigation Provider in readying Member for independent living.
  - Member must receive Housing:

- Transition Navigation supports, which includes a housing assessment and development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy in order to remain in the program. Refer to Housing Transition Navigation CS Policy and Procedure.

Provider must notify Anthem of disenrollment reason at time of discharge/ services ending.

If the Member has an unplanned exit from STPH, the STPH CS Provider should notify the ECM Provider (if applicable) or Anthem CS Service Coordinator within 24 hours or as soon as possible. The ECM Provider (if applicable) or Anthem CS Service Coordinator will:

- Conduct immediate outreach to assess Member's status and needs.
- Coordinate as needed with Special Programs for additional services that may be necessary.
- If the Member chooses to exit STPH before end of authorization or obtaining housing, the Member must be educated that they will forfeit the once in a life-time benefit and any future STPH.
- Member may be involuntarily removed from STPH due to a violation of program rules before the end of their authorization and or obtaining housing.
- Anthem CS Service Coordinator will end authorization for date of exit.
- Anthem CS Service Coordinator will send a Notice of Action (NOA) to the Member using the address on file, as applicable.

CS providers must collaborate with ECM Lead Care Manager, if member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services). CS providers are encouraged to refer member for any additional CS
services or ECM if they find member is eligible based on their assessment. Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.

Service Reporting

Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.

Oversight/Monitoring Processes or Activities

Subject to Anthem's quality oversight and auditing.

The Anthem CS Service Coordinator will monitor authorizations, Member satisfaction and claims, as necessary. Anthem will conduct meetings with provider
and any subcontractors and provide monitoring/oversight.

Recuperative Care (Medical Respite): Provider Reference Information

Back to Overview

Claims/ Billing and Payment

T2033 Residential care not otherwise specified (NOS), waiver. U6 Modifier –Unit of service is per diem.

All claims and service encounters must be submitted timely.

Service Expectations

Recuperative Care, also referred to as Medical Respite Care, is short-term residential care for Members who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows Members to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, Recuperative Care includes interim housing with a bed and meals and ongoing monitoring of the Member's ongoing medical or behavioral health condition (in other words, monitoring of vital signs, assessments, wound care, medication monitoring). Based on Member's needs, the service may also include:

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

Recuperative Care is primarily used for those Members who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment but are not otherwise ill enough to be in a hospital or skilled nursing facility.

The services provided to the Member while in Recuperative Care should not replace or be duplicative of the services provided to Members utilizing the Enhanced Care Management program. Recuperative Care may be utilized in conjunction with other housing CS. Whenever possible, other housing CS will be provided to members onsite in the Recuperative Care facility. When enrolled in Enhanced Care Management, CS will be managed in coordination with ECM providers.

Provider will utilize best practices for members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm

Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The Provider will provide services as outlined in Anthem's contract and may include:

- Member intake to better understand Member's current biopsychosocial needs.
- Ensure Member has been offered Housing Navigation Transition:
  - If Provider is also a Housing Transition Navigation Provider, the Provider will connect the Member to a Housing Navigator within the organization.
  - If Provider is not a Housing Navigation provider, the Provider will present Member with contracted Housing Navigation Provider options.
  - If the Provider is not a Housing Navigation provider, the Provider will send Housing Transition Navigation referral to Service Coordinator for review with Housing Navigation Provider identified within 3 days of intake assessment.
- Ensure health needs are being supported as needed including but not limited to:
  - Providing bed and meals.
  - Coordination of and transportation to medical and behavioral health appointments.
  - Providing Activities of Daily Living (ADL) support.
  - Support Member in accessing other benefits.
  - Assist Member becoming stable with case management relationships and programs.
  - Support Housing Navigation Provider in readying Member for independent living.
  - Monitor Member progress within the facility and provide updates within 10 days and at least monthly or as changes occur to ECM or CS Service Coordinator through a designated platform.
  - Actively participate in transition and care team discussions with Member in coordinating discharge to Short Term Post Hospitalization or other setting.
  - Notifying CS Service Coordinator and/or ECM Provider within 24 hours or as soon as possible of the unplanned exit whether it is voluntary or involuntary.

Unit, Frequency, and/or Duration of Service - New Authorizations

30 days for initial authorization, may approve up to two 30-day extensions.
Unit is per diem. Provider must confirm Member eligibility.

Service Eligibility Criteria

In order to be eligible for Recuperative Care, Members must reside in one of the covered service areas and:

- Be at risk of hospitalization or are post-hospitalization, and
- Live alone with no formal supports; or
- Face housing insecurity or has housing that would jeopardize their health and safety without modification.

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless
- Individuals who meet the HUD definition of at risk of homelessness and have significant barriers housing stability and have one or more serious chronic conditions; have a serious mental illness, or 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), or receiving ECM, or are Transition-Age Youth with significant barriers to housing stability.
- Meet facility specific admissions requirements.

Restrictions/Limitations
Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Recuperative Care/Medical Respite is an allowable CS service if it is:

- Necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions,
- Not more than 90 days in continuous duration and does not include funding for building modification or building rehabilitation.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

Examples of State Plan services to be avoided include but are not limited to Inpatient and Outpatient Hospital services, skilled nursing facility, and Emergency Department services.

Members that switch to Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on initial CS criteria.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section for CS Referrals.

In the event that Recuperative Care is required after hours, and a delay could result in seriously jeopardizing the life or health of a Member or Member's ability to regain maximum function, the

	Provider may submit an authorization request by no later than 3:00 pm the next business day. Best practices for urgent or expedited referrals are to mitigate any delays in the consent, review of eligibility, authorization, and placement processes. This includes immediate contact with the ECM and/or Provider to initiate the review for Recuperative Care. If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.
Additional Information and Documentation	Anthem CS clinician and team will follow up within 30 days prior to the expiration of the authorization. Provider to notify Anthem of disenrollment reason at time of discharge/ services ending. All member discharge summaries are to be submitted to Anthem via provider website or other agreed upon secure method within 1 business day after member is discharged. If Member has an unplanned exit from Recuperative Care, the Recuperative Care Provider should notify the ECM Provider or Service Coordinator within 24 hours or as soon as possible. The ECM Provider or Service Coordinator will: • Conduct immediate outreach to assess Member's status and needs. • Coordinate as needed with Special Programs for additional services that may be necessary. • CS Service Coordinator will end authorization for the date of exit, if applicable. • CS Service Coordinator will send an NOA to Member using the address on file, if applicable. CS providers must collaborate with ECM Lead Care Manager if the member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services). CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment. Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.
Service Reporting	Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.
Oversight/Monitoring Processes or Activities	Subject to Anthem's quality oversight and auditing. Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Respite Services: Provider Reference Information Back to Overview

Claims/ Billing and Payment	**H0045 Respite care services, not in the home. U6 Modifier S5151 Unskilled respite care, not hospice. U6 Modifier S9125 Respite care, in the home. U6 Modifier** Unit of service is 15 min increments Encounter Unit of service is per diem. All claims and service encounters must be submitted timely.
Service Expectations	Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only. Respite services can include any of the following: • Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to Member. • Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to Member. • Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them. Home Respite Services are provided to the Member in their home, or another location being used as the home. Facility Respite Services are provided in an approved out-of-home location. Respite is considered for authorization when it is useful and necessary to maintain a Member in their own home and to preempt caregiver burnout to avoid institutional services for which Anthem is responsible.
Frequency, Duration and Unit of Service - New Authorizations	**Service limit is 336 hours per calendar year, not to exceed 24 hours per day (in combination with member's other direct care services if applicable).** See Service Eligibility Criteria, Restrictions/Limitations for exceptions to limits Unit of service is 15 min increments (effective 1/1/2023).
Service Eligibility Criteria	Eligibility In order to be eligible for Respite Services, Members must reside in one of the covered service areas and live in the community, be

compromised in their Activities of Daily Living (ADLs), be dependent upon a non- paid caregiver who provides most of their support and require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program Members, Members enrolled in California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

Restrictions/Limitations

- Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:
- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

In the home setting, these services, in combination with any direct care services the
Member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in- home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Member without their caregiver. Respite support provided during these episodes can be excluded from the annual limit but must be reviewed and approved by the Medical Director or designee.
Documentation must be submitted to support the exception request and demonstrate the need for additional hours.

This service is intended for unpaid caregivers.

Members that switch to Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on CS criteria.

Please see Anthem CS Provider Guide Section on CS Referrals.

Referral, Authorization, and Capacity	Respite Services are not an emergency back-up program and must be approved in advance unless the Respite Service meets the guidelines for an expedited request. Emergency back- up plans should be addressed by the ECM Provider or CS Service Coordinator as applicable. If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.
Additional Documentation	Provider follow-up activities are to be completed with initial status of follow-up 10 business days post-authorization and CS Provider assignment, and subsequent follow-ups are to be completed prior to the expiration of the authorization. Provider to notify Anthem of disenrollment reason at time of discharge/ services ending. If the Member has an unplanned exit with the Respite Service, the ECM Provider or Anthem CS Service Coordinator will: • Conduct immediate outreach to assess Member's status and needs. • Coordinate as needed with Special Programs for additional services that maybe necessary. • Coordinate with the contracted Respite Provider or other available Respite Provider to continue the needed support. • End the authorization for the date of exit of the caregiver if there is no other available caregiver from the contracted entity. • Create a new authorization if Respite Provider need to change. Anthem CS Service Coordinator will send a Notice of Action (NOA) to the Member using the address on file, if applicable. CS providers must collaborate with ECM Lead Care Manager is member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services) as applicable. CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment. Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.
Service Reporting	Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.
Oversight/Monitoring Processes or Activities	Subject to Anthem's quality oversight and auditing. Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Day Habilitation Services: Provider Reference Information Back to Overview

Claims/ Billing and Payment

T2012 Habilitation, educational. U6 Modifier
T2014 Habilitation, prevocational. U6 Modifier
T2018 Habilitation supported employment. U6 Modifier
T2020 Day Habilitation. U6 Modifier
H2014 Skills training and development. U6 Modifier. (Encounter unit is per 15- minute increments)
H2038 Skills training and development. U6 Modifier
H2024 Supported employment. U6 Modifier
H2026 Ongoing support to maintain employment. U6 Modifier

Unit of services is a bundled per diem = one flat rate per day for all codes Encounter Unit of service is per diem with the exception of H2014.

All claims and service encounters must be submitted timely

Service Expectations

Day Habilitation Programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the Member's natural environment. The services provided are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For homeless Members receiving Enhanced Care Management or other CS, the Day Habilitation Program can provide a physical location for Members to meet with and engage with these Providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

Day Habilitation Program Services include, but are not limited to, training on:

- The use of public transportation.
- Personal skills development in conflict resolution.
- Community participation.
- Developing and maintaining interpersonal relationships.
- Daily living skills (cooking, cleaning, shopping, money management).
- Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to:

- Selecting and moving into a home.
- Locating and choosing suitable housemates.
- Locating household furnishings.
- Settling disputes with landlords.
- Managing personal financial affairs.
- Recruiting, screening, hiring, training, supervising, and dismissing personal attendants.
- Dealing with and responding appropriately to governmental agencies and personnel.
- Asserting civil and statutory rights through self-advocacy.

- Building and maintaining interpersonal relationships, including a circle of support.
- Coordination to link Member to any CS and/or ECM services for which the Member may be eligible.
- Referral to non-Community Supports housing resources if Member does not meet Housing Transition Navigation Services CS eligibility criteria.
- Assistance with income and benefits advocacy including:
- General Assistance/General Relief and Supplemental Security Income (SSI) if client is not receiving these services through CS or ECM.
- Coordination with Anthem to link member to healthcare, mental health services, and substance use prevention or recovery services based on the Member needs for Members who are not receiving this linkage through CS or ECM.

The services provided should utilize best practices for Members who are homeless or formerly homeless including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Housing Transition Navigation or other Housing related CS should be engaged.

Frequency and Duration of Service - New Authorizations

Frequency and duration as needed.

Service Eligibility Criteria

Eligibility
Members who are experiencing homelessness, Members who exited homelessness and entered housing in the last 24 months, and Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a Day Habilitation Program.

Members eligible for Day Habilitation must also be actively participating in Housing Transition Navigation or Housing Tenancy and Sustaining Services.

Restrictions/Limitations
Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

	Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.
Referral, Authorization, and Capacity	Please see Anthem CS Provider Guide Section for CS Referrals If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within two business days.
Additional Documentation	Provider to notify Anthem of disenrollment reason at time of discharge/ services ending. CS providers must collaborate with ECM Lead Care Manager is member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services). CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment. Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.
Service Reporting	Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.
Oversight/ Monitoring Processes or Activities	Subject to Anthem's quality oversight and auditing. Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Nursing Facility Transition/Diversion to Assisted Living Facilities: Provider Reference Information Back to Overview

Claims/Billing and Payment

T2038 Community transition per service. U4 Modifier

Unit of service is Per Member Per Month (PMPM)
Encounter Unit is per service.

H2022 Community wrap-around services. U5 Modifier

Unit of service is Per hour.
Encounter Unit is per service

All claims and service encounters must be submitted timely.

Service Expectations

The goal is to facilitate Nursing Facility Transition Services from a Nursing Facility **or** Nursing Facility Diversion Services for Members living in the community, into a home-like community setting for Members with an imminent need for nursing facility (NF) level of care (LOC). Members have a choice of residing in an Assisted Living setting as an alternative to long-term placement in a Nursing Facility when they meet eligibility requirements.

Nursing Facility Transition and Diversion Services to an Assisted Living Facility assist Members to live in the community and/or avoid institutionalization when possible.

The Assisted Living Facility Provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For Members who are transitioning from a licensed healthcare facility or the community to a living arrangement in an Assisted Living Facility, this includes non-room and board costs (medical, assistance w/ADLs). Allowable expenses are those necessary to enable the Member to establish a community facility residence that does not include room and board and includes:

- Assessing the Member's housing needs and presenting options.
- Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the Assisted Living Facility so the Member can be safely and stably housed in an Assisted Living Facility.
- Assisting in securing a facility residence, including the completion of facility applications, and securing required documentation (in other words, Social Security card, birth certificate, prior rental history).
- Communicating with facility administration and coordinating the move.
- Establishing procedures and contacts to retain facility housing.
- Coordinating with Anthem to ensure that Members who need enhanced services to be safely and stably housed in the Assisted Living setting has CS and/or ECM services that provide the necessary enhanced services or fund the Assisted Living Facility operator directly to provide enhanced services.

Frequency and Duration of Service - New Authorizations

As needed. Units are per service or per hour, depending on HCPCS code and modifier.

Service Eligibility Criteria

Eligibility
For Nursing Facility Transition Services to an Assisted Living Facility, eligible Members must be:

- Receiving medically necessary nursing facility services and in lieu of remaining in, the Nursing Facility setting, is choosing to transition to an Assisted Living Facility and continue to receive medically necessary Nursing Facility LOC services.
- Residents of a Nursing Facility for 60+ days.
- Willing to live in an Assisted Living setting as an alternative to a Nursing Facility; and
- Able to reside safely in an Assisted Living Facility with appropriate and cost- effective supports.

For Nursing Facility Diversion Services to an Assisted Living Facility, eligible Members must be:

- Interested in remaining in the community.
- Currently receiving medically necessary nursing facility services and in lieu of going to a Nursing Facility, is choosing to transition to an Assisted Living Facility and continue to receive medically necessary Nursing Facility LOC services.
- Willing to live in an Assisted Living setting as an alternative to a Nursing Facility; and
- Able to reside safely in an Assisted Living Facility with appropriate and cost- effective supports.

Restrictions/Limitations
Members are directly responsible for paying their own living expenses. Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Community supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

Members that switch to Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on initial CS criteria.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section for CS Referrals

Assessing for appropriateness and Initiating Nursing Facility Transition or Diversion Services to an Assisted Living Facility:

- ECM Provider or Anthem CS Service Coordinator will:
  - Provide education to the Member or representative regarding guidelines of Nursing Facility Transition or Diversion Services to an Assisted Living Facility, including but not limited to eligibility requirements, restrictions, and program limitations.
  - Conduct face to face and telephonic screening of the Member and/or representative if a Member chooses to participate in Nursing Facility Transition or Diversion to an Assisted Living Facility service. The screening will include:
    - Confirmation that the Member wishes to transition to an Assisted Living Facility. The discussion with the Member and/or representative detailing the Member's wishes and ability to transition to the Assisted Living Facility must be clearly documented in the case management system even for cases in which the Member indicates that they do not wish to transition to the Assisted Living Facility at that time.
    - Documentation of the discussion must include, at a minimum, the date of discussion, those present at the meeting, and feedback received from the Member and/or representative regarding their request to continue/not continue the transition process.
    - If, at any time, the Member indicates that they do not wish to transition to the Assisted Living Facility, the screening process for transition to the Assisted Living Facility shall cease.
    - During the screening, the CS Coordinator may determine that a Member is not appropriate for transition to the Assisted Living Facility, signifying an end to the transition process. Factors impacting the Member's ability to transition to the community include, but are not limited to:
      - Member's needs cannot be effectively met in the Assisted Living Facility.
      - The cost of meeting the Member's needs in the community would exceed the cost of Nursing Facility Care.
      - Ensure required documentation is uploaded into designated platform.
      - Request to be reviewed by an CS Service Coordinator.
      - Assign Member to CS Provider if referral is approved.

For those Members whose screening process indicates they are <u>not</u> candidates for transition into the Assisted Living Facility, the CS Service Coordinator will communicate to the Member/and or representative the results of the screening and the determining factors impacting the Member's potential to successfully transition to the community. Should they disagree with the determination, the Member and/or representative

may request to move forward in the transition process for further assessment.

If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.

After authorization and assignment are received, the CS Provider will:

- Complete a Person-Centered Support Plan addressing specific goals and actions to address the medical, social, educational, housing, transportation, vocational, or other services needed by the Member and identify a course of action to respond to the Member's assessed needs, including identification of all Providers, services to be provided and time frame for services to take place.
- Create a Transition Support plan.
- Facilitate Member to obtain and move into housing as follows:
  - Assessing the Member's needs and presenting options.
  - Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the Residential Care Facility for the Elderly/ Adult Residential Facility (RCFE/ARF) in order for the client to be safely and stably housed in an RCFE/ARF.
  - Assisting in securing a facility residence, including the completion of facility applications, and securing required documentation (in other words, Social Security card, birth certificate, prior rental history).
  - Communicating with facility administration and coordinating the move.
  - Establishing procedures and contacts to retain facility housing.
  - Coordinating with Anthem care plan to ensure that the needs of Member who needs enhanced services to be safely and stably housed in Assisted Living Facility settings have CS and/or ECM services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.
- Upon transition, CS Provider will ensure cost effective services to support the Member remaining in the community safely are in place. These may include but are not limited to:
  - Community-based services.
  - Medically tailored meals CS
  - Personal Care Services CS and/or IHSS
  - Respite CS
  - Community Based Adult Services (CBAS)
  - Other waiver programs
- CS Provider will provide Member updates at least monthly and note any change(s) in Member's condition to the CS team via a designated platform or delivery method. Best practice is for the CS Provider to also communicate with the ECM Provider. All updates reported to the CS team are viewable in the Provider Website. The CS team will notify the ECM Provider of any changes or updates of Member and service status, as necessary.

- Upon completion of Nursing Facility Transition or Diversion to an Assisted Living Facility service, Provider will coordinate with ECM or CS Service Coordinator to engage follow-up activities.
- Transition members engaged in ECM will be followed by their ECM Provider to ensure a successful transition. The follow up timeframe provided by ECM will be dependent upon members engagement and progress within ECM.
- For Members not engaged in ECM, Anthem CS Service Coordinator will conduct follow-up with the Member at least monthly, to support the successful transition to the Assisted Living Facility. The timeframe for this follow-up will be based on the Member's choice, not to exceed 12 months.

Provider to notify Anthem of disenrollment reason at time of discharge/services ending.

If Member has an unplanned exit, ECM Provider or CS Service Coordinator will:

- Conduct immediate outreach to assess Member's status and needs.
- Coordinate as needed with Special Programs for additional services that may be necessary.

CS Service Coordinator will:

- End authorization for the date of exit if applicable.
- Send an NOA to Member using the address on file, if applicable.

CS providers must collaborate with ECM Lead Care Manager if member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation services) if applicable. CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment. Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.

Additional Documentation

Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.

Oversight/ Monitoring Processes or Activities

Subject to Anthem's quality oversight and auditing.
Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Community Transitions Services/Nursing Facility Transition to a Home: Provider Reference Information Back to Overview

Claims/ Billing and Payment	**T2038 Community transition per service. U5 Modifier** **Unit of service is Per Member Per Month (PMPM)** **Encounter Unit is Per Service** All claims and service encounters must be submitted timely
Service Expectations	Community Transition Services /Nursing Facility Transition to a Home CS services helps Members to live in the community and avoid further institutionalization. Community Transition Services/Nursing Facility Transition to a Home are non- recurring set-up expenses for Members who are transitioning from a licensed facility to a living arrangement in a private residence where the Member is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable the Member to establish a basic household that do not constitute room and board and include: • 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 (in other words, Social Security card, birth certificate, prior rental history). • Communicating with landlord, if applicable and coordinating the move. • Establishing procedures and contacts to retain housing. • Identifying, coordinating, securing, or funding non-emergency, non-medical 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 the Member to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the Member's health and safety, such as pest eradication and one- time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically- necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.
Frequency and Duration of Service - New Authorizations	Lifetime maximum amount of $7500.

Service Eligibility Criteria

Eligibility
For Community **Transition** Services/Nursing Facility Transition to Home, eligible Members must be:

- Receiving medically necessary nursing facility services and in lieu of remaining in the nursing facility setting, is choosing to transition home and continue to receive medically necessary Nursing Facility LOC services.
- Resident in a nursing facility 60+ days.
- Interested in moving back to the community; and
- Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations
Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

Community Transition Services /Nursing Facility Transition to a Home Services do 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.

Community Transition Services /Nursing Facility Transition to a Home Services are payable up to a total lifetime maximum amount of $7500. The only exception to the $7500 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.

Community Transition Services /Nursing Facility Transition to a Home 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.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded

programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.
Examples of State Plan services to be avoided include but are not limited to skilled nursing facility.

Members that switch to Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on CS criteria.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section on CS Referrals

If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.

Additional Documentation

Anthem CS clinician and team will follow up with provider and/or member prior to transition or end of authorization and no further needs identified.

Upon transition, Community Transition Services /Nursing Facility Transition to a Home CS Provider will ensure cost effective services to support the Member remaining in the community safely are in place. These may include, but are not limited to:

- Community based services
- Medically tailored meals CS
- Personal Care Services CS and/or IHSS
- Respite CS
- Community Based Adult Services (CBAS)
- Other waiver programs

Community Transition Services/Nursing Facility Transition to a Home CS Providers will upload Member updates at least monthly and upon changes in Member's condition to the designated platform to ensure ECM or CS Service Coordinator awareness of Member and service status.

Upon completion of Community Transition Services /Nursing Facility Transition to a Home Services, the CS Provider will coordinate with ECM or Anthem CS Service Coordinator to engage follow up activities.

Provider to notify Anthem of disenrollment reason at time of discharge/ services ending.

CS providers must collaborate with ECM Lead Care Manager if member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services). CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment.

Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.

Service Reporting	Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.
Oversight/ Monitoring Processes or Activities	Subject to Anthem's quality oversight and auditing. Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Personal Care and Homemaker Services: Provider Reference Information

Back to Overview

Claims/ Billing and Payment

S5130 Homemaker services. U6 Modifier
Unit of service is 15 min increments Encounter Unit is 15 min increments.

T1019 Personal care services. U6 Modifier
Unit of service is 15 min increments Encounter Unit is 15 min increments.

All claims and service encounters must be submitted timely.

Service Expectations

Personal Care and Homemaker Services are provided for Members who need assistance with Activities of Daily Living (ADLs) such as house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning, shopping, laundry, and grocery shopping. Personal care and homemaker service programs aid Members who otherwise could not remain in their homes.

Community Supports can be used:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits have been exhausted; and
- As authorized during any In-Home Supportive Services waiting period:
  - (Member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In- Home Supportive Services application date.
  - For Members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services (IHSS) should always be utilized first. Personal Care and Homemaker CS are only utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services per review of the allocation of time assessment data received by the county.

Persons utilizing the Personal Attendant tool will be required to attend a training on how to administer the tool.

Decision and screening criteria are designed to assist an Anthem CS Service
Coordinator in assessing the appropriateness of the CS service. Application of criteria is not absolute but based upon the Member's healthcare needs and in accordance with the Member's specific benefit plan and the capability of healthcare delivery systems.

Frequency, Duration and Unit of Service - New

Frequency is as needed. Duration of time period may vary based on reason for utilization, Unit of service is 15 min.

Authorizations Service Eligibility Criteria

Eligibility
Members at risk for hospitalization, or institutionalization in a nursing facility; or Members with functional deficits and no other adequate support system; or Members approved for In-Home Supportive Services, but who need additional support.

Eligibility criteria for IHSS can be found at:
http://www.cdss.ca.gov/In-Home- Supportive-Services.

Restrictions/Limitations
Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Community supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

This service cannot be utilized in lieu of referring the Member to the In-Home Supportive Services program. All Members are referred to the In-Home Supportive Services program when they meet referral criteria.

If a Member receiving Personal Care and Homemaker Services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional

	hours. Members may continue to receive Personal Care and Homemaker CS during this reassessment waiting period. Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing facilities. Members that switch to Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on CS criteria.
Referral, Authorization, and Capacity	Please see Anthem CS Provider Guide Section on CS Referrals. If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.
Additional Information and Documentation	Personal Care Attendant Tool (PCA): PCA Assessment Tool is used as an instrument for collecting and documenting essential medical and functional information and to establish a member's clinical eligibility for Personal Care Assistant Services. The PCA tool identifies the amount of time it takes to perform each ADL/IADL activity task per week taking into account level of assistance Member needs, the availability of assistance in the Member's household, the specific activities that must be accomplished and the Member's unique circumstances. The PCA scoring tool may have sections utilized to determine Member's eligibility for service. NOTE: Persons utilizing the PCA tool will be required to attend a training on how to administer the tool. The PCA tool identifies the amount of time it takes to perform each ADL/IADL activity task per week taking into account the level of assistance the Member needs, the availability of assistance in the Member's household, the specific activities that must be accomplished and the Member's unique circumstances. The PCA scoring tool may have sections utilized to determine Member's eligibility for service. After the completion of the PCA scoring tool, the tool will calculate the number of hours per day the Member is eligible for. If the tool score does not meet the request, the CS service Coordinator will send to the clinical designee for review. CS providers must collaborate with ECM Lead Care Manager if member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services). CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment. Provider will have access to send referrals to Anthem via provider website, phone, fax, or email. Provider must notify Anthem of disenrollment reason at time of discharge/service ending.

Service Reporting	Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.
Oversight/ Monitoring Processes or Activities	Subject to Anthem's quality oversight and auditing. The Anthem CS Service Coordinator will monitor authorizations, Member satisfaction and claims, as necessary. Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Environmental Accessibility Adaptations (Home Modifications): Provider Reference Information Back to Overview

Claims/Billing and Payment	**S5165 Home modifications. U6 Modifier** Unit of service is Actual costs billed per claim up to lifetime max Encounter unit is Per Service All claims and service encounters must be submitted timely.
Service Expectations	Environmental Accessibility Adaptations (EAA), also known as Home Modifications, are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the Member, or enable the Member to function with greater independence in the home, without which the Member would require institutionalization. Examples of EAAs include: • Ramps and grab-bars to assist Members in accessing the home. • Doorway widening for Members who require a wheelchair. • Stair lifts. • Making a bathroom and shower wheelchair accessible (in other words, constructing a roll-in shower). • Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the member; and • 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) • Levels of PERS service are subject to review by the Director of Special Programs or their designee. 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 (in other words, grab bars, chair lifts, etc.)

Duration of Service - New Authorizations

EAAs are payable up to a total lifetime maximum of $7,500. Lifetime maximums will be tracked and monitored in the authorization platform. The only exceptions to the $7,500 total maximum are if the member's place of residence changes or if the member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the Member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.

Service Eligibility Criteria

Eligibility
For a Member to access this service, they must be at risk for institutionalization in a nursing home, meet medically necessary criteria and address restrictions and limitations.

Restrictions/Limitations
Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance:

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs may include finishing (in other words, drywall, and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (in other words, to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of the modification, Anthem plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for removal of any modification if the Member ceases to reside at the residence.

Decision and screening criteria are designed to assist Service Coordinator in assessing the appropriateness of the CS service. Application of criteria is not absolute but based upon the Members healthcare needs and in accordance with the Member's specific benefit plan and the capability of healthcare delivery systems.

Members that switch to the Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on initial CS criteria.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section on CS Referrals

When authorizing Environmental Accessibility Adaptations as a Community Support service, Anthem must receive and document an order from the Member's current primary care physician or other health professional specifying the requested equipment or service as well as 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.

For Environmental Accessibility Adaptations, Anthem will receive and document:

- A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless Anthem determines it is appropriate to approve without an evaluation. This 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.

Anthem may utilize a contracted Provider with pre-negotiated rates or will work to secure bids from appropriate Providers of the requested services which itemize services, cost, labor, and applicable warranties. A home visit will be conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs will take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the Member receiving the service requests a longer time frame.

If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.

Additional Documentation

Anthem CS clinician and team follow-up cadences based on Member's needs with case being closed after 90 days if no additional requests or needs.

The Provider will provide or assist with the following throughout service delivery:

- Provide education to Member or representative regarding guidelines of EAA, including but not limited to eligibility requirements and program limitations.
- Ensure any requested and supporting documentation is uploaded into designated platform.
- Arrange for a physical or occupational therapy evaluation and report to:
  - evaluate the medical necessity of the requested equipment or service upon notification of the referral being accepted.

Please see Referral, Authorization and Capacity section above for information regarding the physical or occupational therapy evaluation and report.

Depending on the type of adaptation or modification requested, obtain 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. 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.

Upon notification of the referral being accepted:

- Anthem has the right to utilize a contracted Provider with pre-negotiated rates or will work to secure bids from appropriate provides of the requested services with itemize services, cost and labor and applicable warranties.
- The contracted CS Provider will send the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.
- Requests that exceed the $7,500 lifetime max will be sent to a clinical designee for review.

- As needed for extensive home repairs, Anthem or ECM will advocate and coordinate those requests for resolution with other responsible parties.

Ensure that a home visit has been conducted to determine the suitability of any requested equipment or service.

Member progress will be monitored in the following ways:
- Provider will hold care conference shortly after intake to ensure plan is appropriate.
- Provider will facilitate referrals to any other CS services within 90 days, at closure and as needed based upon case notes.
- CS Service Coordinator will monitor authorization, Member satisfaction, and claims, as necessary.

Provider to notify Anthem of disenrollment reason at time of discharge/services ending/completed.

If Member has an unplanned exit, ECM Provider or CS Service Coordinator will:
- Conduct immediate outreach to assess Member's status and needs.
- Coordinate as needed with Special Programs for additional services that maybe necessary.

CS Service Coordinator will:
- End authorization for the date of exit.
- Send an NOA to Member using the address on file.

CS providers must collaborate with ECM Lead Care Manager if member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services). CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment.
Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.

Service Reporting

Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.

Oversight/ Monitoring Processes or Activities

Subject to Anthem's quality oversight and auditing.

Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Medically Supportive Food/Meals/Medically Tailored Meals: Provider Reference Information Back to Overview

Claims/ Billing and Payment

S5170 Home delivered prepared meal. U6 Modifier
Unit of Service is Per Meal (Max of 2 units per day; up to 31 days on a single claim line)
Encounter unit is Per Meal

S9470 Nutritional counseling, diet. U6 Modifier
Unit of Service is Per Assessment Encounter unit is Per Assessment

S9977 Meals – not otherwise specified. U6 Modifier
Unit of Service is Per Week (1 week billed per claim line)
Encounter unit is Per Week

All claims and service encounters must be submitted timely.

Service Expectations

Anthem will provide Medically Supportive Food/Meals/Medically Tailored Meals to eligible Members and include:

- Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable for readmission.
- Medically Tailored Meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.
- Medically Tailored Meals approved by a Registered Dietitian (RD) or other certified nutrition professional that reflects appropriate dietary therapy based on evidence-based nutrition practice guidelines to address a specific medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.
- Medically supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.
- Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above

The ECM Provider, CS Service Coordinator or any other entity providing case management or care coordination must exhaust other sources of Medically Supportive Food/Meals/Medically Tailored Meals before enacting this benefit.

Duration of Service - New Authorizations

Up to two Medically Tailored Meals per day and/or 1 box/voucher per week of medically supportive food and nutrition services for up to 12 weeks or longer if medically necessary.

Subject to Member's eligibility.

Service Eligibility Criteria

In order to be eligible for Medically Supportive Food/Meals/Medically Tailored Meals, Members must reside in one of the covered service areas and:

- Have a chronic condition(s), such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer,

gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders or
- Have a pending discharge from the hospital or skilled nursing facility or must be at high risk of hospitalization or nursing facility placement; or
- Have extensive care coordination needs.

Restrictions/Limitations

Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services or Emergency Department services.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

In addition, Medically Supportive Food/Meals/Medically Tailored Meals do not include the following:

- Meals that are eligible for or reimbursed by alternate programs.
- Meals provided to respond solely to food insecurities.

Members that switch to Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on initial CS criteria.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section on CS Referrals.

If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.

Additional Documentation

CS Providers are expected to outreach to the Member to ensure receipt of meals within 10 Business Days of authorization.

	Provider to notify Anthem of disenrollment reason at time of discharge services ending. CS providers must collaborate with ECM Lead Care Manager if member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services). CS providers are encouraged to refer the Member for any additional CS services or ECM if they find member is eligible based on their assessment. Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.
Service Reporting	Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.
Oversight/ Monitoring Processes or Activities	Subject to Anthem's quality oversight and auditing. Anthem may conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Sobering Centers: Provider Reference Information Back to Overview

Claims/Billing and Payment

H0014 Alcohol and/or drug services; ambulatory detoxification. U5 Modifier
Unit of Service is Per Diem
Encounter unit is Per Diem

No authorization required.

All claims and service encounters must be submitted timely.

Service Expectations

Sobering Centers are alternative destinations for Members who are found to be publicly intoxicated (alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these Members, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling and homeless care support services.:

- When utilizing this service, a direct coordination with the County Behavioral and/or Public Health agencies is required. Coordination will be dependent upon the Member's needs.
- The service also includes screening and linkages to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel and outreach teams to identify and divert Members to Sobering Centers.
- The services provided should utilize best practices for Members who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

If a Clinical Institute Withdrawal Assessment for Alcohol (CIWA or CIWA-Ar) or other evidence-based tool scoring meets eligibility or facility assessment, service is approved. The Clinical Institute Withdrawal Assessment for Alcohol is a 10-item scale used in the assessment and management of alcohol withdrawal.

Duration of Service - New Authorizations

This benefit is covered for a duration of less than 24 hours per occurrence.

Service Eligibility Criteria

Eligibility
Members aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress as demonstrated by utilization and scoring from an evidence-based tool such as the CIWA tool (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at

an emergency department and are appropriate to be diverted to a sobering center.

Restrictions/Limitations
Community Supports are alternative services covered under the State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. A Community Supports can only be covered if:

- The State determines it is medically appropriate and a cost-effective substitute or setting for the State plan service.
- Members are not required to use the CS and
- The CS are authorized and identified in the Medi-Cal managed care plan contracts.
- Consent to release information under 42 CFR Part 2 is received.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance.

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services and Emergency Transportation services.

Referral, Authorization, and Capacity

No authorization is required. An approved screening tool or like assessments such as a CIWA must be completed. Anthem has the right to determine eligibility through review of assessment and notes completed by the CS Provider upon intake. Anthem has the right to determine presumptive eligibility with certain CS Providers.

Providers may utilize bulk referral forms with attestations of eligibility.

The Sobering Center notifies the Anthem's CS Service Coordination team via, fax or email. A case will be created to track the Member's utilization and need of follow-up services with an ECM Provider or CS Service Coordinator.

The Sobering Center then determines if the Member is appropriate for admission to
services. If the Member is not appropriate, the responsibility for the Member is transferred back to the external referral source for triage to a more appropriate service location. The Sobering Center can submit a claim for the screening assessment.

If the Member is not engaged with ECM through County Behavioral Health, but another ECM Provider, the Anthem CS Service Coordinator will notify the ECM Provider within 1 business day and request they provide care coordination and case management activities. The Anthem CS Service Coordinator will follow the procedures as outlined in the Anthem CS Provider Guide Section on CS Referrals.

If a provider is at capacity and unable to accept new referrals and authorizations,
they must notify Anthem CS Authorizations and Referrals Team within 2 business days.

Additional Documentation

After the Sobering Center determines that a Member is appropriate for admission to services, the Provider ensures a safe, supportive environment for the Member who is accepted as appropriate for receiving the services.

The Sobering Center CS Provider must notify County Behavioral Health that the Member is receiving Sobering Center services and may need further evaluation and treatment for substance use disorder. If the County Behavioral Health is an ECM Provider, the member is referred for ECM to complete the assessment and provide care coordination and case management activities.

When readying for discharge, if a Member is not stabilized and needs could be met through Medical Respite, a referral for the Member to Medical Respite will be made, unless in-patient services are warranted.

Provider may be asked to notify Anthem of discharge status and additional discharge information at time of services ending.

If the Member leaves the facility against medical advice, the Anthem CS Service Coordinator will:

- Conduct immediate outreach to assess Member's status and needs.
- Coordinate as needed with Special Programs for additional services that may be necessary.

CS providers must collaborate with ECM Lead Care Manager if member is receiving ECM, and any other CS providers (ex. Housing Transition Navigation Services) as applicable. CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment. Provider must have access to send referrals to Anthem via provider website, phone, fax, or email.

Service Reporting

Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.

Oversight/ Monitoring Processes or Activities

Subject to Anthem's quality oversight and auditing.

Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Asthma Remediation: Provider Reference Information Back to Overview

Claims/Billing and Payment

S5165 Home Modifications. U5 Modifier
Unit of Service is Actual costs billed per claim up to lifetime max Encounter unit is Per Service

All claims and service encounters must be submitted timely.

Service Expectations

Environmental Asthma Trigger Remediations are physical modifications to the Member's home environment that are necessary to ensure the health, welfare, and safety of the Member; or enable the Member to function in the home while reducing acute asthma episodes that could result in the need for emergency services and hospitalization.

Examples of Environmental Asthma Trigger Remediations include:

- Allergen-impermeable mattress and pillow dustcovers.
- High-efficiency particulate air (HEPA) filtered vacuums.
- Integrated Pest Management (IPM) services.
- De-humidifiers.
- Air filters.
- Other moisture-controlling interventions.
- Minor mold removal and remediation services.
- Ventilation improvements.
- Asthma-friendly cleaning products and supplies.
- Other interventions identified to be medically appropriate and cost effective.

Asthma Remediation also includes providing information to Members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

- Identification of environmental triggers commonly found in and around the home, including allergens and irritants.
- Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
- Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

Anthem may utilize the asthma trigger checklist produced by the Centers for Disease Control, the Environmental Protection Agency and Housing and Urban Development. The accompanying training will be made available to the CS team, ECM, and CS Providers.

The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver.

Before authorizing Asthma Remediation CS services, Anthem must receive and document:

- The Member's current licensed healthcare Provider's order specifying the requested remediation(s).

- A brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the Member will still be necessary.
- That a home visit has been conducted to determine the suitability of any requested remediation(s).

Duration of Service - New Authorizations

Asthma Remediations are payable up to a total lifetime maximum of $7,500. Lifetime maximums will be tracked and monitored in the authorization platform. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

Service Eligibility Criteria

Eligibility

Members with poorly controlled asthma (as determined by an emergency department visit, hospitalization, or two sick/urgent care visits in the past 12 months or by a score of 19 or lower on the Asthma Control Test) for whom a licensed healthcare Provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

RESTRICTIONS/LIMITATIONS

Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different Provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

- The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service,
- Members are not required to use the CS and
- Community Supports are authorized and identified in the managed care plan contracts.

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Community Supports shall supplement and not supplant services received by the member through other State, local, or federally funded programs, in accordance with the CalAIM Standard Terms and Conditions (STCs) and federal and DHCS guidance:

- Asthma Remediations will not be authorized if another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
- Asthma Remediations must be conducted in accordance with applicable State and local building codes.
- Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

- Asthma Remediation modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (in other words, drywall, and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Before commencement of a physical adaptation to the home or installation of equipment in the home, Anthem must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.

Members that switch to Anthem health plan while they are currently receiving this CS from another provider may be assessed for eligibility based on initial CS criteria.

Referral, Authorization, and Capacity

Please see Anthem CS Provider Guide Section on CS Referrals.
The assessment, authorization, and remediation must take place within a 90-day time frame beginning with the request for the Asthma Remediation, unless more time is required to receive documentation of homeowner consent, remediation Provider availability, or the Member receiving the service requests a longer time frame.
The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization. Exceptions will be reviewed by the clinical designee.

If a provider is at capacity and unable to accept new referrals and authorizations, they must notify Anthem CS Authorizations and Referrals Team within 2 business days.

Additional Information and Documentation

Follow-up cadence based on Member's needs with case being closed after 90 days if no additional needs or requests.

When CS providers receive an authorization to provide Asthma Remediation CS services, they will:

- Provide information including itemized services, costs, and labor as well as applicable warranties.
- Send the owner and Member written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.
- Advocate and coordinate with Anthem, ECM Providers or other responsible parties for extensive asthma related home repairs requests and resolution.
- Participate in care conference shortly after intake as requested to ensure plan is appropriate, facilitate any other CS services within 90 days and at closure and as needed based upon case notes.

	Provider to notify Anthem of disenrollment reason at time of discharge/services ending. CS providers must collaborate with ECM Lead Care Manager if member is receiving ECM, and any other CS providers as applicable. CS providers are encouraged to refer member for any additional CS services or ECM if they find member is eligible based on their assessment. Provider will have access to send referrals to Anthem via provider website, phone, fax, or email.
Service Reporting	Providers may be requested to complete a CS Staffing and Capacity Report (SCR), Return Transmission File (RTF) and provide additional data per Anthem's request as needed.
Oversight/ Monitoring Processes or Activities	Subject to Anthem's quality oversight and auditing. Anthem will conduct meetings with provider and any subcontractors and provide monitoring/oversight.

Appendices

Anthem 2024 Counties – Homeless Continuums of Care (CoC)

Anthem Counties	CoC	CoC Lead Agency	CoC HMIS Lead Agency	CoC CES Lead Agency	CoC website
Alpine, Inyo, Mono	Eastern Sierra CoC	Inyo County Health and Human Services	Inyo County Health and Human Services	Inyo County Health and Human Services	In development
Amador, Calaveras, Tuolumne	Central Sierra CoC	Amador Tuolumne Community Action Agency	Amador Tuolumne Community Action Agency	Amador Tuolumne Community Action Agency	https://www.centralsierracoc.org
El Dorado	El Dorado Opportunity Knocks CoC	El Dorado County Health and Human Services	El Dorado County Health and Human Services	Tahoe Coalition for the Homeless	https://www.edokcoc.org/
Fresno, Madera	Fresno Madera CoC	Fresno Housing	Fresno Housing	Poverello House	https://fresnomaderahomeless.org
Kern	Bakersfield Kern CoC	Bakersfield Kern Regional Homeless Collaborative	Kern Health Systems	Community Action Partnership of Kern	https://bkrhc.org/
Kings, Tulare	Kings Tulare CoC	Kings Tulare Homeless Alliance	Kings United Way	Kings Tulare Homeless Alliance	https://www.kthomelessalliance.org/
Los Angeles	Los Angeles City County CoC	Los Angeles Homeless Services Authority	Los Angeles Homeless Services Authority	Los Angeles Homeless Services Authority	https://www.lahsa.org/
Sacramento	Sacramento City County CoC	Sacramento Steps Forward	Sacramento Steps Forward	Sacramento Steps Forward	https://sacramentostepsforward.org/
San Francisco	San Francisco City County CoC	San Francisco Department of Homelessness and Supportive Housing	San Francisco Department of Homelessness and Supportive Housing	San Francisco Department of Homelessness and Supportive Housing	https://hsh.sfgov.org/
Santa Clara	Santa Clara CoC	Santa Clara Office of Supportive Housing	Santa Clara Office of Supportive Housing	Santa Clara Office of Supportive Housing	https://osh.sccgov.org/continuum-care

Appendix 1: Community Supports Referral (in DASH, submitted 10/25/2024)

Appendix 2: Homeless Continuum of Care (CoC) Contact List

Appendix 3: CES Guidance – *Coming Soon*