KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Community Supports Services (CSS) Member Identification and Authorization				POLICY #: 17.04-P	
DEPARTMENT: Community Supports Services					
Effective Date: 01/01/2022	Review/Revised Date: 10/16/2023	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date_____
Emily Duran
Chief Executive Officer

_____ Date_____
Chief Medical Officer

_____ Date _____
Senior Director of Provider Network

_____ Date _____
Director of Claims

_____ Date _____
Director of Community and Social Services

PURPOSE

To demonstrate how Kern Health Systems (KHS) will identify and authorize Members for administration of benefits for the Community Supports Services (CSS) Program in compliance with the Department of Health Care Services (DHCS) guidelines.

POLICY

KHS will identify eligible Members for Community Supports benefits through a compliant and comprehensive systems approach including assessments, Community Based Organizations, available data, and reports. KHS will manage the provision, authorization, and referral to Community Supports in coordination with the Enhanced Care Management (ECM) Program and Providers when possible.

DEFINITIONS

Term	Definition
WPC	Whole Person Care Program
HHP	Health Homes Program
PCP	Primary Care Physician
UM	Utilization Management
CSS Care Team	Internal KHS Staff working to assign Members identified for CSS, coordinating with CSS Provider Sites (often CBOs or Community Based Organizations), and connecting Members to all available resources.

PROCEDURES

A. Initiating Delivery of Community Supports

The table below identifies which Community Supports Services will be provided to Members, through which primary methods, and includes expected duration and frequency of service(s).

Primary Delivery Method	Expected Duration and Frequency of Service
Housing Transition/ Navigation Services Individualized assessment of needs and documentation of an individualized housing support plan; Beneficiaries may require and access only a subset of the services listed below: 1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment will include collecting information on the participant'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 participant'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 (e.g., 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.	1. The expected duration of this service depends on the individual Member's need. The frequency of services is as needed and will be identified in the housing support plan.

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 client 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' 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.	
Housing Deposits assist with identifying, coordination, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as: 1. Security deposits required to obtain a lease on an apartment or home. 2. Set-up fees/deposits for utilities or service access and utility arrearages. 3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water. 4. First months and last month's rent as required by landlord for occupancy. 5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy. 6. Goods such as an air conditioner or heater, and other medicallynecessary adaptive aids and services, designed to preserve an individuals' 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.	1. Housing Deposits are available once in an individual's lifetime with the opportunity for approval one additional time with supporting documentation. 2. Housing Deposits are payable up to a total lifetime maximum of $5,000. 3. Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage.
Housing Tenancy and Sustaining Services This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include: 1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, 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.	1. Housing tenancy and sustaining services are only available for a single duration in the individual's lifetime with the opportunity for approval one additional time with supporting documentation. 2. The frequency of services is as needed and may involve coordination with other entities to ensure the

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 (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in). 13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.	individual has access to supports needed to maintain tenancy.
<u>Short-Term Post-Hospitalization Housing</u> provides beneficiaries 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 or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care. This setting provides individuals 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 supports such as Housing Transition Navigation. This setting may include an individual or shared interim housing setting, where residents receive the services described above. Beneficiaries 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 individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.	1. The expected duration of this service depends on the individual Member's condition (or until transition to a more appropriate care setting, not to exceed 30 days). 2. Services are not intended to replace or be duplicative of the services provided to Members utilizing the ECM program. 3. Short-Term Post-Hospitalization Housing may be utilized in conjunction with other housing Community Supports. 4. Whenever possible, other housing Community Supports should be provided to Members onsite in the Short-Term Post-Hospitalization Housing facility.

Recuperative Care (Medical Respite) At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on the individual Member's needs, the service may also include: 1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs 2. Coordination of transportation to post-discharge appointments 3. Connection to any other on-going services an individual may require including mental health and substance use disorder services 4. Support in accessing benefits and housing 5. Gaining stability with case management relationships and programs	1. The expected duration of this service depends on the individual Member's condition (or until transition to a more appropriate care setting, not to exceed 90 days). 2. Services are not intended to replace or be duplicative of the services provided to Members utilizing the ECM program. 3. Recuperative Care may be utilized in conjunction with other housing Community Supports. 4. Whenever possible, other housing Community Supports should be provided to Members onsite in the recuperative care facility.
Asthma Remediation Environmental asthma trigger remediation services are physical modifications available in a home environment that is owned, rented, leased, or occupied by the individual or their caregiver. When authorizing asthma remediation as a Community Supports service, KHS will receive and document: 1. The Member's current licensed health care provider's order specifying the requested remediation(s); 2. Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the Member. A brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the individual will still be necessary. 3. That a home visit has been conducted to determine the suitability of any requested remediation(s). Asthma remediation includes providing information to individuals 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: 1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants. 2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters. 3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.	1. As identified in the Member's current licensed health care provider's order specifying the requested remediation(s); and depending on the type of remediation(s) requested. 2. A home visit must be conducted to determine the suitability of any requested remediation(s). 3. Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

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. When authorizing Respite Services, delivery can include any of the following: 1. 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 individuals. 2. 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 individuals. 3. 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 his or her own home or another location being used as the home. Facility Respite Services are provided in an approved out-of-home location. Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.	1. 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. 2. 2. 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, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit. 3. This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.
Medically Tailored Meals/Medically Supportive Food is a service intended to help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved Member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status, and increased Member satisfaction. When authorizing medically tailored meals as a Community Supports service, KHS will monitor the following service delivery methods which may include: 1. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission. 2. Medically Tailored Meals: meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases. 3. Medically Tailored meals are tailored to the medical needs of the Member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes. 4. Medically supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies. 5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.	1. The expected duration of this service depends upon the individual Member's condition, but allows for up to two (2) meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary. 2. Meal services that are eligible for or reimbursed by alternate programs are not eligible. 3. Meal services are not covered or intended to respond solely to food insecurities.

Sobering Centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. 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, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services. When authorizing sobering centers as a Community Supports service, KHS will ensure the following are in place as required by DHCS: 1. When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged. 2. The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate. 3. This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care. 4. The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive 5. Engagement, Motivational Interviewing, and Trauma-Informed Care.	1. The expected duration of this service is less than 24 hours.
Nursing Facility Transition/Diversion to Assisted Living Facilities services assist individuals to live in the community and/or avoid institutionalization when possible. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals 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. The assisted living 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 individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF). Includes wrap-around services: assistance w/ ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. Includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.	2. The expected duration of this service depends upon the individual Member's condition. 3. Individuals are directly responsible for paying their own living expenses.

Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to: 1. Assessing the Member's housing needs and presenting options. 2. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF. 2. Assisting in securing a facility residence, including the completion of facility applications, and securing required documentation (e.g., Social Security card, birth certificate, prior rental history). 3. Communicating with facility administration and coordinating the move. 4. Establishing procedures and contacts to retain facility housing. 5. Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services. a. Managed care plans may also fund RCFE/ARF operators directly to provide these enhanced services.	
Community Transition Services/Nursing Facility Transition to a Home helps individuals 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 individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include: 1. Assessing the Member's housing needs and presenting options. 2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history). 3. Communicating with landlord (if applicable) and coordinating the move. 4. Establishing procedures and contacts to retain housing. 2. 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. 3. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household 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 individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home	1. Community Transition 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. 2. Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control. 3. Community Transition Services 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.

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.	
Personal Care Services and Homemaker Services are provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Includes services provided through the In-Home Support Services (In-Home Supportive Services) program, including 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. Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes. The Personal Care and Homemaker Services Community Support can be utilized: 1. Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and 2. 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. 3. 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 should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.	1. This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria. 2. 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 the Personal Care and Homemaker Services Community Support during this reassessment waiting period. 3. Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

B. Identifying Members for Community Supports

1. KHS will identify Members who may benefit from Community Supports Services (CSS) using several approaches. These approaches include:
    a. Monthly stratification processes of the KHS population, which uses defined criteria and methodologies of data elements, including but not limited to, medical and pharmacy claims, DHCS fee for service claims, care management program information, ACG modeler files, EMR data, HRA results and other external supplemental data.
    b. Self-referrals or referrals made by family members, caregivers, and support networks.
    c. Primary Care Providers, Specialist, or other Providers in the community
    d. Internal Case Management and Utilization Management Program referrals

2. KHS will identify newly eligible Community Supports Members who were previously enrolled in another plan through the presence of Community Supports service HCPCS codes within the prior 90 days. The presence of such historical utilization data received by KHS via Plan Data Feed will initiate both the standard assignment and outreach and engagement processes for these Members within 30 days of KHS notification.

3. Beginning 2024, when Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a D-SNP, KHS will coordinate with the Medicare Advantage Plan in the provision of Community Supports by notifying and informing the Member's CSS provider through member-level information sharing via established Secure File Transfer Protocol (SFTP) sites.

C. Authorizations and Referrals for Community Supports:

1. KHS will utilize a standardized CSS staff review process for each elected Community Support ensuring appropriate clinical support authorization of Community Supports for Members who meet the Medical Necessity determination. KHS requires all Network Providers using their professional judgement to have determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with all applicable APLs and to be defined in forthcoming guidance.

2. KHS will work with the CSS Providers in order to authorize CSS benefits in the most medically appropriate, equitable, and non-discriminatory manner to each eligible Member. This approach includes consistent:
    a. Validation of Member eligibility for CSS using methodology which will not restrict the authorization of CSS only to Members who are transitioning from WPC and/or HHP.
    b. Monitoring and evaluation of inequitable service authorizations through auditing for quality assurance
    c. Analysis of all CSS reporting measures, activities, and service outcomes
    d. Training and Education that aligns with non-discriminatory practices.

3. For Community Supports without "once in a lifetime" restrictions, KHS will automatically authorize CSS-eligible Members who have received Community Supports services under a previous plan so long as KHS has also elected to offer such services. KHS will identify such Members utilizing CSS encounter data as part of the 12-month historical utilization data set under the Plan Data Feed which ensures Members are included in the CSS stratification process using a 90-day look back period and flagging system.
    a. KHS CSS Care Team will be responsible for the follow-up outreach and coordination with the Member's previous MCP, and the Member or CSS Provider in order to gain access to the Member's Care Management Plan and mitigate any gaps in care.

4. KHS will accept referrals from the following:
    a. Self-referrals
    b. Referrals by family members/caregivers, or authorized representative (AR)
    c. Support networks
    d. Primary Care Providers

e. Specialist
f. Other Providers in the Community

5. KHS will utilize the standard UM Referral and Authorization process (Policy 3.22) to authorize CSS:
    a. All referrals not auto approved based on Member assessment questions, will be evaluated for eligibility by the CSS Care Team within 5 working days for routine authorizations and within 72 working hours of receipt for urgent requests.
    b. If a Member meets eligibility, an authorization will be issued for a period of time based on service requested. Authorization notifications will be sent to the PCP and ECM Provider, if applicable, within 10 business days of authorization.
    c. If a Member does not meet eligibility criteria, the Member's referral will be reviewed by a KHS medical director for consideration.
    d. Notification of approval or denial will be sent to the Member and entity requesting CSS.
    e. If denied, the Member will receive a Denial Notice of Action from KHS and be provided with notification of grievance and appeal rights.

6. KHS will treat the following Community Supports as urgent, or expedited, authorization requests in accordance with Section 4a:
    a. Recuperative Care
    b. Short Term Post Hospitalization Housing
    c. Sobering Centers
    d. Medically Tailored Meals being offered post-acute care.

7. KHS will accept presumptive authorizations for the following Community Supports whereby selected Providers can presumptively authorize services, potentially only for a limited period of time, under specified circumstances when a delay would be harmful to the beneficiary or inconsistent with efficiency and cost-effectiveness:
    a. Recuperative Care
    b. Short Term Post Hospitalization Housing
    c. Sobering Centers

8. For Members enrolled in ECM, KHS will use closed loop referrals and work closely with the ECM Care Team, to communicate the outcome of referrals back to the ECM Provider. This standard process of notifying the ECM Provider within 10 business days of the authorization will also be followed by the CSS Care Team.

9. KHS will also track referrals to CSS Providers to verify if the authorized service(s) have been delivered to the Member. If the Member receiving CSS is also receiving ECM, this too will be tracked to ensure that the ECM Member receives the authorized service from the CSS Provider.

10. KHS Network of CSS Providers will be responsible for the following:
    a. Ensuring the Member agrees to the receipt of Community Supports;

b. Where required by law, ensure that Members authorize information sharing with KHS and all others involved in the Member's care as needed to support the Member and maximize the benefits of Community Supports, in accordance with all applicable DHCS APLs;
c. Communicate Member-level records of any obtained authorization for Community Supports-related data sharing which are required by law, and to facilitate ongoing data sharing with KHS; and
d. Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, if KHS intends to do so.

11. KHS will operationalize a no "wrong door" policy providing Members' access to centralized services.
    a. All requests for services are processed by KHS using a centralized approach in which all referrals can be processed during the same encounter regardless of the type of requested service or program.
    b. If a CSS Provider identifies a Member that needs additional services or care, regardless of what type of service is being provided, the CSS Provider will make the necessary referrals to the appropriate resources either internally to KHS or to community-based resources to ensure that the Member receives the necessary services and/or care.
    c. CSS Providers will receive training regarding all care management programs that are available to KHS Members. If during assessment the CSS Provider identifies that the Member could benefit from other care management programs, the Provider will refer the Member to the appropriate program.
    d. KHS will accept referrals for CSS from Providers, other community-based entities, and Members and their families.

D. Discontinuation of Community Supports Services and/or Outreach

1. Members are able to decline or end Community Supports upon initial outreach and engagement, or at any other time.

2. Reasons CSS Provider has for discontinuing outreach may include:
    a. Member declines participation
    b. Member is well managed and not in need of CSS.
    c. Duplicative services are being provided to Member.
    d. Member displays an unsafe behavior.
    e. Member is not eligible for services.
    f. Member is deceased.

3. Community Supports Providers will notify KHS to discontinue CSS for Members if any of the following circumstances are met:
    a. The Member has met all goals and is in no longer need of services.
    b. The Member loses insurance coverage and no longer eligible for services.
    c. The Member no longer wishes to receive CSS or is unresponsive or unwilling to engage; and/or

d. The CSS Provider has not been able to connect with the Member after multiple attempts.

4. CSS Providers will be notified of Members' CSS discontinuation using disenrollment reasons and codes via an Enrollment File accessed via SFTP.

5. If a CSS is discontinued for any reason, CSS Provider shall support transition planning for the Member into other programs or services that meet their needs.

6. CSS Provider is encouraged to identify additional CSS the Member may benefit from and send any additional request(s) for CSS to KHS for authorization.

7. Members no longer authorized to receive the CSS benefit and who qualify for discontinuation will receive a Notice of Action from KHS identifying their disenrollment from the CSS Program. This includes information of their right to appeal and the appeals process by way of the DHCS outlined NOA process. Notification of disenrollment will be sent to each Member's Provider.

REFERENCE:

UM Referral and Authorization Policy 3.22

Revision 2023-09: Policy updated to comply with DHCS Community Supports Attestation Form due 9/15/2023. **Revision 2023-09:** Policy approved on 9/5/2023 per 2024 Operational Readiness R.0146. **Update 2023-07**: Policy updated to comply with the DHCS 2024 Medi-Cal Managed Care Plan Contract. **2023-05**: Policy received approval on 05/31/2023 per updated DHCS-approved Model of Care (MOC) Template. **2023-02:** Policy submitted per DHCS MOC request. **2022-11**: Policy received approval on 11/30/2022 per updated DHCS-approved Model of Care (MOC) Template. **2022-10:** Policy submitted per DHCS Prime & Subcontractor Authorization Alignment. **2022-09:** Policy submitted per DHCS MOC request. **2022-02:** Policy submitted per DHCS MOC request. **Revision 2021-12**: Policy created to outline processes regarding Member Identification and Authorization. DHCS approval for Legacy Model of Care (MOC) Template Parts 1-3 received 11/30/21 to implement Community Supports Program on January 1, 2022.