KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Community Supports Services (CSS) Member Identification and Authorization	**Policy #**	17.04-P
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Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. 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.

II. POLICY

Kern Health System (KHS) is committed to ensuring that Community Supports (CS) services are provided exclusively to eligible Medi-Cal and dual eligible Members, in alignment with California Department of Health Care Services (DHCS) guidelines. KHS employs a structured, compliant, and data-driven approach to identify, assess, and stratify members based on clinical and social needs.

As part of its Member identification determination process, KHS conducts comprehensive Member assessments, leverages existing clinical and utilization data, and utilizes predictive risk modeling and stratification tools. These efforts support the accurate identification of individuals who would most benefit from Community Supports, ensuring equitable access to services that address social determinants of health and reduce avoidable utilization of higher levels of care.

Members are not required or obligated to use Community Supports. Participation in these services is voluntary and may be declined at any time. Community Supports are not intended to limit or discourage access to Medicaid State Plan services.

III. DEFINITIONS

TERMS	DEFINITIONS
WPC	Whole Person Care Program

HHP	Health Homes Program
PCP	Primary Care Physician
UM	Utilization Management
ECM	Enhanced Care Management
CSS Team	Internal KHS Staff working to assign Members identified for CSS, coordinating with CSS Community Based Organizations (CBOs), and connecting Members to all available resources.

IV. PROCEDURES

SCOPE OF SERVICES

A. Delivery of Community Supports

The table below identifies which Community Supports Services will be provided to eligible Members, including the service definitions, expected duration and frequency of service(s) and any connection with other community supports requirements.

Primary Delivery Method	Expected Duration and Frequency of Service	Delivery with other CS and Enhanced Care Management (ECM)
1. Respite Services Services 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: a. Services provided by the hour on an episodic basis because of the absence of or need for	i. In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed twenty-four (24) hours per day of care. ii. Service limit is up to three hundred thirty-six (336) hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the three hundred thirty-six (336) hour per calendar year limit can be made, with	

relief for those persons normally providing the care to individuals. b. 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. c. 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.	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 three hundred thirty-six (336)-hour annual limit.	
2. Assisted Living Facility Transitions (formerly known as Nursing Facility Transition/Diversion to Assisted Living Facilities (ALF)) Services assist individuals to live in the community and/or avoid institutionalization when possible. For the purposes of this service definition, the term assisted living facility (ALF) includes a Residential Care Facility for the Elderly (RCFE), or Adult Residential Care Facility (ARF). 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). This also applies to Members residing in a private residence or public subsidized housing transitioning to an ALF that meet the criteria for needing a nursing facility LOC. Individuals have a choice of residing in an assisted living setting as an	i. The expected duration of this service depends upon the individual Member's condition.	i. Members may receive other Community Supports (in particular, the time-limited transition services/expenses component of this service and Housing Transition Navigation) at the same time as long as the services provided are nonduplicative, distinct, and necessary.

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 an ALF 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 twenty-four (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. There are two distinct components of this Community Support: Time-limited transition services and expenses (including one-time moving expenses such as mover/moving supplies; and Ongoing assisted living service for members after transitioning into an ALF (excludes room and board). This component of the Community Support does not have a time limit. Time-limited transition services and expenses enable a person to establish a residence in an ALF. Transition services end once the Member establishes residency in the ALF. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to a. Assessing the Member's housing needs and presenting options. b. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the ALF so the Member can be safely and stably housed in an ALF. c. Assisting in securing an ALF residence, including the completion of facility		ii. A Member may be eligible for both the Assisted Living Facility Transitions Community Support and the Assisted Living Waiver (ALW) or California Community Transitions (CCT), they may not receive both at the same time due to the similar services funded under each program.

applications, and securing required documentation (e.g., Social Security card, birth certificate, prior rental history). d. Moving expenses to support a Member's transition, such as movers/moving supplies and necessary private/personal articles to establish an ALF residence. e. Communicating with facility administration and coordinating the move. f. Establishing procedures and contacts to retain facility housing. Ongoing assisted living services are provided to Members on an ongoing basis after they transition into the ALF. Members can receive these services indefinitely, as long as the Member can maintain residency in the ALF. These services include: a. Assistance with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs) b. Meal preparation c. Transportation d. Medication administration and oversight e. Companion services f. Therapeutic social and recreational programming provided in a home-like environment g. Twenty-four (24)-hour direct care staff onsite at the ALF to meet unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security h. Care coordination services to screen for eligibility and support enrollment of Members in Enhanced Care Management (ECM) and other Community Supports		
3. Community or Home Transition Services (formerly known as Community Transition Services/Nursing Facility Transition to a Home) Helps individuals to live in the community and avoid further institutionalization. Community or Home Transition Services are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence or	i. Community Transition Services are non-recurring set-up expenses 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	i. To fund home modifications, Members should first be connected to the Environmental Accessibility Adaptations (Home

public subsidized housing where the person is directly responsible for his or her own living expenses. This service includes two components as follows. Time-limited transition services and expenses to enable a Member to transition from a licensed facility to a private residence or public subsidized housing. Each transitional period will vary in length and services provided based on a Member's unique circumstances. Includes services such as: a. Assessing the Member's housing needs and presenting options. b. 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). c. Communicating with landlord (if applicable) and coordinating the move. d. Establishing procedures and contacts to retain housing. e. 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. f. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility. Non-recurring set-up expenses are those necessary to enable a Member to establish a basic household that does not constitute room and board and include: a. Security deposits required to obtain a lease on an apartment or home. Security deposits should be in alignment with 14AB12, enacted in 2024. b. Set-up fees for utilities or service access and up to six months payment in utility arrears, as necessary to secure the unit; c. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, and necessary repairs to meet Housing Choice Voucher program quality standards where	a provider-operated living arrangement to a living arrangement in a private residence or public subsidized housing through circumstances beyond his or her control.	Modifications) Community Support if eligible and available. If a Member reaches their lifetime maximum of the Environmental Accessibility ii. Adaptions Community Support, funds for non-recurring set-up expenses may be used for similar modifications. iii. Members may receive Housing Transition Navigation, Housing Deposits, and/or Environmental Accessibility Adaptations (Home Modifications) at the same time as the Community Transition Services iv. Community Support as long as the services provided are nonduplicative, distinct, and necessary.

those costs are not the responsibility of the landlord under applicable law; d. Air conditioner or heater; e. Adaptive aids designed to preserve an individual's health and safety in the home, such as hospital beds, Hoyer lifts, bedside commode, shower chair, traction, or non-skid strips, etc., that are necessary to ensure access and safety for the individual upon move-in to the home, when they are not otherwise available to the Member under Medi-Cal (e.g., State Plan, HCBS waiver, etc.).		A Member may be eligible for both Community Transition Services and other relevant waiver/demonstration programs such as CCT and Home & Community Based Alternatives Waiver, they cannot receive both at the same time if the activities provided under each program are duplicative.
4. 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 (IHSS) 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.	i. Authorization of service units will be contingent upon review of the Member's functional status and support needs. This includes, but not limited to, evaluation of the Member's Katz score to determine the level of functional impairment. ii. Review of in-home supportive services (IHSS) approved hours to assess existing coverage and identify potential gaps in care. iii. These factors will be used to determine appropriate level of authorization aligned with the Member's needs.	i. 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

The Personal Care and Homemaker Services Community Support can be utilized: a. 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 b. 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. c. 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 sixty (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.		Services Community Support during this reassessment waiting period. i. 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 California Advancing and Innovating Medi-Cal (CalAIM) Special Terms and Conditions (STCs) and federal and DHCS guidance.
5. Environmental Accessibility Adaptations (EAAs also known as Home Modifications) Are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization. Examples of environmental accessibility adaptations include:	i. The assessment and authorization for EAAs must take place within a ninety (90) day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.	

a. Ramps and grab-bars to assist Members in accessing the home. b. Doorway widening for Members who require a wheelchair. c. Stair lifts. d. Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower). e. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and f. 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). The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.). When authorizing environmental accessibility adaptations as a Community Support, the managed care plan 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. KHS may also receive and document:	ii. Proof of rental for one year will be required for approval iii. EAAs are payable up to a total lifetime maximum of $7,500. 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 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.	

a. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This 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: b. 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. c. 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 d. 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. e. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and f. That a home visit has been conducted to determine the suitability of any requested equipment or service.		
6. Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services Services designed to address individuals' chronic or other serious conditions that are nutrition-sensitive, leading to improved health outcomes and reduced unnecessary costs. Medically Tailored Meals and Groceries: Medically Tailored Meals and Medically Tailored Groceries are covered by this service, defined as follows:	i. 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 twelve (12) weeks, or longer if medically necessary. ii. KHS has identified a list of nutrition sensitive	

a. Medically Tailored Meals (MTM): Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions. b. Medically Tailored Groceries (MTG): Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions. The provision of MTMs/MTGs must include an individual assessment of the Member's nutrition-sensitive condition and nutritional needs conducted or overseen by Registered Dietitian Nutritionist (RDN) to inform the development of a nutritional plan and connection to the appropriate MTM or MTG services. The design of each of the MTM/MTG services (e.g., uncontrolled diabetes meal plan, congestive heart failure grocery plan) must be tailored by an RDN or other appropriate clinician to ensure the food provided adheres to established, evidence-based nutrition guidelines to prevent, manage, or reverse the targeted nutrition-sensitive health condition(s). The MTM and/or MTG assistance provided (singularly or in a combination of meals and groceries) must meet at least two-thirds of the daily nutrient and energy needs of an average individual, as estimated by the RDN/clinician overseeing the design of the MTM/MTG services. "Medically tailored" interventions must be provided in specified quantities to constitute the majority of the Member's diet over the course of the intervention to have the intended impact on health outcomes. MTM/MTG must not contain ultra-processed foods nor foods with excessive sugar or salt. Medically Supportive Food (MSF): Medically Supportive Foods are packages of foods that adhere to national nutrition guidelines to prevent, manage, or reverse nutrition-sensitive conditions of referred Members. Unlike MTM or MTG, MSF is intended to supplement, rather than replace, all or most of the Member's diet. The design or selection of foods or food	conditions to qualify for this service.	

options in MSF services must be overseen and signed off on by an RDN or another appropriate clinician. Medically Tailored When authorizing medically tailored meals as a Community Supports service, KHS will monitor the following service delivery methods which may include: a. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission. b. Medically Tailored Meals: meal and food packages provided to the Member at home that follow national nutrition guidelines and that are appropriate for the nutrition-sensitive conditions identified by the MCP for MTM/MSF services. c. 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. d. Medically supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies. e. MTM/MSF Community Support Providers must consider the cultural preferences/needs (e.g., halal or kosher meals) and food preparation and storage capabilities (e.g., ability to store frozen meals) of each individual Member when determining the appropriate MTM/MSF intervention for the Member. f. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above. Nutrition education may not be provided as a standalone service under the Community Support. As the MTM/MSF sector grows, it is more important for KHS to provide robust oversight of providers and the food itself.		

a. KHS is responsible for ensuring and documenting that the current and prospective MTM/MSF Community Supports Providers are or can provide high quality and safe MTM/MSF services that follow this service definition, via provider contracts and ongoing monitoring. b. Must oversee compliance with the Community Support service definition, including: • Qualifications of the clinical staff and/or RDN staff, and the nutrition standards used to develop the services • Nutritional information of medically tailored meals or grocery services (e.g., macro-nutrient thresholds) • Providers' food preparation licensure, recent inspection records, food safety violations, etc. Routinely collect information regarding Member adherence with the MTM/MSF intervention and assessing whether Members with strong adherence had improved health outcomes		
7. 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:	i. The expected duration of this service is less than twenty-four (24) hours.	

a. 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. b. 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. c. 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. d. 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 Engagement, Motivational Interviewing, and Trauma-Informed Care.		
8. Asthma Remediation Asthma Remediation can prevent acute asthma episodes that could result in the need for emergency services and hospitalization. The Asthma Remediation Community Support consists of supplies and/or physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of a Member, or to enable a Member to function in the home with reduced likelihood of experiencing acute asthma episodes. Asthma Remediation should supplement the Asthma Preventive Services (APS) Medi-Cal State Plan service. APS covers clinic-based asthma self-management education, home-based asthma self-management education, and in-home environmental trigger assessments that identify physical modifications to a home or supplies that would reduce the likelihood of acute asthma episodes. Members with a completed in-	i. If another State Plan service beyond the Asthma Preventative Services (APS), such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, the State Plan service should be accessed first. ii. Asthma remediations must be conducted in accordance with applicable State and local building codes.	

home environmental trigger assessment within the last twelve (12) months through the Asthma Preventive Services benefit that identifies medically appropriate Asthma Remediations and specifies how the interventions meet the needs of the Member are eligible for this Community Support. Supplies and physical modifications for Asthma Remediation covered under this Community Support include, but are not limited to: a. Allergen-impermeable mattress and pillow dustcovers b. High-efficiency particulate air (HEPA) mechanical filtered vacuums c. Integrated Pest Management (IPM) services d. De-humidifiers e. Mechanical air filters/air cleaners f. Other moisture-controlling interventions g. Minor mold removal and remediation services h. Ventilation improvements i. Asthma-friendly cleaning products and supplies j. Other interventions identified to be medically appropriate for the management and treatment of asthma The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver. Services provided to a Member need not be carried out at the same time but may be spread over time, subject to lifetime maximum.	iii. 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.	
9. Housing Transition/ Navigation Services (HTNS) 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: a. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment will include collecting	i. 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. ii. The authorization will consist of a limited amount of services per authorized time frame.	i. Members who meet the eligibility requirements for HTNS are offered ECM. If Member receives HTNS and ECM, service delivery is

information on the participant's housing needs and preferences, potential housing transition strengths barriers, and identification of housing retention strengths and barriers. b. 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. c. Searching for housing and presenting options. d. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history). e. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset. f. Identifying and securing available resources to assist with attaining housing (such as Transitional Rent, Housing and Urban Development (HUD) Housing Choice Voucher, state and local assistance programs etc.) and matching available rental subsidy resources to Members. g. 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. h. Providing education to the Member about Fair Housing and anti-discrimination practices, including assisting with requests for reasonable accommodation, if necessary. i. Landlord education and engagement		coordinated by the ECM Provider to minimize the number of care/case management transitions experienced by the Member. ii. Member can receive both HTNS and Housing Deposits at the same time. HTNS is not a condition of receiving Housing Deposits. iii. A Member cannot receive both Housing Tenancy and Sustaining Services (HTSS) and HTNS at the same time. iv. Member can receive both HTNS and Transitional Rent at the same time. All Members who are determined eligible for Transitional Rent are automatically determined eligible for HTNS.

j. Ensuring that the living environment is safe and ready for move-in. k. Communicating and advocating on behalf of the client with landlords. l. Assisting in arranging for and supporting the details of the move. m. 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. n. 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. o. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.		
10. Housing Deposits Assist with identifying, coordinating, 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: a. Security deposits required to obtain a lease on an apartment or home. b. Set-up fees/deposits for utilities or service access and utility arrearages. c. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water. d. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, along with necessary minor repairs to meet HUD Housing Choice Voucher program quality standards, or other habitability standards, as applicable, where those costs are not the responsibility of the landlord under applicable law. e. Application fees to cover the cost of the lease application.	i. Housing Deposits are available once per demonstration period with the opportunity for approval one additional time with supporting documentation. ii. Housing Deposits are payable up to a total lifetime maximum of $5,000. iii. Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage. iv. The services and goods provided to a Member must be based on an individualized assessment of needs and documented in the Member's housing support plan.	i. Members who meet the eligibility requirements for Housing Deposits are offered ECM. ii. Member can receive both HTNS and Housing Deposits at the same time. However, DHCS is no longer requiring a Member to receive HTNS as a condition of receiving Housing Deposits. iii. Member can receive both HTSS and Housing

f. Goods such as an air conditioner or heater, and other medically necessary 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. g. A housing support plan in place is a condition for authorizing a Member for Housing Deposits. The housing support plan must include: h. Identify the permanent housing strategy and solution for the Member, including the payment sources and mechanisms, that will support the Member in maintaining housing after the Room and Board services covered under the Medi-Cal managed care delivery system are exhausted (e.g., the Member's income, BHSA Housing Interventions, or other long-term subsidies). i. Identify the full range of permanent housing supports that will support the Member in sustaining tenancy (e.g., tenancy sustaining service, utilities). j. Be informed by Member preferences and needs, and reviewed and revised as needed based on changes in Member circumstances. k. Be based on a 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. l. Be developed in a way that is culturally appropriate and trauma-informed		Deposits at the same time. iv. Member can receive both Housing Deposits and Transitional Rent in support of the same housing placement. All Members who are determined eligible for Transitional Rent are automatically determined eligible for Housing Deposits. v. The services and goods provided must be based on their individual housing plan.
a. Housing Tenancy and Sustaining Services (HTSS) b. This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.	i. These services must be identified as reasonable and necessary in the Member's housing support plan. Service duration can be as long as necessary. There is no	i. Members who meet the eligibility requirements for HTSS are offered ECM.

c. Services include: d. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations. e. Education and training on the role, rights and responsibilities of the tenant and landlord. f. Providing education for the Member about Fair Housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary. g. Coaching on developing and maintaining key relationships with landlords/property managers and/or neighbors with a goal of fostering successful tenancy. h. Coordination with the landlord and care/case management provider, which can be the Member's Essential Community Provider (ECP) Provider or non-Medi-Cal housing supportive services providers such as Continuum of Care (CoC) program case manager, to address identified issues that could impact housing stability. i. 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. j. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized. k. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset. l. Assistance with the annual housing recertification process. m. Coordinating with the tenant to review, update and modify their housing support and crisis	limit on how many times an eligible Member may be authorized for HTSS ii. The frequency of services is as needed and may involve coordination with other entities to ensure the individual has access to supports needed to maintain tenancy. iii. The services and goods provided to a Member must be based on an individualized assessment of needs and documented in the Member's housing support plan.	ii. Member cannot receive both HTSS and HTNS at the same time. iii. Member can receive both HTSS and Housing Deposits at the same time. iv. Member can receive both HTSS and Transitional Rent at the same time. All Members who are determined eligible for Transitional Rent are automatically determined eligible for HTSS. v. The services and goods provided must be based on their individual housing plan

plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. n. Continuing assistance with lease compliance, including ongoing support with activities related to household management. o. Health and safety visits, including unit habitability inspections. p. 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). q. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources. r. A housing support plan in place is a condition for authorizing a Member for Housing Deposits. The housing support plan must include: s. Identify the permanent housing strategy and solution for the Member, including the payment sources and mechanisms, that will support the Member in maintaining housing after the Room and Board services covered under the Medi-Cal managed care delivery system are exhausted (e.g., the Member's income, BHSA Housing Interventions, or other long-term subsidies). t. Identify the full range of permanent housing supports that will support the Member in sustaining tenancy (e.g., tenancy sustaining service, utilities). u. Be informed by Member preferences and needs, and reviewed and revised as needed based on changes in Member circumstances. v. Be based on a 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. w. Be developed in a way that is culturally appropriate and trauma-informed		
12. Day Habilitation Program services include, but are not limited to, training on: a. The use of public transportation. b. Personal skills development in conflict resolution. c. Community participation. d. Developing and maintaining interpersonal relationships. e. Daily living skills (cooking, cleaning, shopping, money management); and, f. 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, the following: a. Selecting and moving into a home b. Locating and choosing suitable housemates. c. Locating household furnishings. d. Settling disputes with landlords. e. Managing personal financial affairs. f. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants. g. Dealing with and responding appropriately to governmental agencies and personnel. h. Asserting civil and statutory rights through self-advocacy. i. Building and maintaining interpersonal relationships, including a circle of support. j. Coordination with Medi-Cal managed care plan to link Member to any Community Supports and/or ECM. k. Providing a referral to non-Community Supports housing resources if Member does not meet eligibility criteria for Housing Transition/Navigation Services, Housing Deposits. HTSS or Transitional Rent l. Assistance with income and benefits advocacy including General Assistance/ General Relief	i. Program services are available for as long as necessary, available for authorization renewal every six (6) months. Services can be provided continuously, or through intermittent meetings, in an individual or group setting.	i. While receiving Day Habilitation Program services, Members needing assistance with housing-related services and supports should be referred for the Housing Trio and may also be referred for Transitional Rent.

and SSI if Member is not receiving these services through Community Supports or ECM. Coordination with Medi-Cal managed care plan to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or Enhanced Care Management.		
13. 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: a. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs to the extent permitted by licensure b. Coordination of transportation to post-discharge appointments c. Connection to any other on-going services an individual may require including mental health and substance use disorder services. d. Support in accessing benefits and housing. e. Gaining stability with case management relationships and programs	i. Recuperative Care cannot exceed a duration of six (6) months (182 days) per rolling twelve (12)-month period (but may be authorized for a shorter period based on individual needs) and is subject to the six (6)-month global cap on Room and Board services. ii. Services are not intended to replace or be duplicative of the services provided to Members utilizing the ECM program. iii. Under the global cap, coverage is limited to six (6) months (182 days) of Room and Board services per Member within a rolling twelve (12)-month period. A Member may not receive more than a combined six months of Short-Term Post-Hospitalization Housing, Recuperative Care, and Transitional Rent during any rolling twelve (12)-month period starting with the first date of utilization – not from the date of authorization.	i. Recuperative Care may be utilized in conjunction with other housing Community Supports. ii. Whenever possible, other housing Community Supports should be provided to Members onsite in the recuperative care facility. iii. During a stay in a Recuperative Care setting, Members should be offered HTNS and may be referred for Transitional Rent. If receiving HTNS, this would include a housing assessment and the development

		of housing support plan to help them identify preferences and barriers related to successful housing tenancy after transitioning from Recuperative Care.
14. Short-Term Post-Hospitalization Housing (STPH) 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. a. 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. b. This setting may include an individual or shared interim housing setting, where residents receive the services described above. c. Beneficiaries must be offered Housing Transition Navigation support during the	i. Short-Term Post-Hospitalization Housing cannot exceed a duration of six months (182 days) per rolling twelve (12)-month period (but may be authorized for a shorter period based on individual needs) and is subject to the six (6)-month global cap on Room and Board services ii. Under the global cap, coverage is limited to six (6) months (182 days) of Room and Board services per Member within a rolling twelve (12)-month period. A Member may not receive more than a combined six (6) months of Short-Term Post-Hospitalization Housing, Recuperative Care, and Transitional Rent during any rolling twelve (12)-month period starting with the first date of utilization – not from the date of authorization.	i. Services are not intended to replace or be duplicative of the services provided to Members utilizing the ECM program. ii. Short-Term Post-Hospitalization Housing may be utilized in conjunction with other housing Community Supports. iii. Whenever possible, other housing Community Supports should be provided to Members onsite in the Short-Term Post-

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.		Hospitalization Housing facility. iv. During a stay in a Short-Term Post-Hospitalization Housing setting, Members should be offered HTNS and may be referred for Transitional Rent. If receiving HTNS, this would include a housing assessment and the development of housing support plan to help them identify preferences and barriers related to successful housing tenancy after transitioning from Short-Term Post-Hospitalization Housing.
15. Transitional Rent Transitional Rent may be used to cover the following expenses: a. Rental assistance in allowable settings	i. Under the global cap, coverage is limited to six (6) months (182 days) of Room and Board services per Member within a rolling twelve (12) -month period. A Member may	i. When a Member is authorized for Transitional Rent, they must also be authorized for

b. Storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment Transitional Rent provides up to six (6) months of rental assistance in interim and permanent settings to Members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria. A housing support plan in place as a condition for authorizing a Member for Transitional Rent. The housing support plan must: a. Identify the permanent housing strategy and solution for the Member, including the payment sources and mechanisms, that will support the Member in maintaining housing after the Room and Board services covered under the Medi-Cal managed care delivery system are exhausted (e.g., the Member's income, Bureau of Housing and Support Administration (BHSA) Housing Interventions, or other long-term subsidies). b. Identify the full range of permanent housing supports that will support the Member in sustaining tenancy (e.g., tenancy sustaining service, utilities). c. Be informed by Member preferences and needs, and reviewed and revised as needed based on changes in Member circumstances. d. Be based on a 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.	not receive more than a combined six (6) months of Short-Term Post-Hospitalization Housing, Recuperative Care, and Transitional Rent during any rolling twelve (12) - month period starting with the first date of utilization – not from the date of authorization.	ECM and the Housing Trio Community Supports (HTNS, Housing Deposits, and HTSS). ii. Member can receive both HTNS and Transitional Rent at the same time (if not also receiving HTSS). iii. Member can receive both Housing Deposits and Transitional Rent in support of the same housing placement iv. Member can receive both Transitional Rent and HTSS at the same time (if not also receiving HTNS). v. Member transitions from an interim to a permanent setting without discontinuing service, KHS will not re-assess eligibility but

e. Be developed in a way that is culturally appropriate and trauma informed. When receiving Transitional Rent, a Member can be placed in an interim or permanent setting. The details provided in the housing support plan may differ depending on the type of setting a Member is seeking authorization for: a. For interim settings: For a Member transitioning from homelessness into an interim setting, a housing support plan should address all major elements identified above, though it may be less complete. Required to include documentation from the Member's county behavioral health agency that the Member will be able to transition to BHSA Housing Interventions at the expiration of Transitional Rent. b. For permanent settings: By the time a Member is seeking Transitional Rent in a permanent setting, they will be further along in making progress with their Housing Support Plan to also include goals identified, barriers overcome, documents have been obtained, and a housing search has taken place. If a Member is authorized for Transitional Rent but not yet receiving ECM, KHS must authorize a Member for ECM, assign an appropriately selected ECM Provider, and share all necessary information with the ECM Provider to enable the ECM Provider to begin conducting in-person outreach visits to the Member. KHS is required to ensure that the ECM Provider conducts weekly in-person outreach visits to the Member as soon as feasible and acceptable to the Member, and no later than two (2) weeks after a Member begins receiving Transitional Rent, to invite engagement in ECM until a Member chooses to participate in ECM or declines participation.		would issue a new or revised authorization.

All instances of Transitional Rent should be recorded in the Housing Management Information system (HMIS). Entry may be completed by the Housing Trio Provider, the Transitional Rent Provider, or KHS.		

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, Adjusted Clinical Groups (ACG) modeler files, Electronic Medical Record (EMR) data, Health Risk Assessment (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. To include utilization reviews for high Emergency Room (ER) utilizers, frequent hospital admissions, or long lengths of stay.

2. KHS will identify newly eligible Community Supports Members who were previously enrolled in another plan through the presence of Community Supports service Healthcare Common Procedure Coding System (HCPCS) codes within the prior ninety (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 thirty (30) days of KHS notification.

3. Beginning 2026, when Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a Dual Special Needs Plan (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. Referrals and Authorizations for Community Supports:

1. Prior to authorization we do eligibility verification which includes confirming:

    a. Active Medi-Cal eligibility,
    b. Enrollment in Kern Health System
    c. Eligibility for specific Community Supports services per DHCS and KHS criteria.

2. 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 All Plan Letters (APLs) and to be defined in forthcoming guidance.

3. KHS has a monitoring process in place to track the number of days Members have used for Room and Board services in a rolling twelve (12)-month period to ensure the cap of one hundred eighty-two (182) days is not exceeded. This process also includes tracking of Transitional Rent utilization for a member and their household to ensure they do not exceed one hundred eighty-two (182) days during the demonstration period. Utilization information will be shared with the Transitional Rent Community Based Organization (CBO) no less than monthly or deemed necessary.

4. KHS will work with the CSS CBO 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 Whole Person Care (WPC) and/or Health Homes Program (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.

5. For Community Supports without "once in a lifetime, demonstration period or global cap" 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 twelve (12)-month historical utilization data set under the Plan Data Feed which ensures Members are included in the CSS stratification process using a ninety (90)-day look back period and flagging system.

    a. KHS will be responsible for the follow-up outreach and coordination with the Member's previous Managed Care Plan (MCP), and the Member or CSS CBO in order to gain access to the Member's Care Management Plan and mitigate any gaps in care.

6. 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. Internal Case Management/Utilization Management (UM)
    g. Other Providers in the Community

7. KHS will utilize the standard UM Referral and Authorization process (Policy 3.22-P) 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 seven (7) calendar days for routine authorizations and within seventy-two (72) working hours of receipt for urgent requests.
    b. Notification of approval or denial will be sent to the Member and requesting entity.

    c. 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 ten (10) business days of authorization.

    d. If a Member does not meet eligibility criteria, the Member's referral will be reviewed by a KHS medical director for consideration.

    e. If denied, the Member will receive a Denial Notice of Action from KHS and be provided with notification of grievance and appeal rights.

8. KHS will treat the following Community Supports as urgent, or expedited, authorization requests in accordance with Section C,4, a:

    a. Recuperative Care
    b. Short Term Post Hospitalization Housing
    c. Sobering Centers

9. KHS will accept presumptive authorizations for the following Community Supports whereby selected CBOs 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
d. Transitional rent

10. The KHS contracted behavioral health agency may conduct a streamlined provisional authorization for Transitional Rent under the following conditions:

    a. The county behavioral health agency determines that the Member is BHSA-eligible and commits to providing the Member with BHSA Housing Interventions at the expiration of Transitional Rent, or upon denial of the request for coverage by KHS (denial would primarily be in situations where the Member has reached the global cap on receipt of Room and Board Services.

    b. The county behavioral health agency commits to sending a referral and request for authorization to KHS in a timely manner and at a minimum, within fourteen (14) days of the county behavioral health agency's streamlined provisional authorization.

    c. KHS will either authorize or deny coverage of Transitional Rent within the shortest applicable timeframe, but no longer than five (5) business days from receipt of request.

11. KHS will also track referrals to CSS CBOs 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 CBO.

12. KHS Network of CSS CBOs 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 All Plan Letters (APL).

    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.

    e. KHS will share information with the CBOs via the Member Information Sharing Guidance Community Supports Authorization Status File and CBOs will share information with KHS via the Community Supports Provider Return Transmission File.

13. 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 CBO identifies a Member that needs additional services or care, regardless of what type of service is being provided, the CSS CBO 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 CBOs will receive training regarding all care management programs that are available to KHS Members. If during assessment the CSS CBO identifies that the Member could benefit from other care management programs, the CBO 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 CBO has for discontinuing outreach after multiple attempts may include:

    a. No answer
    b. Left voicemail
    c. Left message with third (3rd) party
    d. Wrong phone number
    e. Disconnected number
    f. Busy signal
    g. No show appointment

3. In alignment with the California Advancing and Innovating Medi-Cal (CalAIM) Data Guidance: Community Supports Member Information Sharing Guidance, Community Supports Providers will notify KHS to discontinue CSS for Members if any of the following circumstances are met via the Community Supports Provider Return Transmission File:

    a. Opted out

b. Reassigned to other Community Supports Provider
c. Deceased
d. Program completed/Graduated.
e. Incarcerated
f. Declined to participate.
g. Duplicative program
h. Lost Medi-Cal coverage
i. Switched health plans.
j. Switched Community Supports Provider
k. Moved out of the county.
l. Moved out of country.
m. Unable to contact/Lost to follow-up.
n. Unsafe behavior or environment
o. Member not reauthorized for Community Supports

4. CSS CBOs will be notified of Members' CSS discontinuation using disenrollment reasons and codes via Community Supports Provider Return Transmission File via SFTP.

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

6. CSS CBO 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 Notice of Action (NOA) process. Notification of disenrollment will be sent to each Member's Provider.

E. Continuity of Care

1. KHS will demonstrate policies, procedures, and processes ensuring Medi-Cal Members with authorizations to receive Community Supports do not experience disruptions to the Community Supports authorization, provider relationships, or services in accordance with the 2024 MCP Transition Policy Guide.

2. KHS will honor all of the Previous MCP's authorizations for Community Supports when both MCPs offer the same Community Supports.

3. KHS will maintain all authorizations for no less than the length of time originally authorized by the Previous MCP (for Community Supports offered by both plans).

4. When both MCPs offer the same Community Support, KHS will honor the Community Support authorization made by the Previous MCP in alignment with the DHCS' Community Supports, Policy Guide.

5. For Community Supports not offered by both MCPs, if KHS does not continue the Previous MCP's authorization for a Member's Community Support, KHS will assess the Member's needs that are addressed by the Community Support and coordinate care to the necessary services, including ECM, to ensure an appropriate transition of care and to prevent the need for higher acuity services.

6. If a Previous MCP's Community Supports Provider does not wish to enter into a contract with the KHS network or if both parties cannot come to an agreement, KHS will offer a CoC for Provider agreement with the Community Supports CBO for up to twelve (12) months.

7. If KHS's efforts do not result in an agreement with the Community Supports CBO, KHS will explain in writing to DHCS why the CBO and KHS could not execute a contract or CoC for Community Support Services Provider agreement.

8. If KHS confirms the Member's existing Community Supports CBO is part of its network, agrees to join its network, or participates under a CoC for Community Support Services Provider agreement, KHS will ensure the Member is connected with their existing Community Supports CBO to ensure the Member's relationship with their Community Supports CBO is not disrupted.

9. If KHS does not bring the Community Supports CBO into its network or establish an agreement with the Community Supports CBO, KHS will transition the Member to an in-network Community Supports CBO.

V. ATTACHMENTS

N/A	

VI. REFERENCES

Reference Type	Specific Reference
Other KHS Policies	UM Referral and Authorization Policy 3.22-P
DHCS Contract (Specify Section)	CalAIM Data Guidance: Community Supports Member Information Sharing Guidance

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	2026-01	Updated to comply with the July 2026 CS MOC.	Community Supports

			Services
Revised	2025-12	Policy updated to comply with the updated January 2026 CS MOC.	Community Supports Services
Revised	2025-08	Policy updated to comply with DHCS Transitional Rent MOC.	Community Supports Services
Revised	2025-06	Policy updated to comply with DHCS Community Supports Policy Guide 4/2025	Community Supports Services
Revised	2024-01	Policy was revised by the Delegation Oversight Manager for the CSS MOC.	Community Supports Services
Revised	2023-09	Policy updated to include requirements of 2024 Medi-Cal Managed Care Plan Transition Policy Guide - Chapter VII Community Supports.	Community Supports Services
Revised	2023-09	Policy updated to comply with DHCS Community Supports Attestation Form due 9/15/2023.	Community Supports Services
Revised	2023-09	Policy approved on 9/5/2023 per 2024 Operational Readiness R.0146.	Community Supports Services
Revised	2023-07	Policy updated to comply with the DHCS 2024 Medi-Cal Managed Care Plan Contract.	Community Supports Services
Revised	2023-05	Policy received approval on 05/31/2023 per updated DHCS-approved Model of Care (MOC) Template.	Community Supports Services
Revised	2023-09	Policy submitted per DHCS MOC request	Community Supports Services
Revised	2022-11	Policy received approval on 11/30/2022 per update DHCS-approved Model of Care Template.	Community Supports Services
Effective	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.	Community Supports Services

VIII. APPROVALS

Committees | Board (if applicable)	Date Reviewed	Date Approved
Choose an item.		