COMMUNITY SUPPORTS
Provider User Guide
December 2021

Purpose

The purpose of this *Community Supports Provider User Guide* is to provide an overview of Community Supports, the likely avoidable Medi-Cal benefits that the services intend to substitute, the integration of Enhanced Care Management (ECM) with Community Supports, the services Santa Clara Family Health Plan (SCFHP) intends to offer over a three-year period, and the Community Supports program models for delivering the required services. This guide also provides an overview of the SCFHP Community Supports member referral process, authorization process, and payment process. Participating providers must adhere to the credentialing, authorization, member outreach, data sharing, reporting, achieving outcomes, and submitting claims and encounters requirements outlined in this *Community Supports Provider User Guide,* and the *Community Supports Vendor Agreement.*

Overview

Community Supports is one element of California Advancing and Innovating Medi-Cal (CalAIM), the Department of Health Care Services' multi-year process to transform Medi-Cal. As an extension of the Whole Person Care (WPC) pilot and the Health Homes Program (HHP), Community Supports contributes to an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. Both the WPC and HHP pilot program will conclude on December 31, 2021. During their implementation and administration, the WPC and HHP pilot programs varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

The Department of Health Care Services (DHCS) defines Community Supports as medically-appropriate and cost-effective substitutes or settings for more costly state-paid health care services. Community Supports are not Medi-Cal benefits, but supplemental services paid by the managed care health plans that focus on addressing combined medical and social determinants of health needs to avoid higher levels of care and are typically delivered by a different provider or in a different setting than traditional Medi-Cal benefits.

In Lieu of Medi-Cal Benefits

Community Supports are flexible wrap-around services that the Medi-Cal managed care plans will integrate into their population health management programs. These services are provided as an alternative to services covered under Medi-Cal, such as hospital care, nursing facility care, and emergency department (ED) utilization. Community Supports need to be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of Community Supports to serve as a transition of the work done through the WPC pilot, HHP, and the Coordinated Care Initiative (CCI), as well as inform the development of future potential statewide benefits that may be instituted.

ECM and Community Supports Integration

The provision of Community Supports is voluntary for plans and optional for beneficiaries, but the combination of ECM and Community Supports allows for a number of integration opportunities, including ensuring eligible members are enrolled in ECM for comprehensive case management and care coordination if needed, supporting members in living independently, and addressing their social determinants of health (SDOH) and other social needs.

Community Supports Election

SCFHP will launch all 14 of the DHCS-approved Community Supports in six-month increments between January 1, 2022 and July 1, 2023. The following are the launch dates for each of the 14 Community Supports:

Community Supports	Launch Date
Housing Transition Navigation Services	1/1/2022
Housing Deposits	1/1/2022
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities	1/1/2022
Community Transition Services/Nursing Facility Transition to a Home	1/1/2022
Medically Supportive Food/Meals/Medically Tailored Meals	1/1/2022
Housing Tenancy and Sustaining Services	7/1/2022
Recuperative Care (Medical Respite)	7/1/2022
Sobering Center	7/1/2022
Personal Care and Homemaker Services	7/1/2022
Respite Services	1/1/2023
Environmental Accessibility Adaptations (Home Modifications)	1/1/2023
Asthma Remediation	1/1/2023
Short-term Post-Hospitalization Housing	7/1/2023
Day Habilitation Programs	7/1/2023

Community Supports Program Models
Each of the 14 DHCS-approved Community Supports have defined eligible populations, code sets, potential providers, restrictions, and limitations. However, individual Community Supports may be used together with other complementary Community Supports based on individual needs and may be combined with ECM services for high-risk, complex-need individuals. The eligibility, requirements, restrictions, and staffing recommendations for each Community Supports are reflected in the program models. See Appendices A-E for the five Community Supports program models that SCFHP is launching on 1/1/2022.

Identification of Eligible Members
SCFHP promotes Community Supports referrals by:
(1) Working with ECM providers to identify members receiving ECM who may be eligible and will benefit from the program
(2) Encouraging referrals from internal SCFHP Case Managers
(3) Conducting trainings with all types of providers and community-based organizations to submit referrals for members who may be eligible

In addition, SCFHP will promote the self-referral process to members, their authorized representatives, and/or family supports.

Referrals and Authorizations

SCFHP encourages direct referrals from providers that are both contracted and non-contracted for Community Supports including, but not limited to Community Supports providers, ECM Lead Care Managers, primary care physicians, specialists, behavioral health representatives, community-based organizations, internal or external case managers, and others. SCFHP receives indirect referrals from members, members' authorized representative, or other individuals. Upon receipt of a referral, SCFHP determines eligibility for the requested Community Supports and either authorizes, denies, or redirects the referral to more appropriate programs, taking into consideration medical necessity and other factors. For authorized Community Supports, members are assigned to a contracted Community Supports provider for services in conjunction with the program model for the specific Community Supports being delivered. For denied Community Supports, SCFHP extensively reviews external and internal data to confirm ineligibility. SCFHP has a *no wrong door* approach and will accept requests for Community Supports by phone, fax, mail, email, in-person, or through the provider portal. In addition, SCFHP will provide support to the member who has been denied Community Supports by referring them to community-based entity or provider who may offer similar services.

SCFHP engages in a closed-loop referral process using an electronic referral form accessible through its provider portal to receive direct referrals from providers. Indirect referrals from members or family supportive individuals are submitted through a number of ways (phone, email, fax, mail) with SCFHP staff entering referral details into its system. All incoming referrals are reviewed, determined as being eligible for Community Supports, and authorized or denied for services. Communication with referring entities on the receipt of referrals, the authorization status of the Community Supports, assignment for authorized Community Supports to an appropriate provider, and the outcome of the services rendered flows between SCFHP and the referring entities in a timely manner.

Data Sharing, Reporting, Outcomes, and Performance Measures

Per DHCS requirements, SCFHP monitors the implementation of and compliance with Community Supports requirements across multiple domains including membership, service provision, grievances and appeals, provider capacity, and quality. In addition, SCFHP will monitor and evaluate outcomes for its members who received Community Supports through the use of quality measures.

Data Sharing

SCFHP requires Community Supports providers to have systems and processes in place that allow them to track and manage referrals for Community Supports and member information. SCFHP shares relevant data with Community Supports providers to enable them to conduct member outreach and promote engagement, provide the contracted services, and report the outcome of the services rendered. SCFHP shares demographic and administrative information confirming the referred member's eligibility and authorization for the requested service; appropriate administrative, clinical, and social service information needed to effectively provide the requested service; and billing information necessary to support the Community Supports providers' ability to submit claims or invoices to SCFHP. In turn, Community Supports providers must share data related to service provision status, encounters, quality, and performance outcomes with SCFHP. The required data elements, frequency, and transmission methods for the bi-directional data exchange between SCFHP and Community Supports providers are detailed in Exhibit C-1 in the *Community Supports Vendor Agreement*.

Reporting

SCFHP requires Community Supports providers to submit *Quarterly Community Supports Implementation Monitoring Reports*, as well as other supplemental reports as required and defined by

DHCS. SCFHP utilizes data reported in the quarterly Implementation Monitoring reports, along with other available data to monitor key indicators for Community Supports. Examples of key implementation indicators that SCFHP will be monitoring include, but are not limited to, members receiving Community Supports and their characteristics, including ECM Populations of Focus, ethnicity, gender, age, and primary language; Community Supports utilization; Community Supports provider types and capacities; and Community Supports grievances and appeals. The required data elements, reporting timing, submission timing, and transmission method are detailed in Exhibit C-1 in the *Community Supports Vendor Agreement*.

Outcomes

As a means of monitoring the provision and impact of Community Supports on reducing the utilization of avoidable and costly Medi-Cal benefits for SCFHP members, the Plan requires Community Supports providers to report on designated outcomes specific to the Community Supports services that were rendered. Outcomes are designed to monitor the timeliness to outreach and engage members, provide the authorized services, update referring entities of the status or completion of the rendered services (closed-loop system), and communicate outcomes to SCFHP. In addition, outcomes assist SCFHP in monitoring the type of services that are rendered to members, any challenges and barriers to engagement and/or the service delivery, and best practices that can be shared with other Community Supports providers. The required outcomes, reporting timing, submission timing, and transmission method are detailed in Exhibit C-1 in the *Community Supports Vendor Agreement*.

Quality and Performance Measures

Per DHCS requirements, SCFHP requires Community Supports providers to prepare and submit data that supports meeting designated quality and performance measures by Community Supports service. The required quality and performance measures, reporting timing, submission timing, and transmission method are detailed in Exhibit C-1 in the *Community Supports Vendor Agreement*.

Claims, Invoices, and Encounters

To the extent possible, SCFHP requires Community Supports providers to submit ANSI ASC X12N 837P claims to SCFHP using DHCS-defined standard specifications and code sets. SCFHP's administrative system requires Community Supports providers to have a valid National provider Identifier (NPI) in order to submit claims to SCFHP. An NPI is a unique identification number for health care providers, which is part of the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For how to apply for an NPI, go to https://nppes.cms.hhs.gov/#/. For the claims submission requirements, see Exhibit C-1 in the *Community Support Vendor Agreement.*

If a Community Supports provider is not able to obtain an NPI, they are able to submit invoices to SCFHP. As required by DHCS, SCFHP requests Community Supports providers to include the *minimum necessary* data elements in their invoices, including information about the member, service(s) rendered, and the rendering provider. Invoices are to be used by SCFHP to pay Community Supports providers and develop DHCS-compliant encounters as part of their regular encounter file submissions to DHCS. SCFHP provides invoice submission instruction, training, and technical assistance to support Community Supports providers in properly submitting invoices to SCFHP. For more details on the invoice submission process, see Exhibit C-1 in the *Community Supports Vendor Agreement*.

Payment

SCFHP releases payment to Community Supports providers for the provision of authorized Community Supports to members in accordance with the requirements outlined in the *Community Supports Vendor*

Agreement. SCFHP adheres to the claims timeline and process as described in Exhibit C-1 in the *Community Supports Vendor Agreement* and directly aligns with the requirements set forth in the contract between DHCS and SCFHP.

SCFHP identifies circumstances under which payment for a Community Supports must be expedited to facilitate timely delivery of the Community Supports to a member (e.g., recuperative care for an individual who is homeless and being discharged from the hospital). See Exhibit C-1 in the *Community Supports Vendor Agreement* for more details.

Provider Credentialing and Oversight
DHCS requires managed care plans to ensure that each contracted Community Supports provider has the appropriate experience and expertise in providing the required services and serving ECM Populations of Focus. See Exhibit I-1 in the *Community Supports Vendor Agreement* for the credentialing requirements for each Community Supports.

Appendix A
HOUSING TRANSITION NAVIGATION

DESCRIPTION

The Housing Transition Navigation services provided under Community Supports should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed below. The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted Community Supports providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

ELIGIBILITY

The eligibility criteria for Housing Transition Navigation services are:

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness or institutionalization or requiring residential series as a result of a substance use disorder and/or exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk for institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residencies, Institutions for Mental Diseases, and state hospitals; or

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

  - (1) An individual or family who:
    - Has an annual income below 30 percent of the median family income of the areas, as determined by HUD;
    - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
      - Meets one of the following conditions:
        - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
        - Is living in the home or another because of economic hardship;
        - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
      - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
      - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
      - Is exiting a publicly funded institution or system of care (such as a health care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
      - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

  - (2) A child or youth who does not qualify as "homeless" under this section but qualifies as 'homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

  - (3) A child or youth who does not qualify as "homeless" under this section but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receiving Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

- o Have one or more serious chronic conditions;
- o Have a serious mental illness;
- o Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents);
- o Are receiving Enhanced Care Management; or
- o Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have serious mental illness and/or are children or adolescents with serious emotional disturbance and/or victims of trafficking or domestic violence.

RESTRICTIONS AND LIMITATIONS

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

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

LICENSING/ALLOWABLE PROVIDERS

Providers must have experience and expertise with providing these unique services in a culturally- and linguistically-appropriate manner. This list is provided as an example of the types of providers SCFHP may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Social services agencies
- Affordable housing providers
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Community Supports providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS All Plan Letters (APLs) including *APL 19-004 Provider Credentialing/Re-credentialing and Screening/Enrollment*. If there is no state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit I in the *Community Supports Vendor Agreement.*

Members who meet the eligibility requirements for Housing Transition and Navigation Services should also be assessed for Enhanced Care Management (ECM) and Housing and Tenancy Support Services (if

offered). When enrolled in ECM, Community Supports should be managed in coordination with ECM providers. When members receive more than one of these services, services should be coordinated by an ECM provider whenever possible to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.

LIKELY AVOIDABLE MEDI-CAL BENEFITS

Examples of Medi-Cal benefits that are likely to be avoided include, but are not limited to, inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

PROGRAM MODEL

The required Housing Transition Navigation services are bundled into four separate categories with an estimated duration of time for providing those bundled services. Community Supports providers are required to provide any or all of the services listed based on member needs and submit claims or invoices to SCFHP that reflect the bundled service categories listed below.

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
Service Bundle A: Housing Assessment and Plan	1. Conducting outreach to referred member. 2. Conducting tenant screening and housing assessment to identify member's preferences and potential housing transition or retention barrier(s). (If an ECM provider, may be included as a component of the Enhanced Case Management (ECM) assessment.) 3. Developing an individualized housing support plan based upon the housing assessment findings; and include short- and long-term measurable goals for each issue and establish member's approach to meeting the goals. 4. Identifying other providers or services that may be needed to meet and maintain goals as stated in the housing support plan.	1 month
Service Bundle B: Housing Search	1. Conducting housing search based on housing assessment and housing support plan. 2. Discussing and presenting options including all relevant housing options (home, family, or other living arrangement, short-term, permanent supportive housing). 3. Completing VI-SPDAT, as applicable. 4. Conducting meetings, phone calls, and/or site visits with stakeholders. 5. Assisting with completion of housing applications and obtaining required documentation. 6. Determining if assistance is needed with benefits advocacy and additional resources for securing housing.	1 month
Service Bundle C: Resources and Accommodations	1. Verifying services are needed to support member access to identified housing options.	2-4 months

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	2. Assisting member with accessing additional benefits and identification documentation, such as SSI eligibility and application process, CalFresh, cash aid, ID/birth certificate/immigration status/financial records/marriage/divorce records/proof of medical conditions, etc. Such services can be subcontracted to retain required specialized skillset. 3. Identifying and securing available resources to subsidize rent and match available rental subsidy resources. 4. If included in the housing support plan, making referrals to appropriate community agencies for assistance with housing deposits, moving costs, adaptive aids, environmental modifications, and other one-time expenses. 5. Monitoring changes in needs and accuracy of those needs that may impact VI-SPDAT score and update as needed. 6. Continuing to provide support and coordination as needed in accordance with the housing support plan. 7. If housing is not available that meets member needs (physically, financially, or preference), Community Supports provider may refer to ECM (if eligible), SCFHP Case management, or other community-based case management programs; then disenroll member from the Community Supports.	
Service Bundle D: Move-in and Housing Retention	1. Confirming member has a housing arrangement and move-in date. 2. Identifying needs for successful move and housing retention, which may include multiple phone calls, meetings, and possible in-person site visits to support development of positive relationships with the landlord. 3. Coordinating and advocating for member needs/preferences with community partners, family members, and other Interdisciplinary Team (IDT) members. 4. Supporting member with aspects of the move that may require additional assistance. 5. Engaging landlord and providing education as needed. 6. Coordinating transportation for day-of-move as necessary. 7. Creating housing support crisis plan with member that enforces prevention/early intervention services to aid in housing retention. 8. Reviewing all agreements with member/family/other supportive individuals, such as lease agreements, housing	1 month

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	rules (if applicable), behavioral expectations, tenant rights, expectations for continued financial responsibility, etc. 9. Evaluating need and coordinating referrals for additional Community Supports to arrange for environmental modifications that may address possible accommodations for accessibility. 10. Evaluating need for continued ongoing support, such as ECM or other community case management services, if applicable, and making referrals to ensure member engages with provider.	

PRICING GUIDE

High-level pricing approach: The pricing includes:

- Non-clinical staff that provide services face-to-face in an office, as well as in the community and via phone/other technology to a midpoint caseload of 1:35 individuals concurrently. The caseload range is based on *DHCS's Community Supports Pricing Guide* and varies from 1:20 to 1:50 individuals concurrently.
- Clinical staff to provide some oversight, but not formal supervision.
- Clinical or non-clinical supervision with a caseload of 1:10 non-clinical and clinical staff.
- Caseloads reflect time spent on behalf of members, such as coordination with landlords or housing research.
- Telehealth is defined as the mode of delivering Community Supports services using telecommunication technologies that facilitate real-time interaction while the member is at an originating site and the Community Supports provider is at a distant site. Telehealth technologies include live video conferencing, asynchronous video (also known as Store-and-Forward), remote monitoring of members, and mobile health.
- A 15% administrative fee.

Payment Rates

	Service Bundle A		Service Bundle B		Service Bundle C		Service Bundle D	
	Rate	HCPCS Code and Modifiers	Rate	HCPCS Code and Modifiers	Rate	HCPCS Code and Modifiers	Rate	HCPCS Code and Modifiers
Midpoint Rate	$403	H0043 Modifiers U6,U7,UA	$613	H0043 Modifiers U6,U8,UB	$588	H2016 Modifiers U6,U9,UB	$470	H0043 Modifiers U6,UA,UB
Minimum Rate	$285	H0043 Modifiers U6,U7,UD	$455	H0043 Modifiers U6,U8,UD	$435	H2016 Modifiers U6,U9,TS	$345	H0043 Modifiers U6,UA,UD
Maximum Rate	$520	H0043 Modifiers U6,U7,UC	$770	H0043 Modifiers U6,U8,UC	$740	H2016 Modifiers U6,U9,TG	$595	H0043 Modifiers U6,UA,TG
Service Unit	PMPM		PMPM		PMPM		PMPM	

	Service Bundle A		Service Bundle B		Service Bundle C		Service Bundle D	
	Rate	HCPCS Code and Modifiers	Rate	HCPCS Code and Modifiers	Rate	HCPCS Code and Modifiers	Rate	HCPCS Code and Modifiers
Maximum Billable Units	1		1		4		1	
Additional Modifier for Telehealth	GQ		GQ		GQ		GQ	

Notes about Payment Rates:

1. The payment rates are defined as:
   - Minimum: Non-clinical staff provides services and are not solely designated to housing assistance; entity does not have clinical staff to provide review of assessments for members with extensive clinical needs; and supervision is provided by non-clinical staff.
   - Midpoint: Non-clinical staff provides services and are solely designated to housing assistance; entity has limited clinical staff to provide review of assessments for members with extensive clinical needs; and supervision is provided by non-clinical staff.
   - Maximum: Non-clinical staff provides the services and are solely designated to housing assistance; entity does not have any limitations on clinical staff being able to review assessments for members with extensive clinical needs; supervision is provided by clinical staff; and entity has documented experienced with serving one or more of the following Enhanced Care Management (ECM) Populations of Focus (POF) – high utilizer adults with frequent ED, hospital, and/or short-term skilled nursing facility stays; individuals at risk of institutionalization and eligible for long-term care services; adults with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD); and children and youth with chronic health conditions; or entity has a licensed Behavioral Health clinician or Licensed Clinical Social Worker (LCSW).
2. The actual rates paid to a contracted Community Supports provider for rendered services are subject to individual agreement provisions and consider POF.

Cost Drivers and Assumptions

Assumptions Informing Pricing Range				
	Assumptions			
Cost Drivers	**Service Bundle A**	**Service Bundle B**	**Service Bundle C**	**Service Bundle D**
Frequency	As needed			
Duration	1 month	1 month	2-4 months	1 month
Setting	In-person/telephone/video			
Provider Staffing and Hourly Costs	Non-clinical staff ($23-$38/hour): Housing Navigator, Housing Specialist, Community Worker, Community Outreach Specialist Clinical staff ($30-$52/hour): Licensed Clinical Social Worker, Registered Nurse Case Manager Non-clinical Supervision ($53-$64/hour): Program Manager I Clinical Supervision ($29-$77/hour):			

Assumptions Informing Pricing Range				
	Assumptions			
Cost Drivers	**Service Bundle A**	**Service Bundle B**	**Service Bundle C**	**Service Bundle D**
	Clinical Service Manager, Licensed Clinical Social Worker, or Supervising Registered Nurse Note: The determination of whether clinical staff and clinical supervision are recommended is based on assessed need as it relates to the Population(s) of Focus. *Benefits and retirement are included at an estimated 35% of hourly wage.*			
Approximate Service Time	Non-clinical staff: 4 hours/month Clinical staff: 2 hours/month Supervision: 1 hour/month	Non-clinical staff: 12 hours/month Supervision: 0.50 hour/month	Non-clinical staff: 11.50 hours/month Supervision: 0.50 hour/month	Non-clinical staff: 9 hours/month Supervision: 0.50 hour/month
Staffing Ratio/Caseload	1 Non-clinical staff: 20 to 50 members 1 Supervisor: 10 non-clinical staff			
Other Pricing Inputs	Indirect expenses: 15% Indirect expenses include: • Administrative overhead – accounting, leadership, marketing, support services, IT, indirect mileage reimbursement, etc. • Program costs – Community Supports-related staff training, direct mileage reimbursement			

Appendix B
HOUSING DEPOSITS

DESCRIPTION

The Housing Deposits provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed below.

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

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage.

ELIGIBILITY

The eligibility criteria for Housing Deposits are:

- Any individual who received Housing Transition Navigation services under Community Supports if offered.

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness or institutionalization or requiring residential series as a result of a substance use disorder and/or exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk for institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residencies, Institutions for Mental Diseases, and state hospitals.

RESTRICTIONS AND LIMITATIONS

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. SCFHP will make a good faith effort to review available information to determine whether an individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when members are unable to meet such expense. Individuals must

also receive Housing Transition and Navigation Services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service.

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

LICENSING/ALLOWABLE PROVIDERS

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator, or housing navigator, may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Community Supports providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS All Plan Letters (APLs) including *APL 19-004 Provider Credentialing/Re-credentialing and Screening/Enrollment*. If there is no state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit I-1 in the *Community Supports Vendor Agreement.*

LIKELY AVOIDABLE MEDI-CAL BENEFITS

Examples of Medi-Cal benefits that are likely to be avoided include, but are not limited to, inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

PROGRAM MODEL

The required Housing Deposit services are bundled into three separate categories with an estimated duration of time for providing those bundled services. Community Supports providers are required to provide any or all of the services listed based on member needs and submit claims or invoices to SCFHP that reflect the bundled service categories listed below.

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
Service Bundle A: Move-in Requirements	1. Reviewing the housing support plan, ensuring it is appropriate, accurate, and timely. (Note: If there is not a housing support plan in place, coordinate the development of one with ECM provider or case manager.) 2. Verifying need and obtaining documentation (contract/lease agreement) in writing for required deposit, services, or goods that may include security deposits to obtain a lease on an apartment or home, set-up fees/deposits for utilities (including, but not limited to	1 month

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	telephone, gas, electricity, heating, and water), first and last month's rent as required by landlord for occupancy. 3. Determining if cost is reasonable and necessary and member capability to meet the expense. 4. Discussing and informing member of any restrictions and ongoing costs.	
Service Bundle B: First/Last Month's Rent	1. Arranging for payment for first and last month's rent. 2. Ensuring payment is released to landlord. 3. Obtaining appropriate documentation confirming landlord's receipt of first and last month's rent.	1 month
Service Bundle C: Health and Safety	1. Determining member needs to address potential health and safety issues (in-person or video verification), which may include pest eradication and/or one-time cleaning prior to occupancy and/or goods such as air conditioner/heater and other adaptive aids or services designed to preserve an individual's health and safety in the home (e.g., hospital beds, Hoyer lifts, air filters, etc.). 2. Confirming with member that goods or services are not covered benefits. 3. Confirming services or goods are cost-efficient, reasonable, and an effective option. 4. Identifying, coordinating, and securing appropriate vendor for services needed to address health and safety issues, including obtaining at least two estimates/bids when possible. 5. Following up with vendor and member to ensure services/goods have been provided. 6. If member needs additional assistance, submitting appropriate referrals to ECM provider, case manager, or other community-based entities.	1 month

PRICING GUIDE

High-level pricing approach: The pricing includes:

- Non-clinical staff that provide services face-to-face in an office, as well as in the community and via phone/other technology to coordinate the housing deposits.
- Clinical supervision or non-clinical supervision of non-clinical staff.
- The cost of first and last month's rent, as well as utility set up fees and good and services needed for the individual's initial move-in.
- Per Fair Market Rate (FMR) for Santa Clara County in 2022, one month's rent is $2,145 for efficiency; $2,418 for one bedroom; and $2,868 for two bedrooms.

- The payment rate range for Service Bundle B (First/Last Month's Rent) includes set up of utilities and may vary depending on the family size with the payment ranges being based on an efficiency, one-bedroom, and two-bedroom units.
- The rate range for Bundle B (First/Last Month's Rent) is $4,790- $6,236:
    - Two times the FMR for an efficiency unit ($4,290) with utilities ($500)
    - Two times the RMR for a one-bedroom unit ($4,836) with utilities ($500)
    - Two times the FMR for a two-bedroom unit ($5,736) with utilities ($500)
- Bundle B (First/Last Month's Rent) must be billed as the exact amount required for move in plus the set up cost for utilities. The total cost may not exceed the maximum rate and the appropriate rate (minimum, midpoint or maximum) must align with the family size (see below for the definition of the rate ranges).
- Telehealth is defined as the mode of delivering Community Supports services using telecommunication technologies that facilitate real-time interaction while the member is at an originating site and the Community Supports provider is at a distant site. Telehealth technologies include live video conferencing, asynchronous video (also known as Store-and-Forward), remote monitoring of members, and mobile health.
- A 15% administrative fee.

Payment Rates

	Service Bundle A		Service Bundle B		Service Bundle C	
	Rate	**HCPCS Code and Modifiers**	**Rate**	**HCPCS Code and Modifiers**	**Rate**	**HCPCS Code and Modifiers**
Midpoint Rate	$192	H0044 Modifiers U2,U7,UB	$5,336	H0044 Modifiers U2,U8,UB	$383	H0044 Modifiers U2,U9,UB
Minimum Rate	$146	H0044 Modifiers U2,U7,UA	$4,790	H0044 Modifiers U2,U8,UA	$292	H0044 Modifiers U2,U9,UA
Maximum Rate	$238	H0044 Modifiers U2,U7,UC	$6,236	H0044 Modifiers U2,U8,UC	$473	H0044 Modifiers U2,U9,UC
Service Unit	PMPM		Exact Amount		PMPM	
Maximum Billable Units	1		1		1	
Additional Modifier for Telehealth	GQ		N/A		GQ	

Notes about Payment Rates:
3. The payment rates are defined as:
    - Bundles A and C:
        - Minimum:
            - Only able to accept referrals and provide services for their own assigned ECM members.
            - Non-clinical staff provides the services and are not solely designated to housing assistance.
            - Supervision is provided by non-clinical staff.
        - Midpoint:

- o Able to accept referrals and provide services for both their own assigned ECM members and other members.
- o Non-clinical staff provides the services and are solely designated to housing assistance.
- o Supervision is provided by non-clinical staff.
  - ▪ Maximum:
    - o Able to accept referrals and provide services for both their own assigned ECM members and other members.
    - o Non-clinical staff provides the services and are solely designated to housing assistance.
    - o Supervision is provided by clinical staff.
  - ▪ Bundle B:
    - ▪ Minimum: Two times the FMR for an efficiency unit for 1-2 individuals with utilities; maximum allowable amount is $4,790.
    - ▪ Midpoint: Two times the FMR for a one-bedroom unit for 2-3 individuals with utilities; maximum allowable amount is $5,336.
    - ▪ Maximum: Two times the FMR for a two-bedroom unit for 4 or more individuals with utilities; maximum allowable amount is $6,236.

4. The actual rates paid to a contracted Community Supports provider for rendered services are subject to individual agreement provisions and consider Populations of Focus.

Cost Drivers and Assumptions

Assumptions Informing Pricing Range			
	Assumptions		
Cost Drivers	Service Bundle A	Service Bundle B	Service Bundle C
Frequency	As needed		
Duration	1 month	1 month	1 month
Setting	N/A		
Provider Staffing and Hourly Costs	Non-clinical staff ($23-$38/hour): Housing Navigator, Housing Specialist, Community Worker, Community Outreach Specialist Non-clinical Supervision ($53-$64/hour): Program Manager I Clinical Supervision ($53-$77/hour): Clinical Service Manager, Licensed Clinical Social Worker, or Supervising Registered Nurse *Benefits and retirement are included at an estimated 35% of hourly wage.*		
Approximate Service Time	Non-clinical staff: 3.5 hours/month Supervision: 0.25 hour/month	Non-clinical staff: 2 hours/month Supervision: 0.25hour/month	Non-clinical staff: 7 hours/month Supervision: 0.50 hour/month
Staffing Ratio/Caseload	N/A		
Other Pricing Inputs	Indirect expenses: 15% Indirect expenses include:		

Assumptions Informing Pricing Range		
	Assumptions		
Cost Drivers	Service Bundle A	Service Bundle B	Service Bundle C
	• Administrative overhead – accounting, leadership, marketing, support services, IT, indirect mileage reimbursement, etc. • Program costs – Community Supports-related staff training, direct mileage reimbursement Indirect expenses apply to Service Bundles A and C only.		

Appendix C
NURSING FACILITY TRANSITION/DIVERSION TO ASSISTED LIVING FACILITEIS, SUCH AS RESIDENTIAL CARE FACILITIES FOR ELDERLY AND ADULT RESIDENTIAL FACILITIES

DESCRIPTION

Nursing Facility Transition/Diversion services help individuals 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 the 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 helping with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs) and providing meals, transportation, and medication administration, as needed.

The service is for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facility for the Elderly (RCFE) or an Adult Residential Facility (ARF). It includes wraparound services such as assistance with ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming, provided in a home-like environment. It also 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. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board).

ELIGIBILITY

The eligibility criteria for Housing Transition Navigation services are:

- For Nursing Facility Transition:
  - Has resided 60+ days in a nursing facility;
  - Is willing to live in an assisted living setting as an alternative to a nursing facility; and
  - Is able to reside safely in an assisted living facility with appropriate and cost-effective supports.

- For Nursing Facility Diversion:
  - Is interested in remaining in the community;
  - Is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
  - Must be currently receiving medically-necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and, in lieu of going into a facility, is choosing to remain in the community and continue to receive medically-necessary nursing facility LOC services at an assisted living facility.

RESTRICTIONS AND LIMITATIONS

Individuals are directly responsible for paying their own living expenses.

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

LICENSING/ALLOWABLE PROVIDERS

Providers must have experience and expertise with providing these unique services in a culturally- and linguistically-appropriate manner. The below list is provided to show examples of the types of Providers SCFHP may choose to contract with but is not an exhaustive list of Providers that may offer the services.

- Case management agencies
- Home Health Agencies
- Medi-Cal managed care plans
- ARF/RCFE operators

Community Supports providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS All Plan Letters (APLs) including *APL 19-004 Provider Credentialing/Re-credentialing and Screening/Enrollment*. If there is no state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports provider Credentialing process as described in Exhibit I-1 in the *Community Supports Vendor Agreement.*

RCFEs/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

LIKELY AVOIDABLE MEDI-CAL BENEFITS

Examples of Medi-Cal benefits that are likely to be avoided include, but are not limited to, inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

PROGRAM MODEL

The required services for Nursing Facility Transition/Diversion to RCFEs or ARFs are bundled into four separate categories with an estimated duration of time for providing those bundled services. Community Supports providers are required to provide any or all of the services listed based on member need and submit claims or invoices to SCFHP that reflect the bundled service categories listed below.

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
Service Bundle A: Transition Services	1. Verifying member meets eligibility for RCFE placement. 2. Determining availability for placement in RCFE network. If there is not any availability, member will be put on waitlist. 3. Reviewing or conducting a housing assessment that includes discussing with the member options for transitioning to an assisted living alternative, and	2 months

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	determining if member is a good candidate for RCFE placement. 4. Assessing member for and determining enhanced on-site services at the RCFE/ARF are necessary for safe and stable housing. 5. Identifying appropriate RCFE to meet member's needs. (Note: SOC 602 is required for admission to RCFE). 6. Coordinating referrals for health plan benefits (home health, OT, LTSS) and community resources or other Community Supports as needed. 7. Assisting member with accessing additional benefits and identification documentation, such as SSI eligibility and application process, CalFresh, cash aid, ID/birth certificate/immigration status/financial records/marriage/divorce records/proof of medical conditions, etc. 8. Conducting site visits with member, as needed. 9. Participating in IDT meetings (two to three meetings in total) with member, facility, and RCFE/ARF staff and other relevant stakeholders. 10. Determining if member requires enhanced services to be safely and stably housed in the RCFE and coordinating with SCFHP to ensure member is enrolled in Community Supports and/or ECM to meet member needs. 11. Assisting member with applying for the Assisted Living Waiver for continued financial support, if member has not yet done so. 12. Reviewing all agreements with member/family/other supportive individuals, such as RCFE lease agreement, housing rules (if applicable), behavioral expectations, tenant rights, expectations for continued financial responsibility, etc. 13. Assessing for transition out of needing Community Supports and determining if additional support is needed through Community Supports. 14. Referring for ECM eligibility or to other community-based case management entities for continued service.	
Service Bundle B: Prevention of Skilled Nursing Facility Admissions	1. Verifying member meets eligibility for RCFE placement. 2. Determining availability for placement in RCFE network. If not any availability, member will be put on waitlist. 3. Reviewing or conducting housing assessment that includes discussing with member the options for transition to an assisted living alternative and determining if member is a good candidate for RCFE placement.	2 months

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	4. Assessing for needed services and determining if enhanced on-site services at RCFE/ARF are necessary for safe and stable housing. 5. Identifying appropriate RCFE for member needs. (SOC 602 required for admission to RCFE.) 6. Coordinating referrals for health plan benefits (home health, OT, LTSS) and community resources or other Community Supports as needed. 7. Assisting member with accessing additional benefits and identification documentation, such as SSI eligibility and application process, CalFresh, cash aid, ID/birth certificate/immigration status/financial records/marriage/divorce records/proof of medical conditions, etc. 8. Conducting site visits with member, as needed. 9. Participating in IDT meetings (two to three meetings in total) with member, facility, and RCFE/ARF staff and other relevant stakeholders. 10. Determining if member requires enhanced services to be safely and stably housed in the RCFE and coordinating with SCFHP to ensure member is enrolled in Community Supports and/or ECM to meet member needs. 11. Assisting member with applying for the Assisted Living Waiver for continued financial support, if member has not yet done so. 12. Reviewing all agreements with member/family/other supportive individuals, such as RCFE lease agreement, housing rules (if applicable), behavioral expectations, tenant rights, expectations for continued financial responsibility, etc. 13. Assessing for transition out of needing Community Supports and determining if additional support is needed through Community Supports. 14. Referring for ECM eligibility or to other community-based case management entities for continued service.	
Service Bundle C: RCFE Support	1. Conducting assessment to confirm specific needs for enhanced services that member requires while residing in the RCFE. 2. Ensuring that the member meets eligibility criteria for purchase of enhanced services by the RCFE. 3. Ensuring that member is assigned to an ECM provider. 4. Developing a support/care plan that includes short- and long-term measurable goals to address the need for enhanced services.	6-month intervals

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	5. Providing ongoing monitoring of enhanced service delivery based on a designated timeframe specified by SCFHP.	
Service Bundle D: RCFE Direct Support	1. Determining if referrals are needed to be submitted for additional Community Supports or RCFE direct payment for enhanced services provided by SCFHP and the RCFE.	6-month intervals

PRICING GUIDE

High-level pricing approach: The pricing includes:

- Two service components – transition services to the Assisted Living Facility, and other services provided in the facility as needed to meet member needs on an ongoing basis. These components are priced separately below.
- For transition services, non-clinical clinical staff providing the transition education and support services face-to-face in the community and via phone/other technology to a total caseload of 25 individuals concurrently. The caseload range in DHCS's *Community Supports Pricing Guide* is based on a 1:20 to 1:30 individuals concurrently. Pricing also includes some services provide by clinical staff and one clinical supervisor per 10 clinical staff members.
- The ongoing services should be consistent with the service definition, and as such can include assistance with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs) as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. Note that the service definition also anticipates 24-hour on-site staff will be available to meet unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security, and pricing should be consistent with these requirements. Ongoing activities may also include coordination with the SCFHP 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 ECM services that provide the necessary enhanced services. Room and board expenses are not included in the service definition or the pricing below. The hourly rate below for ongoing support services assumes an agency-based model.
- Telehealth is defined as the mode of delivering Community Supports services using telecommunication technologies that facilitate real-time interaction while the member is at an originating site and the Community Supports provider is at a distant site. Telehealth technologies include live video conferencing, asynchronous video (also known as Store-and-Forward), remote monitoring of members, and mobile health.
- A 15% administrative fee.

Payment Rates

	Service Bundle A		Service Bundle B		Service Bundle C		Service Bundle D	
	Rate	HCPCS Code and Modifiers	Rate	HCPCS Code and Modifiers	rate	HCPCS Code and Modifiers	Rate	HCPCS Code and Modifiers
Midpoint Rate	$1,068	T2038 Modifier U4,U1,UB	$1,068	T2038 Modifier U4,U3, UB	$420	T2038 Modifier U4,U7, UB	$3,000	H2022 Modifier U4, U8

Minimum Rate	$805	T2038 Modifier U4,U1,UA	$805	T2038 Modifier U4,U3,UA	$300	T2038 Modifier U4, U7, UA	$3,000	H2022 Modifier U4, U8
Maximum Rate	$1,330	T2038 Modifier U4,U1, UC	$1,330	T2038 Modifier U4,U3,UC	$540	T2038 Modifier U4,U7, UC	$3,000	H2022 Modifier U4, U8
Service Unit	PMPM		PMPM		PMPM		PMPM	
Maximum Billable Units	2		2		6 (option for re-authorization)		6 (option for re-authorization)	
Additional Modifier for Telehealth	GQ		GQ		GQ		N/A	

Notes about Payment Rates:

1. The payment rates for Service Bundles A and C are defined as:
   - Minimum: Non-clinical staff provides services and are not solely designated to housing assistance; entity does not have any clinical staff to provide review of assessments for members with extensive clinical needs; and entity is unable provide services to members with high clinical support needs.
   - Midpoint: Non-clinical staff provides services and are solely designated to housing assistance, and entity has limited clinical staff to provide review of assessments for members with extensive clinical needs.
   - Maximum: Designated non-clinical staff (Housing Navigator or Housing Specialist) provides services and are solely designated to housing assistance; entity does not have any limitations on clinical staff to provide review of assessments for members with extensive clinical needs; and entity is able to accept any referral even for embers who have high clinical support needs.

2. The actual rates paid to a contracted Community Supports provider for rendered services are subject to individual agreement provisions and consider Populations of Focus.

Cost Drivers and Assumptions

Assumptions Informing Pricing Range				
	Assumptions			
Cost Drivers	**Service Bundle A**	**Service Bundle B**	**Service Bundle C**	**Service Bundle D**
Frequency	As needed		Monthly	Monthly
Duration	2 months	2 months	6-month intervals	6-month intervals
Setting	Primarily in-person; some services may be completed by phone		In person	

Assumptions Informing Pricing Range				
	Assumptions			
Cost Drivers	**Service Bundle A**	**Service Bundle B**	**Service Bundle C**	**Service Bundle D**
Provider Staffing and Hourly Costs	Non-clinical staff ($23-$38/hour): Housing Navigator, Housing Specialist, Community Worker, Community Outreach Specialist Clinical (non-supervision) staff ($57-$80/hour): Registered Nurse Case Manager Clinical Supervision ($29-$77/hour): Clinical Service Manager, Licensed Clinical Social Worker, or Supervising Registered Nurse *Benefits and retirement are included at an estimated 35% of hourly wage.*			
Approximate Service Time	Non-clinical staff: 10 hours/month Clinical staff: 4 hours/month Supervision: 2 hours/month	Non-clinical staff: 10 hours/month Clinical staff: 4 hours/month Supervision: 2hours/month	Non-clinical staff: 3 hours/month Clinical staff: 1 hours/month Supervision: 2 hour/month	None
Staffing Ratio/Caseload	1 non-clinical/clinical staff: 20 to 30 members 1 clinical supervisor: 10 non-clinical/clinical staff			None
Other Pricing Inputs	Indirect Expenses: 15% Indirect expenses include: • Administrative overhead – accounting, leadership, marketing, support services, IT, indirect mileage reimbursement, etc. • Program costs – Community Supports-related staff training, direct mileage reimbursement Indirect expenses apply to Service Bundles A, B, and C only.			

Appendix D
COMMUNITY TRANSITION SERVICES/NURSING FACILITY TRANSITION TO A HOME

DESCRIPTION

Community Transition Services/Nursing Facility Transition to a Home helps individuals live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home covers nonrecurring setup 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.

ELIGIBILITY

The eligibility criteria for Community Transition Services/Nursing Facility Transition to a Home services are:

1. Is currently receiving medically necessary nursing facility level of care (LOC) services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and

2. Has lived 60+ days in a nursing home and/or Medical Respite setting; and

3. Is interested in moving back to the community; and

4. Is able to reside safely in the community with appropriate and cost-effective supports and services.

RESTRICTIONS AND LIMITATIONS

The following are the restrictions and limitations for Community Transition Services/Nursing Facility Transition to a Home services:

- 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.
- 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.
- 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.

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

LICENSING/ALLOWABLE PROVIDERS

Providers must have experience and expertise with providing these unique services. The list is provided to show examples of the types of providers SCFHP may choose to contract with, but it is not an exhaustive list of providers that may offer the services.

- Case management agencies
- Home Health Agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c Home and Community Based Alternatives/Assisted Living Waiver providers
- California Community Transitions/Money Follows the Person providers

Community Supports providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS All Plan Letters (APLs) including *APL 19-004 Provider Credentialing/Recredentialing and Screening/Enrollmen*t. If there is no state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit I-1 in the *Community Supports Vendor Agreement.*

LIKELY AVOIDABLE MEDI-CAL BENEFITS

Examples of Medi-Cal benefits that are likely to be avoided include, but are not limited to, inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

The required Community Transition Services/Nursing Facility Transition to a Home services are bundled into two separate categories with an estimated duration of time for providing those required services. Community Supports providers are required to provide any or all of the services listed based on member needs and submit claims or invoices to SCFHP that reflect the services rendered.

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
Service Bundle A: Housing Assessment, Search, and Resources	1. Conducting tenant screening and housing assessment to identify member's preferences and potential housing transition or retention barrier(s). (This may be a component of an ECM assessment or it may be provided separately.) 2. Conducting a housing search based on the housing assessment and discussing and presenting options that include all relevant housing options (home, family, or other living arrangement), short-term, or permanent supportive housing). 3. Assisting member with accessing additional benefits and identification documentation, such as SSI eligibility and application process, CalFresh, cash aid, ID/birth certificate/Immigration status/financial records/marriage/divorce records/proof of medical conditions, etc. 4. As needed, making referrals to appropriate community agencies for assistance with housing deposits, moving costs, adaptive aids, environmental modifications, and other one-time expenses. 5. Participating in IDT meetings (two to three meetings in total) with member, facility, and other relevant stakeholders. 6. If housing is not available that meets member needs (physically, financially, or preference), Community Supports provider may refer to ECM (if eligible), SCFHP Case management, or other community-based case management programs; then disenroll member from the Community Supports	2-4 months

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
Service Bundle B: Move-in and Housing Retention	1. Discussing timing and logistics of the move, which could include in-person or telephonic meetings with member, nursing facility staff, member's supportive individuals, and the landlord (if applicable) to coordinate a successful transition. 2. Creating housing support crisis plan with member that enforces prevention/early intervention services to aid in housing retention. 3. Reviewing all agreements with member/family/other supportive individuals, such as lease agreement, housing rules (if applicable), behavioral expectations, tenant rights, expectations for continued financial responsibility, etc. 4. Arranging for transportation, as needed. 5. Evaluating the need and coordinating referrals for additional Community Supports to arrange for environmental modifications to address accommodations for accessibility. 6. Evaluating the need for continued ongoing support, such as ECM or other community-case management services, if applicable, making the referral to ensure member engages with the provider.	1 month

PRICING GUIDE

High-level pricing approach: The pricing includes:

- Non-clinical staff that provide transition education and support services face-to-face in the home and via phone/other technology to a caseload of 25 individuals concurrently. The caseload range in DHCS's *Community Supports Pricing Guide* varies from 1:20 to 1:30 individuals concurrently.
- Clinical supervision of non-clinical staff at a caseload of 1:10 non-clinical staff.
- Telehealth is defined as the mode of delivering Community Supports services using telecommunication technologies that facilitate real-time interaction while the member is at an originating site and the Community Supports provider is at a distant site. Telehealth technologies include live video conferencing, asynchronous video (also known as Store-and-Forward), remote monitoring of members, and mobile health.
- A 15% administrative fee.

Payment Rates

	Service Bundle A		Service Bundle B	
	Rate	**HCPCS Code and Modifiers**	**Rate**	**HCPCS Code and Modifiers**
Midpoint Rate	$1,116	T2038 Modifiers U5, U9, UC	$477	T2038 Modifiers U5, UA, UC
Minimum Rate	$535	T2038 Modifiers U5, U9, UB	$363	T2038 Modifiers U5, UA, UB
Maximum Rate	$1,697	T2038 Modifiers U5, U9, UD	$591	T2038 Modifiers U5, UA, UD
Service Unit	PMPM		PMPM	
Maximum Billable Units	4		1	
Additional Modifier for Telehealth	GQ		GQ	

Notes about Payment Rates:
1. The payment rates are defined as:
   - Minimum: Non-clinical staff provides services and are not solely designated to housing assistance; entity does not have clinical staff to provide review of assessments for members with extensive clinical needs; and supervision is provided by non-clinical staff.
   - Midpoint: Non-clinical staff provides services and are solely designated to housing assistance; entity has limited clinical staff to provide review of assessments for members with extensive clinical needs; and supervision is provided by non-clinical staff.
   - Maximum: Non-clinical staff provides services and are solely designated to housing assistance; entity does not have any limitations of clinical staff being able to review assessments for members with extensive clinical needs; and supervision is provided by clinical staff.

2. The actual rates paid to a contracted Community Supports provider for rendered services are subject to individual agreement provisions and take Populations of Focus into consideration.

Cost Drivers and Assumptions

Assumptions Informing Pricing Range		
Cost Drivers	Assumptions	
	Service Bundle A	**Service Bundle B**
Frequency	As needed	
Duration	2-4 months	1 month
Setting	In-person/telephone	

Assumptions Informing Pricing Range		
	Assumptions	
Cost Drivers	**Service Bundle A**	**Service Bundle B**
Provider Staffing and Hourly Costs	Non-clinical staff ($23-$38/hour): Housing Navigator, Housing Specialist, Community Worker, Community Outreach Specialist Clinical staff ($30-$52/hour): Licensed Clinical Social Worker, Registered Nurse Case Manager Non-clinical Supervision ($53-$64/hour): Program Manager I Clinical Supervision ($53-$77/hour): Clinical Service Manager, Licensed Clinical Social Worker, or Supervising Registered Nurse Note: The determination of whether clinical staff and clinical supervision are recommended is based on assessed need as it relates to the Population(s) of Focus. *Benefits and retirement are included at an estimated 35% of hourly wage.*	
Approximate Service Time	Non-clinical staff: 11.5 hours/month Clinical staff: 1 hour/month Non-clinical/clinical supervision: 1.5 hours/month	Non-clinical staff: 9 hours/month Non-clinical/clinical supervision: 0.50 hour/month
Staffing Ratio/Caseload	1 Non-clinical staff: 20 to 50 members 1 Supervisor: 10 non-clinical staff	
Other Pricing Inputs	Indirect expenses: 15% Indirect expenses include: • Administrative overhead – accounting, leadership, marketing, support services, IT, indirect mileage reimbursement, etc. Program costs – Community Supports-related staff training, direct mileage reimbursement	

Appendix E
MEDICALLY-SUPPORTIVE FOOD/MEALS/MEDICALLY-TAILORED MEALS

DESCRIPTION

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals 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.

At the discretion of SCFHP, DHCS allows managed care plans to define criteria for the level of services determined to be both medically appropriate and cost-effective for members (e.g., Medically-Tailored Meals, groceries, etc.).

ELIGIBILITY

The eligibility criteria for Medically-Supportive Food/Meals/Medically-Tailored Meals are:

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement.
3. Individuals with extensive care coordination needs.

In addition to the above criteria, there is additional eligibility that applies to specific service bundles. The criteria reflected below is established by SCFHP to assist with determining which Medically-Supportive Food option best meets a member's needs. A member must meet the eligibility criteria as described below.

Service Bundle A: Hot Daily Meal Delivery	
Member must meet the criteria for 1 OR 2 AND 3 THROUGH 5	
1	Discharged from an acute hospital or SNF within the last week OR a scheduled discharge from acute hospital or SNF within the next week
2	Extensive care coordination needs that make the member high risk for hospitalization
3	Limited support in the home and in agreement to receive meal delivery M-F as well as weekly in-person wellness screenings
4	Member has a permanent residence in Santa Clara County and is able to store and reheat food
5	Does not require extensive customization to meet medical/dietary needs.

Service Bundle B: Weekly Frozen/Refrigerated Meal Delivery	
Member must meet the criteria for 1 OR 2 AND 3 THROUGH 5 AND 6 OR 7	
1	Discharged from an acute hospital or SNF within the last week
2	Extensive care coordination needs that make the member high risk for hospitalization
3	Member has adequate support in the home
4	Members has a permanent residence in Santa Clara County and is able to store and reheat food
5	Member does not require extensive customization to meet medical/dietary needs
6	Member declined hot daily meal delivery
7	Member requests weekly delivered meals

Service Bundle C: Basic Medically-Supportive Meals	
Member must meet the criteria for 1 OR 2 AND 3 THROUGH 6	
1	Discharge, within the last 4 weeks, from an acute hospital or SNF, OR scheduled discharge from a hospital or SNF within the next 2 weeks; AND diagnosis of one or more of the following: type 2 Diabetes with A1C 7+, Type 1 Diabetes, Depression, Anxiety, other MH/BH that are disabling, Hypertension, CHF (member cannot be eligible for MTM-Food is Medicine Program), cardiovascular disease, stroke, cancer, or other chronic disorder that the referring entity determines is disabling (with documentation)
2	Extensive care coordination needs that make the member high risk for hospitalization AND diagnosis of one or more of the following: type 2 Diabetes with A1C 7+, Type 1 Diabetes, Depression, Anxiety, other MH/BH that are disabling, Hypertension, CHF (member cannot be eligible for MTM-Food is Medicine Program), cardiovascular disease, stroke, cancer, or other chronic disorder that the referring entity determines is disabling (with documentation)
3	Member has limited support in the community and/or lives alone
4	Member has the ability to provide current nutritional panel labs
5	Member has a permanent residence in Santa Clara County and is able to store and reheat food
6	Member is willing to participate in weekly in-person or telephonic wellness checks

Service Bundle D: Medically-Tailored Meals (MTM)	
Member must meet the criteria for 1 OR 2 AND 3a OR 3b AND 4 AND 5	
1	Discharge, within the last 4 weeks, from an acute hospital or SNF AND is at risk for re-hospitalization
2	Extensive care coordination needs that make the member high risk for hospitalization and received a referral from a medical provider with the member's care team
3	Must have one or more of the following diagnosis AND the ability to provide appropriate clinical documentation (e.g., labs may include Basic Nutritional Panel, Vitamin Panel Tests, Mineral and Anemia tests)
	a. Pregnant Women: Diagnosed with Type 2 Diabetes with A1C 7+ (within the last 2 weeks, retest and provide results at 6 weeks ad 12 weeks); Gestational Diabetes with a A1C of 7+ in 3rd trimester- retest and provide results at 6 weeks ad 12 weeks; Hypertension with recent escalation of medication (will need documentation from medical provider or pharmacist to confirm)
	b. Other diagnosis for all other populations: Uncontrolled hypertension with escalation of medication (will need documentation from medical provider or pharmacist to confirm), CHF who do not qualify for the MTM- Food is Medicine Program with recent escalation of medications or recent history of heart attack or MI, CPOD with O2, or recent stroke AND member lives alone
4	Member is able to coordinate with the care team for additional clinical data OR has assistance to coordinate with the care team
5	Member has a permanent residence in Santa Clara County and is able to store and reheat food

RESTRICTIONS AND LIMITATIONS

The restrictions and limitations of Medically-Supportive Food/Meals/Medically-Tailored Meals are:

- Service covers up to three meals per day and/or medically supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

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

LICENSING/ALLOWABLE PROVIDERS

Providers must have experience and expertise with providing these unique services in a culturally- and linguistically-appropriate manner. This list is provided as an example of the types of providers SCFHP may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers
- Medically supportive food and nutrition providers

Community Supports providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS All Plan Letters (APLs) including *APL 19-004 Provider Credentialing/Re-credentialing and Screening/Enrollment*. If there is no state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit I-1 in the *Community Supports Vendor Agreement.*

LIKELY AVOIDABLE MEDI-CAL BENEFITS

Examples of Medi-Cal benefits that are likely to be avoided include, but are not limited to, inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

PROGRAM MODEL

The required Medically-Supportive Food/Meals/Medically-Tailored Meals services are bundled into five separate categories with an estimated duration of time for providing those bundled services. Community Supports providers are required to provide any or all of the services listed as needed by members and submit claims or invoices to SCFHP that reflect the bundled service categories listed below.

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
Service Bundle A: Hot Daily Meal Delivery	1. Conducting initial screening and ensuring member has the ability to receive/store/reheat meals. 2. Assessing for food and nutrition needs and making appropriate referrals to other local resources. 3. Preparing meals following the standard dietary guidelines. 4. Delivering up to 3 meals per day: Monday – Thursday = 1 hot meal + 2 frozen meals; Friday = 1 hot meal + 8 frozen meals to cover through the weekend for up to 12 weeks. 5. Conducting weekly face-to-face 'wellness checks' and providing reports that note any concerns or observed changes. 6. Assessing for disenrollment from Community Supports and determining if an extension of Community Supports is needed based on medical necessity or if additional support is needed. 7. As needed, referring member to ECM for eligibility determination or to other community-based case management entities for continued services.	12 weeks
Service Bundle B: Frozen or Refrigerated Weekly Meal Delivery	1. Conducting initial screening and ensuring member has the ability to receive/store/reheat meals. 2. Assessing for food and nutrition needs and making appropriate referrals to other local resources. 3. Preparing meals following standard dietary guidelines. 4. Delivering meals: 14-21 frozen or refrigerated meals weekly for up to 12 weeks.	12 weeks

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	5. Assessing for disenrollment from Community Supports and determining if an extension of Community Supports is needed based on medical necessity or if additional support is needed. 6. As needed refer for possible ECM eligibility, to other Community -Based Case Management agencies for continued services, and/or additional food and nutrition community services.	
Service Bundle C: Medically-Supportive Meals	1. Conducting initial screening and ensuring member has the ability to receive/store/reheat meals. 2. Assessing for food and nutrition needs and making appropriate referrals to other local resources. 3. Providing one additional one-hour in-person or telephonic nutritional counseling session with individual member, facilitated by a Registered Dietitian or equivalent, that provides education on diagnosis (as it relates to nutrition), meal planning tools, and goal setting activities to address any identified issues and best practices for a healthy lifestyle 4. Preparing medically-supportive meals for members with an approved diagnosis, as defined by SCFHP. Diagnosis: type 2 Diabetes with A1C 7+, Type 1 Diabetes, Depression, Anxiety, other MH/BH that are disabling, Hypertension, CHF (member cannot be eligible for MTM-Food is Medicine Program), cardiovascular disease, stroke, cancer, or other chronic disorder that referring entity determines is disabling (with documentation) 5. Delivering meals: 14-21 frozen or refrigerated meals weekly for up to 12 weeks. 6. Conducting weekly face-to-face or telephonic 'wellness checks' and providing reports that note any concerns or observed changes. 7. Assessing for disenrollment from Community Supports and determining if an extension of Community Supports is needed based on medical necessity or if additional support is needed. 8. As needed, referring member to ECM for eligibility determination or to other community-based case management entities for continued services.	12 weeks
Service Bundle D: Medically-Tailored Meals (MTMs)	1. Conducting initial screening and ensuring member has the ability to receive/store/reheat 7-14 meals per week. 2. Conducting three one hour, in-person or telephonic nutritional counseling sessions with individual member, facilitated by a Registered Dietitian or equivalent. , that	12 weeks

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	provides education on diagnosis (as it relates to nutrition), reviews member current nutritional preferences and needs, tools for meal planning, and member goals setting activates that address any identified issues that follow best practices for a healthy lifestyle. 3. Developing customized MTM monthly plan for member with an approved diagnosis as defined by SCFHP that is based off of evidence-based nutritional practice guidelines that address diagnosis, symptoms, allergies, medication, and possible side effects; and preparing customized meals in accordance with the monthly plan. a. Pregnant Women: diagnosed with Type 2 Diabetes with A1C 7+ (recent-within the last 2 weeks, retest and provide results at 6 weeks ad 12 weeks); Gestational Diabetes with a A1C of 7+ in 3rd trimester- retest and provide results at 6 weeks ad 12 weeks; Hypertension with recent escalation of medication (will need documentation from medical provider or pharmacist to confirm) b. Other Diagnosis for all populations: Uncontrolled hypertension with escalation of medication (will need documentation from medical provider or pharmacist to confirm), CHF who do not qualify for the "MTM program- food is medicine program" with recent escalation of medications or recent history of heart attack or MI, CPOD with O2, or recent stroke and member lives alone 4. Conducting weekly face-to-face or telephonic 'wellness checks' and providing reports that note any concerns or observed changes. 5. Assessing for disenrollment from Community Supports and determining if an extension of Community Supports is needed based on medical necessity or if additional support is needed. 6. As needed, referring member to ECM for eligibility determination or to other community-based case management entities for continued services.	
Service Bundle E: Medically-Supportive Food and Nutrition Services	1. Conducting initial screening and ensuring member has the ability to receive and store groceries for 5-6 days and can use the groceries to make meals. 2. Assessing for food and nutrition needs and making appropriate referrals to other local resources. 3. Preparing medically-appropriate grocery bags that will provide at least 75% of the daily nutritional needs (protein, fruits, vegetables, and non-perishable items) _	12 weeks

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	for members with an approved diagnosis or dietary needs as defined by SCFHP. a. Diagnosis: hypertension, Hyperlipidemia, CHF (who are not eligible for the "MTM program-food is medicine program"), Heart Disease, Stroke, Diabetes, Cancer, Celiac, Depression, Anxiety, Schizophrenia, Low sodium, Vegetarian, Gluten Free 4. Delivering groceries to member or arranging pick-up weekly. 5. Conducting weekly face-to-face or telephonic 'wellness checks' and providing reports that note any concerns or observed changes. 6. Assessing for disenrollment from Community Supports and determining if an extension of Community Supports is needed based on medical necessity or if additional support is needed. 7. As needed, referring member to ECM for eligibility determination or to other community-based case management entities for continued services.	
Service Bundle F: Enhanced Services - Education	1. Provide behavioral, cooking, and/or nutrition education services in conjunction with any of the above service bundles to promote engaging in healthy dietary behaviors. **This service can be requested by the assigned Community Supports provider if it is determined the member needs additional services. Any combination of 4 billable services per month are allowed.	12 weeks

PRICING GUIDE

High-level pricing approach: The pricing includes:
- Weekly food costs per the United States Department of Agriculture (USDA) and the average delivery costs associated with transporting meals and/or food boxes in the U.S.
- A wellness check is built into the meal rates and is defined as a weekly in-person visit or phone call to briefly assess for possible safety issues (unsafe conditions in the home, recent falls/injuries), confirms ability to continue receiving meals (refrigerator and stove/microwave are working), or unusual behavior (confusion, emotional/crying/yelling), and disseminated through 10 or less questions. Any information received during the wellness check should be relayed back to assigned ECM provider, member's authorized representative/ emergency contact person, or SCFHP as applicable.
- A nutritional assessment/nutritional counseling, which assumes a one-hour session provided to only one person at a time from a registered dietician. Consistent with the service definition, the nutritional assessment should be based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to

ensure the best possible nutrition-related health outcomes. The nutritional assessment/nutritional counseling will inform the ongoing menu-planning for the Member.

- Telehealth is defined as the mode of delivering Community Supports services using telecommunication technologies that facilitate real-time interaction while the member is at an originating site and the Community Supports provider is at a distant site. Telehealth technologies include live video conferencing, asynchronous video (also known as Store-and-Forward), remote monitoring of members, and mobile health.
- A 15% administrative fee.

Payment Rates

	Service Bundle A				Service Bundle B			
	Meal	**HCPCS Code and Modifiers**	**Nutritional Counseling**	**HCPCS Code and Modifiers**	**Meal**	**HCPCS Code and Modifiers**	**Nutritional Counseling**	**HCPCS Code and Modifiers**
Midpoint Rate	$14.77	S5170 Modifiers U6, UB, TF	$40.00	S9470 Modifiers U6, UB, TF	$11.32	S5170 Modifiers U6, UC, 99	$40.00	S9470 Modifiers U6, UD, 99
Minimum Rate	$13.62	S5170 Modifiers U6, UB, TG	$40.00	S9470 Modifiers U6, UB, TG	$7.87	S5170 Modifiers U6, UC, 25	$40.00	S9470 Modifiers U6, UD, 25
Maximum Rate	$14.77	S5170 Modifiers U6, UB, TS	$40.00	S9470 Modifiers U6, UB, TS	$14.77	S5170 Modifiers U6, UC, XE	$40.00	S9470 Modifiers U6, UD, XE
Service Unit	per delivered meal		per session		per delivered meal		per session	
Maximum Billable Units	252		1		252		1	
Additional Modifier for Telehealth	N/A		GQ		N/A		GQ	

	Service Bundle C				Service Bundle D			
	Meal	**HCPCS Code and Modifiers**	**Nutritional Counseling**	**HCPCS Code and Modifiers**	**Meal**	**HCPCS Code and Modifiers**	**Nutritional Counseling**	**HCPCS Code and Modifiers**
Midpoint Rate	$11.32	S5170 Modifiers U6, U1, U8	$40.00	S9470 Modifiers U6, U1, U3	$11.32	S5170 Modifiers U6, U1 , 25	$40.00	S9470 Modifiers U6, U2, 99
Minimum Rate	$7.87	S5170 Modifiers U6, UD, U3	$40.00	S9470 Modifiers U6, U1, TG	$7.87	S5170 Modifiers U6, U1 , TG	$40.00	S9470 Modifiers U6,U2, 25
Maximum Rate	$14.77	S5170 Modifiers U6, UD, U7	$40.00	S9470 Modifiers U6, U1, U7	$14.77	S5170 Modifiers U6, UD , XE	$40.00	S9470 Modifiers U6, U2, XE
Service Unit	per delivered meal		per session		per delivered meal		per session	
Maximum Billable Units	252		2		252		3	

	Service Bundle C				Service Bundle D			
	Meal	HCPCS Code and Modifiers	Nutritional Counseling	HCPCS Code and Modifiers	Meal	HCPCS Code and Modifiers	Nutritional Counseling	HCPCS Code and Modifiers
Additional Modifier for Telehealth	N/A		GQ		N/A		GQ	

	Service Bundle E				Service Bundle F	
	Groceries	HCPCS Code and Modifiers	Nutritional Counseling	HCPCS Code and Modifiers	Class or Session	HCPCS Code and Modifiers
Midpoint Rate	$60.56	S9977 Modifiers U6, U2, U9	$40.00	S9470 Modifiers U6, UA, U9	$97.00	S9470 Modifiers U6, XE, U7
Minimum Rate	$55.97	S9977 Modifiers U6, U2, TF	$40.00	S9470 Modifiers U6, UA, TF	$8.00	S9470 Modifiers U6, XE, 99
Maximum Rate	$89.32	S9977 Modifiers U6, U2, UD	$40.00	S9470 Modifiers U6, UA, UD	$187.00	S9470 Modifiers U6, XE , 25
Service Unit	weekly groceries delivered		per session		per session	
Maximum Billable Units	12		1		12	
Additional Modifier for Telehealth	N/A		GQ		GQ	

	Service Bundle E				Service Bundle F	
	Groceries	HCPCS Code and Modifiers	Nutritional Counseling	HCPCS Code and Modifiers	Class or Session	HCPCS Code and Modifiers
Midpoint Rate	$60.56	S9977 Modifiers U6, U2, U9	$40.00	S9470 Modifiers U6, UA, U9	$97.00	S9470 Modifiers U6, XE, U7
Minimum Rate	$55.97	S9977 Modifiers U6, U2, TF	$40.00	S9470 Modifiers U6, UA, TF	$8.00	S9470 Modifiers U6, XE, 99
Maximum Rate	$89.32	S9977 Modifiers U6, U2, UD	$40.00	S9470 Modifiers U6, UA, UD	$187.00	S9470 Modifiers U6, XE , 25
Service Unit	weekly groceries delivered		per session		per session	
Maximum Billable Units	12		1		12	
Additional Modifier for Telehealth	N/A		GQ		GQ	

Notes about Payment Rates
1. The payment rates are defined as:
   - Minimum
     - Service Bundles A -E
       - Engages only in telephonic contact for wellness checks and/or nutritional counseling sessions.
       - Has Registered Dietician-approved meal/grocery menus for common chronic conditions (diabetes, hypertension, renal disease and congestive heart failure, and mental/behavioral health disorders).
       - Is not able to customize menus for all SCFHP-approved diagnoses for the service bundle (if applicable).
     - Service Bundle F: Able to provide limited enhanced services required in service bundle

   - Midpoint
     - Service Bundles A - E
       - Engages in in-person or telephonic wellness checks and/or nutritional counseling.
       - Has Registered Dietician-approved meal/grocery menus for common chronic conditions (diabetes, hypertension, renal disease and congestive heart failure, and mental/behavioral health disorders).
       - Is able to customize meals or groceries for all of the diagnoses under the Pregnant Women population and two or more of the following: uncontrolled hypertension, CHF with recent heart attack, CPOD with O2, or recent stroke for members who live alone.
     - Service Bundle F: Able to provide at least two of the enhanced services required in the required service bundle either through direct contracts with vendor(s) or by providing services in house.

   - Maximum
     - Service Bundle A – E
       - Engages in in-person wellness checks and nutritional counseling.
       - Able to customize meals or groceries for ALL SCFHP-approved diagnoses per service bundle (if applicable).
     - Service Bundle F: Able to provide enhanced services through either direct contracts with vendor(s), OR providing services in house.

2. The actual rates paid to a contracted Community Supports provider for rendered services are subject to individual agreement provisions and consider Populations of Focus.

3. The pricing range reflected above for Service Bundle F is based on an estimate. The actual payments may vary based on the rendered classes and sessions.

Cost Drivers and Assumptions

	Assumptions Informing Pricing Range					
	Assumptions					
Cost Drivers	Service Bundle A	Service Bundle B	Service Bundle C	Service Bundle D	Service Bundle E	Service Bundle F
Frequency	Up to 3 delivered meals per day/delivered groceries for up to 75% of the daily nutritional needs					As needed
Duration	As needed up to 12 weeks					

Cost Drivers	Assumptions Informing Pricing Range					
	Assumptions					
	Service Bundle A	Service Bundle B	Service Bundle C	Service Bundle D	Service Bundle E	Service Bundle F
Setting	N/A					
Approximate Service Time	Registered dietician: $32- 43/hour					Varies depending on class or session
Staffing Ratio/ Caseload	A single one-hour nutritional counseling session per 12 weeks	Two one- hour nutritional assessments per 12 weeks	Three One--hour nutritional assessments per 12 weeks	A single one-hour nutritional counseling session per 12 weeks		• Cooking: A one-hour class with 1 instructor: 15 participants • Behavioral health education: Two sessions every 4 weeks • Nutritional education: Two 45-minute sessions in 4 weeks
Other Pricing Inputs	• Food costs: $58.40 per week for food box (based on USDA weekly food costs); Delivery: $7.50 per weekly box • Indirect expenses: 15% • Indirect expenses include: ▪ Administrative overhead – accounting, leadership, marketing, support services, IT, indirect mileage reimbursement, etc. ▪ Program costs – Community Supports-related staff training, direct mileage reimbursement • Indirect expenses does not apply to Service Bundle F.					None