Santa Clara Family Health Plan™

COMMUNITY SUPPORTS

Provider User Guide

August 2022

40721

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 concluded 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	1/1/2023
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 launched on January 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:

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

LIMITATIONS

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

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 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. Assisting member with accessing additional benefits and identification documentation, such as SSI eligibility and	2-4 months

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	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 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	1 month

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	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,UA,U8	$613	H0043 Modifiers U6,UB,U8	$588	H2016 Modifiers U6,UC,U8	$470	H0043 Modifiers U6,UD,U8
Minimum Rate	$285	H0043 Modifiers U6,UA,U7	$455	H0043 Modifiers U6,UB,U7	$435	H2016 Modifiers U6,UC,U7	$345	H0043 Modifiers U6,UD,U7
Maximum Rate	$520	H0043 Modifiers U6,UA,U9	$770	H0043 Modifiers U6,UB,U9	$740	H2016 Modifiers U6,UC,U9	$595	H0043 Modifiers U6,UD,U9
Service Unit	PMPM		PMPM		PMPM		PMPM	
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): 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.*			

Assumptions Informing Pricing Range				
	Assumptions			
Cost Drivers	**Service Bundle A**	**Service Bundle B**	**Service Bundle C**	**Service Bundle D**
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.

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 telephone, gas, electricity, heating, and water), first and last month's rent as required by landlord for occupancy.	1 month

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	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,UA,U8	$5,336	H0044 Modifiers U2,UB,U8	$383	H0044 Modifiers U2,UC,U8
Minimum Rate	$146	H0044 Modifiers U2,UA,U7	$4,790	H0044 Modifiers U2,UB,U7	$292	H0044 Modifiers U2,UC,U7
Maximum Rate	$238	H0044 Modifiers U2,UA,U9	$6,236	H0044 Modifiers U2,UB,U9	$473	H0044 Modifiers U2,UC,U9
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:
       - Able to accept referrals and provide services for both their own assigned ECM members and other members.
       - Non-clinical staff provides the services and are solely designated to housing assistance.
       - Supervision is provided by non-clinical staff.
     - Maximum:

    - Able to accept referrals and provide services for both their own assigned ECM members and other members.
    - Non-clinical staff provides the services and are solely designated to housing assistance.
    - 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: • 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.		

SERVICES BUNDLE B - ADDITIONAL EXPECTATIONS

SCFHP expects:

- Housing Deposits funds should be paid directly to landlord, unit manager, leasing agency, or utility company.
- Both ECM and Community Supports providers to explain to the member that the Housing Deposit Community Support is provided once per lifetime.
- If the landlord returns it to the member, the expectation from SCFHP is the member use that money towards their next rental.
- If a landlord wants to return it to the ECM provider, the provider should return it to the member and have the member sign off stating they understand this money is to be used for future deposits and is a once per lifetime Community Support provided by SCFHP.

Appendix C
Housing Tenancy and Sustaining Services

DESCRIPTION

The Housing Tenancy and Sustaining 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, county housing agencies, and SCFHP. Community Supports providers should expect to coordinate access to these housing resources through the appropriate entity when needed.

The Housing Tenancy and Sustaining Services may help member create a housing payment schedule to ensure member pays their rent on time. This could include crucial coordination with local entities to ensure that available options for room and board or rental payments are also coordinated with housing services. However, members are responsible for provisions of room and board or payment of rental costs.

ELIGIBILITY

The eligibility criteria for Housing Tenancy and Sustaining Services are:

- Member must first be housed in order to provide tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.
- Any individual who received Housing Transition/Navigation Services Community Support from SCFHP are eligible for Housing Tenancy and Sustaining Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local Homeless Coordinated Entry System (HMIS) 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 (SUD) 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 (ECM), or who have one or more serious chronic conditions and/or serious mental illness (SMI) and/or are at risk for institutionalization or requiring residential services as a result of an SUD. 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 receive Housing Tenancy and Sustaining Services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a serious mental illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents);
  - Are receiving ECM; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have serious mental illness and/or are children or adolescents with serious emotional disturbance and/or victims of trafficking or domestic violence.

LIMITATIONS

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services. Service duration can be as long as necessary.

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

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service, but it is not a prerequisite for eligibility. Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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.*

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.

Members who meet the eligibility requirements for Housing Tenancy and Sustaining Services should also be assessed for ECM and may have received Housing Transition/Navigation Services (if provided in their county). When enrolled in ECM, Community Supports should be managed in coordination with ECM providers. When members receive more than one of these services, SCFHP ensures coordination 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.

PROGRAM MODEL

The required Housing Tenancy and Sustaining 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 listed services based on member needs and submit claims or invoices to SCFHP that reflect the bundled service categories. If more than one service bundle is required simultaneously, providers may bill for more than one bundle at a time.

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
Service Bundle A: Housing Tenancy and Sustaining Services Assessment Plan	1. Conducting outreach to referred member. If an ECM provider, may be included as a component of the ECM assessment. 2. Conducting tenant screening and housing assessment to identify crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in, rent assistance). If an ECM provider, may be included as a component of the ECM assessment. 3. Providing education and training on the role, rights, and responsibilities of the tenant and landlord. 4. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources. 5. Identifying other providers or services that may be needed to meet and maintain goals as stated in the housing support plan. 6. Following up with community resource referrals made by member's case managers to ensure other services needed were provided to member (i.e., "closed loop referrals") including Santa Clara Family Health Plan Community Supports staff regarding Community Supports services completed with member.	1 – 2 Months
Service Bundle B: Interventions Towards Sustaining Housing	1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations based on individualized housing tenancy & sustaining support plan made with member. 2. Advocating for and linking to community resources to prevent eviction when housing is or may potentially become jeopardized in the future. 3. Assisting with the annual housing recertification process and health and safety visits, including unit habitability inspections (if applicable). 4. Coaching and discussing how to develop and maintain key relationships with landlords/property managers with a goal of fostering successful tenancy (home, family, or other living arrangement, short-term, permanent supportive housing). 5. Coordinating with the landlords/property managers to address identified issues that could impact housing stability.	2 – 3 Months

	6. Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing occurring housing retention barriers. 7. Following up with community resource referrals made by member's case managers to ensure other services needed were provided to member (i.e., "closed loop referrals") including Santa Clara Family Health Plan Community Supports staff regarding Community Supports services completed with member.	
Service Bundle C: Housing Interventions and Retention	1. Providing assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action, including developing a repayment plan or identifying funding in situations in which the member owes back rent or payment for damage to the unit. 2. Conducting health and safety visits, including unit habitability inspections. 3. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources. 4. Continuing assistance with lease compliance, including ongoing support with activities related to household management. 5. Completing a Homeless Preventive Assessment Tool (HPAT), if applicable. 6. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process, CalFresh, EDD, cash aid, etc. Such services can be subcontracted to retain required specialized skillset, as applicable. 7. Updating member's housing support and crisis plan to reflect most current needs and ensure services were provided regarding community resource referrals made by case manager. 8. If member's needs and housing retention are not possible through The Housing Tenancy and Sustainability program. The Community Supports provider may refer to ECM (if eligible), SCFHP Case Management, or other community-based case management programs as an alternative. If this is done by a provider, member must first be disenrolled from Community Supports. In addition, to following up with alternative community – based program to ensure warm hand off regarding member's case (i.e., closed loop referrals).	6-month intervals

	9. Monitoring changes in needs and accuracy of those needs that may impact a VI-SPDAT score and update as needed. 10. Providing member with safe temporary shelter resources in Santa Clara County, if member's needs and housing retention are not possible through the Housing Tenancy and Sustainability program. 11. Following up with community resource referrals made by member's case managers to ensure other services needed were provided to member (i.e., "closed loop referrals") including Santa Clara Family Health Plan Community Supports staff regarding Community Supports services completed with member.	
Service Bundle D: Housing Interventions and Retention Continuation	1. Determining if referrals are needed to be submitted for additional Housing Tenancy and Sustaining Services direct payment for enhanced services provided. 2. Completing any member services still needed to be rendered from Bundle C.	6-month intervals

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 1:25 individuals concurrently. The caseload range is based on *DHCS's Community Supports Pricing Guide* and varies from 1:20 to 1:30 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	$397	T2051 Modifiers U6,UA,U7	$439	T2051 Modifiers U6,UB,U7	$439	T2051 Modifiers U6,UC,U7	$275	T2050 Modifiers U6,UD,U7

Minimum Rate	$343	T2051 Modifiers U6,UA,U8	$378	T2051 Modifiers U6,UB,U8	$378	T2051 Modifiers U6,UC,U8	$240	T2050 Modifiers U6,UD,U8
Maximum Rate	$452	T2051 Modifiers U6,UA,U9	$500	T2051 Modifiers U6,UB,U9	$500	T2051 Modifiers U6,UC,U9	$311	T2050 Modifiers U6,UD,U9
Service Unit	PMPM		PMPM		PMPM		PMPM	
Maximum Billable Units	2		3		6		6	
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 – 2 Months	2-3 Months	6 - Month Intervals	6 - Month Intervals
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 ($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, if the individual is enrolled in Enhanced Care Management. *Benefits and retirement are included at an estimated 35% of hourly wage.*			
Approximate Service Time	Model with only Non-clinical staff: 8 - 9 hours/month Model with mixed Clinical and Non-clinical staff: 7 hours/month Model with only Clinical staff: 8 – 9 hours/month Supervision: 1 hour/month *Applies to Bundle A, B, & C.*		Model with only Non-clinical staff: 5 hours/month Model with mixed Clinical and Non-clinical staff: 4 hours/month Model with only Clinical staff: 5 hours/month Supervision: 1 hour/month *Applies to Bundle D.*	
Staffing Ratio/Caseload	1 Non-clinical staff: 20 to 30 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 • Non-Billable Time: Training 40 hours/year, PTO 25 days/year			

Appendix D
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.

LIMITATIONS

Individuals are directly responsible for paying their own living expenses.

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 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	2 months

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	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. 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.	2 months

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	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. 5. Providing ongoing monitoring of enhanced service delivery based on a designated timeframe specified by SCFHP.	6-month intervals
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,UA,U8	$1,068	T2038 Modifier U4,UB,U8	$420	T2038 Modifier U4,UC,U8	$3,000	H2022 Modifier U4,UD, U8
Minimum Rate	$805	T2038 Modifier U4,UA,U7,	$805	T2038 Modifier U4,UB,U7	$300	T2038 Modifier U4,UC,U7	$3,000	H2022 Modifier U4,UD, U7
Maximum Rate	$1,330	T2038 Modifier U4,UA,U9	$1,330	T2038 Modifier U4,UB,U9	$540	T2038 Modifier U4,UC,U9	$3,000	H2022 Modifier U4,UD, U9
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

<table>
<tr><th colspan="5">Assumptions Informing Pricing Range</th></tr>
<tr><th rowspan="2">Cost Drivers</th><th colspan="4">Assumptions</th></tr>
<tr><th>Service Bundle A</th><th>Service Bundle B</th><th>Service Bundle C</th><th>Service Bundle D</th></tr>
<tr><td>Frequency</td><td colspan="2">As needed</td><td>Monthly</td><td>Monthly</td></tr>
<tr><td>Duration</td><td>2 months</td><td>2 months</td><td>6-month intervals</td><td>6-month intervals</td></tr>
<tr><td>Setting</td><td colspan="2">Primarily in-person; some services may be completed by phone</td><td colspan="2">In person</td></tr>
<tr><td>Provider Staffing and Hourly Costs</td><td colspan="4">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.</td></tr>
<tr><td>Approximate Service Time</td><td>Non-clinical staff: 10 hours/month
Clinical staff: 4 hours/month
Supervision: 2 hours/month</td><td>Non-clinical staff: 10 hours/month
Clinical staff: 4 hours/month
Supervision: 2hours/month</td><td>Non-clinical staff: 3 hours/month
Clinical staff: 1
Supervision: 2 hour/month</td><td>None</td></tr>
<tr><td>Staffing Ratio/Caseload</td><td colspan="3">1 non-clinical/clinical staff: 20 to 30 members
1 clinical supervisor: 10 non-clinical/clinical staff</td><td>None</td></tr>
<tr><td>Other Pricing Inputs</td><td colspan="4">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.</td></tr>
</table>

Appendix E
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.

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.

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.

PROGRAM MODEL

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.	2-4 months

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	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.	
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,UA,U8	$477	T2038 Modifiers U5,UB,U8
Minimum Rate	$535	T2038 Modifiers U5,UA,U7	$363	T2038 Modifiers U5,UB,U7
Maximum Rate	$1,697	T2038 Modifiers U5,UA,U9	$591	T2038 Modifiers U5,UB,U9
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		
	Assumptions	
Cost Drivers	**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 F
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, 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 chronic conditions.
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 clearance 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 with recent escalation of medications or recent history of heart attack or MI, CPOD with O2, or recent stroke AND member lives alone; or two or more chronic conditions 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.
Service Bundle E: Medically-Supportive Food and Nutrition Services 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; and diagnosed with 1 or more chronic conditions: hypertension, Hyperlipidemia, CHF, Heart Disease, Stroke, Diabetes, Cancer, Celiac, Depression, Anxiety, Schizophrenia, Low sodium, Vegetarian, Gluten Free.
2	Extensive care coordination needs that make the member high risk for hospitalization; and diagnosed with 1 or more chronic conditions.
3	Adequate support in the home to cook full meals with groceries or is able to cook full meals without assistance.
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 F: Enhanced Services-Education Member must meet the criteria for 1 or 2, AND 3	
1	Approved for Services Bundle A-E AND Discharge, within the last 4 weeks, from an acute hospital or SNF AND is at risk for re-hospitalization.
2	Approved for Services Bundle A-E AND Extensive care coordination needs that make the member high risk for hospitalization.
3	Member has a permanent residence in Santa Clara County and is able to store and reheat food.

LIMITATIONS

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

- Service covers up to two 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.

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 six separate categories with an approved 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 2 meals per day: Monday – Thursday = 1 hot meal +1 frozen meals; Friday = 1 hot meal + 5 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: 7-14 frozen or refrigerated meals weekly for up to 12 weeks. 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.	12 weeks
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	12 weeks

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	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, cardiovascular disease, stroke, cancer, or other chronic disorder that referring entity determines is disabling (with documentation) 5. Delivering meals: 7-14 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.	
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 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 and 12 weeks); Gestational Diabetes with a A1C of 7+ in 3rd trimester- retest and provide results at 6 weeks and 12 weeks; Hypertension with recent escalation of medication (will need documentation from medical provider or pharmacist to confirm).	12 weeks

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	b. Other Diagnosis for all populations: Uncontrolled hypertension with escalation of medication (will need documentation from medical provider or pharmacist to confirm), CHF with recent escalation of medications or recent history of heart attack or MI, CPOD with O2, or recent stroke AND member lives alone; or two or more chronic conditions 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) _ for members with an approved diagnosis or dietary needs as defined by SCFHP. a. Diagnosis: hypertension, Hyperlipidemia, CHF, 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.	12 weeks
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.	12 weeks

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	**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.	

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,UA,U8	$40.00	S9470 Modifiers U6,UA,U8	$11.32	S5170 Modifiers U6,UB U8	$40.00	S9470 Modifiers U6,UB,U8
Minimum Rate	$13.62	S5170 Modifiers U6,UA,U7	$40.00	S9470 Modifiers U6,UA,U7	$7.87	S5170 Modifiers U6,UB,U7	$40.00	S9470 Modifiers U6,UB,U7
Maximum Rate	$14.77	S5170 Modifiers U6,UA,U9	$40.00	S9470 Modifiers U6,UA,U9	$14.77	S5170 Modifiers U6,UB,U9	$40.00	S9470 Modifiers U6,UB,U9

Service Unit	per delivered meal	per session	per delivered meal	per session
Maximum Billable Units	168	1	168	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,UC,U8	$40.00	S9470 Modifiers U6,UC,U8	$11.32	S5170 Modifiers U6,UD,U8	$40.00	S9470 Modifiers U6,UD,U8
Minimum Rate	$7.87	S5170 Modifiers U6,UC,U7	$40.00	S9470 Modifiers U6,UC,U7	$7.87	S5170 Modifiers U6,UD,U7	$40.00	S9470 Modifiers U6,UD,U7
Maximum Rate	$14.77	S5170 Modifiers U6,UC,U9	$40.00	S9470 Modifiers U6,UC,U9	$14.77	S5170 Modifiers U6,UD,U9	$40.00	S9470 Modifiers U6,UD,U9
Service Unit	per delivered meal		per session		per delivered meal		per session	
Maximum Billable Units	168		2		168		3	
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, UE, U8	$40.00	S9470 Modifiers U6, UE, U8	$97.00	S9470 Modifiers U6, UF, U8
Minimum Rate	$55.97	S9977 Modifiers U6, UE, U7	$40.00	S9470 Modifiers U6, UE, U7	$8.00	S9470 Modifiers U6, UF, U7
Maximum Rate	$89.32	S9977 Modifiers U6, UE, U9	$40.00	S9470 Modifiers U6, UE, U9	$187.00	S9470 Modifiers U6, UF, U9
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

	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**
Duration	As needed up to 12 weeks					
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

Appendix G
Sobering Center

DESCRIPTION

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

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to the Sobering Centers. The Sobering Centers must be prepared to identify members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for members who are experiencing homelessness and who have complex health and/or behavioral health conditions including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma-informed care.

ELIGIBILITY

The eligibility criteria for the Sobering Center are:

- Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and
- Who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

RESTRICTIONS AND LIMITATIONS

This service is covered for a duration no more than 23 hours and 59 minutes.

Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions (STC) and federal and DHCS guidance.

LICENSING/ALLOWABLE PROVIDERS

Providers must have experience and expertise with providing these unique services with these unique populations. 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.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. SCFHP will consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. SCFHP must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. SCFHP shall monitor the provision of all the services included above.
- All allowable providers must be approved by the SCFHP to ensure adequate experience and appropriate quality of care standards are maintained.

All contracted Community Supports providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, Community Supports providers, which may extend to individuals employed by or delivering services on behalf of the Community Supports provider, must participate in a vetting process to ensure the provider can meet the capabilities and standards required to serve as a Community Supports provider.

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 provided at the Sobering Center are listed below. Community Supports providers are required to provide any or all of the listed services based on member needs and submit claims or invoices to SCFHP that reflect the bundled service categories.

	Services
Required Services	1. Conduct patient screening to determine level of intoxication, willingness to participate in services, possible medical distress, and housing status. 2. Ability to accept referrals from law enforcement, hospitals/emergency departments, ECM providers, and other community based organizations such as in patent treatments centers, Skilled Nursing Facilities, or Community Based Care Management Agencies. 3. Services may be provided for up to 23 hours and 59 minutes and include: • Temporary bed or recliner to rest • Temporary place to store personal items • Oral rehydration and food service • Shower and laundry facilities

	Services
	• Substance use education: counseling, peer support, and referrals and coordination with county behavioral health agency to access treatment • Linkage to ongoing supportive services such as ongoing case management, housing navigation, behavioral health services, necessary healthcare services, public benefits support, legal services and homeless care support services. 4. Develop a wellness/safety plan that includes contact information to access community resources and next steps. 5. Provide warm handoffs to for all additional offered services.
Additional Services *Providers may provide some or all services listed*	6. Medical triage 7. Lab testing- COVID-19, Tuberculosis (TB), etc. 8. Medication treatment for nausea 9. Wound and dressing changes 10. Medication management 11. Transportation

PRICING GUIDE

High-level pricing approach

The pricing includes:

- Rates calculated as Per Member Per Day, with around-the-clock support from a team of staff with the ability to provide care for up to 20 participants at one time.
- Excludes covered services through Medi-Cal.
- Non clinical direct care workers serve as front line staff that provide screenings and supervision of program participants with a ratio of 1 direct care worker to every 5 participants.
- Clinical licensed staff to provide formal supervision per the scope of their license, as well as medical services if applicable, with a ratio of 1 licensed staff to 3 direct care workers.
- A 15% administrative fee.

Payment Rates

	Sobering Center	
	Rate	**HCPCS Code and Modifiers**
Midpoint Rate	$207	H0014 Modifiers U6,U7,UA
Minimum Rate	$164	H0014 Modifiers U6,U7,UD
Maximum Rate	$249	H0014 Modifiers U6,U7,UC
Service Unit	Per Member Per Day	
Maximum Billable Units	1 unit per day with no more than 7 units per week	

Notes about Payment Rates:

5. The payment rates are defined as:
    - Minimum: Non-clinical staff provides participant supervision, eligibility determination, and all other services; entity can provide at least one of the six of the additional services listed due to limited access to appropriate clinical staff with adequate scope. Day to day operations supervision is provided by non-clinical staff.
    - Midpoint: Non-clinical staff provides participant supervision, eligibility determination, and all other services; entity has clinical staff that are on-call or part-time and who possess a license or have adequate training to provide 3-4 of the six additional services listed. Day to day operations supervision is provided by non-clinical staff.
    - Maximum: Non-clinical staff provides participant supervision, eligibility determination, and all other services; entity is able to provide all six additional services listed, has clinical staff employed and/or on-call 6 days out of the week with license or training to provide services within their scope. Day to day operations supervision is provided by clinical or non-clinical staff; and Licensed staff is supervised by appropriate clinical staff.
6. The actual rates paid to a contracted Community Supports provider for rendered services are subject to individual agreement provisions and consider Populations of Focus (POF).

Cost Drivers and Assumptions

Assumptions Informing Pricing Range	
Cost Drivers	**Assumptions**
Frequency	As needed
Setting	In-person/telephone/video
Provider Staffing and Hourly Costs	Non-clinical direct care workers ($25-$42/hour) Examples of positions include Community Worker, Community Outreach Specialist, Substance Use Counselors, Navigators, peer staff trained in mental health and substance use disorder, or behavioral health counselors, sobering specialist, Emergency Medical Technician (EMT), Licensed Vocational Nurse (LVN) Clinical staff ($30-66$/hour): 1-2 staff person providing direct medical care on site 3 days per week for 4-6 hours; and rotating on call staff available for phone consultation or emergencies. Some kind of clinical support will be provided Examples of positions include Licensed Clinical Social Worker, Licensed Clinical Nurse Licensed Practical Nurse Non-clinical Supervision ($53-$64/hour): 1 staff person Examples of positions include Program Manager, Program Director Clinical Supervision ($29-$hour): 1:3 Direct care Examples of positions include Clinical Service Manager, Licensed Clinical Social Worker (LCSW), Supervising Registered Nurse, Medical Director Note: The determination of whether clinical staff and clinical supervision are recommended are based on assessed need and takes POF into consideration.

Assumptions Informing Pricing Range	
Cost Drivers	**Assumptions**
	Benefits and retirement are included at an estimated 35% of hourly wage.
Approximate Service Time	Non-clinical staff: 3-4 staff for 6-8 hours per day Clinical staff: 1-2 staff 10-20 hours per day on site; 10-15 hours per day On call Clinical Supervision: 2-3 staff 16-24 hours per day Non Clinical Supervisor- 1:3 direct care worker
Staffing Ratio/Caseload	1 Non-clinical staff: 5 Participants total 12-20 participants 1 Supervisor: 3 Direct care workers
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 H
MEDICAL RESPITE CARE (RECUPERATIVE CARE)

DESCRIPTION

Medical Respite is short-term residential care for individuals who no longer require hospitalization, but still need to heal from injury or illness; including behavioral health conditions and whose condition would be exacerbated by unstable living conditions.

An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations (couch surfing, temporary shelters, living in cars) who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the Enhanced Care Management (ECM) program. Recuperative Care may be utilized in conjunction with other housing Community Supports, and whenever possible, should be provided to Members onsite in the recuperative care facility. When a member is enrolled in ECM, Community Supports should be managed in coordination with ECM providers.

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

ELIGIBILITY

The eligibility criteria for Medical Respite services are:

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. *Note: For this population, the service could be coordinated with home modifications (which are covered as a separate Community Support) and serve as a temporary placement until the Member can safely return home. This service will be launching January 2023.*
- 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 is at risk of institutionalization or requiring residential services as a result of a substance use disorder.

- 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.

RESTRICTIONS AND LIMITATIONS

Recuperative Care/Medical Respite is an allowable Community Supports service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions; 2) not more than 90 days in continuous duration; and 3) does not include funding for building modification or building rehabilitation.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

LICENSING/ALLOWABLE PROVIDERS

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

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. SCFHP must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. SCFHP can adopt or adapt local or national standards for recuperative care. SCFHP shall monitor the provision of all the services included below.

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/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.

PROGRAM MODEL

The required services for Medical Respite are categorized below based on clinical scope and intensity. SCFHP will approve only one service bundle per member and Community Supports providers must adhere to the estimated duration of the time for providing those services. Community Supports providers are required to provide any 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: Coordinated Clinical Care	**Intake and assessment:** 1. Assessing member and developing a treatment plan **Treatment:** 2. Providing temporary housing with a bed and meals 3. Providing ongoing monitoring of member's medical conditions by clinical staff (coordinate office and telehealth appointments with doctors, wound care, address acute medical conditions, daily wellness check, connection to PCP/home health before discharge) 4. Coordinating transportation to post-discharge appointments (Escort if necessary). 5. Managing medication for member to self-administer (medication storage, medication reconciliation, pharmacy pick-up/delivery; education to self-manage) 6. Providing ongoing monitoring of member's behavioral health conditions (screening/assessment, substance use counseling, onsite group therapy, recovery group) 7. Connecting to any other on-going services the member may require including mental health and substance use disorder (SUD) services 8. Laundry services and 24/7 onsite staff available **Transition and Discharge:** 9. Providing Social support to member: assisting member with accessing Income, benefits and identification documentation (e.g., general assistances/SSDI eligibility and application process, CalFresh, cash aid, ID/birth certificate/Immigration status/financial records/marriage/divorce records/proof of medical conditions, complete VI-SPDAT, Section 8 waitlist) 10. Referring to Community Supports (e.g., Housing navigation and/or ECM) 11. Referring to home-based clinical services (e.g., home health, physical therapy, speech and occupational therapy)	Up to 90 Days
Service Bundle B: Integrated Clinical Care	**Intake and assessment:** 1. Assessing member and developing a treatment plan **Treatment:** 2. Providing temporary housing with a bed and meals 3. Providing ongoing monitoring of member's medical conditions by clinical staff (coordinate office and telehealth appointments with doctors, wound care,	Up to 90 Days

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	address acute medical conditions, daily wellness check, connection to PCP/home health before discharge) 4. Providing Psychiatric care (assessment, care plan and treatment) 5. Psychosocial care (assessment, 1:1 therapy, crisis interventions) 6. Managing Chronic conditions (e.g., self-management and treatment, self-management education) 7. Coordinating transportation to post-discharge appointments (Escort if necessary) 8. Laundry services and 24/7 onsite staff available 9. Managing medication for member to self-administer (medication storage, pharmacy pick-up/delivery; education to self-manage, weekly check-in, medication reconciliation) 10. Providing ongoing monitoring of member's behavioral health conditions (screening/assessment, substance use counseling, onsite group therapy, recovery group) 11. Assisting to any other on-going services the member may require including mental health and substance use disorder (SUD) services (overdose prevention) **Transition and Discharge:** 12. Providing Social support to member: assisting member with accessing Income, benefits and identification documentation (e.g., general assistances/SSDI eligibility and application process, CalFresh, cash aid, ID/birth certificate/Immigration status/financial records/marriage/divorce records/proof of medical conditions, complete VI-SPDAT, Section 8 waitlist) 13. Referring to Community Supports (e.g., Housing navigation and/or ECM) 14. Referring to home-based clinical services (e.g., home health, physical therapy, speech and occupational therapy) 15. Connecting to any other on-going services the member may require including mental health and substance use disorder (SUD) services	
Service Bundle C: Comprehensive Clinical Care	**Intake and assessment:** 1. Assessing member and developing a treatment plan **Treatment:** 2. Providing temporary housing with a bed and meals	Up to 90 Days

Service Bundle	Bundled Services	Estimated Duration to Provide all Bundled Services
	3. Providing limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs) 4. Providing ongoing monitoring of member's medical conditions by clinical staff (coordinate office and telehealth appointments with doctors, wound care, address acute medical conditions, daily wellness check, connection to PCP/home health before discharge) 5. Providing Psychiatric care (assessment, care plan and treatment) 6. Psychosocial care (assessment, 1:1 therapy, crisis interventions) 7. Managing Chronic conditions (e.g., self-management and treatment, self-management education) 8. Coordinating transportation to post-discharge appointments (Escort if necessary) 9. Laundry services and 24/7 onsite staff available 10. Managing medication for member to self-administer (medication storage, pharmacy pick-up/delivery; education to self-manage, weekly check-in, medication reconciliation) 11. Providing ongoing monitoring of member's behavioral health conditions (screening/assessment, substance use counseling, onsite group therapy, recovery group) 12. Assisting to any other on-going services the member may require including mental health and substance use disorder (SUD) services (overdose prevention) **Transition and Discharge:** 13. Providing Social support to member: assisting member with accessing Income, benefits and identification documentation (e.g., general assistances/SSDI eligibility and application process, CalFresh, cash aid, ID/birth certificate/Immigration status/financial records/marriage/divorce records/proof of medical conditions, complete VI-SPDAT, Section 8 waitlist) 14. Referring to Community Supports (e.g., Housing navigation and/or ECM) 15. Referring to home-based clinical services (e.g., home health, physical therapy, speech and occupational therapy) 16. Connecting to any other on-going services the member may require including mental health and substance use disorder (SUD) services	

PRICING GUIDE:

High-level pricing approach: The pricing includes:

- Non-clinical staff to provide services face to face in a facility with total of caseload of 10 to 20 beds
- Clinical staff to provide services in a facility of 10 to 20 beds
- Clinical supervisor with a caseload of 1:10 clinical
- Psychiatric Professional with a caseload of 1: 4 clinical staff
- A 15% program cost and administrative fee.
- A $25 per day per member for daily food and supply costs
- 100 square feet per enrollee and 400 square feet in common/staff space at $4.00 per square foot

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
Rate	$210	T1002 Modifiers U6, U7, UA	$262	T1002 Modifiers U6, U7, UB	$314	T1002 Modifiers U6, U7, UC
Service Unit	PMPD		PMPD		PMPD	
Maximum Billable Units	90		90		90	
Additional Modifier	N/A		N/A		N/A	

Notes about Payment Rates:

7. The payment rates are defined as:
   - Service Bundle A: Non-clinical staff provides services such as gathering information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and collect data to help identify community health. Clinical staff provide services, determine eligibility, create the care plan, review assessments, and supervision is provided by clinical and non-clinical Supervisor
   - Service Bundle B: Non-clinical staff provides services such as gathering information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and collect data to help identify community health. Clinical staff provide services, determine eligibility, create the care plan, review assessments, and supervision is provided by clinical and non-clinical Supervisor with Psychiatric Professional.
   - Service Bundle C: Non-clinical staff provides services such as gathering information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and collect data to help identify community health. Non-clinical staff also provide limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs). Clinical staff

provide services, determine eligibility, create the care plan, and review assessments for members with extensive clinical needs, and supervision is provided by clinical and non-clinical Supervisor. Clinical Supervisor and Psychiatrist professional provide supervision to clinical staff.

Cost Drivers and Assumptions

Assumptions Informing Pricing Range			
	Assumptions		
Cost Drivers	**Service Bundle A**	**Service Bundle B**	**Service Bundle C**
Frequency	As needed		
Duration	Up to 90 Days	Up to 90 Days	Up to 90 Days
Setting	In-person		
Provider Staffing and Hourly Costs	Non-clinical staff ($18-$31): Community Health Workers (CHW), Certified Nurse Assistant, Social Worker/Substance Abuse worker Clinical staff ($25-$43.41/hour): LVN, Registered Nurse and MSW Non-Clinical Supervision ($47-$77/hour): CHW Manager, Medical and Health Services Manager Clinical Supervision ($47-$77/hour): Supervising Registered Nurse, LCSW Medical Director ($76.54-$120.19) Psychiatric Professional ($61.72-$100) 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: 2 staff: 7 hours per day Clinical staff: 2 staff: 7 hours per day Supervision: 1 staff: 7 hours per day	Non-clinical staff: 3 staff: 7 hours per day Clinical staff: 2 staff: 7 hours per day Supervision: 2 staff: 7 hours per day Psychiatric Professional: 1 staff: 4 hours	Non-clinical staff: 3 staff: 7 hours per day Clinical staff: 2 staff: 7 hours per day Supervision: 2 staff: 7 hours per day Psychiatric Professional: 1 staff: 4 hours
Staffing Ratio/Caseload	1 Non-clinical staff: 10 to 20 members 1 Clinical staff: 10 to 20 members 1 Supervisor: 10 clinical staff 1 Psychiatrist Professional: 4 Clinical staff		
Other Pricing Inputs	Indirect Expenses: 5% program costs, 10% administration Indirect expenses include: • Administrative overhead – accounting, leadership, marketing, support services, IT, indirect mileage reimbursement, etc.		

Assumptions Informing Pricing Range			
	Assumptions		
Cost Drivers	Service Bundle A	Service Bundle B	Service Bundle C
	• Program costs – Community Supports-related staff training, direct mileage reimbursement Facility Costs and Utilities: 100 square feet per enrollee and 400 square feet in common/staff space at $4.00 per square foot Daily Food and Supply Costs: $25 per day per resident		