Santa Clara Family Health Plan™

COMMUNITY SUPPORTS

Provider User Guide

January 2026

41559

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Purpose

The purpose of this *Community Supports Provider User Guide* is to:

- Provide an overview of Community Supports and the likely avoidable benefits that the services intend to substitute;
- Describe the integration of Enhanced Care Management (ECM) with Community Supports;
- Elaborate on the services Santa Clara Family Health Plan (SCFHP) offers to its members; and
- Review SCFHP's processes for referral submission, authorization of members for services, and billing and claims submission.

Contracted Community Supports providers must adhere to the requirements for:

- Conducting outreach to engage members,
- Delivering required services to members,
- Sharing data with SCFHP and member care teams, and
- Reporting and billing as outlined in this *Community Supports Provider User Guide* and the *Community Supports Vendor Agreement.*

Overview

Community Supports is one initiative of California Advancing and Innovating Medi-Cal (CalAIM), the Department of Health Care Services' (DHCS) multi-year process to transform Medi-Cal. Community Supports contribute to an integrated approach to coordinating medical care, behavioral health, and social services to improve health outcomes.

DHCS defines Community Supports as medically-appropriate and cost-effective substitutes or settings for costlier state-paid health care services. Community Supports are not health plan benefits, but supplemental services paid for by SCFHP that address combined medical and social determinants of health (SDOH) needs to avoid higher levels of care. These services are typically delivered by different providers and/or in different settings than traditional Medi-Cal benefits.

In Lieu of Medi-Cal Benefits

SCFHP integrates Community Supports as flexible, wrap-around services into its Population Health Management programs. These services are provided as an alternative to services covered under Medi-Cal, such as inpatient and outpatient care, skilled nursing facility care, emergency transport services, and emergency department (ED) utilization. Community Supports are 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 SDOH. Higher utilization of Community Supports services will influence DHCS's assessment of which Community Supports become statewide benefits.

ECM and Community Supports Integration

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

Community Supports Election

SCFHP launched 14 of the 15 DHCS-approved Community Supports in six-month increments between January 1, 2022, and January 1, 2026. 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
Assisted Living Facility (ALF) Transitions	1/1/2022
Community or Home Transition Services	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
Day Habilitation Programs	7/1/2023
Transitional Rent	1/1/2026
Short-Term Post-Hospitalization Housing	7/1/2026

Community Supports Service Models

Each of the offered 14 DHCS-approved Community Supports has defined member and provider eligibility criteria, service requirements, and restrictions and limitations. These items, as well as payment structure and payment assumptions, are reflected in the service models of each Community Supports. See Sections A-N for the individual Community Supports service models.

Each individual Community Supports may be used in conjunction with other Community Supports based on individual need and may be combined with ECM services for high-risk, complex-need individuals.

Identification of Eligible Members

Individuals who are enrolled in Medi-Cal or DualConnect with SCFHP and meet the eligibility criteria for the specific Community Supports service are eligible for services.

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 services,
2. Encouraging referrals from internal SCFHP case managers,
3. Supporting primary care providers, case managers, and other providers with referring to Community Supports, and
4. Training various types of providers and community-based organizations on submitting referrals for members who may be eligible for services.

In addition, SCFHP promotes the referral process to members themselves, their authorized representatives, and family supports.

Referrals and Authorizations

SCFHP encourages direct referrals from providers that are contracted and not 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 also receives referrals from members, members' authorized representatives, and other individuals. SCFHP accepts referrals for Community Supports through SCFHP's Provider Portal, by fax, or by phone.

Upon receipt of a referral, SCFHP determines member eligibility for the requested Community Supports and either authorizes or denies the member for services, taking into consideration medical necessity and other factors. For authorized Community Supports, SCFHP assigns members to a contracted Community Supports provider for services described in the appropriate service model. For denied Community Supports, SCFHP extensively reviews external and internal data to confirm that the member is not eligible to receive services. In addition, SCFHP provides support to the member denied for Community Supports and refers them to a community-based entity or provider who may offer similar services.

SCFHP engages in a closed-loop referral process in which communication occurs between SCFHP and the referring individual to confirm authorization of services and delivery of services. SCFHP ensures timely communication with referring individuals 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.

Data Sharing, Reporting, Outcomes, and Performance Measures

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 monitors and evaluates outcomes for its members who received Community Supports using quality measures.

Data Sharing

SCFHP requires Community Supports providers to have systems and processes in place that allow them to track and manage referrals and member information for Community Supports services.

SCFHP shares relevant data with Community Supports providers to enable them to conduct member outreach, promote engagement, provide authorized 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 authorized 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 A in the *Community Supports Vendor Agreement*.

Member Profile

SCFHP shares member data with assigned Community Supports provider through SCFHP's Member Profile, which is accessible through SCFHP's Provider Portal (providerportal.scfhp.com). Community Supports providers can access information for only those members to which they are assigned to deliver authorized Community Supports. The Member Profile contains member contact information, demographics, social needs, inpatient and ED admissions and discharges in the past 12 months, prescribed medications within the past 12 months, primary care physician details, lab results in the past 12 months, ECM provider details, and a list of authorized Community Supports and their authorization periods. Community Supports providers can view and download documents, as well as upload and share documents with SCFHP. Community Supports providers may utilize the Member Profile to report the status of the delivery of authorized Community Supports.

Authorization Status File

SCFHP shares an *Authorization Status File (ASF)* on a bi-monthly basis with Community Supports providers, so they have access to member-level information, including authorization status for all assigned members. The *ASF* contains a cumulative list of all assigned and authorized members for 18 months prior to the reporting date. The data elements and specifications for the *ASF* are detailed in the *Community Supports Authorization Status File Technical Specifications*.

Reporting

SCFHP requires Community Supports providers to submit *Monthly Provider Return Transmission Files (RTFs)* to SCFHP, which contain consolidated member-level information about the status of member engagement and Community Supports services delivered for all authorized members. Community Supports providers must use the most timely and accurate data available. The required data elements and specifications are detailed in the *Community Support Provider Return Transmission File Technical Specifications.*

Closed-Loop Communication

Community Supports providers are required to report service delivery status to SCFHP utilizing the RTFs. In addition, if there are any barriers or challenges to delivering the authorized services to members, Community Supports providers should communicate the issues to SCFHP by email (cs@scfhp.com) as soon as possible.

For members who transitioned from a nursing facility to either an assisted living facility (e.g., ARF, RCFE) or the community, the assigned Community Supports provider is required to send an email to SCFHP within one (1) business day to confirm the transition is complete and discuss the next steps related to seeking authorization for additional service categories if needed.

Provider Monitoring

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, SCFHP conducts formal quarterly monitoring of all Community Supports by requiring providers to report on designated outcomes specific to the Community Supports services that were rendered. The measures 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 communication), and communicate outcomes to SCFHP. In addition, the measures 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.

Quality and Performance Measures

SCFHP requires Community Supports providers to prepare and submit data that supports meeting designated quality and performance measures for rendered Community Supports services. SCFHP monitors the progress to achieve quality and performance measures through the formal quarterly monitoring of Community Supports outcomes.

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) 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 instructions on applying for an NPI, go to https://nppes.cms.hhs.gov/#/. For the claims submission requirements, see Exhibits B-1 and B-2 in the *Community Support Vendor Agreement.*

If a Community Supports provider is unable to obtain an NPI, they can 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 used by SCFHP to pay Community Supports providers and develop DHCS-compliant encounters as part of its regular encounter file submissions to DHCS. SCFHP provides invoice submission instructions, training, and technical assistance to support Community Supports providers in properly submitting invoices to SCFHP. For more details on the invoice submission process, see *Exhibits B-1* and *B-2* 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 I* 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 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 I* in the *Community Supports Vendor Agreement* for more details.

For more information on billing and payment requirements, see the *Community Supports Provider Billing and Payment Guide*.

Provider Credentialing and Oversight

SCFHP is required by DHCS to ensure that each contracted Community Supports provider has the appropriate experience and expertise in providing the required services and serving target populations. See *Exhibits H-1* and *H-2* in the *Community Supports Vendor Agreement* for the credentialing requirements for each Community Supports.

Electronic Visit Verification (EVV)

SCFHP requires all staff and contractors of Community Supports providers who are providing Day Habilitation Programs, Personal Care and Homemaker Services, or Respite Services and who enter a

member's home to deliver such services, to register and use an Electronic Visit Verification (EVV) or the California Electronic Visit Verification (CalEVV) system. These Community Supports providers are required to use an EVV system or CalEVV to verify the type of service performed, the individual receiving the service, the date of service, the location of service delivery, the individual providing the services, and the time the service begins and ends.

If a Community Supports provider wants to use CalEVV, SCFHP will provide training on how to register entities and individuals who are delivering the services. Applicable Community Supports providers must be registered with an EVV system or CalEVV and be ready to use it upon full execution of a *Community Supports Vendor Agreement*.

SECTION A
HOUSING TRANSITION NAVIGATION SERVICES

DESCRIPTION

Housing Transition Navigation Services (HTNS) assist members with finding, applying for, and obtaining housing. The services provided to a member must be based on an individualized assessment of needs and documented in the member's Housing Support Plan (see *Appendix F: Housing Support Plan Requirements*). As such, a member may only require a subset of the following activities.

HTNS activities include:

1. Conducting a housing assessment that identifies the member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the member's housing needs and preferences, potential housing transition strengths and barriers, and identification of housing retention strengths and barriers.
2. Developing a housing support plan based upon the housing assessment.
3. Assisting in searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process. Such service can be subcontracted out to retain any specialized skillset needed.
6. Identifying and securing available resources to assist with attaining housing—such as Transitional Rent, HUD Housing Choice Voucher, and other state and local assistance programs—and matching available resources to members.
7. Identifying and securing resources including but not limited to Housing Deposits, to cover expenses such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses (see Housing Deposits Community Support).
8. Providing education to the member about Fair Housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary.
9. Landlord education and engagement.
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the member with landlords.
12. Assisting in, arranging for, and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptations).

HTNS with ECM: HTNS Community Supports provider should ensure that members who meet the eligibility requirements for HTNS are referred to ECM, and members are highly encouraged to receive both services. The case management provided through HTNS is focused on securing and transitioning members into safe and stable housing that meets the needs and preferences of the member. ECM is broadly focused on coordinating all primary, acute, behavioral, oral, social needs, and long-term services and supports for members. It also includes administering a comprehensive assessment and care

management plan, which is separate and distinct from the housing support plan that is one of the HTNS service activities.

If a member is receiving HTNS and ECM at the same time, the HTNS Community Supports provider must ensure that service delivery is coordinated by the ECM provider to minimize the number of care/case management transitions experienced by the member and to improve overall care coordination and management. A provider can simultaneously provide and receive payment for both HTNS and ECM if they serve as a contracted network provider with SCFHP to provide both services.

HTNS with Housing Deposits: A member can receive both HTNS and Housing Deposits at the same time. SCFHP does not require a member to receive HTNS as a condition of receiving Housing Deposits.

HTNS with Housing Tenancy and Sustaining Services (HTSS): A member cannot receive both HTSS and HTNS at the same time. HTNS Community Supports providers must assist members with obtaining housing while HTSS supports members in maintaining housing. These services form a continuum of supports as a member transitions from finding a home to maintaining it and are often performed by the same organization/case manager. Many members may receive HTNS before receiving HTSS, but HTNS is not a prerequisite for eligibility for HTSS.

HTNS with Transitional Rent: A member can receive both HTNS and Transitional Rent at the same time. All members who are determined to be eligible for Transitional Rent are automatically determined to be eligible for HTNS. HTNS delivery will require close coordination with the Transitional Rent provider, and may also require coordination with the ECM provider, other Community Supports providers, and/or other entities such as local Coordinated Entry System, homeless services authorities, public housing authorities, county agencies (including county behavioral health agencies), and other operators of local rental subsidies.

ELIGIBILITY

The eligibility criteria for HTNS are:

1. Individuals who meet the following social and clinical risk factor requirements:
    a. **Social Risk Factor Requirement:** Experiencing or at risk of homelessness AND
    b. **Clinical Risk Factor Requirement:** Must have one or more of the following qualifying clinical risk factors:
        i. Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS); or
        ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS); or
        iii. One or more serious chronic physical health conditions; or
        iv. One or more physical, intellectual, or developmental disability; or
        v. Individuals who are pregnant up through 12-months postpartum.

OR

2. Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTNS.

OR

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

RESTRICTIONS AND LIMITATIONS

Services do not include the provision of Room and Board or payment of rental assistance.

Services are not subject to the Room and Board provisions.

Actions to be taken under HTNS must be identified as reasonable and necessary in the member's Housing Support Plan (See *Appendix F*).

Members eligible for HTNS can only be authorized one time between January 1, 2026 and December 31, 2026.

While it is appropriate and optimal for members to receive HTNS prior to Housing Deposits and/or Transitional Rent, it is not a prerequisite.

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 Standard Terms and Conditions (STCs) and federal and DHCS guidance.

LICENSING/ALLOWABLE PROVIDERS

Providers must have experience and expertise in 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 all providers who may contract to provide the services.

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

- Vocational services agencies
- Homeless services provider organizations (e.g., supportive housing providers)
- Life skills training and education providers
- County agencies, including county behavioral health agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers
- Social services agencies
- Affordable housing providers
- Federally qualified health centers and rural health clinics
- Public housing agencies

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 not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in *Exhibit H* in the *Community Supports Vendor Agreement.*

SERVICE MODEL

The required HTNS are divided into four categories with the maximum billable units and the associated billing codes per category. Community Supports providers are required to provide any or all the listed

services based on member needs and submit claims or invoices to SCFHP that reflect the services delivered.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Housing Assessment and Plan a. Conduct outreach to the assigned member to engage them in housing navigation services. b. Conduct and document a screening and housing assessment to identify the member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the member's housing needs, potential housing transition barriers, and identification of housing retention barriers. c. Review the member's Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) in Santa Clara County's Homeless Management Information System (HMIS). • If member does not have a completed VI-SPDAT, complete it. • If the member's VI-SPDAT has not been updated within the last 12 months, update the VI-SPDAT. d. Develop an individualized housing support plan based upon the housing assessment that: • Addresses identified barriers including short- and long-term measurable goals for each issue; • Establishes member's approach to meeting the goals; and • Identifies when other providers or services (either reimbursed or not reimbursed by Medi-Cal) may be required to meet the goals.	5 Months	H0043 U6 GQ
2. Housing Search a. Conduct housing searches based on the housing assessment and housing support plan. b. Discuss and present options including all relevant housing options (home, family, or other living arrangement, short-term, and/or permanent supportive housing) to the member. c. Conduct meetings, phone calls, and/or site visits with relevant stakeholders, as needed. d. Assist with completing housing applications and obtaining required documentation. e. Determine if assistance is needed with benefits advocacy and additional resources that help with securing housing.		
3. Resource Assistance a. Assist the member with accessing additional benefits, including assistance with obtaining identification and documentation for Social Security Insurance (SSI) eligibility and supporting the SSI application process, applying for food security resources, and		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
obtaining other services that help the member to obtain and retain housing. b. Identify and secure available resources to assist with subsidizing rent, such as Transitional Rent, a Section 8 housing voucher or state or local assistance resources, and match available rental subsidy resources. c. Monitor changes in needs and accuracy of those needs that may impact the member's VI-SPDAT score and update as needed. d. Continue to provide support and coordination as needed in accordance with the housing support plan. e. Providing education to the member about Fair Housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary. f. Maintain continual communication with the member's care/case manager to keep them updated on the status of securing housing. g. Screen for eligibility for case management programs, such as ECM, SCFHP case management, or other community-based case management programs and assist with applying for a program.		
4. Move-In and Initial Housing Retention a. Confirm the member has a housing unit or space and move-in date. b. Identify and secure resources to cover expenses related to moving in, such as security deposit, moving costs, adaptive aids, environmental modifications, deposits for utilities, and other one-time expenses. c. Identify needs for successful move and housing retention, which may include multiple phone calls, meetings, and possible in-person site visits to support development of a positive relationship with the landlord or property manager. d. Coordinate and advocate for member needs and preferences with community partners, family members, and others. e. Maintain continual communication with the member's care/case manager to keep them updated on the progress made to move into a housing unit. f. Support the member with aspects of the move that may require additional assistance. g. Engage landlord and provide education as needed. h. Coordinate transportation for day-of-the-move as necessary. i. Create a housing support crisis plan with the member that enforces prevention and early intervention services to aid in housing retention. j. Review all agreements with member/family/other supportive individuals, such as lease agreements, housing rules (if	1 Month	H2016 U6 GQ

Service Categories and Required Services	Maximum Billable Units	Billing Codes
applicable), behavioral expectations, tenant rights, expectations for continued financial responsibility, etc. k. Evaluate need and coordinate referrals for additional Community Supports to arrange for asthma remediation services, environmental modifications, and/or housing tenancy and sustaining services.		

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical staff provide services face-to-face in an office, in the community, and phone or video with a 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.
2. Clinical staff provide services when needed based on member needs.
3. Non-clinical and clinical supervision with a caseload of 1:10 non-clinical and clinical staff.
4. Caseloads reflect time spent with or on behalf of members.
5. 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.
6. A billable unit being defined as per member per month (PMPM).
7. The total maximum billable units (PMPM) are 12 months per member per authorization.
8. Costs associated with conducting initial and ongoing outreach to engage and provide services to a member are built into the service delivery payment rates.
9. An administration fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

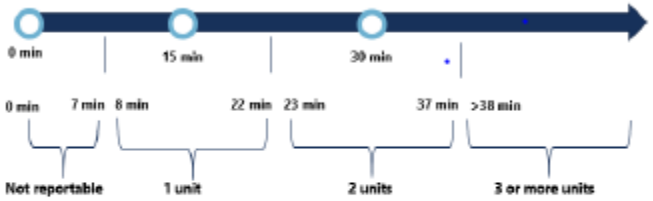
Payment Rates

Initial Outreach	In-Person	Telephonic/Electronic
HCPCS Code	T1016	T1016
Outreach Modifier	U8	U8
Telephonic/Electronic Modifier	None	GQ
Billing Increments	Every 15 Minutes after the 7th Minute	Every 15 Minutes after the 7th Minute
Outreach Attempts	Successful and Unsuccessful	Successful and Unsuccessful
Outreach Method	Outreach conducted in-person with member	Outreach conducted by phone or electronic methods, including text messaging or sending secure emails to the individual member
Payment Rate	$0	$0

Service Category	Service Categories 1-3	Service Category 4
Category Name	1. Housing Assessment and Plan 2. Housing Search 3. Resource Assistance	4. Move-In and Initial Housing Retention
HCPCS Code	H0043	H2016
Service Modifier	U6	U6
Telehealth Modifier	GQ	GQ
Payment Rate	$733	$733
Service Unit	Per Member Per Month (PMPM)	Per Member Per Month (PMPM)
Maximum Billable Units per Authorization	5	1
Maximum Billable Amount per Authorized Member	$3,665	$733
Authorization Period	6 Months	

Billing and Payment Instructions

1. Community Supports providers are expected to report on their successful and unsuccessful outreach efforts to engage a member to initial service delivery. Community Supports providers should not be reporting their ongoing outreach efforts to keep a member engaged in service delivery. Community Supports providers must report initial outreach efforts that last eight or more minutes in 15-minute increments.



- 0-7 minutes – Not reportable
- 8-22 minutes – Equals 1 unit *(following the "rule of eights")*
- 23-37 minutes – Equals 2 units *(following the "rule of eights")*
- >38 minutes – Equals 3 or more units *(continuing to follow "rule of eights")*

2. Community Supports providers must utilize the above HCPCS codes and modifiers for both initial outreach efforts and service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
3. No payment is associated with billing for outreach efforts nor a maximum number of billable units. The cost of conducting initial outreach to engage a member and for ongoing outreach efforts for service delivery are built into the service delivery payment rates.
4. 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. If services are provided via telehealth, the Community Supports provider is required to bill using the GQ modifier.
5. For the *Move-In and Initial Housing Retention* service category, Community Supports providers should only provide and bill for these services if housing is identified and feasible for a member. If

feasible housing is not identified, Community Supports providers should not bill for this service category.

6. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in Payment Rate Tables. See the *Community Supports Billing Guide* for more information on the billing requirements.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing between 1.00-10.00 hours of service per member per month.
2. Clinical Staff: Hourly rate range of $33 - $57 per hour, providing between 0.50-2.00 hours of service per member per month.
3. Non-Clinical Supervision: Hourly rate range of $58 - $70 per hour, providing between 0.50-1.00 hours of service per member per month.
4. Clinical Supervision: Hourly rate range of $59 - $88 per hour, providing between 0.50-1.00 hours of service per member per month.
5. Benefits and retirement costs: Included at 35% of hourly rate.
6. Administrative fee: A 15% fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement for in-person travel to meet SCFHP members.

SECTION B
HOUSING DEPOSITS

DESCRIPTION

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household.

The services and goods provided to a member must be based on an individualized assessment of needs and documented in the member's Housing Support Plan (see *Appendix F: Housing Support Plan Requirements*). As such, a member may only require a subset of these services/goods.

Housing Deposits include:

1. Security deposits required to obtain a lease on an apartment or home.
2. Application fees to cover the cost of the lease application.
3. Set-up fees/deposits for utilities or service access and payment in utility arrears.
4. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, along with necessary minor repairs to meet HUD Housing Choice Voucher program quality standards, or other habitability standards, as applicable, where those costs are not the responsibility of the landlord under applicable law.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individual's health and safety in the home. These can include hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon moving-in to the home, when they are not otherwise available to the member under Medi-Cal.
7. Goods required to establish a basic household.

Housing Deposits with ECM: The Housing Deposit Community Supports providers must ensure that members who meet the eligibility requirements for Housing Deposits are referred to ECM, and members are highly encouraged to receive both services. Housing Deposit Community Supports providers must ensure that service delivery is coordinated by the ECM providers to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.

Housing Deposits with Housing Tenancy and Sustaining Services (HTSS): A member can receive both HTSS and Housing Deposits at the same time.

Housing Deposits with Transitional Rent: A member can receive both Housing Deposits and Transitional Rent in support of the same housing placement. All members who are determined to be eligible for Transitional Rent are automatically determined to be eligible for Housing Deposits. Housing Deposits service delivery will require close coordination with the Transitional Rent Provider and may also require coordination with the ECM provider, other Community Supports providers, and/or other entities such as the local Coordinated Entry System, homeless services authorities, public housing authorities, county agencies (including county behavioral health agencies), and other operators of local rental subsidies.

ELIGIBILITY

The eligibility criteria for Housing Deposits are as follows:

1. Individuals who meet the following social and clinical risk factor requirements:
   A. **Social Risk Factor Requirement:** Experiencing or at risk of homelessness AND
   B. **Clinical Risk Factor Requirement:** Must have one or more of the following qualifying clinical risk factors:
      i. Meets the access criteria for SMHS; or
      ii. Meets the access criteria for DMC or DMC-ODS; or
      iii. One or more serious chronic physical health conditions; or
      iv. One or more physical, intellectual, or developmental disabilities; or
      v. Individuals who are pregnant up through 12-months postpartum.

OR

2. Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTNS.

OR

3. 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:
   A. Disabilities and/or
   B. One or more serious chronic conditions and/or
   C. Serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or
   D. Is exiting incarceration.

RESTRICTIONS AND LIMITATIONS

Services do not include the provision of Room and Board or payment of rental assistance.

Housing Deposits are available once in a five-year period. 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.

Community Supports shall supplement and not supplant services received by the Medi-Cal or Medicare 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 in providing these unique services in a culturally and linguistically appropriate manner. Examples of the type of providers that may provide Housing Deposits are:

- County agencies, including county behavioral health agencies
- Flex Pools
- Homeless services provider organizations (e.g., supportive housing providers)
- Social services agencies
- Affordable housing providers
- Public housing agencies
- Other providers of services for individuals experiencing homelessness

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 not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit H in the *Community Supports Vendor Agreement.*

Members who meet the eligibility requirements for Housing Deposits should be assessed for ECM and Housing and Tenancy Support Services. When enrolled in ECM, Community Supports providers are expected to deliver the housing services in coordination and collaboration with ECM providers. When members receive more than one Community Supports housing service, services must be coordinated by the assigned ECM provider or case manager whenever possible to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.

SERVICE MODEL

The required Housing Deposit services are divided into two categories with the maximum billable units and the associated billing codes identified per category. Community Supports providers are required to provide any or all the listed services based on member needs.

Important for Referral Submission to SCFHP

For referrals for Housing Deposits, SCFHP requires the referring entity to conduct an initial assessment to determine what is needed by a member to move into the pre-identified housing unit and identify the estimated expenses in the following six cost categories, if applicable, based on member need:

1. Deposit and/or first month's cost for utilities and payment for utilities in the arrears (maximum reimbursement is $500),
2. Security deposit (maximum reimbursement is $3,446[1]),
3. Application fees to cover the cost of the lease application (maximum reimbursement is $100),
4. Health and safety services (pest eradication and/or one-time cleaning prior to occupancy; maximum reimbursement is $2,000),
5. Goods such as an air conditioner or health and other medically-necessary adaptive aids and services, designed to preserve an individual's health and safety in the home (e.g., hospital beds, Hoyer lifts, air filters, etc.) (maximum reimbursement is $500), and
6. Goods required to set up a basic household (maximum reimbursement is $1,500)

The referring entity must submit the assessment and a cost estimate of each item requested broken down into the six cost categories with the referral. Once SCFHP receives the referral and cost estimate, the Community Supports team reviews for eligibility determination and appropriateness of the items included in the cost estimate. If authorized for services, the Community Supports team will provide written approval of the cost estimate. The total cost estimate cannot exceed $9,000 per member per authorization.

Important for Claims Submission by Community Supports Provider

Community Supports providers are expected to submit a single comprehensive invoice with the:

1. Staffing reimbursement that does not exceed $749 per member per authorization,
2. Approved cost estimate by cost category submitted with the referral,

[1] Based upon the FY 2025 Santa Clara County Fair Market Rate, the average rent for a two-bedroom unit is $3,446.

3. Actual costs incurred by cost category for which the provider is seeking reimbursement and does not exceed $8,251 per member per authorization, and
4. Invoices and receipts that validate each cost incurred by the provider.

It is expected that the Community Supports provider adheres as closely to the approved cost estimate as possible. Once SCFHP's Community Supports team receives the invoice and required documentation, they review and provide written approval. If the Community Supports provider receives written approval from SCFHP, the provider can submit a single claim for the total amount that they are seeking reimbursement. If SCFHP does not approve the invoice, the Community Supports team will work with the Community Supports provider to address any concerns with the incurred costs and review any subsequently submitted revisions to a single comprehensive invoice with the intent of granting approval to submit a single claim for the total approved amount.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Move-In Readiness a. Review the housing support plan, and ensure it is appropriate, accurate, and timely. (Note: If there is not a housing support plan in place, coordinate the development of one with the member's ECM provider or case manager.) b. Verify the need for obtaining documentation (contract/lease agreement) in writing for required deposit, services, or goods that may include a security deposit 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), and first and last month's rent as required by landlord or property manager for occupancy. c. With the member, determine if the monthly rent is reasonable and affordable. d. Determine if there are any restrictions and ongoing costs and inform the member. e. Arrange for any necessary services for the member's health and safety, such as pest eradication and one-time cleaning prior to occupancy. f. Arrange for the purchase of necessary goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve the member's health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies, etc., that are necessary to ensure access and safety for the member upon move-in to the unit. g. For pest eradication, cleaning, and/or equipment/products that address pest issues, and/or asthma remediation, consult SCFHP for separate Community Supports services that may address these issues. h. Ensure that the member understands that Housing Deposits Community Support is once in a lifetime.	3 Months	H0044 U2 GQ

Service Categories and Required Services	Maximum Billable Units	Billing Codes
i. Submit a referral to SCFHP for Housing Tenancy and Sustaining Services Community Support. j. Assess the member for need and eligibility for other Community Supports and submit referrals for needed services.		
2. Housing Deposit a. Arrange for the payment to cover the requirements set forth by the landlord, which may include but is not limited to: • Rent for first and/or last month • Security deposit • Set up fees/deposits for utilities • First month coverage of utilities (e.g., telephone, gas, electricity, heating, water) • Goods like air conditioner/heater/air filters or pest control supplies. b. Ensure first and last month's rent and/or security deposit is paid to the landlord or property manager and not to the member. c. Obtain appropriate documentation confirming the landlord or property manager's receipt of first and last month's rent and/or security deposit. d. Collect all receipts, invoices, lease/rental agreements, confirmations of security deposits and/or first and last month's rent, and other documentation that confirm the amounts paid to all entities for incurred costs required to move in and maintain all documentation for auditing purposes conducted by SCFHP.		

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical staff who provide face-to-face services in an office, in the community, and via phone or video to coordinate the housing deposits and related services.
2. Non-clinical supervision of non-clinical staff.
3. The cost to meet move-in requirements may include but are not limited to deposit, utility set up fees, utility costs for the first month, and goods and services needed for the individual's initial move-in.
4. According to the FY 2025 Santa Clara County Fair Market Rate, the average rent for a two-bedroom unit is $3,446.
5. A billable unit being defined as the total amount that the Community Supports provider is seeking reimbursement from SCFHP.
6. The total maximum number of billable units that Community Supports providers can bill is 1 unit. Community Supports providers must adhere to the instructions in the Service Model Section relating to first obtaining approval of a cost estimate at the point of referral and then a second approval prior to submitting a claim for reimbursement.
7. The total maximum reimbursement amount is $9,000 per member per authorization.

8. Costs associated with conducting initial and ongoing outreach to engage and provide services to a member are built into the service delivery payment rates.
9. An administration fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

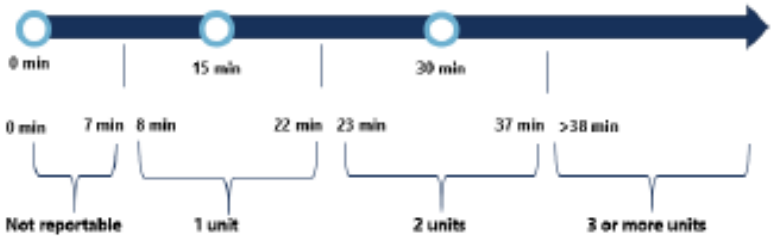
Payment Rates

Initial Outreach	In-Person	Telephonic/Electronic
HCPCS Code	T1016	T1016
Outreach Modifier	U8	U8
Telephonic/Electronic Modifier	None	GQ
Billing Increments	Every 15 Minutes after the 7th Minute	Every 15 Minutes after the 7th Minute
Outreach Attempts	Successful and Unsuccessful	Successful and Unsuccessful
Outreach Method	Outreach conducted in-person with member	Outreach conducted by phone or electronic methods, including text messaging or sending secure emails to the individual member
Payment Rate	$0	$0

Service Category	Service Categories 1-2
Category Name	1. Move-In Readiness 2. Housing Deposit
HCPCS Code	H0044
Service Modifier	U2
Telephonic/Electronic Modifier	GQ
Payment Rate	Actual Amount
Service Unit	Total Costs Per Member
Maximum Billable Units per Authorization	1
Maximum Billable Amount per Authorized Member	$9,000
Authorization Period	6 Months

Billing and Payment Information

1. Community Supports providers are expected to report on their successful and unsuccessful outreach efforts to engage a member for initial service delivery. Community Supports providers should not report their ongoing outreach efforts to keep a member engaged in service delivery. Community Supports providers must report initial outreach efforts that last eight or more minutes in 15-minute increments.



- 0-7 minutes – Not reportable
- 8-22 minutes – Equals 1 unit *(following the "rule of eights")*
- 23-37 minutes – Equals 2 units *(following the "rule of eights")*
- >38 minutes – Equals 3 or more units *(continuing to follow "rule of eights")*

2. Community Supports providers must utilize the above HCPCS codes and modifiers for both initial outreach efforts and service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
3. No payment is associated with billing for outreach efforts nor a maximum number of billable units. The cost of conducting initial outreach to engage a member and for ongoing outreach efforts for service delivery are built into the service delivery payment rates.
4. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in Payment Rate Tables. See the *Community Supports Billing Guide* for more information on the billing requirements.
5. 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. If services are provided via telehealth, the Community Supports provider is required to bill using the GQ modifier.
6. SCFHP expects Community Supports providers to bill only a single claim once SCFHP provides written approval after reviewing a comprehensive invoice. See the *Service Model* section for all of the requirements. The total maximum billable amount is $10,645 per member per authorization, which includes staffing costs that are reimbursable to the provider at a maximum amount of $749 per member per authorization.
7. Returned Security Deposit:
   If a landlord or property manager returns a security deposit to the Community Supports provider, the expectation is that the money goes towards another member needing a housing deposit once authorized.
   a. If a landlord or property manager returns a security deposit directly to a member, the member must sign a document stating that they understand that the returned money must be used for a future security deposit as a member can only receive this service once per lifetime.
   b. The Community Supports provider is responsible for maintaining all documentation that tracks the receipt and re-release of a security deposit and is subject to auditing by SCFHP to ensure adherence to all requirements.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing up to 12.50 hours of service during the entire duration of the services being delivered.

2. Non-Clinical Supervision: Hourly rate range of $58 - $70 per hour, providing between 0.50 and 1.00 hours of service during the entire duration of the services being delivered.
3. Benefits and retirement costs: Included at 35% of hourly rate.
4. Administrative fee: A 15% fee includes overhead/indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement for in-person travel to meet with SCFHP members.

SECTION C
HOUSING TENANCY AND SUSTAINING SERVICES

DESCRIPTION

Housing Tenancy and Sustaining Services (HTSS) help a member maintain safe and stable tenancy once housing is secured.

The services provided to a member must be based on an individualized assessment of needs and documented in the member's Housing Support Plan (*see Appendix F: Housing Support Plan Requirements*). As such, a member may only require a subset of the following activities.

HTSS activities include:

1. Providing early identification and intervention for behaviors that may jeopardize housing stability and/or violate the lease, such as late rental payment, hoarding, substance use, etc.
2. Providing education and training to the member on the role, rights, and responsibilities of the tenant and landlord.
3. Providing education to the member about Fair Housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary.
4. Coaching the member on developing and maintaining key relationships with landlords/property managers and/or neighbors with a goal of fostering successful tenancy.
5. Coordinating with the landlord and care/case management provider, which can be the member's ECM Provider or non-Medi-Cal housing supportive services providers such as a Continuum of Care (CoC) program case manager, to address identified issues that could impact housing stability.
6. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action, such as developing a repayment plan or identifying funding in situations in which the member owes back rent or payment for damage to the unit.
7. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
8. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted to retain any specialized skillset needed.
9. Assistance with the annual housing recertification process.
10. Coordinating with the member to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
11. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
12. Health and safety visits, including ensuring the unit remains safe and habitable.
13. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).
14. Providing independent living and life skills including assistance with and training in budgeting, including financial literacy and connection to community resources.

HTSS with ECM: HTSS Community Supports providers must ensure that members who meet the eligibility requirements for HTSS are referred to ECM, and members are highly encouraged to receive both services. The case management provided through HTSS is focused on maintaining safe and stable

tenancy for a member once housing has been secured. ECM is broadly focused on coordinating all primary, acute, behavioral, oral, social needs, and long-term services and supports for members, and includes administering a comprehensive assessment and care management plan, which is separate and distinct from the housing support plan that the HTSS is responsible for updating and maintaining.
If a member is receiving both HTSS and ECM at the same time, HTSS Community Supports providers must ensure that service delivery is coordinated by the ECM providers to minimize the number of care/case management transitions experienced by the member and to improve overall care coordination and management.

HTSS with HTNS: A member cannot receive both HTSS and HTNS at the same time; HTNS assists members with obtaining housing while HTSS supports members in maintaining housing. These services form a continuum of supports as a member transitions from finding a home to maintaining it and are often performed by the same organization/case manager. Many members may receive HTNS before receiving HTSS, but HTNS is not a prerequisite for eligibility for HTSS.

HTSS with Housing Deposits: A member can receive both HTSS and Housing Deposits at the same time.

HTSS with Transitional Rent: A member can receive both HTSS and Transitional Rent at the same time. All members who are determined to be eligible for Transitional Rent are automatically determined to be eligible for HTSS. The service delivery of HTSS Community Supports providers will require close coordination with the Transitional Rent provider, the landlord, and may also require coordination with other entities such as the local Coordinated Entry System, homeless services authorities, public housing authorities, county behavioral health agencies, and other operators of local rental subsidies.

ELIGIBILITY

The eligibility criteria for HTSS are:

1. Individuals who meet the following social and clinical risk factor requirements:
    a. **Social Risk Factor Requirement:** Experiencing or at risk of homelessness AND
    b. **Clinical Risk Factor Requirement:** Must have one or more of the following qualifying clinical risk factors:
        i. Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS); or
        ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS); or
        iii. One or more serious chronic physical health conditions; or
        iv. One or more physical, intellectual, or developmental disabilities; or
        v. Individuals who are pregnant up through 12-months postpartum.

OR

2. Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTNS.

OR

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

RESTRICTIONS AND LIMITATIONS

Services do not include the provision of Room and Board.

These services must be identified as reasonable and necessary in the member's Housing Support Plan. Members eligible for HTNS can only be authorized two times in six-month consecutive increments between January 1, 2026, and December 31, 2027.

Many individuals will have also received HTNS (at a minimum, the associated tenant screening, housing assessment, and housing support plan) before this service, but it is not a prerequisite for eligibility. Community Supports shall supplement and not supplant services received by the Medi-Cal or Medicare 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 in 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 all providers who may contract to provide the services.

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

- Vocational services agencies
- Homeless services provider organizations (e.g., supportive housing providers)
- Life skills training and education providers
- County agencies, including county behavioral health agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers
- Social services agencies
- Affordable housing providers
- Federally qualified health centers and rural health clinics
- CoC-affiliated entities
- Public housing agencies

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 not a 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.*

SERVICE MODEL

The required HTSS are divided into three categories with the maximum billable units and the associated billing codes identified per category. Community Supports providers are required to provide any or all the listed services based on the member's needs and submit claims or invoices to SCFHP that reflect the services delivered.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Engagement and Assessment a. Conduct outreach to the assigned member to engage them in housing tenancy and sustaining services. b. Conduct a tenant screening and housing assessment to provide early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations. c. Update the member's housing support plan. d. Develop a housing crisis plan, if needed. e. Identify other providers or services that may be needed to meet and maintain goals as stated in the housing support plan. f. Complete a Homeless Preventive Assessment Tool (HPAT), if applicable. g. Assess the member for need and eligibility for other Community Supports and submit referrals for needed services. h. Communicate status of receiving housing tenancy and sustaining services to the ECM provider or case/care manager.	4 Months	T2051 U6 GQ
2. Tenant Education and Advocacy a. Provide education and training on the role, rights, and responsibilities of a tenant and landlord. b. Providing education for the member about Fair Housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary. c. Coach member on developing and maintaining key relationships with landlord or property manager with a goal of fostering successful tenancy. d. Coordinating with the landlord and care/case management provider, which can be the member's ECM Provider or non-Medi- Cal housing supportive services providers such as a CoC program case manager, to address identified issues that could impact housing stability. e. Advocate for and link the member to community resources to prevent eviction when housing is or may potentially become jeopardized in the future. f. Assist with the annual housing recertification process and health and safety visits, including unit habitability inspections (if applicable). g. Communicate with the landlord or property manager to address identified issues that could impact housing stability.		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
h. Coordinate with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. i. Assist with accessing other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).		
3. Financial Support and Resources a. Provide education and support with independent living and life skills, on budgeting, including financial literacy and connection to community resources. b. Assist in resolving disputes with landlords or property manager 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. c. Assist with benefits advocacy, including assistance with obtaining identification and documentation for Social Security Insurance (SSI) eligibility and supporting the SSI application process. d. Continue assistance with lease compliance, including ongoing support with activities related to household management. e. Connect the member to other financial resources that help them retain their housing.	2 Months	T2050 U6 GQ

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical staff provide face-to-face services in an office, in the community, and via phone or video with 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.
2. Clinical staff who provide services when needed based on member needs.
3. Non-clinical and clinical supervision with a caseload of 1:10 non-clinical and clinical staff.
4. Caseloads reflect time spent with or on behalf of members.
5. 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.
6. A billable unit being defined as per member per month (PMPM).

7. The total maximum billable units (PMPM) are 12 months per authorization for services for a member. If needed, Community Supports providers may submit a referral for another 12 months of services if needed by the member.
8. Costs associated with conducting initial and ongoing outreach to engage and provide services to a member are built into the service delivery payment rates.
9. An administrative fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Initial Outreach	In-Person	Telephonic/Electronic
HCPCS Code	T1016	T1016
Outreach Modifier	U8	U8
Telephonic/Electronic Modifier	None	GQ
Billing Increments	Every 15 Minutes after the 7th Minute	Every 15 Minutes after the 7th Minute
Outreach Attempts	Successful and Unsuccessful	Successful and Unsuccessful
Outreach Method	Outreach conducted in-person with member	Outreach conducted by phone or electronic methods, including text messaging or sending secure emails to the individual member
Payment Rate	$0	$0

Service Category	Service Categories 1-2	Service Category 3
Category Name	1. Engagement and Assessment 2. Tenant Education and Advocacy	3. Financial Support and Resources
HCPCS Code	T2051	T2050
Service Modifier	U6	U6
Telehealth Modifier	GQ	GQ
Payment Rate	$646	$646
Service Unit	Per Member Per Month (PMPM)	Per Member Per Month (PMPM)
Maximum Billable Units per Authorization	4	2
Maximum Billable Amount per Authorized Member	$2,584	$1,292
Authorization Period	6 Months	

Billing and Payment Instructions

1. Community Supports providers are expected to report on their successful and unsuccessful outreach efforts to engage a member in initial service delivery. Community Supports providers should not report their ongoing outreach efforts to keep a member engaged in service delivery. Community Supports providers must report initial outreach efforts that last eight or more minutes in 15-minute increments.

- 0-7 minutes – Not reportable
- 8-22 minutes – Equals 1 unit *(following the "rule of eights")*
- 23-37 minutes – Equals 2 units *(following the "rule of eights")*
- >38 minutes – Equals 3 or more units *(continuing to follow "rule of eights")*

2. Community Supports providers must utilize the above HCPCS codes and modifiers for both initial outreach efforts and service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
3. No payment is associated with billing for outreach efforts nor a maximum number of billable units. The cost of conducting initial outreach to engage a member and for ongoing outreach efforts for service delivery are built into the service delivery payment rates.
4. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in the Payment Rate tables. See the *Community Supports Billing Guide* for more information on the billing requirements.
5. 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. If services are provided via telehealth, the Community Supports provider is required to bill using the GQ modifier.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing between 6.00-9.00 hours of service per member per month.
2. Clinical Staff: Hourly rate range of $33 - $57 per hour, providing between 0.50-1.50 hours of service per member per month.
3. Non-Clinical Supervision: Hourly rate range of $58 - $70 per hour, providing between 0.50-1.00 hours of service per member per month.
4. Clinical Supervision: Hourly rate range of $59 - $88 per hour, providing between 0.50-1.00 hours of service per member per month.
5. Benefits and retirement costs: Included at 35% of hourly rate.
6. Administrative fee: A 15% fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement for in-person travel to meet SCFHP members.

SECTION D
MEDICALLY TAILORED MEALS/MEDICALLY SUPPORTIVE FOOD (MTM/MSF)

DESCRIPTION

Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address a member's chronic or other serious conditions that are nutrition-sensitive, leading to improved health outcomes and reduced unnecessary costs.

Medically Tailored Meals and Groceries: MTMs and Medically Tailored Groceries (MTGs) (MTM going forward refers to both MTMs and MTGs) are covered by this service and defined as follows:

- MTMs: Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.
- MTGs: Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

The provision of MTMs must include an individual assessment of the member's nutrition-sensitive condition and nutritional needs conducted or supervised by Registered Dietitian Nutritionist (RDN) to inform the development of a nutritional plan and connection to the appropriate MTM services.
The design of each of the MTM services (e.g., uncontrolled diabetes meal plan, congestive heart failure grocery plan) must be tailored by an RDN or other appropriate clinician to ensure the food provided adheres to established, evidence-based nutrition guidelines to prevent, manage, or reverse the targeted nutrition-sensitive health condition(s).

Members can receive a combination of MTMs and MTGs based on need.

Medically Supportive Food (MSF): MSF is defined as packages of foods that adhere to national nutrition guidelines to prevent, manage, or reverse nutrition-sensitive conditions of referred members. Unlike MTM, MSF is intended to supplement, rather than replace, all or most of a member's diet.

The design or selection of foods or food options in MSF services must be overseen and signed off on by an RDN or another appropriate clinician. RDNs do not need to oversee the assembly of each grocery box or produce prescription, but, for example, should provide or review the nutrition parameters of the types of foods to be included or approved for the food packages for the targeted conditions. Though MSF food packages do not need to meet minimum nutrient and energy requirements, Community Supports providers that provide MSF should design food packages to support participants to meet minimum recommendations for fruit, vegetables, or other targeted daily servings for nutrients.

1. The categories of MSF are defined as follows: *Medically Supportive Groceries*: Preselected foods that follow the federal Dietary Guidelines for Americans (DGA) and meet recommendations for the nutrition-sensitive health conditions of the member to whom they are prescribed.
2. *Produce Prescriptions*: Fruits and vegetables, typically procured in retail settings, such as grocery stores or farmers' markets, obtained via a financial mechanism such as a physical or electronic voucher or card.
3. *Healthy Food Vouchers*: Vouchers used to procure pre-selected foods that follow the DGA and meet recommendations for the nutrition-sensitive health conditions of the member, via retail settings such as grocery stores or farmers' markets.
4. *Food Pharmacy*: A model that specifically combines MSF and nutrition supports to remove barriers to healthy eating and build the knowledge and skills of participants to cook and eat

foods appropriate for their nutrition-sensitive conditions. Food pharmacies are often housed within (or managed by) a health care setting, providing a patient cohort with coordinated clinical, food, and nutrition education services targeted at specific nutrition-sensitive health conditions. The healthy food "prescription" includes access to a selection of specific whole foods appropriate for the specific chronic or serious health condition(s) that follow the DGA and meet recommendations for the targeted health condition(s). The food is typically paired with peer supports, nutrition education, counseling, and/or culinary classes to build cooking and healthy eating skills and habits.

Community Supports providers must ensure that MTM and MSF service packages are tailored or designed at the service level for the identified target chronic or serious health conditions (e.g., MSF recommended and tailored for a member with chronic heart failure, or the Dietary Approaches to Stop Hypertension (DASH) diet for a member with hypertension who may benefit from a low sodium diet). Meals, groceries, produce, prescriptions, or nutritional intervention packages do not need to be individually customized for each member but must be appropriate based on evidence-based guidelines for the targeted nutrition-sensitive health conditions(s) for which the MTM/MSF service is intended to improve.

Community Support providers must consider the cultural preferences/needs (e.g., halal or kosher meals) and food preparation and storage capabilities (e.g., ability to store frozen meals) of each individual member when determining the appropriate MTM/MSF intervention for a member.

Nutrition Education

Health coaching, counseling, classes, behavioral supports, and tools, including equipment and materials, that are based on a member's health conditions and needs. The requirements for nutrition education are as follows:

- Any nutrition education offered must adhere to nationally established, evidence-based nutrition guidelines and be approved by an RDN or other appropriate clinician. The education must be appropriate to a member's chronic or serious health condition and the MTM/MSF intervention the member is receiving. Nutrition education can be provided in an individual or group setting. Nutrition education classes do not need to be delivered by an RDN. The organization delivering nutrition education may be the same as the organization providing the MTM/MSF but is not required to be the same organization.
- Nutrition education provided as part of this service does not supplant other Medi-Cal services. MCPs are encouraged to identify and refer members who are receiving MTM/MSF Community Support services to other Medi-Cal covered services for which they may be eligible such as Medical Nutrition Therapy and Diabetes Self-Management Education.

Food Requirements

All Community Supports MTM/MSF providers must adhere to the following food requirements with SCFHP monitoring for strict compliance with the requirements:

1. The MTM assistance provided (singularly or in a combination of meals and groceries) must meet at least two-thirds of the daily nutrient and energy needs of an average individual, as estimated by the RDN/clinician overseeing the design of the MTM services.
2. "Medically tailored" interventions must be provided in specified quantities to constitute most of the member's diet over the course of the intervention to have the intended impact on health outcomes.
3. MTM must not contain ultra-processed foods nor foods with excessive sugar or salt.

Provider Monitoring

SCFHP is required to monitor all Community Supports MTM/MSF providers to ensure compliance with the requirements of delivering MTM/MSF services. As such, SCFHP will collect documentation from providers to manage the oversight of:

- Nutrition standards used by providers
- Nutritional information on MTM/MSF, including macro- and/or micro-nutrient thresholds
- Average energy content and ingredients
- Food preparation licensure, recent inspection records, and/or food safety violations
- Service locations, meal production location, transparency in units of food
- Member adherence with MTM/MSF interventions and improved health outcomes

ELIGIBILITY

The eligibility criterion for MTM/MSF is: Individuals who have (a) chronic or other serious health condition(s) that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes with an A1C of 9.0 or higher in the last 90 days or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

IMPORTANT: Members referred to MTM/MSF will first be authorized (approved) for Nutritional Counseling so members can be assessed by a RDN to confirm their eligibility and determine the appropriate food service. If MTM or MSF is recommended, the Nutritional Counseling provider will send a recommendation to SCFHP with an appropriate food provider assignment based on the cultural preferences and dietary restrictions of the member.

RESTRICTIONS AND LIMITATIONS

The restrictions and limitations of MTM/MSF are:

- Service covers up to two (2) meals and/or meal packages per day using a combination of MTMs and MSF interventions.
- MTM/MSF can be authorized for up to twelve (12) weeks and may be reauthorized thereafter if medically necessary. Community Supports providers are required to check in with members who are receiving this MTM/MSF services at a more frequent cadence to assess whether members are obtaining and eating the foods/meals provided through this Community Support, and whether any changes need to be made to improve the effectiveness of the MTM/MSF.

Since MTM/MSF services are delivered as part of a member's clinical care to address or mitigate nutritional needs from a chronic or serious health condition, they are not covered in responding solely to food insecurities.

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 in 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 contract to provide the services:

- MTM providers
- MSF and nutrition providers such as produce prescription services providers
- Medically Tailored or supportive grocery providers (e.g., food banks)
- Home delivered meal providers
- Area Agencies on Aging
- Nutrition services providers with expertise serving pregnant and postpartum individuals
- Nutritional Education Services to help sustain healthy cooking and eating habits

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 not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit H in the *Community Supports Vendor Agreement.*

Members who meet the eligibility requirements for MTM/MSF services should be assessed for Enhanced Care Management (ECM). When enrolled in ECM, Community Supports providers are expected to deliver all required services in coordination and collaboration with ECM providers. When members receive more than one Community Support and/or ECM services, the services must be coordinated by the assigned ECM provider or case manager whenever possible to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.

SERVICE MODEL

The required MTM/MSF services are divided into four categories with the maximum billable units and the associated billing codes identified per category. Community Supports providers are required to provide any or all the services listed based on the member's need and submit claims or invoices to SCFHP that reflect the services delivered.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Nutritional Counseling a. Using a registered dietitian (RD), conduct an initial assessment to determine the risk level of the member (low, medium, high) and the appropriate services needed to address concerns with the member being able to monitor (a) chronic condition(s) and become self-sufficient. b. Assess food and nutrition needs and assist with accessing appropriate local and federal resources including but not limited to CalFresh/SNAP, WIC, food banks, and other free or low-cost food resources.	Up to 12 Units	S9470 U6 GQ

Service Categories and Required Services	Maximum Billable Units	Billing Codes
c. Assess the home setting of the member to ensure the recommended MTM/MSF are appropriate for storage and reheating. d. Determine the type of MTM/MSF is appropriate to meet the unique dietary needs for those with chronic diseases. e. Prepare and submit a referral to SCFHP for authorization and assignment to one of SCFHP's contracted food providers for the coordination and delivery of the recommended food services. f. Work collaboratively and in conjunction with SCFHP's food providers to ensure a streamlined delivery of food services and effective communication between the member, RD, and assigned food provider. g. Continue to provide nutritional counseling sessions as needed to the member to promote self-sustainability and autonomy. h. Communicate the outcome of the nutrition counseling sessions to the ECM provider or care/case manager if applicable. i. Provide access to personalized, digital meal planning and grocery shopping tools that will educate and empower the member to make nutritious meals to promote autonomy, empowerment, and self-efficacy around food in the long term, if needed.		
2. Medically Tailored Meals a. Accept the authorized recommendation from SCFHP's nutritional counseling provider. b. Provide the recommended and authorized meal services. c. Ensure that the meal services meet the following requirements: i. Are tailored by an RD or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes. ii. Meet the unique dietary needs of those with chronic diseases that follow nationally recognized dietary standards. d. Meet national dietary standards immediately following discharge from a hospital or nursing home when member is most vulnerable to re-admission. Conduct periodic wellness checks that gather member feedback and/or assess for possible safety issues or other concerns. Any information received during the wellness check should be communicated to the assigned ECM provider, care/case manager, member's authorized representative/emergency contact person, and/or SCFHP as applicable.	Up to 2 Meals Per Day for Up to 12 Weeks or a Total of 168 Meals	S5170 U6 GQ

Service Categories and Required Services	Maximum Billable Units	Billing Codes
e. Communicate the outcome of the delivery of meal services to the ECM provider or care/case manager if applicable. f. Coordinate with nutritional counseling provider to determine if an extension of MTM is needed based on medical necessity.		
3. Medically-Supportive Food a. Prepare medically-appropriate groceries that will provide enough food to make two (2) meals per day for seven (7) days per week that meets at least 75% of the daily nutritional needs for an individual (protein, dairy, fruits, vegetables, and non-perishable items). b. Deliver groceries or arrange for groceries to be picked up on a weekly basis or a frequency agreed upon with the member. c. Conduct periodic wellness checks that gather member feedback and/or assess for possible safety issues or other concerns. Any information received during the wellness check should be communicated to the assigned ECM provider, care/case manager, member's authorized representative/emergency contact person, and/or SCFHP as applicable. d. Communicate the outcome of the delivery of meal services to the ECM provider or care/case manager if applicable. e. Coordinate with nutritional counseling provider to determine if an extension of MSF is needed based on medical necessity.	Up to 12 Weeks	S9977 U6 GQ
4. Nutritional Education Services a. Assess the meals and food services being provided and determine what type of education would complement and assist the member in managing their chronic conditions and becoming more self-sufficient. b. Provide behavioral, cooking, or other nutritional education in alignment with a member receiving medically tailored meals or medically supportive food by food providers and nutritional counseling by nutritional counseling provider. c. Communicate the outcome of the nutritional education services to the ECM provider or care/case manager if applicable. d. Coordinate with nutritional counseling provider to determine if an extension of nutritional education services is needed based on medical necessity.	Up to 12 Units	S9470 U6 GQ

PAYMENT GUIDE

The payment approach includes:

1. 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.
2. The cost of conducting wellness checks is included in the payment rates and is defined as a weekly in-person visit or phone call to briefly:
   i. Assess possible safety issues (unsafe conditions in the home, recent falls/injuries),

ii. Confirm ability to continue receiving meals or food and be able to store and reheat the food, and
iii. Assess unusual behavior (confusion, emotional/crying/yelling) through the dissemination of a questionnaire containing 10 or less questions.

3. A billable unit being defined as:
   i. Nutritional Counseling – 15-minute increment
   ii. Medically-Tailored Meals – one meal
   iii. Medically-Supportive Food – one week of groceries
   iv. Nutritional Education Services – 15-minute increment
4. The total maximum billable units are:
   i. Nutritional Counseling – 12 sessions or a total of 3 hours
   ii. Medically-Tailored Meals – 2 meals per day for 12 weeks or 168 meals
   iii. Medically-Supportive Food – weekly groceries for 12 weeks
   iv. Nutritional Education Services – 12 sessions or a total of 3 hours
5. An administration fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Service Category	Service Category 1	Service Category 2	Service Category 3	Service Category 4
Category Name	1. Nutritional Counseling	2. Nutrition Education Services	3. Medically Tailored Meals	4. Medically-Supportive Food
HCPCS Code	S9470	S9470	S5170	S9977
Service Modifier	U6	U6	U6	U6
Telehealth Modifier	GQ	GQ	None	None
Payment Rate	$48	$48	$15	$115
Service Unit	Per 15-minute increment	Per 15-Minute Increment	Per Meal	Per Weekly Grocery Delivery
Maximum Billable Units per Authorization	12	12	168	12
Maximum Billable Amount per Authorized Member	$576	$576	$2,520	$1,380
Authorization Period	6 Months			

Billing and Payment Instructions

1. For the *Nutritional Counseling* and *Nutritional Education Services* categories, Community Supports providers should only bill for a maximum number of billable units of six (6) per category.
2. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in Payment Rate Table. See the *Community Supports Billing Guide* for more information on the billing requirements.
3. 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. If services are provided via telehealth, the Community Supports provider is required to bill using the GQ modifier.

Cost Drivers and Assumptions

1. Nutritional Counseling: RD at $192 per hour.
2. Meal: Staff, staff supervision, food costs, delivery and transportation at $15.00 per meal.
3. Groceries: Staff, staff supervision, food costs, delivery and transportation at $115 per weekly grocery delivery.
4. Nutritional Education Services: RD or another qualified individual at $192 per hour.
5. Administrative fee: A 15% fee that includes overhead/indirect costs and staff training related to the provision of Community Supports services.

SECTION E
ASSISTED LIVING FACILTY (ALF) TRANSITIONS

DESCRIPTION

Assisted Living Facility (ALF) Transitions (formerly known as "Nursing Facility Transition/Diversion to Assisted Living Facilities such as Residential Care Facilities for the Elderly and Adult Residential Facilities") Community Support is designed to assist individuals living in the community and/or avoid institutionalization when possible.

The goal of the services is to facilitate nursing facility transition back into a home-like, community setting, and/or to prevent skilled nursing admissions for members living in the community. The service is intended for individuals with an imminent need for nursing facility level of care (LOC) and is intended to provide a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility.

For the purposes of this service definition, the term assisted living facility (ALF) includes a Residential Care Facility for the Elderly (RCFE) or an Adult Residential Care Facility (ARF). This service includes the following two components:

1. **Time-limited transition services and expenses** to enable a person to establish a residence in an ALF. Transition service ends once the member establishes residency in an ALF. The transition period will vary in length and services provided based on a member's unique circumstances. Allowable expenses are those necessary to enable a member to establish an ALF residence (except room and board), including, but not limited to:
    - Assessing a member's housing needs and presenting them with options.
    - Assessing the service needs of a member to determine if they need enhanced on-site services at the ALF, so the member can safely and stably be housed.
    - Assisting in securing an ALF residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
    - Moving expenses to support a member's transition, such as movers/moving supplies and necessary private/personal articles to establish an ALF residence.
    - Communicating with facility administration and coordinating the move.
    - Establishing procedures and contacts to retain housing at the ALF.
    - Coordinating with SCFHP to ensure if that member needing enhanced services has access to other Community Supports and/or Enhanced Care Management (ECM) services that provide the necessary enhanced services.

2. **Ongoing assisted living services** are provided to members on an ongoing basis after they transition into the ALF. Members can receive these services indefinitely, if the member can maintain residency in the ALF. These services include:
    - Assistance with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs)
    - Meal preparation
    - Transportation
    - Medication administration and oversight
    - Companion services
    - Therapeutic social and recreational programming provided in a home-like environment

- 24-hour direct care staff onsite at the ALF to meet unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security
- Care coordination services to screen for eligibility and support enrollment of members in ECM and other Community Supports

ELIGIBILITY

Eligible members for ALF Transitions are those:

- Members residing in a nursing facility who:
  - Have resided 60+ days in a nursing facility; and
  - Are willing to live in an assisted living setting as an alternative to a nursing facility; and
  - Can reside safely in an ALF.
- Members residing in the community who:
  - Are interested in remaining in the community; and
  - Are willing and able to reside safely in an ALF; and
  - Meet the minimum criteria to receive nursing facility LOC services and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF.

Members residing in the community include members living in a private residence or public subsidized housing and members already residing in an ALF who are at risk of institutionalization.

Members who receive facility level health care services on an acute or post-acute care basis (such as hospitalization or a short-term skilled nursing facility stay) may be eligible for this Community Support, provided they otherwise meet the eligibility criteria.

Members receiving this service may also be eligible for other Community Supports. Community Supports providers should work with members' ECM, SCFHP, or other case managers to ensure they appropriately screen and refer members for services for which they may be eligible. For example, members can be connected to Housing Transition Navigation Services at the same time as the time-limited transition component of this service (if they meet eligibility criteria) if the activities provided are distinct and not duplicative between the Community Supports services.

RESTRICTIONS AND LIMITATIONS

Room and board expenses are not included in this service. Members may receive assistance with room and board from other sources at the same time as receiving this service. Additional details on how members can obtain assistance for payment of room and board when residing in an ALF can be found on the DHCS ALW website.

Assisted Living Waiver (ALF) and California Community Transitions (CCT) Enrollment: A member can be eligible for both the ALW and CCT program and this service; however, they cannot receive both at the same time. Community Supports providers are encouraged to assist members with enrollment in eligible and available waiver programs, such as the ALW, as appropriate. Community Supports providers are required to coordinate with ALW providers to avoid overlapping service delivery and to facilitate seamless transitions when members move between the two programs. For example, for a member transitioning out of a nursing facility who is awaiting enrollment in the ALW may use the time-limited transition component of this Community Support to support their transition to the ALF. The member

may then use the ongoing assisted living services component of this Community Support to support their services received from the ALF until their enrollment in the ALW is completed. Members who are on the ALW waiting list are eligible for this Community Supports.

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 in 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 is not an exhaustive list of providers who may contract to provide the services:

- Case management agencies
- Home health agencies
- ARF/RCFE operators
- 1915c Home & Community Based Alternatives (HCBAs)/ALW providers
- CCT/Money Follows the Person providers

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

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 H in the *Community Supports Vendor Agreement.*

SERVICE MODEL

The required services for ALF Transitions are divided into three categories with the maximum billable units and the associated billing codes per category. Community Supports providers are required to provide any or all the services listed based on member needs and submit claims or invoices to SCFHP that reflect the services rendered.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Transition Services a. Verify the member meets eligibility for RCFE placement. b. Determine availability for placement in an RCFE. If there is no availability, the member will be put on a waitlist. c. Review or conduct a housing assessment that includes discussing with the member options for transitioning to an assisted living alternative and determining if the member is a good candidate for RCFE placement. d. Assist the member with completing an application for a facility and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).	3 Months	T2038 U4 GQ

Service Categories and Required Services	Maximum Billable Units	Billing Codes
e. Identify appropriate RCFE to meet the member's needs. (Note: SOC 602 is required for admission to a RCFE). f. Coordinate referrals for health plan benefits (home health, occupational therapy, physical therapy, long-term services and supports) and community resources (e.g., Community Supports) as needed. g. Assist the member with accessing additional benefits and identification documentation, such as Social Security Insurance (SSI) eligibility, CalFresh, cash aid, birth certificate, prior rental history, etc. h. Conduct site visits with the member, as needed. i. Participate in interdisciplinary team (IDT) meetings with the member, facility, RCFE/ARF staff, and other relevant stakeholders. The estimate is two to three IDT meetings in total. j. Determine if member requires enhanced services to be safely and stably housed in an RCFE/ARF and coordinate with SCFHP to ensure member is enrolled in Community Supports and/or ECM to meet the member needs. k. Assist the member with applying for the Assisted Living Waiver (ALW) for continued financial support, if the member has not yet done so. l. Review all agreements with member/family/other supportive individuals, such as RCFE/ARF agreement, housing rules (if applicable), behavioral expectations, tenant rights, expectations for continued financial responsibility, etc. m. Communicate with facility administration and coordinate the move. n. Establish procedures and contacts to retain facility housing. o. Assess for transition out of needing Community Supports and determine if additional support is needed through Community Supports. p. Refer the member to ECM if not currently enrolled or to other community-based case management entities for continued service. q. Send email to SCFHP to confirm the transition is complete within one (1) business day of the completed transition.		
2. RCFE Support Assessment a. Coordinate with facility to arrange for support with ADLs and/or IADLs. b. Conduct assessment to confirm specific needs for enhanced services that the member requires while residing in an RCFE. c. Ensure that the member meets eligibility criteria for purchase of enhanced services by the RCFE. d. Ensure that the member is assigned to an ECM provider. e. Develop a support/care plan that includes short- and long-term measurable goals to address the need for enhanced services.		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
f. Provide ongoing monitoring of enhanced service delivery based on a designated timeframe specified by SCFHP.		
3. Moving Expense Purchase and Coordination a. Assess the moving needs of the member for their transition, such as movers and moving supplies. b. Select appropriate moving company and schedule them. c. Coordinate the packing of the member's personal belongings. d. Coordinate and purchase the private/personal items to establish an ALF residence. e. Ensure all private/personal items get delivered/transferred to the ALF residence. f. Pay the movers.		
4. RCFE Enhanced Services a. Assist the member with enrollment in eligible and available waiver programs, such as the Assisted Living Waiver (ALW), as appropriate. b. Coordinate with ALW providers to avoid overlapping service delivery and to facilitate seamless transitions when the member moves between the ALF Transitions Community Supports and ALW or another program. c. Determine if referrals are needed to be submitted for additional Community Supports. d. Coordinate direct payment from SCFHP to RCFE for enhanced services provided by the RCFE.	6 Months	H2022 U5

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical staff who provide face-to-face services where it is appropriate to meet with members with a caseload of 1:20 to 1:30 individuals concurrently. The caseload range in DHCS's *Community Supports Pricing Guide* varies from 1:20 to 1:30 individuals concurrently.
2. Clinical staff who provide services when needed based on member need.
3. Non-clinical and clinical supervision with a caseload of 1:10 non-clinical and clinical staff.
4. Caseloads reflect time spent with or on behalf of members.
5. A billable unit being defined as per member per month.
6. For Service Categories 1 and 2, the total maximum billable units (PMPM) are 6 months per member per authorization.
7. For Service Category 3, the total maximum billable units (PMPM) are 6 months per member per authorization.
8. A one-time cost of $500 to cover the cost of packing up and moving a member's belonging to an ALF and the purchasing of items to establish residency in an ALF.
9. An administrative fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Service Category	Service Categories 1-2	Service Category 3
Category Name	1. Transition Services 2. RCFE Support Assessment 3. Moving Expense Purchase and Coordination	4. RCFE Enhanced Services
HCPCS Code	T2038	H2022
Service Modifier	U4	U5
Telehealth Modifier	GQ	None
Payment Rate	$1,605	$4,468
Service Unit	Per Member Per Month (PMPM)	Per Member Per Month (PMPM)
Maximum Billable Units per Authorization	3	6
Maximum Billable Amount per Authorized Member	$4,815	$26,808
Authorization Period	9 Months	

Billing and Payment Instructions

1. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in Payment Rate Table. See the *Community Supports Billing Guide* for more information on the billing requirements.
2. All direct payments from SCFHP to a RCFE pass through the Community Supports provider. The payment in its entirety must be sent directly to the RCFE or ARF.
3. 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. If services are provided via telehealth, the Community Supports provider is required to bill using the GQ modifier.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing between 3.00-7.00 hours per member per month.
2. Clinical Staff: Hourly rate range of $33 - $57 per hour providing between 6.00-10.00 hours per member per month.
3. Non-Clinical Supervision: Hourly rate range of $58 - $70 per hour providing between 1.00-3.00 hours per member per month.
4. Clinical Supervision: Hourly rate range of $59 - $88 per hour providing between 2.00-3.00 hours per member per month.
5. Benefits and retirement costs: Included at 35% of hourly rate.
6. Administrative fee: A 15% administrative fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement for in-person travel to meet SCFHP members.
7. For Service Category 3, the direct payment to a RCFE for enhanced services is based on an average rate between the ALW tiers 3 and 4, which results in a daily rate of $148.92.

SECTION F
COMMUNITY OR HOME TRANSITION SERVICES

DESCRIPTION

Community or Home Transition Services (formerly known as "Community Transition Services/Nursing Facility Transition to a Home") helps members live in the community and avoid further institutionalization in a nursing facility.

Community or Home Transition Services supports members in transitioning from a license nursing facility to a living arrangement in a private residence or public subsidized housing where members are responsible for identifying funding for their living expenses. This service covers non-recurring set-up expenses necessary for members to establish a basic household.

This service includes two components. They are as follows:

1. **Time-limited transition services and expenses** to enable a member to transition from a licensed facility to a private residence or public subsidized housing. Each transitional period will vary in length and services provided based on a member's unique circumstances. Services include:
   - Assessing a member for housing needs and presenting options.
   - Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
   - Communicating with a landlord (if applicable) and coordinating the move.
   - Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist member with mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
   - Identifying the need and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

2. **Non-recurring, set up expenses** are those necessary to enable a member to establish a basic household that does not constitute room and board and include:
   - Security deposits required to obtain a lease for an apartment or home. Security deposits should be in alignment with AB-12 enacted in 2024;
   - Set-up fees for utilities or service access and up to six months' payment in utility arrears, as necessary to secure the unit;
   - Services necessary for the member's health and safety, such as pest eradication and one-time cleaning prior to occupancy, and necessary repairs to meet Housing Choice Voucher program quality standards where those costs are not the responsibility of the landlord under applicable law;
   - Air conditioner or heater; and
   - Adaptive aids designed to preserve the member's health and safety in the home, such as hospital beds, Hoyer lifts, bedside commode, shower chair, traction, or non-skid strips, etc., that are necessary to ensure access and safety for the member upon move-in to the home, when they are not otherwise available to the member under Medi-Cal (e.g., State Plan, HCBS waiver, etc.).

3. Note that Community Supports providers may not limit this service to only component 1 or component 2 and must provide both to the extent that they are applicable to each member.

Coordinated Referrals

If a member needs:

- *Housing Navigation:* Refer the member to Housing Navigation Transition Services prior to referring to Community or Home Transition Services to obtain assistance with completing a housing assessment plan, searching for housing, and securing resources. Once a housing unit is identified, the member should be referred for these transition services.
- *Housing Deposits:* Refer the member to Housing Deposits while receiving Community or Home Transition Services to coordinate the funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as security deposits required to obtain a lease for an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the member's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
- *Asthma Remediation:* Refer the member to Asthma Remediation while receiving Community or Home Transition Services for assessment and coordination of products and services needed for the housing unit to properly manage their asthma.
- *Home Modifications:* Refer the member to Environmental Accessibility Adaptations (Home Modifications) while receiving Community or Home Transition Services for coordinating items such as an air conditioner or heater, and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.
- *Housing Tenancy and Sustaining Services:* Refer the member to Housing Tenancy and Sustaining Services once the member is moved into the housing unit to assist them with maintaining safe and stable housing once secured.

ELIGIBILITY

The eligibility criteria for Community or Home Transition 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 a medical respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
2. Has lived 60+ days in a nursing home and/or medical respite setting; and
3. Is interested in moving back to the community; and
4. Is able to reside safely in the community with appropriate and cost-effective supports and services.

RESTRICTIONS AND LIMITATIONS

The following are the restrictions and limitations for Community or Home Transition Services:

- Does 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.
- Are payable up to a total lifetime maximum amount of $7,500. The only exception to the $7,500 total maximum is if the member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond their control.
- 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.

A member can be eligible for relevant waiver/demonstration programs (e.g., California Community Transitions (CCT) Program, Home & Community Based Alternatives, etc.) and this Community Support; however, they cannot receive both at the same time if activities provided under each program are duplicative.

Community or Home Transition Services are not intended to replace Transitional Care Services (TCS), which SCFHP provides for members transitioning from one setting or LOC to another under the Population Health Management (PHM) program. For members already enrolled in Enhanced Care Management (ECM) during the time of transition, the ECM Lead Care Manager provides all necessary TCS and coordinates Community or Home Transition Services with the assigned Community Supports provider on the member's behalf.

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. 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 contract to provide the services:

- Case management agencies
- Home health agencies
- County-operated or county behavioral health providers
- 1915c Home and Community Based Alternatives (HCBA)/Assisted Living Waiver (ALW) providers
- California Community Transitions (CCT)/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 H in the *Community Supports Vendor Agreement.*

SERVICE MODEL

The required Community or Home Transition Services are divided into two categories with the maximum billable units and the associated billing codes per category. 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 services rendered.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Pre-Transition Coordination a. Identify, coordinate, secure, or fund non-emergency, non-medical transportation to assist the member with their mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.	6 months	T2038 U5 GQ

Service Categories and Required Services	Maximum Billable Units	Billing Codes
b. Identify the need for and coordinate funding for environmental modifications to install necessary accommodations for accessibility by submitting a referral for Environmental Accessibility Adaptations (Home Modifications) and/or Asthma Remediation Community Supports. c. Identify the need for and coordinate funding for a one-time cleaning prior to occupancy. d. Refer the member for other Community Supports based on need. e. Assist the member with accessing additional benefits and identification documentation, such as SSI eligibility and application process, CalFresh, cash aid, documentation, etc. f. Submit a referral for Housing Deposits Community Supports for assistance with security deposit, first/last month's rent, set-up fees of utilities, and goods to establish a basic household. g. Participate in interdisciplinary team (IDT) meetings with the member, facility representative, and other relevant stakeholders. The expected estimate is two to three IDT meetings in total. h. If the member does not have identified housing, refer them to Housing Navigation Transition Services Community Supports before providing these services and notify SCFHP. i. Refer the member to Enhanced Care Management (ECM) if eligible and not currently enrolled.		
2. Transition Services a. Discuss timing and logistics of the move, which could include in-person and/or telephonic meetings with the member, nursing facility staff, member's supportive individuals, and the landlord (if applicable) to coordinate a successful transition. b. Create a housing support crisis plan with the member that reinforces prevention/early intervention services to aid in housing retention. c. Review all agreements with the member/family/other supportive individuals, such as the lease agreement, housing rules (if applicable), behavioral expectations, tenant rights, expectations for continued financial responsibility, etc. d. Arrange for transportation, as needed. e. Evaluate the need and coordinate referrals for additional Community Supports, such as Housing Tenancy and Sustaining Services.		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
f. Send an email to SCFHP to confirm the transition is complete within one (1) business day of the completed transition.		

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical staff who provide transition education and support services face-to-face where it is appropriate to meet with members or by phone or other technology with a caseload of 1:25 individuals concurrently. The caseload range in DHCS's *Community Supports Pricing Guide* varies from 1:20 to 1:30 individuals concurrently.
2. Clinical staff who provide services when needed based on member need.
3. Non-clinical and clinical supervision with a caseload of 1:10 non-clinical and clinical staff
4. Clinical supervision of non-clinical staff at a caseload of 1:10 non-clinical staff.
5. Caseloads reflect time spent with or on behalf of members.
6. A billable unit is defined as per member per month (PMPM).
7. The maximum billable units (PMPM) is 6 months per member per authorization.
8. An administrative fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Service Category	Service Categories 1-2
Category Name	1. Pre-Transition Coordination 2. Transition Services
HCPCS Code	T2038
Service Modifier	U5
Telehealth Modifier	GQ
Payment Rate	$1,153
Service Unit	Per Member Per Month (PMPM)
Maximum Billable Units per Authorization	6
Maximum Billable Amount per Authorized Member	$6,918
Authorization Period	6 Months

Billing and Payment Instructions

1. Community Supports providers must utilize the above HCPCS codes and modifiers for both initial outreach efforts and service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
2. No payment is associated with billing for outreach efforts nor a maximum number of billable units. The cost of conducting initial outreach to engage a member and for ongoing outreach efforts for service delivery are built into the service delivery payment rates.
3. Community Supports providers are expected to bill using only the designated code and modifier as reflected in Payment Rate Table. See the *Community Supports Billing Guide* for more information on the billing requirements.

4. 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. If services are provided via telehealth, the Community Supports provider is required to bill using the GQ modifier.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing between 2.00-8.00 hours per member per month.
2. Clinical Staff: Hourly rate range of $33 - $57 per hour providing between 2.00-7.00 hours per member per month.
3. Non-Clinical Supervision: Hourly rate range of $58 - $70 per hour providing between 1.00-3.00 hours per member per month.
4. Clinical Supervision: Hourly rate range of $59 - $88 per hour providing between 1.00-2.00 hours per member per month.
5. Benefits and retirement costs: Included at 35% of hourly rate.
6. Administrative fee: A 15% administrative fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement for in-person travel to meet SCFHP members.

SECTION G
DAY HABILITATION PROGRAMS

DESCRIPTION

Day Habilitation Programs are designed to assist a member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to successfully reside in their natural environment. The services are provided in a member's home or an out-of-home, non-facility setting. The services are often considered peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision.

For members experiencing homelessness who are receiving Enhanced Care Management (ECM) or other Community Supports, Day Habilitation Programs can provide a physical location for members to meet, and engage, with these providers. If possible, these services are provided by the same entity to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.

Day Habilitation Program includes, but are not limited to, member training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Obtaining and maintaining employment;
6. Daily living skills (cooking, cleaning, shopping, money management); and
7. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include member assistance with, but not limited to, the following:

1. Selecting and moving into a home;
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords;
5. Managing personal financial affairs;
6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordinating with SCFHP to link the member to any Community Supports and/or ECM services;
11. Providing a referral to non-Community Supports resources if the member does not meet the eligibility criteria for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, or Transitional Rent;
12. Assisting with income and benefits advocacy including General Assistance/General Relief and Social Security Insurance (SSI) if the member is not receiving these services through Community Supports or ECM; and

13. Coordinating with SCFHP to link the member to health care, mental health services, and Substance Use Disorder services based on the individual needs of the member for members who are not receiving this linkage through Community Supports or ECM.

Program services are available for as long as necessary. SCFHP authorizes services for a designated amount of time with the opportunity to extend that period based on member needs. Services should be person-centered and can be provided through any combination of the following: continuously, intermittently, an individual or group setting, in person or virtually, set curriculum that includes set classes or customized to provide services when needed.

For Day Habilitation Programs delivered in class settings, Community Supports providers are expected to track attendance and have members sign in. All attendance records are required to be kept on file for seven (7) years and should be available upon request by SCFHP. Certificates for completed classes should be provided to members upon completion.

The services provided should utilize best practices for members who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Day Habilitation and Housing Trio
Community Supports providers delivering Day Habilitation services to authorized members should assess assigned members for the need for housing-related services and supports. If members are determined to be eligible for Community Supports Housing Trio services (Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services), the providers must submit referrals to SCFHP for the appropriate housing services based on member needs.

Day Habilitation and ECM
Community Supports providers delivering Day Habilitation Programs to authorized members should assess assigned members for the need for ECM. If members are determined as needing care management and are not currently eligible for or enrolled in ECM, the providers must submit a referral to SCFHP for ECM.

Employees or contractors of Community Supports providers that deliver Day Habilitation Programs are required by DHCS to register and use an Electronic Visit Verification (EVV) or the California Electronic Visit Verification (CalEVV) system if they enter a member's home to:

- Conduct an assessment or in-home visit;
- Deliver and/or install products;
- Provide services of any kind; and/or
- Provide education, instructions, or trainings.

EVV systems are telephone and computer-based systems that electronically verify that in-home service visits occur. They verify the type of service performed, the individual receiving the service, the date of service, the location of service delivery, the individual providing the services, and the time the service begins and ends. If Community Supports providers want to use CalEVV, SCFHP will provide training on

how to register entities and individuals who are delivering the services. Applicable Community Supports providers must be registered with an EVV system or CalEVV and be ready to use it upon full execution of a *Community Supports Vendor Agreement.*

ELIGIBILITY

The eligibility criteria for Day Habilitation Programs are:

- Individuals who are experiencing homelessness, or
- Individuals who exited homelessness and entered housing in the last 24 months.

RESTRICTIONS AND LIMITATIONS

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 in 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 contract to provide the services.

- County agencies, including county behavioral health agencies
- Mental health or substance use disorder treatment providers
- Community-based providers, including federally qualified health centers
- Vocational skills agencies
- Licensed clinicians with capacity and training in providing Day Habilitation Services to eligible members, including licensed psychologists, licensed certified social workers, and registered nurses
  - Home health agencies,
  - Professional fiduciary

SERVICE MODEL

The required Day Habilitation services are divided into five distinct categories with the maximum billable units and the associated billing codes shown per category. Community Supports providers are required to provide any or all the listed services based on the member's needs and submit claims or invoices to SCFHP that reflect the service delivered.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Habilitation Education a. Provide training or resources to assist the member with acquiring living skills and achieving independence, such as: • The use of public transportation; • Personal skills development in conflict resolution; • Community participation; • Developing and maintaining interpersonal relationships;	40 Hours	T2012 U6 GQ

Service Categories and Required Services	Maximum Billable Units	Billing Codes
• Daily living skills (cooking, cleaning, shopping, budgeting, money management); • Community resource awareness such as police, fire, or local services to support independence in the community; and • Other education that help members acquire living skills, engage in appropriate behavior, and achieve greater independence. b. Provide training or resources to assist the member with securing and retaining housing, such as: • Selecting and moving into a home • Locating and choosing suitable housemates • Locating household furnishings • Settling disputes with landlords • Managing personal financial affairs, and • Other education that assists with retaining housing. c. If eligible, submit and monitor referrals to Community Supports housing services (Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services). If ineligible, submit and monitor referrals to non-Community Supports housing resources. d. For all Day Habilitation education provided to a member in a home setting: • Ensure the assigned educator has access to and is ready to utilize an EVV or the CalEVV system prior to delivering education to a member in a home for the first time, and • Ensure continued use of an EVV or the CalEVV system for every subsequent education provided to a member in a home setting.		
2. Pre-Vocational Education a. Provide training and resources that assist the member with developing independence, responsibility, and work and life readiness, such as: • Time management; • Communication skills and personal responsibility; • Goal setting, adaptability, decision-making, and stress management; • Problem solving and task initiation; • Social skills, self-advocacy, and safety awareness; • Job readiness, workplace etiquette, and technology use; and • Other education that support a member with preparing for greater independence, responsibility, and work readiness.		T2024 U6 GQ

Service Categories and Required Services	Maximum Billable Units	Billing Codes
e. For all Day Habilitation education provided to a member in a home setting: • Ensure the assigned educator has access to and is ready to utilize an EVV or the CalEVV system prior to delivering education to a member in a home for the first time, and • Ensure continued use of an EVV or the CalEVV system for every subsequent education provided to a member in a home setting.		
3. Supported Employment Education a. Provide training or resources that assist a member with obtaining employment skills, such as: • Developing job skills; • How to focus a job search related to current skill set, talents, and core values; • Resume development; • Networking strategies; • Interview preparation that may include an overview of different interview types, effective interviewing techniques, how to present accomplishments, and mock interviews; • Navigating job offers; • Job success and retention strategies; and • Other education that assists a member with gaining skills needed to secure employment. b. For all Day Habilitation education provided to a member in a home setting: • Ensure the assigned educator has access to and is ready to utilize an EVV or the CalEVV system prior to delivering education to a member in a home for the first time, and • Ensure continued use of an EVV or the CalEVV system for every subsequent education provided to a member in a home setting.		T2018 U6 GQ
4. Ongoing Support to Maintain Employment a. Provide education or resources that support a member with maintained employment, such as: • Self-regulation, • Being a team player, • Motivation and communication skills, • How to resolve a dispute or conflict in the workplace, • How to ask for help, and • Other education that will help a member maintain employment. b. For all Day Habilitation education provided to a member in a home setting:		H2026 U6 GQ

Service Categories and Required Services	Maximum Billable Units	Billing Codes
• Ensure the assigned educator has access to and is ready to utilize an EVV or the CalEVV system prior to delivering education to a member in a home for the first time, and • Ensure continued use of an EVV or the CalEVV system for every subsequent education provided to a member in a home setting.		
5. Skills Training and Development a. Provide education and resources to assist a member with developing self-advocacy, such as: • Recruiting, screening, hiring, training, supervising, and dismissing caregivers; • Dealing with and responding appropriately to governmental agencies and personnel; • Asserting civil and statutory rights through self-advocacy; • Building and maintaining interpersonal relationships, including a circle of support (a group of people that share a common goal to contribute to the well-being of the member); • Coordination with SCFHP to link the member to any Community Supports and/or Enhanced Care Management (ECM) services for which the member may be eligible; • Assistance with income and benefits advocacy including General Assistance/General Relief and Social Security Insurance (SSI) if member is not receiving these services through Community Supports or ECM; • Coordination with SCFHP to link the member to heath care, mental health services, substance use disorder services based on the individual need of the member for those who are not receiving these services through Community Supports or ECM; and • Any other education that will assist a member with gaining the skills to advocate for themselves. b. For all Day Habilitation education provided to a member in a home setting: • Ensure the assigned educator has access to and is ready to utilize an EVV or the CalEVV system prior to delivering education to a member in a home for the first time, and c. Ensure continued use of an EVV or the CalEVV system for every subsequent education provided to a member in a home setting.	10 Hours	H2014 U6 GQ

PAYMENT GUIDE

The payment approach includes:

1. The education or resources described in the service categories do not require clinical staff in any capacity.
2. The services may be provided and billed for a single one-time service per authorized member.
3. Community Supports providers may bill for services provided either individually or in a group setting. SCFHP defines a group as two (2) or more SCFHP members who receive services at the same time from the same staff member either in-person or virtually.
4. A billable unit being defined as:
    - Service Categories 1, 2, 3, and 4 – a 60-minute increment of time.
    - Service Category 5 – a 15-minute increment of time.
5. SCFHP does not incorporate overtime pay into the payment rate for any of the required services. It is the responsibility of the Community Supports provider to account for any overtime pay as part of its cost of doing business.
6. An administration fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Service Category	Service Category 1	Service Category 2	Service Category 3	Service Category 4
Category Name	Habilitation Education	Pre-Vocational Education	Supported Employment Education	Ongoing Support to Maintain Employment
HCPCS Code	T2012	T2014	T2018	H2026
Service Modifier	U6	U6	U6	U6
Telephonic/Electronic Modifier	GQ	GQ	GQ	GQ
Payment Rate	$49	$49	$49	$49
Service Unit	Per Diem	Per Diem	Per Diem	Per Diem
Maximum Billable Units per Authorization	40 Units			
Maximum Billable Amount per Authorized Member	$1,960			
Authorization Period	12 Months			

Service Category	Service Category 5
Category Name	Skills Training and Development
HCPCS Code	H2014
Service Modifier	U6
Telephonic/Electronic Modifier	GQ
Payment Rate	$12.25
Service Unit	Per 15 Minutes
Maximum Billable Units per Authorization	40 Units

Service Category	Service Category 5
Maximum Billable Amount per Authorized Member	$490
Authorization Period	12 Months

Billing and Payment Instructions

1. Community Supports providers must utilize the above HCPCS codes and modifiers for both initial outreach efforts and service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
2. No payment is associated with billing for outreach efforts nor a maximum number of billable units. The cost of conducting initial outreach to engage a member and for ongoing outreach efforts for service delivery are built into the service delivery payment rates.
3. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in Payment Rate Tables. See the *Community Supports Billing Guide* for more information on the billing requirements.
4. 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. If services are provided via telehealth, the Community Supports provider is required to bill using the GQ modifier.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing either services within 15-minute increments of time or on an hourly basis.
2. Benefits and retirement costs: Included at 35% of hourly rate.
3. Administrative fee: A 15% fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement for in-person travel to meet SCFHP members.

SECTION H
ASTHMA REMEDIATION

DESCRIPTION

Asthma Remediation can prevent acute asthma episodes that could result in the need for emergency services and hospitalization of a member. The Asthma Remediation Community Support consists of supplies and/or physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of a member, or to enable a member to function in the home with reduced likelihood of experiencing acute asthma episodes.

Asthma Remediation should supplement the Asthma Preventive Services (APS) Medi-Cal State Plan service. APS covers clinic-based asthma self-management education, home-based asthma self-management education, and in-home environmental trigger assessments that identify physical modifications to a home or supplies that would reduce the likelihood of acute asthma episodes.

Examples of Asthma Remediation goods and services provided through this Community Supports include:

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

The services are available in a home that is owned, rented, leased, or occupied by the member or their caregiver. Services provided to a member need not be carried out at the same time but may be spread over time, subject to lifetime maximums.

Members must utilize the APS Medi-Cal benefit for in-home environmental trigger assessments and asthma self-management education rather than those services being utilized under Asthma Remediation Community Supports. The APS services are defined as:

- In-home environmental trigger assessments are defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants. This assessment guides the supplies, home modifications, and asthma self-management education about actions to mitigate or control environmental exposures offered to the member.
- Asthma self-management education can include, but is not limited to:
    - Teaching members how to manage their asthma, including how to use inhalers
    - Teaching members how to identify environmental triggers commonly found in their own home, including allergens and irritants
    - Informing members about various options for reducing environmental triggers such as using dust-proof mattresses and pillow covers, asthma- friendly cleaning products, air filters, etc.

The Centers for Disease Control (CDC), the Environmental Protection Agency (EPA), and the Housing and Urban Development (HUD) collaborated to develop and issue an asthma trigger checklist. Community

Supports providers are encouraged to use this checklist to determine the appropriateness of the recommended interventions.

ELIGIBILITY

The eligibility criterion is that a member must have a completed in-home environmental trigger assessment within the last 12 months through the APS benefit that identifies needed medically appropriate asthma remediations and specifies how those interventions meet the needs of the member.

The referring entity and/or Community Supports provider must submit the in-home environmental trigger assessment with documentation that attests to the medical appropriateness of the asthma remediations for SCFHP to review and authorize prior to providing any products and/or services.

RESTRICTIONS AND LIMITATIONS

The following are limitations set forth by DHCS on Asthma Remediation services:

- If another Medi-Cal or Medicare benefit such as Durable Medical Equipment (DME) is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, then the member is ineligible for Asthma Remediation under Community Supports.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the member's condition has changed so significantly that those additional modifications are necessary to:
    - Ensure the health, welfare, and safety of the member, or
    - Enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.
- Asthma Remediation modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household.
- Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the Community Supports provider must provide the owner and member with written documentation that the modifications are permanent, and that SCFHP is not responsible for maintenance or repair of any modification nor for removal of any modification if the member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to allergen impermeable mattress and pillow dust covers, high-efficiency particulate air (HEPA) filtered vacuums, de-humidifiers, portable air filters, and asthma-friendly cleaning products and supplies.

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

LICENSING/ALLOWABLE PROVIDERS

Asthma Remediation services must be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise in providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers that may contract to provide the services:

- Lung health organizations
- Healthy housing organizations
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- SCFHP applies the minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. SCFHP monitors the provision of all the services provided under this Community Supports.
- All allowable providers must be approved by SCFHP to ensure adequate experience and appropriate quality of care standards are maintained.

Asthma Remediation providers must enroll in the Medi-Cal program to continue providing in-home trigger assessments and asthma self-management education under the APS benefit.

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 not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit H in the *Community Supports Vendor Agreement.*

SERVICE MODEL

The required Asthma Remediation services are divided into five separate categories with the maximum billable units and the associated billing codes shown per category. Community Supports providers are required to provide any or all the listed services based on member needs and submit claims or invoices to SCFHP that reflect the services delivered.

Important for Referral Submission to SCFHP

For referrals for Asthma Remediation, SCFHP requires the referring entity to use the order from a licensed health care provider, the written evaluation, and the home visit to determine what is needed by a member to enable them to function in their home without acute asthma episodes divided into the following cost categories:

1. Asthma remediation products, and
2. Asthma remediation intervention services.

The referring entity must submit a cost estimate of each item and service requested divided into the two cost categories with the referral. Once SCFHP receives the referral and cost estimate, the Community Supports team reviews for eligibility determination and appropriateness of the items included in the cost estimate. If authorized for services, the Community Supports team will provide written approval of the cost estimate. The total cost estimate cannot exceed $7,500 per member per lifetime.

Important for Claims Submission by Community Supports Provider

Community Supports providers are expected to submit a single comprehensive invoice with the:

1. Staffing reimbursement that does not exceed $1,524 per member per lifetime,

2. Approved cost estimate by the two cost categories submitted with the referral, and
3. Invoices and receipts that validate each cost incurred by the provider with the total not to exceed $7,500.

It is expected that the Community Supports provider adheres as closely to the approved cost estimate as possible. Once SCFHP's Community Supports team receives the invoice and required documentation, they review and provide written approval. If the Community Supports provider receives written approval from SCFHP, the provider can submit a single claim for the total amount for which they are seeking reimbursement. If SCFHP does not approve the invoice, the Community Supports team will work with the Community Supports provider to address any concerns with the incurred costs and review any subsequently submitted revisions to a single comprehensive invoice with the intent of granting approval to submit a single claim for the total approved amount.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Document Collection a. Ensure the member has all the following documentation to meet eligibility for asthma remediation: • Order from a licensed medical provider specifying requested service. • Written evaluation describing how and why the service meets the member's needs. • Proof that a home visit was conducted and the Asthma In-Home Assessment was provided to verify the sustainability of the service requested. b. Inform and collect a consent document from both the landlord and member. The consent document must contain the following statement, "I understand that all modifications are permanent and Santa Clara Family Health Plan is not responsible for any maintenance, repairs, or removal of any modifications in which they have paid for under any circumstances." If the owner/landlord refuses to consent to modifications, document the reason(s) and contact SCFHP to discuss next steps.	1 Unit	S5165 U5 GQ
2. Asthma Remediation Product Coordination a. Based on the Asthma In-Home Assessment, determine the appropriate product(s), size, quantities, and/or brand or vendor. b. Order or purchase items. The acceptable items are listed in Service Category 3. c. When appropriate, purchase a three-month supply for products that need to be replaced in some regularity (e.g., filters, cleaning supplies, etc.). d. Discuss with the member the features of the items and/or equipment to ensure member can comfortably use them (e.g., different features on a HEPA-filtered vacuum). e. Coordinate product delivery, including verifying the mailing address that the product(s) should be delivered to, providing the expected delivery date and time, and closely monitoring order to ensure delivery of all product(s).		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
f. Provide the member and/or caregiver education and necessary training to set up, install, use, maintain, and provide details on reordering any products provided, if applicable. g. Follow up to ensure the correct product(s) was/were delivered to the member's home. If incorrect product/s were delivered, follow up with vendor to correct the error. Evaluate the member's needs and coordinate referrals for additional Community Supports for which the member may benefit from and be eligible. Evaluate the need for continued ongoing support, such as Enhanced Care Management (ECM) or other community case management services and make referrals to ensure the member engages with provider(s).		
3. Asthma Remediation Product Purchase a. Purchase any of the following products based on the In-Home Asthma Assessment: • Allergen-impermeable mattress and pillow dustcovers • High-efficient HEPA mechanical filtered vacuums • De-humidifiers • Mechanical air filters/air cleaners, • Asthma-friendly cleaning products and supplies. b. Adhere to the maximum cost guidelines as described in the *Cost Drivers and Assumptions* section. c. Retain receipts for all purchased products to submit with a single comprehensive invoice to SCFHP for approval prior to submitting a single claim.		
4. Home Asthma Remediation Intervention Services Coordination a. Based on the In-Home Asthma Assessment, determine the appropriate service(s) that will address potential asthma-related health and safety issues with in-person or video verification. A list of home asthma remediation services is in Service Category 5. b. Confirm services are cost-efficient, reasonable, and an effective option. c. Identify, coordinate, and secure an appropriate vendor for needed home services to address potential asthma-related health and safety issues. When possible, obtain at least two estimates/bids. d. Facilitate necessary preparation of the home to ensure the vendor can provide services prior to the vendor arriving. This may include, but is not limited to moving large items/furniture out of the way or to another room, ridding of clutter, cleaning surfaces, etc. e. Ensure the member is aware of the date and time that the vendor will arrive at their home. f. Follow up with the vendor and member to ensure services are rendered.		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
g. Provide additional assistance and submit appropriate referrals to ECM provider, case manager, or other community-based entities providing care coordination to the member, if needed.		
5. Home Asthma Remediation Services Purchase a. Purchase any of the following services based on the In-Home Asthma Assessment: • Integrated Pest Management (IPM) services • Other moisture-controlling interventions • Minor mold removal and remediation services • Ventilation improvements • Other interventions identified to be medically appropriate and cost effective b. Adhere to the maximum cost guidelines as described in the *Cost Drivers and Assumptions* section. c. Retain receipts for all purchased services to submit with a single comprehensive invoice to SCFHP for approval prior to submitting a single claim.		

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical staff who provide services in person with a 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.
2. Clinical staff who provide services when needed based on member need.
3. Non-clinical and clinical supervision with a caseload of 1:10 non-clinical and clinical staff.
4. A billable unit is defined as 12 months.
5. Community Supports providers are reimbursed the actual cost of the asthma remediation products and asthma remediation home services.
6. Community Supports providers must ensure that the entities that perform the asthma home services/modifications are licensed, bonded, and have appropriate knowledge of permitting requirements.
7. Community Supports providers must submit actual vendor receipts and/or invoices for all purchased asthma products and home services transactions as part of a single comprehensive invoice submitted to SCFHP for approval prior to submitting a single claim for reimbursement.
8. Community Supports providers must ensure that the products are purchased from a reputable vendor and meet all industry standards and requirements.
9. It is the responsibility of the contracted Community Supports provider to manage the schedules of the individuals delivering the services to ensure that services can be provided on a weekend or holiday.
10. SCFHP does not incorporate overtime pay into the payment rate for any of the service bundles. It is the responsibility of the contracted Community Supports provider to account for any overtime pay as part of the cost of doing business.
11. An administration fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Service Category	Service Categories 1, 2 and 4	Service Categories 3 and 5
Category Name	1. Document Collection 2. Asthma Remediation Product Coordination 4. Asthma Remediation Services Coordination	3. Asthma Remediation Product Purchase 5. Asthma Remediation Services Purchase
HCPCS Code	S5165	S5165
Service Modifier	U5	U5
Telephonic/Electronic Modifier	GQ	GQ
Payment Rate	$1,524	Actual Amount*
Service Unit	Per Authorization	Total Costs Per Member
Maximum Billable Units per Authorization	1	
Maximum Billable Amount per Authorized Member	$1,524	$7,500
Authorization Period	12 Months	

*Refer to the maximum cost guidelines in the *Cost Drivers and Assumptions* section.

Billing and Payment Instructions

1. Community Supports providers must utilize the above HCPCS codes and modifiers for both initial outreach efforts and service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
2. No payment is associated with billing for outreach efforts nor a maximum number of billable units. The cost of conducting initial outreach to engage a member and for ongoing outreach efforts for service delivery are built into the service delivery payment rates.
3. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in Payment Rate Tables. See the *Community Supports Billing Guide* for more information on the billing requirements.
4. 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.
5. SCFHP expects Community Supports providers to bill only a single claim once SCFHP provides written approval after reviewing a comprehensive invoice. See the *Service Model* section for all the requirements. The total maximum billable amount for staff costs, products, and services cannot exceed $9,024 per member per lifetime, which includes staffing costs that are reimbursable to the provider at a maximum amount of $1,524 per member per lifetime.
6. Community Supports providers must adhere to the maximum cost guidelines as described in the *Cost Drivers and Assumptions* section.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing between 3.00 and 5.00 hours of service per month.
2. Clinical Staff: Hourly rate range of $33 - $57 per hour, providing between 1.00 and 3.00 hours of service per month.
3. Non-clinical Supervision: Hourly rate of $58 - $70 per hour, providing between 0.50 and 1.0 hour of service per month.

4. Clinical Supervision: Hourly rate range of $59 - $88 per hour, providing between 0.50 and 1.00 hour of service per month.
5. Benefits and retirement costs: Included at 35% of hourly rate.
6. Administrative fee: A 15% fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement for in-person travel to meet SCFHP members.
7. The actual cost of purchased products and services are capped at $7,500 and staff costs are capped at $1,524.
8. Community Supports providers are expected to adhere to the following maximum cost guidelines for all purchased products and services, which align with the United States Department of Housing and Urban Development (HUD) definitions.

Actual Asthma Remediation Good Services	**Maximum Cost per Purchased Quantity**
1. Allergen-impermeable mattress dustcovers and pillow dustcovers	$190
2. High-efficiency particulate air (HEPA) filtered vacuums	$400
3. High-efficiency particulate air (HEPA) filters	$300
4. Integrated Pest Management (IPM) services	$600
5. De-humidifiers	$300
6. Air filters/air cleaners	$300
7. Other moisture-controlling interventions	$750*
8. Minor mold removal and remediation services	$2,500
9. Ventilation improvements	$750*
10. Asthma-friendly cleaning products and supplies	$100

*If the cost exceeds the maximum, the Community Supports provider must submit at least two cost quotes to SCFHP and seek approval to exceed the maximum before purchasing the products or services.

SECTION I
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (HOME MODIFICATIONS)

DESCRIPTION

Environmental Accessibility Adaptations (EAA; also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the member, or enable them to function with greater independence in the home without which they would require institutionalization.

Examples of EAA include:

- Ramps and grab-bars to assist a member in accessing their home;
- Doorway widening for a member who requires a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower);
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of a member; and
- Installation and testing of a Personal Emergency Response System (PERS) for a member who is alone for significant parts of the day without a caregiver and who otherwise requires routine supervision (including monthly service costs, as needed).

The services are provided in a home that is owned, rented, leased, or occupied by the member. For a home that is not owned by the member, the member must obtain written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab-bars, stair lifts, etc.). The written consent must be submitted to SCFHP before approval is given.

For SCFHP to authorize EAA, SCFHP must receive and document an order from the member's current primary care physician or other healthcare professional specifying:

1. The requested equipment and/or service; and
2. A description of how the equipment and/or service meets the medical needs of the member; and
3. Any supporting documentation describing the purpose and efficacy of the equipment.

Note: Brochures will suffice in showing the purpose and efficacy of the request; however, a brief written evaluation specific to the member that describes how and why the equipment and/or service meets the needs of the member is also necessary.

Depending on the member's situation, SCFHP may also require a Community Supports provider to acquire and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment and/or service. The evaluation should be conducted by an entity that does not have any connection to the requesting entity or individual. The physical or occupational therapy evaluation and report should contain at least the following:
    a. An evaluation of the member and the current equipment needs specific to the member, describing how and why the current equipment does not meet the needs of the member;
    b. An evaluation of the requested equipment or service that includes a description of why it is necessary for the member and how it reduces the risk of institutionalization. The evaluation should also include information on the ability of the member and/or the primary caregiver to learn about and appropriately use any requested item; and

c. A description of similar equipment used either currently or in the past which has demonstrated to be inadequate for the member and a description of the inadequacy.
2. If possible, a minimum of two bids from appropriate providers for the requested service, which itemize the services, cost, labor, and applicable warranties; and
3. That a home visit has been conducted to determine the suitability of any requested equipment or service.

Upon request by SCFHP, the Community Supports provider must submit all required documents as described above to SCFHP within 60 days of receipt of the member assignment so that SCFHP can authorize the member for EAA within a 90-day timeframe from when SCFHP received the referral.

ELIGIBILITY

The eligibility is any member at risk for institutionalization in a nursing facility.

RESTRICTIONS AND LIMITATIONS

The following are the restrictions and limitations for EAA services:

- If a covered Medi-Cal or Medicare benefit is available for all or portions of the request and it would accomplish the same goals of independence and avoid institutional placement (e.g., Durable Medical Equipment (DME), portable stair ramp, shower rails, seats stools, benches, etc.), that benefit should be accessed prior to receiving EAA.
- EAA must be conducted in accordance with applicable State and local building codes.
- EAA are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the:
  1. Member's place of residence changes;
  2. Member's condition has changed so significantly that additional EAA services are necessary to ensure the health, welfare, and safety of the member; or
  3. Member requires additional EAA services to enable them to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAA may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household.
- Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- For members who do not own their home, the Community Supports provider must provide both the owner and member with written documentation that the modifications are permanent, and that SCFHP is not responsible for maintenance or repair of any modification nor removal of any modification if the member ceases to reside at the residence. The written document must be received by the owner prior to the commencement of physical adaptation to a home or equipment that is physically installed in a home (e.g., grab bars, chair lifts, etc.).

Members may not receive duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Community Supports services.

LICENSING/ALLOWABLE PROVIDERS

Providers must have experience and expertise in providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers that SCFHP

may choose to contract with, but it is not an exhaustive list of providers that may contract to provide the services:

- Area Agencies on Aging
- Local health departments
- Community-based providers and organizations

All EAA that are physical adaptations to a residence must be performed by an individual holding a valid California Contractor's License except for a PERS installation, which may be performed in accordance with the system's installation requirements. Contracted Community Supports providers may employ individuals who hold the license or subcontract the physical adaptations to an entity or individual that holds the license.

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/Enrollmen*t. If there is not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in the *Community Supports Vendor Agreement*.

SERVICE MODEL

The required EAA services are divided into nine categories with the maximum billable units and the associated billing codes shown per category. Community Supports providers are required to provide any or all the listed services based on member needs and submit claims or invoices to SCFHP that reflect the services delivered.

Important for Referral Submission to SCFHP

For referrals for EAA services, SCFHP requires the referring entity to use the required order from a licensed health care provider, the rationale, and the supporting documentation and divide the estimated expenses into the following four cost categories:

1. Equipment with or without home modification,
2. PERS services,
3. Pest removal or eradication services, and
4. Home modification(s).

The referring entity must submit a cost estimate of each item and service being requested broken down into the four cost categories with the referral. Once SCFHP receives the referral and cost estimate, the Community Supports team reviews to determine member eligibility and appropriateness of the items or services included in the cost estimate. If a member is authorized for services, the Community Supports team will provide written approval of the cost estimate. The total cost estimate cannot exceed $7,500 per member per lifetime, unless for the exceptions listed above.

Important for Claims Submission by Community Supports Providers

Community Supports providers are expected to submit a single comprehensive invoice with the:

1. Staffing reimbursement that does not exceed $3,150 per member per lifetime,
2. Approved cost estimate by the four cost categories submitted with the referral, and
3. Invoices and receipts that validate each cost incurred by the provider with the total not to exceed $7,500.

It is expected that the Community Supports provider adheres as closely to the approved cost estimate as possible. Once SCFHP's Community Supports team receives the invoice and required documentation, they review and provide written approval. If the Community Supports provider receives written approval from SCFHP, the provider can submit a single claim for the total amount that they are seeking reimbursement. If SCFHP does not approve the invoice, the Community Supports team will work with the Community Supports provider to address any concerns with the incurred costs and review any subsequently submitted revisions to a single comprehensive invoice with the intent of granting approval to submit a single claim for the total approved amount.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Evaluation and Recommendations a. Coordinate an in-person home evaluation conducted by a Physical Therapist (PT) or Occupational Therapist (OT) within 40 calendar days from the date the provider received the initial authorization. The evaluation must result in a report that articulates the specific home modifications that are needed and indicate if the equipment or services are medically necessary. See the above *Description* section for the requirements for the evaluation report. *Note: If the report contains a home modification that requires landlord/owner consent, the Community Supports provider may request an extension in the timeframe from SCFHP.* b. Submit the evaluation report to SCFHP within 5 business days of it being completed.	1 Unit	S5165 U6 GQ
2. Equipment Purchase Coordination a. Coordinate the purchase, delivery, and/or installation (if applicable) of the equipment needed. All equipment is reimbursed by SCFHP at the actual cost. b. Provide education to the member or caregiver on how to use the equipment. c. Conduct an in-person confirmation visit that may include the Enhanced Care Management (ECM) Lead Care Manager to ensure equipment has been delivered and meets member's needs and notify SCFHP once completed. d. Confirm in writing that the member or caregiver was educated or trained how to use the equipment. For example, how to use or operate the stair lift, raised toilet, accessible light switches or electric outlets, grab bars or lifts, etc. e. Evaluate the need for continued support, such as ECM or other community case management services, and make referrals to ensure member engages with providers.		
3. Equipment Purchase a. Seek reimbursement of the actual cost of the purchased equipment, including the equipment needed for both non-home modifications and home modifications.		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
b. Track and manage the actual costs to ensure the collective requested reimbursement for all purchased equipment and services does not exceed $7,500.		
4. PERS Service Coordination a. Review the evaluation and recommendation report to ensure all recommended services are available and appropriate to address the member's needs. b. Conduct outreach to coordinate one or more of the following: • Home visit (if applicable) • Member interest in PERS and accessory preference (e.g., necklace/arm button, fall detection option, and/or mobile link) • Consent for installation • Installation date c. Coordinate the installation of the system; conduct testing to ensure system is in working order within 48 hours of installation; and provide the member or representative education on use, regular maintenance, and repairs. d. Obtain written acknowledgement signed by the member or authorized representative confirming they were educated or trained and understand they need to become financially responsible for all ongoing services beginning the month following the end of the service date listed on the authorization (i.e., month 13) e. Provide ongoing monitoring of the PERS service for up to 12 months. f. Evaluate the need for continued support, such as ECM or other community case management services, and make referrals to ensure the member engages with providers.		
5. PERS Service a. Seek reimbursement of the actual cost of the PERS service for a total of 12 months. b. Track and manage the actual costs to ensure the collective requested reimbursement for all purchased equipment and services does not exceed $7,500.		
6. Pest Removal or Eradication Services Coordination a. Review the evaluation and recommendation report to ensure all recommended services are available and appropriate to address the member's needs, in which services may vary depending on the type of pests. b. Conduct outreach to coordinate one or more of the following: • Home visit (if applicable), • Confirmation of the need for pest removal services, • Consent for services, and/or		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
• Service date. c. Administer treatment or other related services, provide any follow up that may be necessary for up to 3 months after initial services are rendered including additional treatments, and provide the member or authorized representative education on prevention for re-infestation. d. Obtain a written acknowledgement signed by the member or representative confirming they were educated on how to prevent infestation in the future. e. Evaluate the need for continued support, such as ECM or other community case management services, and make referrals to ensure the member engages with providers.		
7. Pest Removal or Eradication Services a. Seek reimbursement of the actual cost of the pest removal or eradication services. b. Track and manage the actual costs to ensure the collective requested reimbursement for all purchased equipment and services does not exceed $7,500.		
8. Home Modification Coordination a. Review the evaluation and recommendation report and make a home visit to begin coordinating the home modification(s). b. If the member rents, the landlord/owner must provide their written consent to the modifications and assist with collecting the consent if the member's attempts are not successful. c. Coordinate and manage the appropriate and approved home modification(s) to the member's home to ensure completion. d. Provide the member and/or caregiver education and necessary training to maintain home modification(s). e. Obtain a written acknowledgement signed by the member or authorized representative confirming they were educated or trained how to maintain the home modification(s). f. Conduct an in-person confirmation visit that may include the ECM Lead Care Manager to ensure modifications have been completed and notify SCFHP once completed. g. If modification includes equipment or other services that require education or training, obtain a written acknowledgement signed by member or representative confirming the equipment was completely installed and the related individuals were educated or trained. h. Evaluate the need for continued support, such as ECM or other community case management services, and make referrals to ensure the member engages with providers.		
9. Home Modification Labor a. Seek reimbursement of the actual cost of the labor for home modification(s).		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
b. Track and manage the actual costs to ensure the collective requested reimbursement for all purchased equipment and services does not exceed $7,500.		

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical staff who provide face-to-face services in an office, in the community, and via phone or video with 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.
2. Clinical staff who provide services when needed based on member need.
3. Non-clinical and clinical supervision with a caseload of 1:10 non-clinical and clinical staff.
4. Community Supports providers must ensure that the entities that perform EAA hold a valid California Contractor's License throughout the entire process.
5. When applicable, at least two bids are required for completion of the EAA.
6. Community Supports providers are reimbursed for staffing costs associated with coordinating the purchase, delivery, and installation of products, as well as coordinating the services through to completion.
7. Community Supports providers are reimbursed the actual cost of the products and services, with a lifetime maximum of $7,500.
8. Community Supports providers must ensure that the equipment is purchased from a reputable vendor and meets all industry standards and requirements.
9. Community Supports providers must submit actual vendor receipts and/or invoices for all purchased equipment, services, and EAA labor transactions as part of a single comprehensive invoice submitted to SCFHP for approval prior to submitting a single claim for reimbursement.
10. It is the responsibility of the contracted Community Supports provider to manage the schedules of the individuals delivering the services to ensure that services can be provided on a weekend or holiday.
11. SCFHP does not incorporate overtime pay into the payment rate for any of the service categories. It is the responsibility of the contracted Community Supports provider to account for any overtime pay as part of the cost of doing business.
12. A billable unit is defined as 13 months.

Payment Rates

Home Modifications Only:

Service Category	Service Categories 1, 2, 6 and 8	Service Categories 3, 7 and 9
Category Name	1. Evaluation and Recommendations 2. Equipment Purchase Coordination 6. Pest Removal or Eradication Services Coordination	3. Equipment Purchase 7. Pest Removal or Eradication Services 9. Home Modification Labor

Service Category	Service Categories 1, 2, 6 and 8	Service Categories 3, 7 and 9
	8. Home Modification Coordination	
HCPCS Code	S5165	S5165
Service Modifier	U6	U6
Telephonic/Electronic Modifier	GQ	GQ
Payment Rate	$2,760	Actual Amount*
Service Unit	Per Member Per Authorization	Total Costs Per Member
Maximum Billable Units per Authorization	1	
Maximum Billable Amount per Authorized Member	$2,760	$7,500
Authorization Period	13 Months	

*Refer to the maximum cost guidelines in the *Cost Drivers and Assumptions* section.

Personal Emergency Response System (PERS) Only:

Service Category	Service Categories 2 and 4	Service Categories 3 and 5
Category Name	2. PERS Equipment Purchase Coordination 4. PERS Service Coordination	3. PERS Equipment Purchase 5. PERS Service
HCPCS Code	S5165	S5165
Service Modifier	U6	U6
Telephonic/Electronic Modifier	GQ	GQ
Payment Rate	$390	Actual Amount**
Service Unit	Per Member Per Authorization	Per Member Per Month
Maximum Billable Units per Authorization	1	12
Maximum Billable Amount per Authorized Member	$390	$540
Authorization Period	13 Months	

** The maximum payment rate is $45 per month for up to 12 months.

Billing and Payment Instructions

1. Community Supports providers must utilize the above HCPCS codes and modifiers for both initial outreach efforts and service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
2. No payment is associated with billing for outreach efforts nor a maximum number of billable units. The cost of conducting initial outreach to engage a member and for ongoing outreach efforts for service delivery are built into the service delivery payment rates.

3. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in Payment Rate Tables. See the *Community Supports Billing Guide* for more information on the billing requirements.
4. 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. If services are provided via telehealth, the Community Supports provider is required to bill using the GQ modifier.
5. SCFHP expects Community Supports providers to bill only a single claim once SCFHP provides written approval after reviewing a comprehensive invoice. See the *Service Model* section for all the requirements. The total maximum billable amount for staff costs, products, and services cannot exceed $11,595 per member per lifetime, which includes staffing costs that are reimbursable to the provider at a maximum amount of $3,150 per member per lifetime.
6. Community Supports providers must adhere to the maximum cost guidelines as described in the *Cost Drivers and Assumptions* section.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing between 2.00 and 4.00 hours of service per month
2. Clinical Staff: Hourly rate range of $33 - $57 per hour, providing between 0.50 and 1.00 hour of service per month.
3. Non-clinical Supervision: Hourly rate of $58 - $70 per hour, providing between 0.25 and 0.75 hour of service per month.
4. Clinical Supervision: Hourly rate range of $59 - $88 per hour, providing between 0.25 and 0.75 hour of service per month.
5. Benefits and retirement costs: Included at 35% of hourly rate.
6. Administrative fee: A 15% fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement for in-person travel to meet SCFHP members.
7. The actual cost of purchased products and services are capped at $7,500 and staff costs are capped at $3,150.

SECTION J
PERSONAL CARE AND HOMEMAKER SERVICES (PCHS)

DESCRIPTION

Personal Care Services and Homemaker Services (PCHS) are provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. PCHS can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

Services covered under PCHS include similar services to those provided through the In-Home Support Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

PCHS can be used:

- When a member has transitioned from a hospital, skilled nursing facility, or recuperative care facility within the last 90 days; and
- Has already applied for Santa Clara County IHSS; and
- Has not yet been assessed by IHSS;
  OR
- When a member has been approved by IHSS and is waiting for a caregiver.

ELIGIBILITY

The eligibility criteria for PCHS are:

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or
- Individuals approved for IHSS. IHSS eligibility criteria can be found at http://www.cdss.ca.gov/In-Home-Supportive-Services.

Overlap with Home and Community Based Alternatives (HCBA) Waiver: While IHSS must be the primary source of support for eligible members, PCHS may be provided when additional support is needed beyond authorized IHSS hours or when IHSS allocations are insufficient. In such cases, PCHS can supplement IHSS and extend care to ensure a member's needs are fully met.

Waiver Personal Care Services (WPCS) provided through the HCBA Waiver must be coordinated separately from IHSS to ensure there is no duplication of authorized hours. Members enrolled in the HCBA Waiver and eligible for or receiving WPCS are not eligible to receive PCHS. However, members who are on the waitlist for HCBA Waiver may receive PCHS while they are awaiting HCBA waiver approval.

RESTRICTIONS AND LIMITATIONS

PCHS cannot be utilized in lieu of referring to the IHSS program. Members must be referred to IHSS when they meet the referral criteria.

If a member is receiving PCHS and experiences any change in their current condition, they must be referred to IHSS for reassessment and determination of additional hours.

Community Supports shall supplement and not supplant services received by the Medi-Cal/Medicare 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 in 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 contract to provide the services:

- Home health agencies
- County agencies
- Personal care agencies
- Area Agency on Aging

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 not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit H in the *Community Supports Vendor Agreement.*

All Community Supports providers who are providing PCHS and enter a member's home to provide services are required by DHCS to register and use an Electronic Visit Verification (EVV) system or the California Electronic Visit Verification (CalEVV) system. EVV systems are telephone and computer-based systems that electronically verify that in-home service visits occur. They verify the type of service performed, the individual receiving the service, the date of service, the location of service delivery, the individual providing the services, and the time the service begins and ends. If Community Supports providers want to use CalEVV, SCFHP will provide training on how to register entities and individuals who are delivering the services. Applicable Community Supports providers must be registered with an EVV system or CalEVV and be ready to use it upon full execution of a *Community Supports Vendor Agreement.*

SERVICE MODEL

The required PCHS are divided into two categories with the maximum billable units and the associated billing codes shown per category. Community Supports providers are required to provide any or all the listed services based on member needs and submit claims or invoices to SCFHP that reflect the services delivered.

If a member is approved for IHSS, the IHSS services must be utilized prior to SCFHP authorizing PCHS Community Supports. The referring entity must submit a breakdown of approved IHSS service hours with the referral to SCFHP for eligibility determination and authorization.

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Personal Care Services a. Assessment and Care Plan Development	3,300 Units	T1019 U6

Service Categories and Required Services	Maximum Billable Units	Billing Codes
i. Conduct outreach to the authorized member; confirm the member requires and is willing to receive Personal Care Services; verify the member was referred to IHSS for evaluation; and verify and document the member was denied for IHSS services due to not meeting eligibility criteria, has exhausted the approved IHSS hours without an increase, or is in a waiting period for approval for additional hours. ii. Conduct a needs and safety assessment with the member and/or caregiver using SCFHP's Assessment Template (accessible at https://www.scfhp.com/communitysupports/) to determine the appropriate hours and services, which need to equate to goals and be included in a care plan, share the care plan with the member's ECM Lead Care Manager or other case manager, and work collaboratively on the coordination of services. iii. Develop an individualized care plan based on the results of the needs and safety assessment to ensure the member will be supported and safe. All care plans must include: • A breakdown of all required tasks that are billable under Personal Care services. • Short-term measurable goals that are linked to tasks. • For each task, indicate the number of days per week and number of hours per day being recommended to ensure the member is supported and safe. • For a member transitioning from a skilled nursing facility or hospital to a home setting, the care plan must account for any potential needs or tasks associated with the transition. • The potential needs and/or tasks must be included in the task breakdown and linked to goals with timeframes for completion. iv. Connect and communicate with other care team service providers and provide feedback regarding any additional needs that have been identified for the member that are not being met. Communication between the care team, IHSS, and/or SCFHP representatives are required for: • Newly approved IHSS hours, and • Services/tasks identified in any assessment that are not services included in the approved IHSS breakdown.		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
• When applicable, an IHSS reassessment must be requested when the member's functional status or situation has significantly changed. v. Submit or upload any assessments and/or care plans to SCFHP's Member Profile, accessible through SCFHP's Provider Portal, for SCFHP to review. b. Personal Care Service Delivery i. Assist with Activities of Daily Living (ADLs)*, such as bathing, dressing, toileting, or assisting with incontinence, medication reminders, transfers, ambulation, and any other common tasks associated with assisting with ADLs. ii. For a member who has exhausted IHSS hours and without approval of additional hours: 1. Ensure the member's home is safe and needs are met. 2. When appropriate, refer the member to additional services in the community such as Enhanced Care Management (ECM), additional Community Supports, or other community-based case management programs. 3. Assess for member need four business days prior to the authorized hours are exhausted to determine if an extension of services is needed. 4. If appropriate, submit a referral to SCFHP for a request for additional services. iii. For a member who is in a waiting period for approval for IHSS services: 1. Coordinate with the IHSS caregiver and/or other support persons for the member to ensure there is not any overlap in services. 2. Ensure the member's home is safe and needs are met. 3. When appropriate, refer the member to additional services in the community such as Enhanced Care Management (ECM), additional Community Supports, or other community-based case management programs. 4. Assess for member need four business days prior to the authorized hours are exhausted to determine if an extension of services is needed. 5. If appropriate, submit a referral to SCFHP for a request for additional services.		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
iv. For a member who needs services to avoid a skilled nursing facility stay and are not eligible for IHSS and who are not eligible for IHSS: 1. Coordinate with the IHSS caregiver and/or other support people for the member to ensure there is not any overlap of services. 2. Ensure the member's home is safe and needs are met. 3. When appropriate, refer the member to additional services in the community such as Enhanced Care Management (ECM), additional Community Supports, or other community-based case management programs. 4. Assess for member need four business days prior to the 60-day maximum limit is reached to determine if an extension of services is needed. 5. If appropriate, submit a referral to SCFHP for a request for additional services. c. Ensure the assigned caregiver has access to and is ready to use an EVV or the CalEVV system prior to visiting a member in the home for the first time and ensure continued use for every subsequent in-home visit. d. Reassessment for Continued Personal Care Services: Reassess member for the need for continued services, document continued need in the care plan and submit a referral form to SCFHP for review and authorization.		
2. Homemaker Services a. Assessment and Care Plan Development i. Conduct outreach to the authorized member; confirm the member requires and is willing to receive Personal Care Services; verify the member was referred to IHSS for evaluation; and verify and document the member was denied for IHSS services due to not meeting eligibility criteria, has exhausted the approved IHSS hours without an increase, or is in a waiting period for approval for additional hours. ii. Conduct a needs and safety assessment with the member and/or caregiver using SCFHP's Assessment Template (accessible at https://www.scfhp.com/communitysupports/) to determine the appropriate hours and services, which need to equate to goals and be included in a care plan, share the care plan with the member's ECM Lead Care Manager or other case manager, and work collaboratively on the coordination of services.		S5130 U6

Service Categories and Required Services	Maximum Billable Units	Billing Codes
iii. Develop an individualized care plan based on the results for the needs and safety assessment to ensure the member will be supported and safe. All care plans must include: • A breakdown of all required tasks that are billable under Personal Care services. • Short-term measurable goals that are linked to tasks. • For each task, indicate the number of days per week and number of hours per day being recommended to ensure the member is supported and safe. • For members transitioning from a skilled nursing facility or hospital to a home setting, the care plan must account for any potential needs or tasks associated with the transition. • The potential needs and/or tasks must be included in the task breakdown and linked to goals with timeframes for completion. iv. Connect and communicate with other care team service providers and provide feedback regarding any additional needs that have been identified for the member that are not being met. Communication between the care team, IHSS, and/or SCFHP representatives are required for: • Newly approved IHSS hours, and • Services/tasks identified in any assessment that are not services included in the approved IHSS breakdown. • When applicable, an IHSS reassessment must be requested when the member's functional status or situation has significantly changed. v. Submit or upload any assessments and/or care plans to SCFHP's Member Profile, accessible through SCFHP's Provider Portal, for SCFHP to review. b. Homemaker Service Delivery i. Provide general household chores to maintain cleanliness of the home, such as light housekeeping, routine laundry, meal preparation/clean up, help organize personal space, grocery shopping, accompaniment to appointments, and any other common tasks associated with maintaining a safe home. ii. For a member who has exhausted IHSS hours and without approval of additional hours: 1. Ensure the member's home is safe and needs are met. 2. When appropriate, refer the member to additional services in the community such as Enhanced Care		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
Management (ECM), additional Community Supports, or other community-based case management programs. 3. Assess for member need four business days prior to the authorized hours are exhausted to determine if an extension of services is needed. 4. If appropriate, submit a referral to SCFHP for a request for additional services. iii. For a member who is in a waiting period for approval for IHSS services: 1. Coordinate with IHSS caregiver and/or other support persons for member to ensure there is not any overlap of services. 2. Ensure the member's home is safe and needs are met. 3. When appropriate, refer the member to additional services in the community such as Enhanced Care Management (ECM), additional Community Supports, or other community-based case management programs. 4. Assess for member need four business days prior to the authorized hours are exhausted to determine if an extension of services is needed. 5. If appropriate, submit a referral to SCFHP for a request for additional services. iv. For a member who needs services to avoid a skilled nursing facility stay and are not eligible for IHSS: 1. Coordinate with the IHSS caregiver and/or other support persons for member to ensure there is not any overlap of services. 2. Ensure the member's home is safe and needs are met. 3. When appropriate, refer the member to additional services in the community such as Enhanced Care Management (ECM), additional Community Supports, or other community-based case management programs. 4. Assess for member need four business days prior to the 60-day maximum limit is reached to determine if an extension of services is needed. 5. If appropriate, submit a referral to SCFHP for a request for additional services. c. Ensure assigned caregiver has access to and is ready to use an EVV or the CalEVV system prior to visiting a member in the		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
home for the first time and ensure continued use for every subsequent in-home visit. d. Reassessment for Continued Homemaker Services: Reassess the member for the need for continued services, document continued need in the care plan and submit a referral to SCFHP for review and authorization.		

Important Note: Community Supports providers are expected to adhere to the following requirements related to the provision of services to members:

- Personal Care/Homemaker Services are available to members who not only meet the above eligibility criteria but also need the services due to needing assistance with ADLs and/or IADLs.
- Services are not available to members based on them solely needing an individual to aid with housecleaning, meal preparation, grocery shopping, money management, laundry, and/or accompaniment to medical appointments.
- All services must be provided to a member in their place of residence for the entire authorization period unless the member moves their residency. If the member moves, the Community Supports provider must communicate the move to SCFHP and seek approval prior to continuing to provide services.
- Community Supports providers are required to adhere to the following guidelines for the provision of services to authorized members.

Service	Guidelines
1. Grocery Shopping	• Limit of two locations per shopping trip • Limit of two shopping trips per week
2. Laundry	• All laundry soap and materials are required to be present in the home prior to doing laundry.
3. Meal Preparation	• Limit of three meals prepared per day. • Prepared meals must be reasonable with the quantity being appropriate for the member.
4. Other Errands	• Other errands that are outside of the services outlined in the *Service Model* section are prohibited.

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical staff who provide services in person in a member's home with a 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.

2. Non-clinical supervision of non-clinical staff.
3. Caregivers who have been trained to provide caregiving services based on industry best practices.
4. It is the responsibility of the contracted Community Supports provider to manage the schedules of the individuals delivering the services to ensure that services can be provided on a weekend or holiday.
5. SCFHP does not incorporate overtime pay into the payment rate for any of the service bundles. It is the responsibility of the contracted Community Supports provider to account for any overtime pay as part of the cost of doing business.
6. A billable unit is defined as a 15-minute increment of time.
7. An administrative fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Service Category	**Service Category 1**	**Service Category 2**
Category Name	1. Personal Care Services	2. Homemaker Services
HCPCS Code	T1019	S5130
Service Modifier	U6	U6
Payment Rate	$13.35	$13.35
Service Unit	Per Unit	Per Unit
Maximum Billable Units per Authorization	3,300 Units	
Maximum Billable Amount per Authorized Member	$44,055	
Authorization Period	6 Months	

Billing and Payment Instructions

1. Community Supports providers must utilize the above HCPCS codes and modifiers for both initial outreach efforts and service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
2. No payment is associated with billing for outreach efforts nor a maximum number of billable units. The cost of conducting initial outreach to engage a member and for ongoing outreach efforts for service delivery are built into the service delivery payment rates.
3. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in Payment Rate Tables. See the *Community Supports Billing Guide* for more information on the billing requirements.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing 0.97 of an hour of service to a member per hour.
2. Non-clinical Supervision: Hourly rate of $58 - $70 per hour, providing 0.03 of an hour of service to a member per hour.
3. Benefits and retirement costs: Included at 35% of hourly rate.
4. Administrative fee: A 15% fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, mileage reimbursement for in-person travel to meet SCFHP members.

SECTION K
RESPITE SERVICES

DESCRIPTION

Respite Services are provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence, or need for relief, of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from Recuperative Care (Medical Respite) as rest is for the caregiver only.

Respite Services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of, or need for relief for, those persons who normally provide care to members.
2. Services provided during the day and/or overnight on a short-term basis because of the absence of, or need for relief for, those persons who normally provide care to members.
3. Services that attend to the member's basic self-help needs and other Activities of Daily Living (ADLs), including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite Services are provided to the member in his or her own home or another location being used as their home.

Facility Respite Services are provided in an approved out-of-home location.

Respite Services should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout and thus to avoid institutional services for which SCFHP is responsible.

ELIGIBILITY

Members who live in the community and are compromised in at least two ADLs and are therefore dependent upon a qualified caregiver to provide most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include members under the age of 18 who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, members enrolled in either California Children's Services (CCS) or the Genetically Handicapped Persons Program (GHPP), and members with complex care needs.

RESTRICTIONS AND LIMITATIONS

In a home setting, Respite Services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day.

The service limit is up to 240 hours (10, 24-hour days) per calendar year. The service is inclusive of all in-home and in-facility services.

Exceptions to the 240 hours per calendar year limit can be made, with SCFHP's prior authorization, when the caregiver experiences an episode, including medical treatment and hospitalization, which leaves a member without their caregiver.

This service is only to be used to avoid placements for which SCFHP would be responsible.

Respite Services cannot be provided virtually, or via telehealth.

Community Supports shall supplement services received by the Medi-Cal/Medicare beneficiary through other State, local, or federally funded programs other than those listed above, in accordance with the CalAIM STCs and federal and DHCS guidance.

LICENSING/ALLOWABLE PROVIDERS

Providers must have experience and expertise in 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 that may contract to provide the services:

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
  - Providers contracted with the County of Santa Clara Behavioral Health Services
- Other community settings that are not private residences, such as:
  - Adult Family Home/Family Teaching Home
  - Certified Family Homes for Children
  - County of Santa Clara agencies
  - Residential Care Facility for the Elderly (RCFE)
  - Child Day Care Facility; Child Day Care Center; Family Child Care Home
  - Respite Facility; Residential Facility: Small Family Homes (children only)
  - Respite Facility; Residential Facility: Foster Family Agency (FFA) - Certified Family Homes (children only)
  - Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
  - Respite Facility; Residential Facility: Group Homes (children only)
  - Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
  - Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
  - Respite Facility; Residential Facility: Foster Family Homes (FFHs) (children only)
  - Short-term Residential Therapeutic Program providers or other care providers who are serving youth with complex needs
  - Community-Based Adult Services (CBAS) facilities/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 not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit H in the *Community Supports Vendor Agreement.*

All Community Supports providers who are providing Respite Services in a home setting and enter a member's home to conduct an assessment or in-home visit; deliver and/or install products; provide services of any kind; and/or provide education, instructions, or trainings are required by DHCS to register and use an Electronic Visit Verification (EVV) or the California Electronic Visit Verification

(CalEVV) system. EVV systems are telephone and computer-based systems that electronically verify that in-home service visits occur. They verify the type of service performed, the individual receiving the service, the date of service, the location of service delivery, the individual providing the services, and the time the service begins and ends. If Community Supports providers want to use CalEVV, SCFHP will provide training on how to register entities and individuals who are delivering the services. Applicable Community Supports providers must be registered with an EVV system or CalEVV and be ready to use it upon full execution of a *Community Supports Vendor Agreement.*

SERVICE MODEL

The required Respite Services are divided into two categories with the maximum billable units and the associated billing codes shown per category, taking into consideration that the maximum billable units cannot exceed the 240-hour maximum. Community Supports providers are required to provide any or all the listed services based on member needs and submit claims or invoices to SCFHP that reflect the services delivered**.**

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. In-Home Respite Care a. Conduct an initial screening with the member within 24 hours for an urgent request or up to four (4) business days for non-urgent requests. b. Assess and create a care plan that includes all the services needed by the members and the timeframe to deliver those services. c. Match the member with a caregiver and schedule needed services. d. Ensure the assigned caregiver has access to and is ready to use an EVV or the CalEVV system prior to visiting a member in the home for the first time and ensure continued use for every subsequent in-home visit. e. Coach the caregiver about the member's diagnosis(es) and medication reminders. f. Assist with ADLs including but not limited to: bathing/showering, grooming, nail/oral care, dressing, feeding, maintaining continence, and transferring. g. Assist with Instrumental Activities of Daily Living (IADLs) including the following but not limited to: managing transportation (running errands and appointments), communication (phone, technology), shopping and meal preparation, housework (laundry, dishes, vacuuming, light housekeeping), and monitoring medications. h. Handle crises or medical emergencies. i. Create an end-of-shift report to record the member's status. j. Provide support to ensure member accesses community and support resources, including medical appointments, attending social activities, etc.	240 Hours	S9125 U6

Service Categories and Required Services	Maximum Billable Units	Billing Codes
2. Facility Respite Care a. Conduct an initial screening with the member within 24 hours for an urgent request or up to four (4) business days for non-urgent requests. b. Assess and create a care plan that includes all the services needed by the member and the timeframe to deliver those services. c. Schedule the appropriate amount of time needed by the caregiver for services and confirm with the member and/or caregiver. c. Provide the member with room and board, and meals with snacks. d. Assist with ADLs including but not limited to toileting, grooming, feeding, maintaining continence, and transferring. e. Assist with IADLs including but not limited to: managing transportation (door-to-door service), communication (phone, technology), shopping and meal preparation, housework (laundry, dishes, vacuuming, light housekeeping), and monitoring medications. f. Assist with Domestic Activity of Daily Living (DADLs) including but not limited to: companionship/socialization, physical exercise (walking), mental exercise (doing a crossword puzzle or playing solitaire), hobbies (knitting), caring for pets, activities in the community, and learning new things. g. Handle crises or medical emergencies. h. Create an end-of-shift report to record the member's status. i. Provide support to ensure the member accesses community and support resources, including medical appointments, attending social activities, etc. j. Provide transportation for the member to and from the member's residence and the facility.		H0045 U6

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical staff who provide services in person with a 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.
2. Clinical staff who provide services when needed based on member need.
3. Non-clinical and clinical supervision with a caseload of 1:10 non-clinical and clinical staff.
4. *In-Home Respite*
   a. For services provided in a home setting, a billable unit is defined as a 60-minute increment of time.

b. Community Supports providers are reimbursed for a minimum of four hours for in-home services.
c. It is the responsibility of the contracted Community Supports provider to manage the schedules of the individuals delivering the services to ensure that services can be provided on a weekend or holiday.

5. *Facility-Based Respite*
   a. Facility-based respite may lead to rate and cost variability compared to these assumptions. This service is well established in California's Medicaid program, so other comparable programs serve as benchmarks in determining an appropriate payment structure.
   b. For services provided in a facility setting, a billable unit is defined as a 60-minute increment of time.
6. *For both In-Home and Facility Respite:*
   a. The payment structure assumes an agency model and, as such, assumes a supervisor with a caseload of 1:10 direct care workers.
   b. The total maximum billable units for both in-home and facility respite is 240.
7. SCFHP does not incorporate overtime pay into the payment rate for any of the service bundles. It is the responsibility of the contracted Community Supports provider to account for any overtime pay as part of the cost of doing business.
8. Administrative fee: A fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Service Category	Service Category 1	Service Category 2
Category Name	1. In-Home Respite	2. Facility Respite
HCPCS Code	S9125	H0045
Service Modifier	U6	U6
Payment Rate	$58	$58
Service Unit	Per Unit	Per Unit
Maximum Billable Units per Authorization	240 Units	
Maximum Billable Amount per Authorized Member	$13,920	
Authorization Period	Up to 12 Months in a Calendar Year[1]	

Billing and Payment Instructions

1. Community Supports providers must utilize the above HCPCS codes and modifiers for both initial outreach efforts and service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
2. No payment is associated with billing for outreach efforts nor a maximum number of billable units. The cost of conducting initial outreach to engage a member and for ongoing outreach efforts for service delivery are built into the service delivery payment rates.
3. For *In-Home Respite services*, Community Supports providers can bill SCFHP for a minimum of four hours of service.

[1] A calendar year is January 1 to December 31. The authorization period would always end on December 31 of the year the authorization period began.

4. For *Facility Respite services*, Community Supports providers can start the billable period for services at the time of admission and can bill for each unit of service in 60-minute increments.
5. For both *In-Home and Facility Respite services*, Community Supports providers can bill a full 60-minute hour if the service timeframe is between 31-59 minutes.
6. Community Supports providers are expected to bill using only the designated codes and modifiers as reflected in Payment Rate Tables. See the *Community Supports Billing Guide* for more information on the billing requirements.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing 0.85 of an hour of service to a member per hour.
2. Clinical Staff: Hourly rate range of $33 - $57 per hour, providing 0.05 of an hour of service to a member per hour.
3. Non-clinical Supervision: Hourly rate of $58 - $70 per hour, providing 0.05 of an hour of service to a member per hour.
4. Clinical Supervision: Hourly rate range of $59 - $88 per hour, providing 0.05 of an hour of service to a member per hour.
5. Benefits and retirement costs: Included at 35% of hourly rate.
6. Administrative fee: A 15% fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, mileage reimbursement for in-person travel to meet SCFHP members.

SECTION L
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 experiencing homelessness 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.

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.

When implementing this service, direct coordination with the Santa Clara County Behavioral Health Services is also required. 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 (SUD) treatment and housing options, as appropriate.

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 an 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 of no more than 23 hours and 59 minutes. Members who are receiving duplicative services covered by Medi-Cal and Medicare are not eligible for Sobering Center services for the same period.

Community Supports shall supplement and not supplant services received by the Medi-Cal or Medicare 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 to this unique population. 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 that may contract to provide the services:

- Sobering Centers, or other appropriate and allowable SUD 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 SUD services and other behavioral health services.
- These facilities may be 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.

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 not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit H in the *Community Supports Vendor Agreement.*

SERVICE MODEL

The required Sobering Center services are listed below with the maximum billable units and the associated billing codes. Community Supports providers are required to provide any or all the listed services based on member needs and submit claims or invoices to SCFHP that reflect the services delivered.

Required Services	Maximum Billable Units	Billing Codes
1. Accept referrals from law enforcement, hospitals, emergency personnel, outreach teams, and/or other community-based organizations for sobering center services. 2. Conduct a screening of the member to determine level of intoxication, willingness to participate in services, possible medical distress, and housing status. 3. Provide services and submit external referrals based on member need, which may include but are not limited to: • Medical triage • Lab testing (e.g., COVID-19, Tuberculosis, etc.) • Wound and dressing changes • Medication management • Temporary bed or recliner to rest • Temporary place to store personal items • Oral rehydration and food service • Shower and laundry facilities • Transportation	1 Day	H0014 U6

Required Services	Maximum Billable Units	Billing Codes
• Substance use education, including counseling, peer support, and referrals and coordination with the county behavioral health agency to access treatment • Link to ongoing supportive services such as case management, housing navigation, behavioral health services, and necessary health care services • Connect to public benefits, legal services, and/or homeless care support services. 4. Develop a wellness/safety plan that includes contact information for the member to access community resources and next steps. 5. Provide warm handoffs to all additional external services for which the member was referred.		

PAYMENT GUIDE

The payment approach includes:

1. Non-clinical direct care workers serve as front-line staff who provide screenings and deliver the required services with a caseload of 1:5 individuals concurrently.
2. Clinical staff to provide services per the scope of their license based on member need.
3. Non-clinical and clinical supervision with a caseload of 1:10 non-clinical and clinical staff.
4. Caseloads reflect time spent with or on behalf of members.
5. A billable unit being defined as per 24-hour period (per diem).
6. The total maximum billable unit is 1 per member per authorization.
7. An administrative fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Community Support	Sobering Center
HCPCS Code	H0014
Service Modifier	U6
Payment Rate	$275
Service Unit	Per Member Per Day (PMPD)
Maximum Billable Units per Authorization	1
Maximum Billable Amount per Authorized Member	$275
Authorization Period	1 (One) 24-Hour Period

Billing and Payment Instructions

1. SCFHP allows Community Supports providers to submit either:
   a. An expedited referral for authorization of Sobering Center services, or
   b. A retroactive referral once services have been rendered to SCFHP members.
2. Community Supports providers must bill a single time per authorized member for the per unit rate as described in the Payment Rate Table.

3. Community Supports providers are expected to bill using only the designated code and modifier as reflected in Payment Rate Table. See the *Community Supports Billing Guide* for more information on the billing requirements.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing between 1.00-2.00 hours per member per day.
2. Clinical Staff: Hourly rate range of $33 - $57 per hour providing between 0.50-1.25 hours per member per day.
3. Non-Clinical Supervision: Hourly rate range of $58 - $70 per hour providing between 0.25-1.00 hours per member per day.
4. Clinical Supervision: Hourly rate range of $59 - $88 per hour providing between 0.25-1.00 hours per member per day.
5. Benefits and retirement costs: Included at 35% of hourly rate.
6. Administrative Fee: A 15% a fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, mileage reimbursement for in-person travel to meet SCFHP members.

SECTION M
RECUPERATIVE CARE (MEDICAL RESPITE)

DESCRIPTION

Recuperative Care, also known as medical respite care, is for individuals who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness (including behavioral health condition). A stay in a recuperative care setting allows an individual to recover from an injury or illness while also obtaining access to primary care, behavioral health services, case management, and other supportive social services, such as transportation, food, and housing. It is for individuals who have medical needs significant enough to result in emergency department (ED) visits, hospital admissions, or other institutional care.

At a minimum, the service will include interim housing with a bed, meals, and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

- Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs) to the extent permitted by licensure.
- Coordination of transportation to post-discharge appointments.
- Connection to any other ongoing services an individual may require, including mental health and substance use disorder services.
- Support in accessing benefits and housing.
- Gaining stability with case management relationships and programs.

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

- Individuals requiring recovery to heal from an injury or illness; and
- Individuals experiencing or at risk of homelessness as defined by the U.S. Housing and Urban Development (HUD) in Section 91.5 of Title 24 of the Code of Federal Regulations (CFR), with the following three modifications:
    - If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; and
    - The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days; and

- For the at risk of homelessness definition at 24 CFR section 91.5, the requirement to have an annual income below 30 percent of median family income for the area, as determined by HUD, will not apply.

Members do not need to be exiting an institution to qualify for Recuperative Care services but must have been determined by a provider to have medical needs significant enough to result in ED visits, hospital admissions, or other institutional care.

RESTRICTIONS AND LIMITATIONS

Recuperative Care 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. Does not exceed a duration of six months per rolling 12-month period (but may be authorized for a shorter period based on individual needs) and is subject to the six-month global cap on Room and Board services; and
3. Facility operator and their employed staff providing Recuperative Care that are not licensed as Community Care Facilities may not directly assist members with ADLs or IADLs[1].

Room and Board Services and Global Cap

DHCS considers Recuperative Care, Short-Term Post-Hospitalization Housing, and Transitional Rent as *Room and Board Services*. As such, they are subject to a *global cap*. Under the cap, coverage is limited to six months of Room and Board services per member within a rolling 12-month period. This means that a member may not receive more than a combined six months of Recuperative Care, Short-Term Post-Hospitalization Housing, and Transitional Rent during any rolling 12-month period.

SCFHP counts the rolling 12-month period starting from the member's first date of utilization of Recuperative Care, Short-Term Post-Hospitalization Housing, or Transitional Rent — not from the date of authorization. In addition to the global cap, which is applicable to all three Room and Board services, Transitional Rent—as a Room and Board-only intervention without accompanying clinical services—is subject to an additional cap of six months per household, per demonstration period.

The table below reflects the duration and frequency restrictions per Room and Board service and across the three services.

Service	Limits per Service[2]	Limits across the Services[3]
Recuperative Care	6-month limit per rolling 12-month period per member	6-month limit per rolling 12-month period per member also applies across all three Room and Board services
Short-Term Post-Hospitalization Housing	6-month limit per rolling 12-month period per member	
Transitional Rent	6-month limit per rolling 5-year demonstration period per household	

[1] See Title 22, Division 6 of the California Code of Regulations (CCR).
[2] The 12-month rolling timeframe begins on the first day the member uses any of these services.
[3] The 12-month rolling timeframe begins on the first day the member uses any of these services.

Community Supports shall supplement and not supplant services received by the Medi-Cal or Medicare 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 in 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 all providers who may contract to provide the services:

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

Facilities may be unlicensed. SCFHP applies minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. SCFHP adopts national standards for recuperative care. SCFHP monitors 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 not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in *Exhibit H* in the *Community Supports Vendor Agreement*.

SERVICE MODEL

The required services for Recuperative Care are divided into three categories with the maximum billable units and the associated billing codes shown per category. Community Supports providers are required to provide any or all the listed services based on member needs and submit claims or invoices to SCFHP that reflect the services delivered**.**

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Intake and Assessment a. Conduct member intake. b. Assess the member and develop a treatment plan.	Up to 90 Days	T2033 U6
2. Treatment a. Provide temporary housing with a bed and meals. b. Provide limited or short-term assistance with IADLs and/or ADLs, if needed by the member. c. Provide ongoing monitoring of the member's medical conditions by clinical staff (e.g., coordinate office and telehealth appointments with doctors, wound care, address acute medical conditions, daily wellness check, connection to primary care physician (PCP)/home health aid before discharge).		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
d. Provide behavioral health or psychiatric care (e.g., assessment, care plan and treatment). e. Psychosocial care (e.g., assessment, one-on-one therapy, crisis interventions). f. Manage chronic conditions (e.g., self-management and treatment, self-management education). g. Coordinate transportation to post-discharge appointments and escort if necessary. h. Provide access to laundry services with onsite staff available 24 hours a day/7 days a week i. Manage medication for member to self-administer, including medication storage, pharmacy pick-up/delivery, education on self-managing medication, weekly check-ins, medication reconciliation. j. Provide ongoing monitoring of the member's behavioral health conditions (e.g., screening and assessment, substance use counseling, onsite group therapy, recovery group). k. Assist the member with accessing any other ongoing services such as mental health services, Substance Use Disorder services, and overdose prevention.		
3. Transition and Discharge a. Provide social support to the member, such as assisting member with accessing income, benefits, and identification documentation (e.g., general assistances/SSI 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). b. Refer to Community Supports based on member needs (e.g., Short-Term Post-Hospitalization Housing, Housing Navigation Transition Services, Housing Deposits, Housing Tenancy and Sustaining Services, Asthma Remediation, Environmental Accessibility Adaptations (Home Modifications), Personal Care and Homemaker Services, ECM). c. Refer member to home-based clinical services (e.g., home health, physical therapy, speech and occupational therapy). d. Connect to any other ongoing services that may be required for the member, including mental health and/or substance use disorder services.		

PAYMENT GUIDE

The payment approach includes:

1. Both clinical and non-clinical staff who provide face-to-face services in a facility with a total caseload of 10 to 20 beds.
2. Clinical supervisor with a caseload of 1:5 clinical staff and/or a non-clinical supervisor with a caseload of 1:10 non-clinical staff.
3. $24 per day per member for occupancy calculated at 125 sq. ft. per member for bed space and 50 sq. ft. for common space at $4.00 per sq. ft.
4. $25 per day per member for daily food and supply costs.
5. A billable unit being defined as per 24-hour period (per diem).
6. The total maximum billable units (per diem) are 90 days per member per authorization.
7. An administrative fee of 15% for indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement.

Payment Rates

Service Category	Service Categories 1-3
Category Name	1. Intake and Assessment 2. Treatment 3. Transition and Discharge
HCPCS Code	T2033
Service Modifier	U6
Payment Rate	$365
Service Unit	Per Diem
Maximum Billable Units per Authorization	Up to 90
Maximum Billable Amount per Authorized Member	$32,850
Authorization Period	Up to 90 Days (subject to the global cap requirements)

Billing and Payment Instructions

1. Community Supports providers must utilize the HCPCS codes and modifiers as reflected in the Payment Rate Table for service delivery and bill the associated payment amount up to the maximum billable units per authorization per member.
2. See the *Community Supports Billing Guide* for more information on the billing requirements.

Cost Drivers and Assumptions

1. Non-Clinical Staff: Hourly rate range of $25 - $42 per hour, providing between 1.50-3.00 hours of service per member per day.
2. Clinical Staff: Hourly rate range of $33 - $57 per hour, providing between 1.00-2.50 hours of service per member per day.
3. Non-Clinical Supervision: Hourly rate range of $58 - $70 per hour, providing between 0.25-0.50 hours of service per member per day.
4. Clinical Supervision: Hourly rate range of $59 - $88 per hour, providing between 0.25-0.50 hours of service per member per day.

5. Benefits and retirement costs: Included at 35% of hourly rate.
6. Daily occupancy rate: $24 per member per day.
7. Daily meal and supply rate: $25 per member per day.
8. Administrative fee: A 15% fee that includes overhead/indirect costs, staff training related to the provision of Community Supports services, and mileage reimbursement for in-person travel to meet SCFHP members.

SECTION N
TRANSITIONAL RENT – BEHAVIORAL HEALTH POPULATION OF FOCUS

DESCRIPTION

Transitional Rent provides up to six months of rental assistance in *interim* and *permanent* settings to members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria.

The objectives of Transitional Rent are:

1. Ensure a connection to long-term housing supports, such as rental subsidies, for members receiving Transitional Rent and provide a pathway to housing stability and prevent a return to homelessness.
2. Use the temporary housing stability afforded by Transitional Rent as an opportunity to help members connect to needed health care services.
3. Minimize administrative barriers (without compromising program integrity), so that members experiencing or at risk of homelessness can readily access Transitional Rent.

Transitional Rent may be used to cover the following expenses:

- Rental assistance in allowable settings, excluding eviction prevention (i.e., rental arrears (back rent) or prospective rental assistance for members who are housed but at risk of homelessness)
- Storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment

LIMITATIONS/RESTRICTIONS

Transitional Rent can provide up to six months of rental assistance and rent and housing fees per demonstration period[1], subject to the six-month global cap on Room and Board services within a rolling 12-month period. The six months of Transitional Rent are not required to be continuous.

Room and Board Services and Global Cap

DHCS considers Recuperative Care, Short-Term Post-Hospitalization Housing, and Transitional Rent as *Room and Board Services*. As such, they are subject to a *global cap*. Under the cap, coverage is limited to six months of Room and Board services per member within a rolling 12-month period. This means that a member may not receive more than a combined six months of Recuperative Care, Short-Term Post-Hospitalization Housing, and Transitional Rent during any rolling 12-month period.

SCFHP counts the rolling 12-month period starting from the member's first date of utilization of Recuperative Care, Short-Term Post-Hospitalization Housing, or Transitional Rent — not from the date of authorization. In addition to the global cap, which is applicable to all three Room and Board services, Transitional Rent—as a Room and Board-only intervention without accompanying clinical services—is subject to an additional cap of six months per household, per demonstration period.

The table below reflects the duration and frequency restrictions per Room and Board service and across the three services.

[1] The demonstration period for Transitional Rent is currently defined as a five-year period beginning on January 1, 2025, and ending on December 31, 2029.

Service	Limits per Service[2]	Limits across the Services[3]
Recuperative Care	6-month limit per rolling 12-month period per member	6-month limit per rolling 12-month period per member also applies across all three Room and Board services
Short-Term Post-Hospitalization Housing	6-month limit per rolling 12-month period per member	
Transitional Rent	6-month limit per rolling 5-year demonstration period per household	

ELIGIBILITY

Individuals are eligible for Transitional Rent if they meet **all** of the following criteria:

1. **Clinical Risk Factor**: Individual must have **one or more** of the following qualifying clinical risk factors:
   a. Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS)[4]; or
   b. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS)[5]; or
   c. One or more serious chronic physical health conditions[6]; or
   d. One or more physical, intellectual, or developmental disability; or
   e. Individuals who are pregnant up through 12-months postpartum.

AND

2. **Social Risk Factor**: Individual **must** be experiencing or at risk of homelessness[7]

AND

3. **Situation Factor**: Individual must meet **one** of the following requirements:
   a. **Transitioning Population**: Must be included within **one** of the following transitioning populations:
      i. **Transitioning out of an institutional or congregate residential setting**: Individuals transitioning out of an institutional or congregate residential setting, including but not limited to an inpatient hospital stay, an inpatient or residential substance use disorder treatment facility, an inpatient or residential mental health facility, or nursing facility.
      ii. **Transitioning out of a carceral setting**: Individuals transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting

[2] The 12-month rolling timeframe begins on the first day the member uses any of these services.
[3] The 12-month rolling timeframe begins on the first day the member uses any of these services.
[4] See Appendix A: Medi-Cal Specialty Mental Health Services (SMHS) Access Criteria.
[5] See Appendix B: Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) Access Criteria.
[6] Examples of serious chronic physical health conditions include, but are not limited to hypertension, rheumatoid arthritis, diabetes, chronic kidney disease, anemia, chronic obstructive pulmonary disease, hyperlipidemia, and asthma.
[7] The definition of experiencing or at risk of homelessness is based on the U.S. Department of Housing and Urban Development's (HUD) definitions with three modifications detailed in *Appendix C*.

where they have been in custody and held involuntarily through operation of law enforcement authorities.

iii. **Transitioning out of an interim housing**: Individuals transitioning out of transitional housing, rapid rehousing, domestic violence shelter or domestic violence housing, a homeless shelter, or other *interim* housing, whether funded or administered by HUD, or at the state or local level.

iv. **Transitioning out of recuperative care or short-term post-hospitalization housing**[8]: Individuals transitioning out of short-term post-hospitalization housing or recuperative care, whether the stay was covered by Medi-Cal managed care, or another source.

v. **Transitioning out of foster care**: Individuals who aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state.

OR

b. **Experiencing Unsheltered Homelessness**: Individuals or families with a primary night-time residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground.

OR

c. **Full-Service Partnership (FSP) Eligible**[9]: FSP is a comprehensive behavioral health program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services.

Additional Criteria for the Situation Factor:

- **Transitioning Populations – Institutional/Congregate Residential, Carceral, Interim Housing, Recuperative Care/Short-Term Post-Hospitalization Housing**: A member must receive authorization for Transitional Rent within six months (i.e., within 182 days) of the transition event (e.g., date of discharge, date of release). For six months from the date of authorization, the member may use the Transitional Rent benefit without a redetermination of eligibility.
- **Transitioning Population – Foster Care**: Members transitioning out of foster care on or after their 18th birthday are eligible to receive Transitional Rent, assuming satisfaction of the other eligibility requirements, until their 26th birthday and may be authorized at any time during this window. For six months from the date of authorization, a member may use the Transitional Rent benefit without a redetermination of eligibility.
- **Experiencing Unsheltered Homelessness**: Members experiencing unsheltered homelessness, assuming satisfaction of the clinical risk factor eligibility requirement, may be authorized at any time. For six months from the date of authorization, a member may use the Transitional Rent benefit without a redetermination of eligibility.

[8] While in Medi-Cal managed care, a member may not receive more than a combined six months of Short-Term Post-Hospitalization Housing, Recuperative Care, and Transitional Rent during any rolling 12-month period. This is a global cap.

[9] See *Appendix D: Full-Service Partnership Eligibility Criteria*. Members who are FSP eligible meet the Clinical Risk Factor for Transitional Rent as they meet the access criteria for SMHS, DMC, or DMC-ODS.

- **FSP-Eligible**: Members eligible for FSP, assuming satisfaction of the social risk factor[10] eligibility requirement may be authorized at any time. For six months from the date of authorization, a member may use the Transitional Rent benefit without a redetermination of eligibility.

ALLOWABLE SETTINGS AND HABITABILITY REQUIREMENTS

Transitional Rent may be for a member's housing in a *permanent* or *interim* setting, or provide a combination of time in an interim setting and then a permanent setting. When permanent housing is not immediately available, temporary placement in an interim setting may be appropriate.

Permanent vs. Interim Settings[11]

DHCS defines:

- *Permanent* settings: those with a renewable lease agreement with a term of at least one month.
- *Interim* settings: If there is not a lease agreement or the lease term is not renewable, the setting is considered *interim*.

When Transitional Rent is used to place a member in interim housing, the goal of the Transitional Rent provider is to transition the member to appropriate permanent housing as quickly as possible. In all situations, Transitional Rent providers must ensure that member placement is driven by the needs and preferences of the member.

Allowable **Permanent Settings** are:

- Single-family and multi-family homes (e.g., duplexes)
- Apartments
- Housing in mobile home communities
- Accessory dwelling units (ADUs)
- Shared housing—where two or more people live in one rental unit
- Project-based or scattered site permanent supportive housing
- Single room occupancy (SRO) units
- Tiny homes
- Recovery housing
- License-exempt room and board

Allowable **Interim Settings** are:

- Single room occupancy (SRO) units
- Tiny homes
- Hotels/motels when serving as the member's primary residence
- Interim settings with a small number of individuals per room (not large dormitory sleeping halls)
- Transitional and recovery housing with no lease agreement, including:
  - Bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming

[10] Members who are FSP eligible meet the Clinical Risk Factor for Transitional Rent as they meet the access criteria for SMHS, DMC, or DMC-ODS.

[11] See *Appendix E: Resources for Definitions on Permanent Settings*.

- License-exempt room and board
- Peer respite

Note: There are several settings that can be permanent or interim. The distinguishing factor between a permanent and interim setting is if the member has a renewable lease agreement.

Family Housing

SCFHP expects a Transitional Rent provider to house a member receiving Transitional Rent in a setting that is appropriate to accommodate the member's family, which may include a partner or spouse or one or more children.[12] A member should be housed in a setting that provides the smallest number of bedrooms necessary to house the member's family without overcrowding[13] and that meets the family's needs, including the unique needs of individuals with disabilities and pregnant and postpartum individuals and families.

Habitability Requirements

Transitional Rent providers are required to ensure all settings are compliant with applicable U.S. Department of Housing and Urban Development's (HUD) quality standards[14] or habitable as defined by state law.[15] Transitional Rent providers must conduct a basic unit or setting inspection to verify compliance with HUD or state habitability standards, document the inspection and its outcome, and share the inspection details with SCFHP and/or DHCS upon request. An attestation of compliance, either with the HUD standards or state habitability standards, must be submitted with a referral for Transitional Rent by the Transitional Rent provider as a condition of authorization by SCFHP.

ALLOWABLE PROVIDERS

Transitional Rent providers must have experience, expertise, and the appropriate staffing to provide all the required services and have the financial means to administer rent payments directly to landlords or property managers prior to seeking reimbursement from SCFHP. The required experience and expertise differ based on whether the provider is directly furnishing the housing, issuing payment for the housing, or contracting with organizations that provide or issue payment for housing.

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 that may contract to provide the services:

- County agencies, including county behavioral health agencies
- Flex Pools
- Affordable housing providers
- Supportive housing providers
- Continuum of Care (CoC)-affiliated entities

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[12] As defined by HUD and in alignment with the BHSA County Policy Manual, a *Family* includes, but is not limited to, regardless of marital status, actual or perceived sexual orientation, or gender identity, any group of persons presenting for assistance together with or without children and irrespective of age, relationship, or whether or not a member of the household has a disability.

[13] This is a standard applied by HUD for the Housing Choice Voucher program (see 24 CFR section 982.402(b)).

[14] The relevant HUD standards are the National Standards for the Physical Inspection of Real Estate (NSPIRE) standard.

[15] See California Civil Code §§ 1941, 1941.1, 1941.3.

- Social services agencies
- Public Housing Authorities (PHAs)
- Other providers of services for individuals experiencing homelessness

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 not a state-level enrollment pathway, Community Supports providers must adhere to SCFHP's Community Supports Provider Credentialing process as described in Exhibit H in the *Community Supports Vendor Agreement.*

REFERRAL REQUIREMENTS

Streamlined Provisional Authorization: To minimize delays in eligible members accessing Transitional Rent, SCFHP allows only the County of Santa Clara Behavioral Health Services (SCCBHS) to conduct streamlined provisional authorization for Transitional Rent if all the following conditions are met:

1. SCCBHS is contracted with SCFHP as a Transitional Rent Provider.
2. SCCBHS determines that the referred member is BHSA eligible and commits to providing the member with BHSA Housing Interventions at the expiration of Transitional Rent, or upon denial of the request for coverage by SCFHP.
3. SCCBHS commits to (a) sending a referral and request for authorization to SCFHP in a timely manner and within 15 calendar days of SCCBHS' streamlined provisional authorization start date, and (b) submitting the required documentation with the referral and in accordance with SCFHP's referral submission process.

Referral Submission Process: SCFHP accepts referrals for Transitional Rent from Transitional Rent providers via its Provider Portal. The required information in the Transitional Rent Referral Form adheres to DHCS's Housing Trio (Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services) and Room and Board Services Referral and Authorization Standards.

When a Transitional Rent provider submits a referral for Transitional Rent to SCFHP it must include **all** the following:

1. A completed online referral form for Transitional Rent.
2. A comprehensive Housing Support Plan (See *Appendix F: Housing Support Plan Requirements*)
3. A written attestation from SCCBHS that the referred member is BHSA eligible and SCCBHS commits to provide the member with BHSA Housing Interventions at the expiration of Transitional Rent or upon denial of the referral request for authorization by SCFHP.

Housing First: In accordance with California (W&I) Code section 8256, SCFHP administers Transitional Rent in accordance with Housing First requirements. As such, SCFHP does not condition authorization for or continued receipt of Transitional Rent on sobriety, engagement in or completion of certain services,[16] or "housing readiness."[17] Recovery housing is an allowable *interim* setting under Transitional Rent when it is the choice of the member. Members who want to live in a recovery environment can

[16] The only exception is Housing Transition Navigation Services as a Housing Support Plan is required. This is a prerequisite for authorization of Transitional Rent.
[17] See California W&I Code section 8255(d) for the definition of Housing First.

have access to recovery housing; however, members who prefer low-barrier housing are not limited to just recovery housing. Recovery housing is an option but never the only option available to individuals eligible for Transitional Rent.

SERVICE REQUIREMENTS

A Transitional Rent provider is the entity that:

1. Issues payment for rental subsidies for members receiving Transitional Rent,
2. Provides housing for members receiving Transitional Rent (as in the case of a nonprofit organization that owns and operates a permanent supportive housing project), and/or
3. Contracts with other organizations that directly provide or issue payments for rental subsidies

Transitional Rent providers administer payments directly to the landlords or property managers and seek reimbursement in arrears from SCFHP in accordance with standard billing requirements.

The services required under Transitional Rent are divided into four categories with the maximum billable units and the associated billing codes shown per category. Community Supports providers are required to provide any or all the services below based on member needs and submit claims to SCFHP that reflect the services delivered**.**

Service Categories and Required Services	Maximum Billable Units	Billing Codes
1. Housing Unit Acquisition a. Work with the member's Housing Transition Navigation Services (HTNS) provider if not the Transitional Rent provider for coordination to secure unit. b. Obtain agreement from the member to move forward with securing the identified unit. c. Meet with landlord or property owner to proceed with leasing the identified unit. d. Conduct an inspection to ensure the housing unit is habitable and meets either HUD's quality standards or state habitability standards. e. Document the habitability inspection with all applicable details and the outcome of the inspection.	6 Units	• Permanent Setting = H0044, U6 • Interim Setting = H0043, U2
2. Lease Execution a. Serve as a liaison between member and landlord or property owner to ensure the rent structure is affordable and reasonable. b. Review the lease agreement to ensure that it is compliant and legal. c. Assist the member in reviewing, understanding, and executing the lease agreement. d. Ensure member has a copy of the fully executed lease and understands all terms and requirements.		

Service Categories and Required Services	Maximum Billable Units	Billing Codes
3. Other Services Coordination (Note: If member is eligible and the services are applicable.) a. Coordinate with the member's Enhanced Care Management (ECM) Lead Care Manager to ensure they have the most recent contact information for the member for in-person outreach to engage and enroll the member into ECM. • Coordinate with the member's Housing Transition Navigation Services (HTNS) provider if member is placed in an interim setting to support the member with identifying and securing placement in a permanent setting. • Coordinate with the member's Housing Deposits provider if member is needing this service simultaneously with Transitional Rent for the same housing placement. • Coordinate with the member's Housing Tenancy and Sustaining Services (HTSS) provider to ensure the member sustains their housing while receiving Transitional Rent. • Coordinate with Santa Clara County's local Coordinated Entry System, homeless services authorities, public housing authorities, county agencies, other operators of local rental subsidies, and SCCBHS, as needed. • Document all coordination efforts in the member's Housing Support Plan.		
4. Housing Management Information System (HMIS) Documentation a. Complete an intake (VI-SPDAT) in HMIS if not already completed or not updated in the last 12 months. b. Ensure all instances of Transitional Rent are recorded in HMIS. c. Preserve the member's status as homeless or chronically homeless in HMIS.		
5. Monthly Rent Payments a. Issue timely payments to the landlord, property manager, or other relevant entity on behalf of the member before the stated monthly deadline. b. Ensure that the rent payment structure is set up with SCCBHS to ensure that the rent payments are assumed by SCCBHS after Transitional Rent ends.		

AUTHORIZATION FOR COMPLIMENTARY SERVICES

When SCFHP authorizes a member for Transitional Rent, it will also authorize members for the following services based on need and if they are not already receiving those services:

- Enhanced Care Management (ECM)
- Housing Transition Navigation Services (HTNS)
- Housing Deposits
- Housing Tenancy and Sustaining Services (HTSS)

SCFHP will share the assigned providers and their contact information with the assigned Transitional Rent provider so that they can collectively update a member's Housing Support Plan and coordinate the delivery of complimentary services alongside Transitional Rent.

MONITORING AND OVERSIGHT

SCFHP provides continual monitoring and oversight of the Transitional Rent providers to ensure compliance with the contractual requirements and those detailed in this *Community Supports Provider User Guide*. SCFHP utilizes data-driven tools to:

(1) Ensure the effective and seamless implementation of Transitional Rent at and after launch on January 1, 2026;
(2) Engage in opportunities to resolve challenges and for process improvement; and
(3) Conduct ongoing monitoring and oversight to ensure quality and timely services are provided to SCFHP members.

Ongoing monitoring may include chart review and requests for data to establish that timely and quality services were provided.

PAYMENT STRUCTURE

See the C*ommunity Supports Transitional Rent Provider Billing and Payment Guide* for details on the payment and billing structure for Transitional Rent.

Santa Clara Family Health Plan™

APPENDIX A
MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES (SMHS)
ACCESS CRITERIA BY PROGRAM AND AGE GROUP

Medi-Cal Specialty Mental Health Services (SMHS) Access Criteria by Program and Age Group	
SMHS Adults	Medi-Cal members aged 21 or older qualify for SMHS if they meet **both** of the following criteria: 1. The individual has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability or dysfunction in social, occupational, or other important activities. b. A reasonable probability of significant deterioration in an important area of life functioning. **AND** 2. The individual's condition is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems. b. A suspected mental disorder that has not yet been diagnosed.
SMHS Children	Medi-Cal members under age 21 qualify for SMHS if they meet **both** of the following requirements: 1. The individual has at least one of the following: a. A significant impairment b. A reasonable probability of significant deterioration in an important area of life functioning c. A reasonable probability of not progressing developmentally as appropriate. d. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal MCP is required to provide. **AND** 2. The individual's conditions as described in 1. above is due to one of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the International Statistical Classification of Disease and Related Health Problems. b. A suspected mental health disorder that has not yet been diagnosed. c. Health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, or neglect.

APPENDIX B
DRUG MEDI-CAL (DMC) OR DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) ACCESS CRITERIA BY PROGRAM AND AGE GROUP

Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) Access Criteria by Program and Age Group	
DMC and DMC-ODS Adults	Medi-Cal members age 21 or older meet access criteria for DMC-ODS or DMC services if they meet **at least one** of the following criteria: 1. Have at least one diagnosis from the most current version of the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders. OR 2. Have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco Related Disorders and Non- Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.
DMC and DMC-ODS Children	Medi-Cal members under 21 are eligible for DMC-ODS or DMC if they meet the medical necessity standard for one or more SUD services provided through these delivery systems, as recommended by a licensed behavioral health practitioner.

APPENDIX C
DEFINITION OF EXPERIENCING OR AT RISK OF HOMELESSNESS

Members must meet the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (CFR), with the following three modifications:

1. If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; and
2. The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days; and
3. For the at risk of homelessness definition at 24 CFR section 91.5, the requirement to have an annual income below 30 percent of median family income for the area, as determined by HUD, will not apply.

APPENDIX D
FULL-SERVICE PARTNERSHIP ELIGIBILITY CRITERIA

The Full-Service Partnership (FSP) eligibility criteria are as follows:

Timeline	Eligibility Criteria
In effect until July 1, 2026	Set forth in CCR Title 9, section 3620.05 and require: 1. a significant mental health condition as described in W&I Code section 5600.3, and 2. the presence of at least one qualifying risk factor (as identified in CCR Title 9, section 3620.05), such as experiencing or a risk of homelessness.
Take effect on July 1, 2026	Set forth in W&I Code section 5887(d), to be eligible for FSP a person 25 and under must: 1. meet the criteria for a mental health condition specified in W&I Code section 14184.402(d), notwithstanding the age limitations provided therein, or have an SUD as defined in W&I Code section 5891.5(c) and 2. be in one of the priority populations identified in W&I Code section 5892(d), which includes those who are experiencing or at risk of homelessness, among other groups. For those 26 and over, the eligibility requirements are the same as for those 25 and under except that the criteria for a qualifying mental health condition are set forth in W&I Code section 14184.402(c).

APPENDIX E
RESOURCES FOR DEFINITIONS ON PERMANENT SETTINGS

Allowable Settings

The specific settings allowable for Transitional Rent are authorized under California's BH-CONNECT Special Terms and Conditions (STCs). See the CMS Approval Letter and BH-CONNECT STCs Technical Corrections and Protocols (January 2025), Attachment G. Available at https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT-Resources.aspx. Accessed April 2025.

Setting Type	Setting	Definition
Permanent	Accessory dwelling units (ADUs)	An ADU is a smaller, independent residential dwelling unit located on the same lot as a stand-alone primary residence. (See the California Department of Housing and Community Development. Accessory Dwelling Unit Handbook. January 2025. Available at https://www.hcd.ca.gov/policy-and-research/accessory-dwelling-units. Accessed April 2025.)
Permanent	Shared housing—where two or more people live in one rental unit	See also the BHSA County Policy Manual for a description of shared housing. (DHCS. BHSA County Policy Manual. April 2025. Available at https://www.dhcs.ca.gov/BHT/Pages/Policy-Manual.aspx. Accessed April 2025.)
Permanent	Project-based or scattered site permanent supportive housing	See also the BHSA County Policy Manual for a description of permanent supportive housing.
Permanent	Recovery housing	See also the BHSA County Policy Manual for a description of recovery housing.

APPENDIX F
HOUSING SUPPORT PLAN REQUIREMENTS

Community Supports providers that are contracted to deliver Housing Transition Navigation Services (HTNS), Housing Deposits, and/or Transitional Rent are required to develop, monitor, and update a Housing Support Plan for their assigned members.

The requirements for a comprehensive Housing Support Plan are as follows:

1. Identify the permanent housing strategy and solution for the member, including the payment sources and mechanisms, that will support the member in maintaining housing after the Room and Board services[1] covered by SCFHP are exhausted (e.g., the member's income, BHSA Housing Interventions, or other long-term subsidies).
2. Identify the full range of permanent housing supports that will support the member in sustaining tenancy (e.g., tenancy sustaining service, utilities).
3. Be informed by the member's preferences and needs, and review and revise the Housing Support Plan as needed based on changes in member circumstances.
4. Be based on a housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member's approach to meeting the goals, and identifies when other providers or services, both reimbursed and not reimbursed by SCFHP, may be required to meet the goals.
5. Be developed in a way that is culturally appropriate and trauma informed.
6. Transitional Rent Only: Documented confirmation from Santa Clara County Behavioral Health Services (SCCBHS) that the member is the California Behavioral Health Services Act (BHSA) eligible and SCCBHS commits to provide the member with BHSA Housing Interventions at the expiration of Transitional Rent.

Transitional Rent

When receiving Transitional Rent, a member can be placed in an *interim* or *permanent* setting. SCFHP understands that a Housing Support Plan may vary depending on the type of setting in which a member is placed. As such, below are additional documentation requirements for a Housing Support Plan for a member receiving Transitional Rent based on setting.

- **For interim settings**: For a member transitioning from homelessness into an interim setting, a Housing Support Plan must address all major elements identified above, though it may be less complete, given that establishing trust, along with identifying a member's housing strategy and solution, and payment sources and mechanisms can take time. However, SCFHP requires written documentation to accompany a referral for Transitional Rent where the SCCBHS commits to transitioning the member to BHSA Housing Interventions at the expiration of Transitional Rent. This written documentation fulfills the requirement of the member's housing solution in their Housing Support Plan (i.e., if the member is otherwise not able to secure a U.S. Housing and Urban Development (HUD) Housing Choice Voucher, permanent supportive housing subsidy, or other long-term rental subsidy to transition to at the expiration of coverage under Transitional Rent).
- **For permanent settings**: By the time a member is seeking Transitional Rent in a permanent setting, they will be further along in making progress with their Housing Support Plan. In this

[1] Room and Board services include Recuperative Care, Short-Term Post-Hospitalization Housing (STPHH), and Transitional Rent.

situation, the Housing Support Plan must address all major elements identified above, but the content and overall level of detail will look different than when the Housing Support Plan was initially created. The Housing Support Plan must indicate a member's goals have been identified, barriers overcome (e.g., documents have been obtained), and a housing search has taken place. So, a Housing Support Plan should appear to be more complete.