Community Supports	Anthem	Health Net	Kaiser	Molina
Housing Transition Navigation Services	X	X	X	X
Housing Deposits	X	X	1/1/2024	X
Housing Tenancy and Sustaining Services	X	X	X	X
Short-Term Post-Hospitalization	X	X	1/1/2024	X
Recuperative Care (Medical Respite)	X	X	1/1/2024	X
Respite Services	X	X	1/1/2024	X
Day Habilitation Programs	X	X	1/1/2024	X
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities	X	X	1/1/2024	1/1/2024
Community Transition Services/Nursing Facility Transition to a Home	X	X	1/1/2024	X
Personal Care and Homemaker Services	X	X	1/1/2024	X
Environmental Accessibility Adaptations (Home Modifications)	X	X	1/1/2024	X
Medically Tailored Meals/Medically-Supportive Food	X	X	1/1/2024	X
Sobering Centers	X	X	1/1/2024	X
Asthma Remediation	X	X	1/1/2024	X

Anthem BlueCross

Referring a member for Community Supports (CS)

Community Supports

[14] Department of Health Care Services (DHCS) Community Supports services approved:

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining
- Short-term post-hospitalization housing
- Recuperative care (medical respite)
- Respite services
- Day habilitation programs
- NF transition/diversion to assisted living facilities
- Community transition services/NF transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations (home modifications)
- Medically Tailored Meals/Medically-Supportive Food
- Sobering centers
- Asthma remediation

Approval/denial turnaround time for referrals

Referrals received with all suggested supporting documentation to meet criteria will be processed within [five] business days of receipt. Urgent turnaround time is [three] business days of receipt.

Risk for delays would include:

- Inadequate documentation
- Unable to reach member
- Unable to obtain documentation from provider in order to meet criteria
- Unable to obtain consent from member to proceed with services — please include in your documentation when submitting referral if possible

Referrals — No wrong door approach

Community Supports:

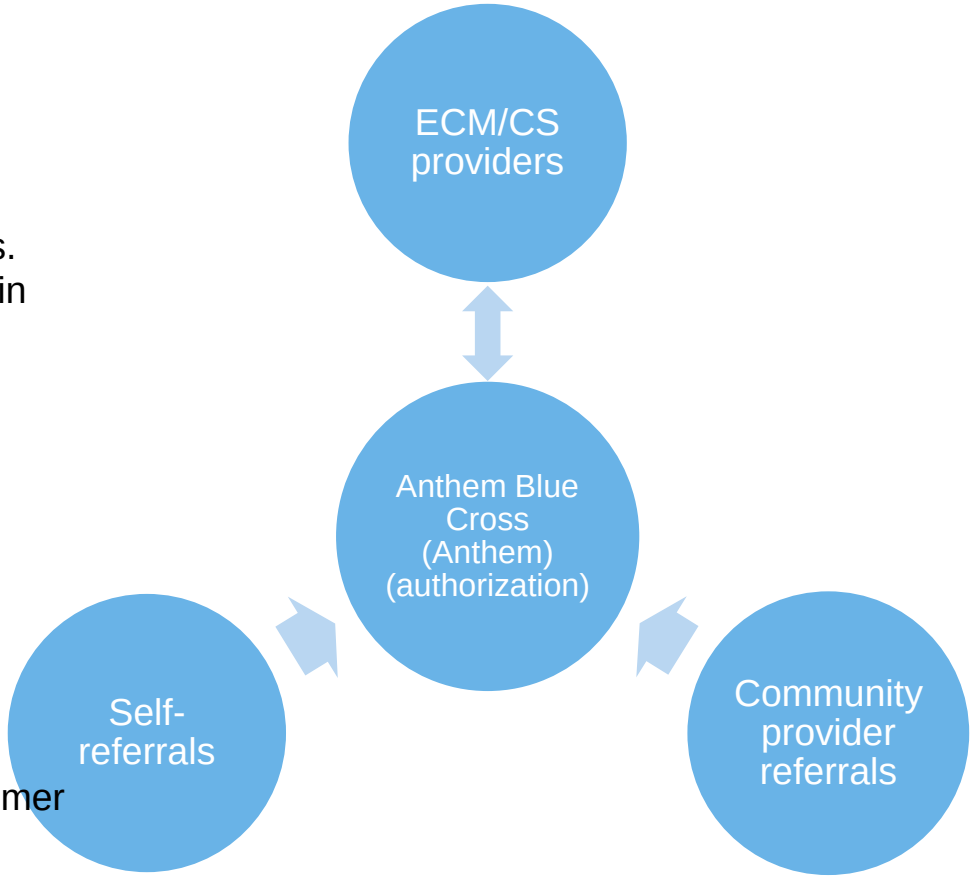
- Are designed to complement Enhanced Care Management (ECM); however, the eligibility criteria is not as strict.
- Community Supports went live in every county [January 2022], dependent on county readiness.
- Additional Community Supports may be added in a county as the county becomes ready, on a [bi-annual] basis and/or as networks are being assessed

Referral sources:

- Member self-referrals
- ECM provider referrals
- Community Supports provider referrals
- Other sources

Process:

- Submit via Care Central portal, email, fax, customer care phone number
- Authorization
  - Supporting documentation



CS referral — suggested supportive documentation

- **Housing transition and navigation:** Documentation of homelessness or at risk for homelessness by service providers, PCPs, specialists, or outreach providers; documentation of entries/exits from shelters; notices from current landlord; financial statements
- **Housing tenancy and sustaining:** Housing support plan; lease agreements
- **Housing deposits:** Housing support plan; lease agreements; utility bill/deposit agreements; financial statements
- **Short-term post-hospitalization:** Emergency department or inpatient discharge paperwork; documentation of homelessness by service providers, PCP, specialists, or outreach providers; documentation of member participating in housing transition navigation services
- **Recuperative care (medical respite):** Emergency department, inpatient, or skilled nursing discharge paperwork; documentation of homelessness by service providers, PCPs, specialists, or outreach providers; documentation of entries/exits from shelters; documentation from any support agency indicating services/supports member needs; documentation/office visit notes with diagnosis and identification of frailty; assessment determining limitations in ADLs; medication/treatment orders
- **Respite services:** Documentation/office visit notes with diagnosis and identification of frailty; documentation from support agencies indicating services/supports member needs or receives; attestation from unpaid caregiver(s) requesting services

CS referral — suggested supportive documentation (cont.)

- **Day habilitation programs:** Documentation of housing status by service providers, PCP, specialist or outreach providers; documentation of participation in housing transition/navigation or housing tenancy and sustaining services
- **NF transition/diversion to assisted living facilities:** Documentation from support agencies indicating services/supports member needs or receives; documentation/office visit notes with diagnosis and identification of frailty; medication/treatment orders
- **Community transition services/NF transition to a home:** Skilled nursing discharge plan/paperwork; documentation from support agencies indicating services/supports member needs or receives; documentation/office visit notes with diagnosis and identification of frailty; documentation of home modifications/services completed; medication/treatment orders
- **Personal care and homemaker services:** Documentation/office visit notes with diagnosis and identification of frailty; assessments identifying members physical needs; documentation from support agencies indicating services/supports member needs or receives; physical therapy/durable medical equipment evaluation documenting safety needs; medication/treatment orders

CS referral — suggested supportive documentation (cont.)

- **Environmental accessibility adaptations (home modifications):** Order from the member's current primary care physician or other health professional specifying the requested equipment; physical therapy/durable medical equipment evaluation documenting safety needs; documentation/office visit notes with diagnosis and identification of frailty
- **Medically-tailored meals/medically-supportive food:** Documentation/office visit notes with diagnosis or identification of chronic illness requiring special diet; skilled nursing discharge plan; documentation from support agencies indicating services/supports member needs or receives; ED, inpatient, skilled nursing discharge paperwork; medication/treatment orders
- **Sobering centers:** A completed CIWA screening tool or other evidenced-based tool as well as the member's consent to share information with Anthem should be submitted to Anthem to obtain the authorization for the day of services
- **Asthma remediation:** Documentation of asthma diagnosis from service provider, PCP, or specialists; pulmonary function tests; prescriptions; asthma treatment plan; list of asthma medications

Community Supports team

- Provide the authorization for services once criteria is met and match provider to member.
- Provide notification to provider and member with final decision.
- Staff will follow up in [10] days with member to ensure contact has been made by provider. We will continue follow up every [30] days thereafter with member.
- Staff will also follow up with provider after [10] days if contact has not been made with member.
- Meetings may be conducted with providers for updates/collaboration as needed with services coordinators and/or lead RN/manager for certain services on a case-by-case basis as needed.

If you have questions or concerns, email [CalAIM@anthem.com].

Referring a member to Enhanced Care Management (ECM)

[Three] steps to the ECM screening and referral process

- Complete **Part A** of this checklist to identify potential duplicative/wrap programs in which the member may need to choose between programs or if coordination needs to occur between programs.
  - Part A — Exclusionary screening checklist
    - Absolute exclusion criteria
    - Duplicative programs — Either ECM or another program
    - ECM as a wrap — Can be in both programs

[Three] steps to the ECM screening and referral process (cont.)

- Part B — Populations of focus screening checklist
  - Individuals experiencing homelessness**
  - Adult high utilizers
  - Adults with serious mental illness (SMI) or substance use disorder (SUD)

**** Examples of supporting documentation for homelessness:**

- Eviction notice(s)
- Documentation of entries/exits from shelters
- Documentation of homelessness or at risk for homelessness by service providers, PCP/specialists or outreach providers
- Documentation/office visit note with diagnosis or identification of at least [one] complex physical, behavioral, or developmental health need
- Medication/treatment orders
- Financial statements

Complex physical, behavioral health, and developmental conditions

Complex physical, behavioral health, and developmental conditions (check all that apply)	
Physical health	
☐ Asthma	☐ Dementia requiring assistance with IADLS
☐ Chronic kidney disease	☐ Diabetes (insulin-dependent) poorly controlled
☐ Chronic liver disease	☐ History of stroke or heart attack
☐ Chronic obstructive pulmonary disease (COPD)	☐ Hypertension (poorly controlled)
☐ Congestive heart failure (CHF)	☐ Traumatic brain injury (TBI)
☐ Coronary artery disease	☐ Other, please note:
Behavioral health	
☐ Bipolar disorder	☐ Psychotic disorders, including schizophrenia
☐ Major depressive disorder	☐ Substance use disorder, please specify:
☐ Other, please note:	
Developmental	
☐ Intellectual/developmental disability	☐Other, please note

Member's eligible population(s) of focus (check all that apply)	
☐	Member passes Part A of checklist.
☐	Member passes Part B: is eligible for one or more of the following POF: homeless, high utilizer, adult with SMI/SUD
☐	Fill out Anthem *ECM Referral Form* and submit completed *ECM Referral Form* and necessary supportive documentation to [CalAIMreferrals@anthem.com] or Submit electronic ECM referral and attach supportive documentation through Care Central/Availity Portal.*

Suggested reading

- ECM Policy Guide
- Community Supports Policy Guide
- Other resources: https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM.aspx

Resources

- Anthem CalAIM Website
- Anthem CalAIM ECM Referral Form
- Anthem CalAIM CS Referral Form

If you have questions or concerns, email CalAIM@anthem.com.

health net™

California's Trusted Medi-Cal Partner

Working to Transform Our Communities One Person at a Time

Identifying and Referring Clients for Community Supports

Process With findhelp

Findhelp is a social services platform that makes it simple for contracted & non contracted providers to find and connect to community supports services or free and reduced cost community programs to address social needs.

- Anyone can use FindHelp links to make a referral
- Contracted and non contracted providers can create a login to track referrals

https://communitysupportsecm.findhelp.com/

Process Without findhelp

- Utilize the Community Supports (CS) authorization guides to determine eligibility
- Providers can identify CS providers through the provider directory
- Providers contact the CS provider and provide them with the member contact information & supplemental information used to determine eligibility
- CS authorization guides are posted inside the Community Supports section in the link below:

CalAIM Resources for Providers

What Happens After Referral to CS Provider?

If you used findhelp to make the referral:	If you did NOT use findhelp:
• Providers can go into findhelp and check on the referral status. • More details will be given during the findhelp training	• Providers will need to call the CS provider directly to check on the referral status

Identifying and Referring Clients for Enhanced Care Management

How to Submit a Referral for ECM?

Submit ECM referral by using the Health Net Provider Portal or faxing in the member information that supports their ECM eligibility

ECM referral template can be used, but it is not a requirement

ECM referral templates can be found on CalAIM Provider Resources under Forms & Tools

- Fax ECM Referral Templates to 800-743-1655

What Happens After an Authorization is Submitted?

- You may be contacted for additional information
- You will receive a letter indicating authorization status from Health Net
- You can also see your authorization status on the portal

Health Net Resources

Resource Name	Resource Link
Health Net and CalViva Health Provider Portal Login Pg.	provider.healthnetcalifornia.com
Health Net and CalViva Health Provider Library	https://providerlibrary.healthnetcalifornia.com/
ECM Provider Guide	https://providerlibrary.healthnetcalifornia.com/medi-cal/calaim/enhanced-care-management--ecm-.html
CalAIM Provider Training Recording	https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/provider_engagement.html
ECM/CS Provider Directory (This list will be updated as we receive additional contracts)	https://www.healthnet.com/content/healthnet/en_us/members/medi-cal/provider-directory.html (Go to: CalAIM ECM and CS Providers (PDF)
Claims/Invoice (Option for billing if claims submission is not possible)/Billing Guidelines – providers can submit a claim OR an invoice	https://www.healthnet.com/content/healthnet/en_us/providers/claims/claims-procedures.html For providers without a contract as of 01/01/2022, we will process the claim for authorized services based on county default rates derived from the DHCS pricing guidance to not interrupt cash flow to the provider. Once we have an executed contract, we will process claims based on the negotiated rates prospectively from the effective date based on the claim receipt date. We will adjust any claims with a receipt date on or after the effective date processed before rates were loaded to our system to reflect the contracted rates.
Medi-Cal Provider Guide	Click on new provider training deck for Medi-Cal https://www.healthnet.com/content/healthnet/en_us/providers/support/provider-welcome.html

Resources

For more information, providers can access the following guides on the DHCS website:

- ✓ **DHCS ECM AND Community Supports FAQ:**
  - —https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Community-Supports-Dec-FAQ.pdf
- ✓ **ECM and Community Supports Homepage:**
  - — https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx
- ✓ **ECM Key Design Implementation Decisions:**
  - — https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Key-Design-Implementation-Decisions.pdf
- ✓ **ECM Policy Guide:**
  - — https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide-September-2021.pdf
- ✓ **Community Supports Policy Guide:**
  - — https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf
- ✓ **Coding Options for ECM and Community Supports:**
  - — https://www.dhcs.ca.gov/Documents/Coding-Options-for-ECM-and-ILOS-06-22-21.pdf

THANK YOU!

Kaiser Permanente Community Services (CS) Referral Process

CS Services Offered in Sacramento* *(effective January 1, 2022)*
Housing Transition Navigation Services
Housing Tenancy and Sustaining Services

**All remaining CS services will be offered beginning January 1, 2024*

ECM Populations of Focus *(effective January 1, 2022)*
Determined by DHCS
Individuals and Families Experiencing Homelessness
Adult High Utilizers
Adults with SMI/SUD

Kaiser Permanente employs a ***"No Wrong Door"*** approach to referrals for Community Supports, meaning referrals for Community Supports will be accepted from all points of care within the continuum. Referrals will be accepted from family members and/ or care givers. Self-referrals will also be accepted.

Who can submit referrals?

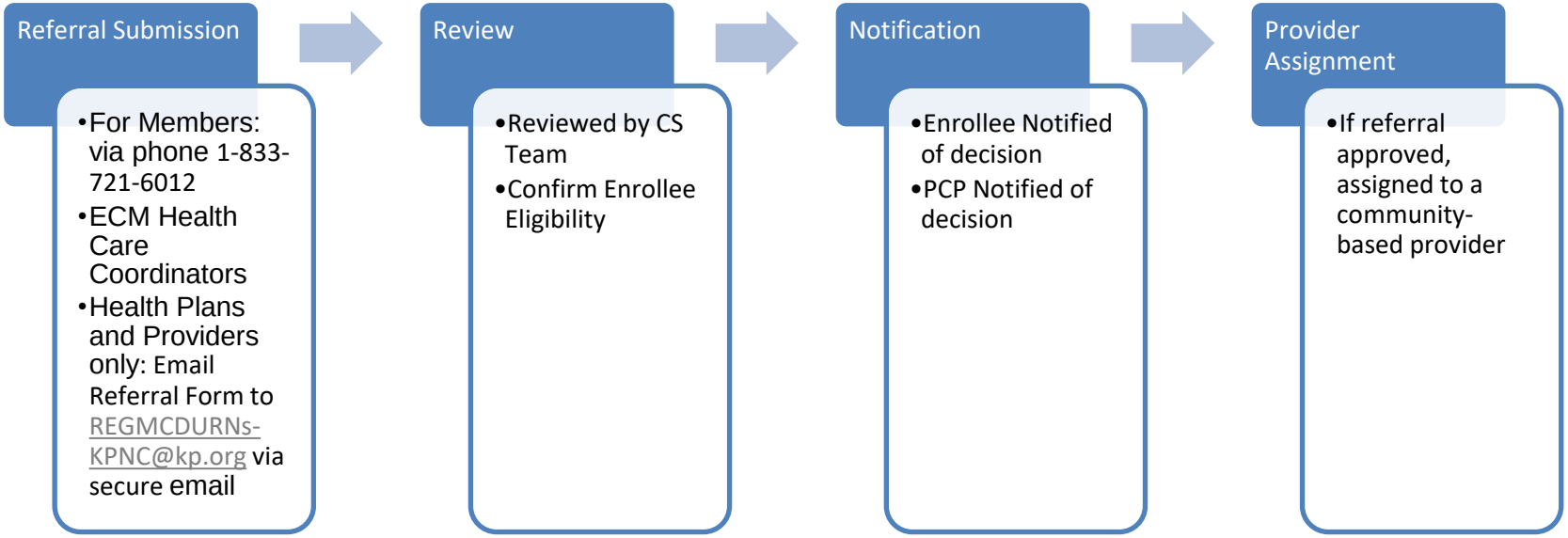
- Provider
- Self-Referral
- Family Members/Care Givers

What information is needed?

- Providers – Use Sacramento MCP ECM Referral Form
- Members - Enrollee contact information and Reason for Referral

What is the Eligibility Criteria?

- Assessment of needs verified
- Enrollees may qualify for both ECM and CS



Referral Request	Turnaround Times
Non-Urgent	Reviewed within 5 business days of request
Urgent	Reviewed within 72 hours

CS Referrals

- Only for Health Plans and Healthcare providers, Secure Email: REGMCDURNs-KPNC@kp.org *with "CS Referral" as the subject line*
- For Members, Phone: **1-833-721-6012**

ECM Referrals

- Only for Health Plans and Healthcare providers, Secure Email: REGMCDURNs-KPNC@kp.org *with "ECM Referral" as the subject line*
- For Members, Phone: **1-833-721-6012**

Provider Directory: https://thrive.kaiserpermanente.org/medicaid/medi-cal-california/new-members

Molina Healthcare

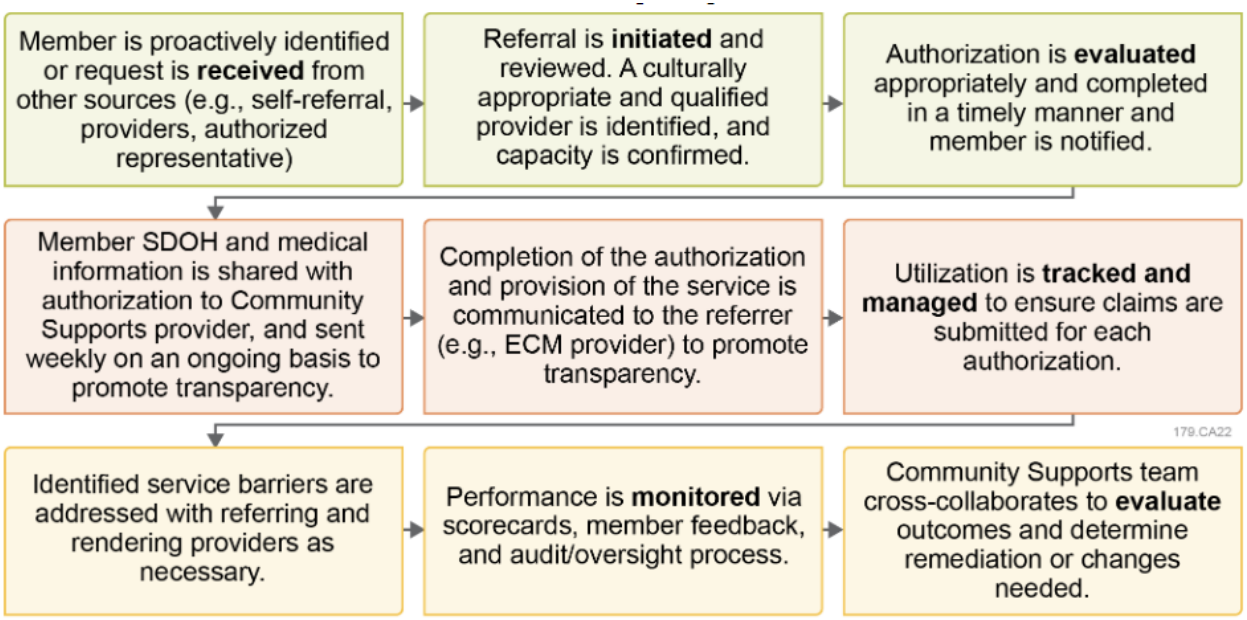
CS Eligibility Criteria

Completed referrals must be submitted to the CA HCS Community Supports/LTSS team for review

CS services require prior authorization (except Sobering Centers)

Each CS has specific qualifying criteria in order for members to be approved for the service. The request will be reviewed and decisioned by the HCS Community Supports team.

Referral and Authorization Process

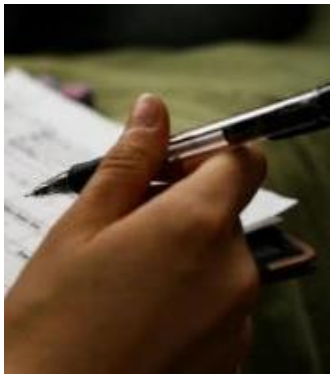


How to Refer a Member

- https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

- **CS Referrals**
  - Submit referral form to MHC_CS@molinahealthcare.com

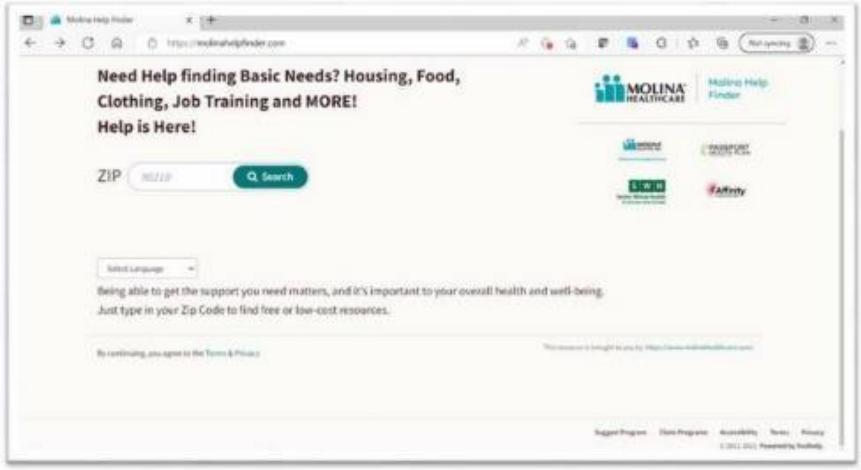
- **ECM Referrals**
  - Submit referral form to MHC_ECM@Molinahealthcare.com



Provider Search

- https://molina.sapphirethreesixtyfive.com/?ci=ca-molina&network_id=13&geo_location=34.038247754662045,-118.29833344757583&locale=en_us

- Molina Help Finder: www.molinahelpfinder.com



Thank you!

Questions?