	<p style="text-align: center;">POLICIES AND PROCEDURES</p>
Policy #: 404-1747	Lead Department: Utilization Management
Title: Community Supports Policy for Housing Transition Navigation Services	
Original Date: 04/18/2024	Date Published: 01/16/2025
Approved by: UMWG	

Purpose:

To provide an overview of Central California Alliance for Health’s (the Alliance’s) Housing Transition Navigation Services benefit.

Policy:

These services are to be provided on an individualized assessment of needs and documented in the individualized housing support plan.

Renewals require a clear sharing of the individualized assessment and individualized housing support plan demonstrating clear ongoing support. These required services must be identified.

Definitions:


Community Supports: Community Supports are alternative services or settings to those provided under the California Medicaid State Plan that Managed Care Plans (MCPs) may choose to offer to their Members, according to 42 CFR section 438.3(e)(2). These supports require pre-approval by the Department of Health Care Services (DHCS) as medically appropriate and cost-effective substitutes for covered services or settings under the State Plan. Community Supports build on the efforts of Whole Person Care (WPC) and Health Homes Program (HHP), expanding access to services previously available only through home and community-based initiatives and addressing health-related social needs. Federal regulations permit states to offer Community Supports as an option to Members, which can substitute for and potentially reduce the utilization of various covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use.

Enhanced Care Management: Enhanced Care Management (ECM) is a comprehensive, community-based care management service designed to address the complex needs of individuals with multiple chronic conditions, significant behavioral health issues, or social determinants of health that impact their well-being. ECM involves the coordination of medical, behavioral, and social services, focusing on personalized care plans, intensive case management, and close collaboration among healthcare providers, social workers, and community resources. The goal of ECM is to improve health outcomes, reduce hospitalizations and emergency department visits, and enhance the overall quality of life for high-need, high-cost patients by providing tailored, holistic care.


Procedures:

Eligible Individuals:

- 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; or

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- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) For this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institutions for Mental Disease, and State Hospitals; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
 - (1) An individual or family who:
 - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
 - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
 - Meets one of the following conditions:
 - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
 - Is living in the home of another because of economic hardship;
 - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
 - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
 - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
 - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient’s approved consolidated plan;
- A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7

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U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or


- A child or youth who does not qualify as “homeless” under this section but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him. Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
 - Have one or more serious chronic conditions;
 - Have a Serious Mental Illness;
 - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents);
 - Are receiving Enhanced Care Management; or
 - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

CCAH may accept an attestation of the need for housing to satisfy any documentation requirements regarding the Member’s housing status.

Services Provided:

Housing transition services assist members with obtaining housing and include:

1. Conducting a tenant screening and 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, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member’s approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. 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).

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5. 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 out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as HUD's Housing Choice Voucher Program (Section 8), or state and local assistance programs) and matching available rental subsidy resources to Members.
7. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
8. Assisting with requests for 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 Community Support).
16. Managing member expectations of housing benefits including what services are and are not covered

Authorization Procedure:


Initial requests for Housing Transitions and Navigation Services will be approved for eligible patients for an initial period (typically 6 months).

Must be homeless or at risk of homelessness (definition above) and need help with a housing plan.

After this initial authorization:

Patients are expected to either be housed, document ready but unhoused, or unhoused without documents

For members who have not had 1), 2), 5), 6), 7), 13), completed (e.g. document/plan ready) a clear explanation needs to be given as to why not. Re-approval can be considered if documentation demonstrates why member is more likely to be successful with completing above tasks with additional time (See Alliance Policy #404-1201 for full authorization request processes).

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For other tasks beyond those described above, documentation must clearly state:

1. What task(s) member still requires assistance with
2. Why member is more likely to be successful with completing task(s) with additional time

For members who are “document/plan” ready, a minimum of 4-5 housing opportunities need to be applied for each month. If none available, or fewer opportunities exist, then the member’s ECM provider or care coordinator can assist with these applications.

For members who have already completed their initial authorization with one housing provider, a new authorization with a different housing provider can be considered if the following conditions are met:

1. Understanding of why the switch - must have a good cause (e.g. fractured relationship, never established services/received services, etc.) and requires medical director review
2. Transfer of plan / progress if any

References:

Alliance Policies:

- 300-4110 - Organizational Provider Credentialing Guidelines
- 300-4025 - Provider Screening and Enrollment Guidelines
- 404-1201 - Authorization Request Process
- 404-1101 - Utilization Management Program
- 405-1310 Community Supports Overview

Impacted Departments:

- Enhanced Health Services
- Claims
- Provider Services
- Member Services
- Care Management

Regulatory:

- S9470 U6
- S5170 U6
- S9977 U6

Legislative:


- Welfare and Institutions Code 14042.1

Contractual (Previous Contract):

Contractual (2024 Contract):

- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.5.2
- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.5.3.F

DHCS All Plan Letter:

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California Department of Health Care Services. (2019). *Medi-Cal managed care health plan guidance on the provision of health and wellness education and health management programs for beneficiaries* (APL 19-004).

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-004.pdf>

NCQA:

Supersedes:

Other References:

California Department of Health Care Services. (n.d.). *Coding options for ECM and Community Supports*. <https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf>

California Department of Health Care Services. (n.d.). *Community supports policy guide*. <https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy->

Attachments:

Lines of Business This Policy Applies To

☐ DSNP

☒ Medi-Cal

☐ Alliance Care IHSS

LOB Effective Dates

(01/01/2026 - present)

(01/01/1996 - present)

(07/01/2005 - present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
8/28/2024	8/28/2024	Sabryna Sherman, UM Manager - Authorizations and Transportation Coordination	UMWG
11/12/2024	11/12/2024	Michael Wang, MD Medical Director	UMWG