CalAIM – Community Supports Service Frequently Asked Questions

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What is CalAIM?
CalAIM is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of individuals. This initiative is a long-term commitment to transform and strengthen Medi-Cal by offering individuals a more equitable, coordinated, and person-centered approach including the implementation of a broad delivery system, program, and payments reforms across Medi-Cal.

What are Community Supports Services?
CalAIM - Community Supports (CS) Services are non-Medi-Cal services that Partnership HealthPlan of California (Partnership) offers in lieu of a traditional Medi-Cal covered benefit allowing the plan to address Social Determinates of Health. Individuals do not need to receive and/or be enrolled with Enhanced Care Management (ECM) in order to qualify for CS and vice-versa. These services do not receive additional funding and must be cost-effective in lieu of a normal covered service. Partnership does not receive any reimbursement.

What Community Supports Services does Partnership offer?
As of January 1, 2023, Partnership offers ten (10) CS services to eligible members:

- ✓ Housing Transition Navigation Services
- ✓ Housing Deposits
- ✓ Housing Tenancy and Sustaining Services
- ✓ Short-Term Post-Hospitalization Housing
- ✓ Recuperative Care (Medical Respite)
- ✓ Respite Services
- ✓ Personal Care and Homemaker Services
- ✓ Medically Tailored Meals or Medically Supportive Food
- ✓ Day Habilitation**
- ✓ Sobering Centers**

** Note that these services may not be available in all counties, depending upon whether there are providers contracted to provide the service in the county.

Will Partnership add any more CS Services?
Partnership will be adding Transitional Rent and Asthma Remediation as a service in January 1, 2026.

Are there eligibility restrictions for Community Supports Services?

- Yes, there are restrictions for individuals that would like to receive CS Services: Individual(s) must have full-scope Medi-Cal benefits assigned to Partnership during the time the Treatment Authorization Request (TAR) is submitted and must remain eligible throughout the time

services are provided.
- Individual(s) must meet CS criteria

Where can I find the list of CS codes?
The list of codes can be found on our website and on DHCS' website.

Where can I find a list of CS providers?
You can locate all contracted CS providers in our Provider Directory by clicking on printable directories.

Where can providers access the recordings of previous training?
Providers can access pre-recorded webinars on the Community Supports webpage.

Can a member be eligible for CS services if they are enrolled in other programs?
This will depend upon the services the member is receiving. The member's situation will be reviewed on a case-by-case basis. If necessary, additional information may be required to show the individual is not receiving duplicate services.

Are all rates paid as a once a month service?
No, CS service rates vary by service. Partnership has chosen a mid-point rate based on DHCS guidelines. The Partnership CS Rates are available on our website.

What does PMPM mean?
Per member, per month is defined as 30 days from the start date of when you initially see the member (e.g. 01/24-02/24)

Do we need to submit a new TAR for any new service an individual receives and/or qualifies for?
Yes, a new authorization is required for any new CS services, individual(s) must continue to meet criteria for the new service being requested.

What CS services qualify as urgent?
Per DHCS guidelines, services such as Recuperative Care, Short-Term Post-Hospitalization Housing, and/or Medically Tailored Meals or Housing Deposits may qualify as urgent. However, the authorization will be reviewed and assessed. If the TAR is proven not to be urgent, the authorization will be changed to a non-urgent timeframe of 5 days for review.
Please see Partnership Policy-MCAP7001 Treatment Authorization Request (TAR) Review Process

Is it possible to have an ECM and CS contract?

Yes, providers may contract as both an ECM and CS provider.

When are Community Supports appropriate?
CS Services are substitute services or settings that are cost-effective alternatives to the health plan in-lieu of a traditional Medi-Cal benefit. Providers and members are encouraged to utilize other programs when available prior to requesting CS.

What if a member wants to change CS provider?
The member should reach out to our member's services department so we can be notified and assist them appropriately.

Housing Transition Navigation Services

Is the housing rate per member, per month regardless of how much time you spend on the member's services?
Yes, the housing rate is per member, per month.

What is the start date of the 30 days for housing assistance per member, per month?
The 30 days will begin on the TAR approval date.

What documentation should be submitted with the TAR?
A fully completed CS Referral form is required with as much information as possible.

Can more than one person in a household receive HTNS and HD?
No. At this time HTNS and HD may only be offered per household regardless of the number of members within the household.

Housing Deposits

Is the removal of first month's rent from housing deposits going into effect 7/1/2025 or 1/1/26 when transitional rent goes into effect?
Effective 7/1/2025 DHCS removed coverage of first and last month's rent – avoiding duplication with Transitional Rent. Note those that do not meet criteria for Transitional Rent will not receive first/last month's rent, only security deposit if they meet eligibility requirements.

If the landlord is asking for two times the rent for deposit request, would the provider submit it?
We ask for the providers to add information on the landlord in the TAR so we can review. Currently, the security deposit limit per California Law is that it equals one month's rent.

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Can Housing Deposits be used and offered to members who have not received Housing Transition Navigation Services?
Yes.

What documents and information are required for providers when submitting a Housing Deposit TAR?
Partnership requires:

- ✓ Housing Support Plan including budget planning, achievements, members' communication skills, and activities done between provider and member in addition to resources shared during the time Housing Transition Navigation Services were rendered (if applicable)
- ✓ A copy of the lease agreement
- ✓ CS Referral Form
- ✓ An itemized list included with the total amounts requested (i.e. set-up fees/deposits for utilities, application fees) up to $5,000.
- ✓ Date of the landlord engagement
- ✓ Date of visit to the living environment to ensure it is safe and ready for move-in

Can Housing Deposits be used to pay for applications and/or utilities?
Yes, applications and old or past due utilities can be paid for by using this service to ensure individuals establish basic households. However, the total amount used will be deducted from up to $5,000. Reference the DHCS Policy Guide for more information.

Can individuals use Housing Deposits to pay rent?
No, housing deposits **cannot** be used to pay rent.

Does Partnership have a letter to give the landlord showing the payments will be completed?
Partnership works directly with the contracted housing provider, not the landlord. CS providers must first receive an approved housing deposit TAR prior to paying the deposit to ensure reimbursement from the plan.

Can we use housing deposits to cover documentation fees such as birth certificates, State I.D Cards, etc?
Members experiencing homelessness may obtain documents such as State I.D Cards, birth certificates, etc. at no cost through their local Social Security Office, DMV, and/or county office. For additional information on how to obtain the documents mentioned please contact your local SSI, County, and/or DMV office.

If the member can pay for Housing Deposits, does Partnership HealthPlan reimburse the

member?
No, Partnership does not reimburse members. If the members can pay for their own home/apartment deposits, CS Services may not be necessary or appropriate.

Housing Tenancy and Sustaining Services

Are providers required to offer Housing Transition Navigation Services to offer Housing Tenancy and Sustaining Services?
No. Housing Transition Navigation would be offered when a qualified or eligible member is unsheltered and in search of housing. Housing Tenancy would be appropriate when a member is already housed, as this service is to help members remain housed. CS providers must be contracted for the services they intend to offer.

What documentation should be submitted with the Housing Tenancy and Sustaining Services TAR?
Submit a completed Referral Form with the TAR with as much information as possible. If submitting a reauthorization/extension, include the housing support plan listing what activities have been done and any information to justify the reauthorization.

Can more than one person in a family unit receive HTSS?
More than one member can receive HTSS if they are not a family unit as formerly defined by HUD and can be found in pg. 66, footnote 109 of the DHCS CS Policy Guide Volume 2.

Global Cap Requirement (1/1/2025)

What is the Global Cap?
Per DHCS' updated Community Supports Policy Guide Vol 2, pg 2 the global cap coverage of Short-Term Post-Hospitalization Housing (STPHH), Recuperative Care (RC), and Transitional Rent are limited to a combined 182-days of utilization in a rolling 12-month period. This means a member may not receive more than the combined six months (182 days) of STPHH, RC, and Transitional Rent during any 12-month rolling period.

When does the Global Cap go into effect?
The global cap went into effect starting 1/1/2025 per DHCS' Effective Date for Community Supports Policy Guide Updates

The Global Cap for STPHH is 182 days in a 12-month period. Does this mean this is no longer a once in a lifetime service for up to 6 months?

There is no longer a lifetime for STPHH. It is 182 days in a 12-month rolling period.

Short-Term Post-Hospitalization Housing

What were the new guidelines for STPHH?

Per the April 2025 Policy Guide Vol 2 update: exiting an institution and experiencing/at risk of homelessness and receiving ECM, have ongoing serious chronic condition, SUD, physical/BH needs. Part of this went into effect 1/1/2025 and the other half 7/1/2025.

What kind of documentation is required for services such as STPHH rendered during weekends?

A complete CS Referral Form must be included in the TAR. Currently, no other documentation is required; however, providers are encouraged to keep basic documentation daily (at a minimum) while member(s) receive CS services- this applies for weekdays and weekends. In the event an extension is required, such documentation will be required and attached to the new TAR for consideration.

How will providers submit TARs for STPHH/RC? What will the quantities be?

Providers should submit any recuperative care or STPHH TARs with a **single quantity (1).** Partnership will update the quantities based on the number of days available for the member. Providers can check for TAR updates on the provider portal.

Recuperative Care (Medical Respite)

What kind of documentation is required for Recuperative Care rendered during weekends?

If a member is admitted to recuperative care on a weekend, a TAR should be submitted promptly. Documentation regarding member engagement and services administered are important to facilitate authorization extensions, or additional services.

Respite Service

Can anyone receive Respite Services?

No, Respite Services can only be approved for a member who has a caregiver that needs relief. Respite Services is to assist the caregiver of the members.

Personal Care and Homemaker Services

How many hours does Partnership approve for Personal Care and Homemaker Services?

Partnership allows 4 hours a day for up to 20 hours a week, or as determined by intake assessment. Hours will be determined by medical staff based on the members' needs. We approve for 20 hours a week for 3 months currently.

Can providers offer Personal Care and Homemaker Services if a member is not enrolled in In-

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Home Support-Services (IHSS)?
Personal Care and Homemaker Services is above and beyond any approved hours by IHSS. Members who are pending IHSS or who are exiting surgery will be reviewed on a case-by-case basis.

Are Personal Care and Homemaker Providers required to use California Electronic Visit Verification (CalEVV) system?
Yes. For more information, please visit the following DHCS resources:

- APL 22-014
- DHCS CalEVV website

Medically Tailored Meals/Groceries (MTM/G)

Is there a list of acceptable ICD-10 codes for contracted Community Supports meal providers?
Yes, you may utilize Z5948. You can locate other the codes on our website under Partnership Resources Social Determinants of Health ICD-10 Codes

Is there a resource providers can utilize in order to start assisting individuals with CalFresh?
Yes, please click on this link to learn more: BenefitsCal. Together, we benefit.

How should MTG providers collect clinical data to confirm that the member meets criteria? Can it be self-reported or is this something that should be requested from a medical provider?
The information can be self-reported by the member, but it is highly encouraged and as a best practice to seek that information from a clinical perspective for auditing and oversight purposes.

Does the assessment need to be done before sending the meals or after?
The assessment should be done first before delivering meals to ensure the information provided is correct and the member agrees to receive the service and agrees to the recommended meal menu.

Does the nutritional education session need to be done by a RD or can it be a PCP?
It can also be performed by the members' PCP since they provide the care and it would be helpful to have them involved. Nutritional education can be provided by any MTM/G staff that are overseen by an RD, it does not have to be done by a RD nor a PCP.

Is it correct that the RDN determines how assessments are conducted based on client presentation and needs - informed by standards of practice & professional performance, nutrition care process, code of ethics, and known evidence (e.g. standards of care, guidelines). So client/patient situation and needs drive the assessment?
Yes, that is correct, the Registered Dietitian Nutritionist (RDN) will determine how the assessments will be conducted based on the member's medical needs, ie., chronic conditions.

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Will there be a change in the nutritional sessions?
Partnership has changed the number of consults to 6 but are giving the providers control to bill as needed. Partnership is not requiring the full 6, but will recommend it to make sure the members like the meals, education on how the food is helping with their chronic condition and how they can learn to prepare meals when the service ends.. It will be 1 session per week (for 4 weeks) and then 1 session per month for the next 2 months.

If we are not able to get a hold of the member, can we still send the meals?
If you are not able to get a hold of the member for the assessment, it is best practice not to send the meals until you have connected with the member. Again, you will want to confirm the member has agreed to having the meals and you can confirm conditions and address.

For the ROI form, should we send that to members to sign, and then forward the signed document to the PCP provider to receive the member's clinical data?
Providers can utilize the assigned CS ROI and work with the PCP.

Can we get an extended authorization time frame ~15 weeks to give us time to make contact with the member for the assessment to not cut into their weeks or meals?
Currently, we approve MTM TARs with a duration of 6 months to allow time to contact the member. MTM/MTG services are for 12 weeks (3 months).

Does the MTM affect their CalFresh?
No MTM services do not affect CalFresh.

What documentation will providers need to submit with their TARs? (for example, referral from PCP or RD? RD eval notes?
CS referral form should be submitted with all TARs. Providers should indicate in the “additional information” section of the CS referral form which condition(s) and criteria the member meets, including any details you want to share with Partnership.

Can a member get an extension of the MTM program?
The MTM program is designed to address the member’s chronic condition and provide education on what foods to eat per the diagnosis. This service is 12 weeks or until medically necessary and provides the member up to six (6) nutrition counseling appointments to help the member transition once the 12 weeks are up. If the provider feels the member would benefit for another 12 weeks, we will need to know how the 12 weeks benefited the member and what an additional 12 weeks would accomplish. This information should be provided on the referral included documentation from a clinician.

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Contracting

What is the first step to contracting as a CS provider?
All providers interested in contracting as a CS provider should email CalAIM@partnershiphp.org to receive a Readiness Questionnaire and additional information.

What is the timeline for approval once a Readiness Questionnaire is submitted to Partnership?
Partnership will conduct a review and approval by stakeholders/leadership upon receiving a completed Readiness Questionnaire. Once a decision has been made, the provider will be asked to complete an application and provide a list of necessary documents to start the process of becoming a contracted CS provider.

What is the timeline if we are interested in contracting for CS?
The contracting timeline varies. On average, the contract process for new providers is between 9-17 weeks depending on when documentation is provided to Partnership.

What should I do if I am an existing contracted provider and need to make an address or phone number change?
Please complete a Provider Information Change Form and submit to: ChangesProviders@partnershiphp.org and include the CS helpdesk.

What if my organization has new staff members that should be included in reports, referrals, and/or program email notifications?
If there are new staff members, we ask providers to notify us as soon as possible by completing a CS Provider Contact Form

Claims (Billing Inquiries)

Can any qualified employee at our FQHC bill for Community Supports?
You must be a contracted CS provider to bill for CS.

Does each billing employee need to sign up for Partnership Portal?
No, but Partnership encourages providers to have multiple employees enroll as an eAdmin or user. An eAdmin can designate who has access to various modules within the portal. For questions contact eSystemsSupport@partnershiphp.org.

Can we submit retro-invoice(s) for services rendered to individuals before having a fully executed contract with Partnership or being credentialed by the plan?
No, you cannot submit retro invoices or TARs. As a provider, you must have a fully executed contract,

be credentialed by Partnership and be added to our systems to be able to submit TARs and claims.

Will providers receive payment for an unsuccessful attempt to connect with the referred individual(s)?
CS does not pay for outreach attempts; however, providers are expected to keep track of their outreach based on the ECM and CS HCPCS Coding Guidance recently updated.

Will CS have an equivalent billing spreadsheet, such as the invoice for ECM?
CS providers will be paid according to what is billed and the approved TAR. For billing questions, providers can contact the Claims Resolution Team at claimsecmhelpdesk@partnershiphp.org.

Will providers be notified if there is a mistake or missing information on a Treatment Authorization Request (TAR)?
If there is an error or missing information, you will receive a pended (Notice of Action) or denial TAR notification via fax. Providers now have the capability to add attachments to pended corrections on our provider online portal (OLS).

Can we bill once a month, or all together once services are completed?
You can submit a claim monthly, or once services are completed. Providers have 365 days from the date of service to submit claims to Partnership.

Can I submit a claim before the TAR is approved?
No, an approved TAR is required for claims to be processed. If a claim is submitted prior to a TAR approval, the claim will be denied.

Who would we contact for information and set up electronic claims?
To submit claims electronically, contact our Electronic Data Interchange (EDI) Team for assistance at (707) 863-452 or email EDI-Enrollment-Testing@partnershiphp.org.

Does the TAR number need to be included on the claim form?
Yes, the TAR number should be noted on the submitted claim form.

Treatment Authorization Requests (TARs)

Is a TAR required for CS services?
Yes, a TAR is required for all CS services and is requested via the provider portal.

What is the difference between a TAR and a RAF?
A TAR is a request to render services to a member. Referral Authorization Form (RAF) is a form to

refer members to Partnership for CS services. CS Providers should utilize the **CS referral form** for referrals.

What is a TAR's timeframe?
The timeframe for a TAR is:
- Non-urgent 5 days
- Urgent-72 hours – Life threatening situation
- Retro 15 days

Please note that not all CS services qualify for urgent requests. Please see Partnership Policy-MCAP7001 TAR Review Process.

What are continuation or extension requests?
Authorizations are approved based on the members' needs. If services are still needed after the approved amounts, a new TAR should first be submitted with an explanation of why additional care is needed and Partnership will review for consideration. The member must continue to be eligible with Partnership and meet criteria for CS to qualify for a continuation/extension of services.

Can I use the same Release of information (ROI) for ECM and CS?
A Release of Information is not required for Community Supports.

Do you have guidance on how many medical records are required?
Not all providers have access to medical records. Providers should include any documentation available to support the need for CS in addition to a brief description of the individual(s) case to better understand the members' needs.

Do we need to attach a diagnosis to show that we are providing services in lieu of services?
What if provider does not have access to medical records?
A Social Determinant of health diagnosis is required such as Z5900 for homelessness. There must be medical or mental health chronic illness to be approved for CS.

If multiple providers submit a TAR for the same member, will both TARs be approved?
Members can only be serviced by one CS provider per duration. If we receive multiple authorizations, each TAR will be evaluated for duplication. An indicator will show all active CS and/or ECM benefits approved for the member. This information can be viewed when checking eligibility in the provider portal.

What if we cannot contact a member within the three months of the approved TAR?
If a member is unresponsive after 3 attempts, providers will submit a correction via the provider

portal. If the member later contacts you and is still in need of services, a new TAR can be submitted with a referral.

What if we run into complications and are unable to secure housing within the approved months of the TAR?
We are aware that affordable housing is difficult to find. If the TAR span expires, submit a new TAR for a new 6-month span and include the CS Referral Form indicating why the member needs additional time

Community Support Referrals

What is the referral method for Community Supports?
Partnership has a no-wrong-door policy, referrals may come from anyone. The CS Referral Form can be completed and should be sent to the CommunitySupports@partnershiphp.org. Partnership must track and report on all referrals.

Can providers refer an individual who is receiving CS to ECM or vice versa, if appropriate?
Yes, the provider(s) will need to complete an ECM Referral form or CS Referral Form located on our website.

How does the referral process work?
Contracted CS Providers:
- Contracted providers can submit a TAR with the CS Referral Form attached

Non-Contracted CS Providers:
- Providers not contracted with Partnership for CS must complete a CS Referral Form and send to CommunitySupports@partnershiphp.org

Will CS providers receive referrals directly from Partnership, or will CS providers only provide services when a TAR is submitted?
CS providers can submit TARs with attached referrals to Partnership and/or Partnership may refer members for services; Partnership will only refer members to providers open to accepting new referrals based on their CS Capacity Report.

What should providers do if they are unable to accept additional referrals for CS?
If your organization is at capacity or cannot take on any more CS referrals from Partnership, you will indicate this on the CS Capacity Report sent to providers monthly. If at any time throughout the month you no longer can take referrals, please email CommunitySupports@partnershiphp.org so we do not send referrals.

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Can a member reach out to the Community Supports Helpdesk to check referral status; if not, where can members reach out to if they have questions about their referral request?
Members can call our Member Services Department at 800-863-4155, Monday – Friday from 8:00 a.m. - 5:00 p.m.
As a reminder, communication via email may not be secure. Members should not include personal identifying information such as their birth date, or personal medical information in emails sent to our helpdesk.

Community Supports Reports

What reports are CS providers required to submit?
Contracted providers are required to submit a monthly CS Capacity Report and a CS Return Transmission File (RTF). Beginning September 1, 2023, DHCS mandates Partnership and CS providers to share and exchange additional information. Click here for the most recent published information on DHCS' data guidance as of December 2024.

Capacity Report

What is a CS Capacity Report?
The capacity report is a Microsoft Form that reflects provider capacity information. Partnership utilizes the capacity report to make appropriate referrals to providers and for quarterly reporting purposes as required by DHCS. All CS contracted providers will receive an emailed link to complete the report on the second Monday of every month and will be due Friday of the same week. If you have any issues or would like assistance filling out the report please contact the CS Helpdesk

Is the Capacity report for the same month or next month?
The Capacity report is for **availability the next month, and the number of members you are serving in** the current month.
Will providers receive a CS Capacity Report before they are contracted with Partnership?
No, the CS Capacity Report will not be sent to providers that are not fully contracted with Partnership for Community Support.

How do Capacity Reports affect our referrals?
Organizations who do not submit a capacity for the reporting period will not receive referrals from Partnership. As a reminder the Monthly Capacity Report is a DHCS requirement and is part of our oversight process.

We missed the due date to submit capacity. What are our options?Capacity reports should be submitted according to the due dates listed in the Reporting Schedule on our website. If you need to submit a late capacity, please notify us at communitysupports@partnershiphp.org.

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Authorization Status File (ASF) and Return Transmission File (RTF)

When does Partnership send out the reports?
The reporting schedule is listed on the Partnership HealthPlan website under CS reporting.

If I am also an ECM provider, will we have a separate (Secure File Transfer Portal) SFTP for CS?
Providers who utilize different NPIs for ECM and CS will have separate SFTPs.

How often is the Authorization Status File (ASF) sent to providers?
The ASF is sent every month. This report is informational for providers and can assist when completing the RTF.

What is the Return Transmission File (RTF)?
The RTF must contain a list of all members who have been newly authorized to receive, are pending outreach, are currently receiving, or have disenrolled in CS services during the most recent calendar month.

When do I send Partnership the Return Transmission File (RTF)?
Providers are required to send Partnership the RTF every month. The file can be sent to Partnership via SFTP. A blank RTF template is available on our website:
http://www.partnershiphp.org/Community/Pages/Community-Supports.aspx

Do I need to return the RTF to Partnership if our organization did not offer services during the period being reviewed?
If a provider has not rendered services during the reporting period, providers are not required to complete the RTF. However, providers are required to advise Partnership via email to our CS helpdesk.

Additional Resources

For questions not found on this document, please email us:
CalAIM: CalAIM@partnershiphp.org
Community Supports CommunitySupports@partnershiphp.org
Enhance Care Management ECMhelpdesk@partnershiphp.org
Claims ClaimsHelpDeskSR@partnershiphp.org

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Provider Education eSystemsSupport@partnershiphp.org
Provider Information Change and/or Updates: ChangesProviders@partnershiphp.org

Partnership CalAIM Website: http://www.partnershiphp.org/Community/Pages/Community-Supports.aspx
DHCS CalAIM Website: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx
DHCS Coding Options for ECM and CS: https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf
DHCS CalAIM Data Guidance April 2023: https://www.dhcs.ca.gov/Documents/MCQMD/CS-Member-Information-Sharing-Guidance.pdf
DHCS Policy Guide Vol 1: DHCS - Community Supports Policy Guide Volume 1
DHCS Policy Guide Vol 2: DHCS Community Supports Policy Guide: Volume 2

Acronyms

ASF: Authorization Status File
CalAIM: California Advancing and Innovating Medi-Cal
CS: Community Supports
DHCS: Department of Health Care Services
ECM: Enhance Care Management
ED: Emergency Department visit
EDI: Electronic Data Interchange
FQHC: Federal Qualified Health Center
Partnership: Partnership HealthPlan of California
PMPM: Per member, per month
RAF: Referral Authorization Form
ROI: Release of Information
RTF: Return Transmission File
SFTP: Secure File Transfer Protocol
SMI: Severe Mental Illness
SUD: Substance Use Disorder
TAR: Treatment Authorization Request