Housing CS Guide:
HHSS Authorizations (HN & TSS)

L.A. Care HEALTH PLAN
For All of L.A.

Update March 2024

Background

Community Supports and HHSS

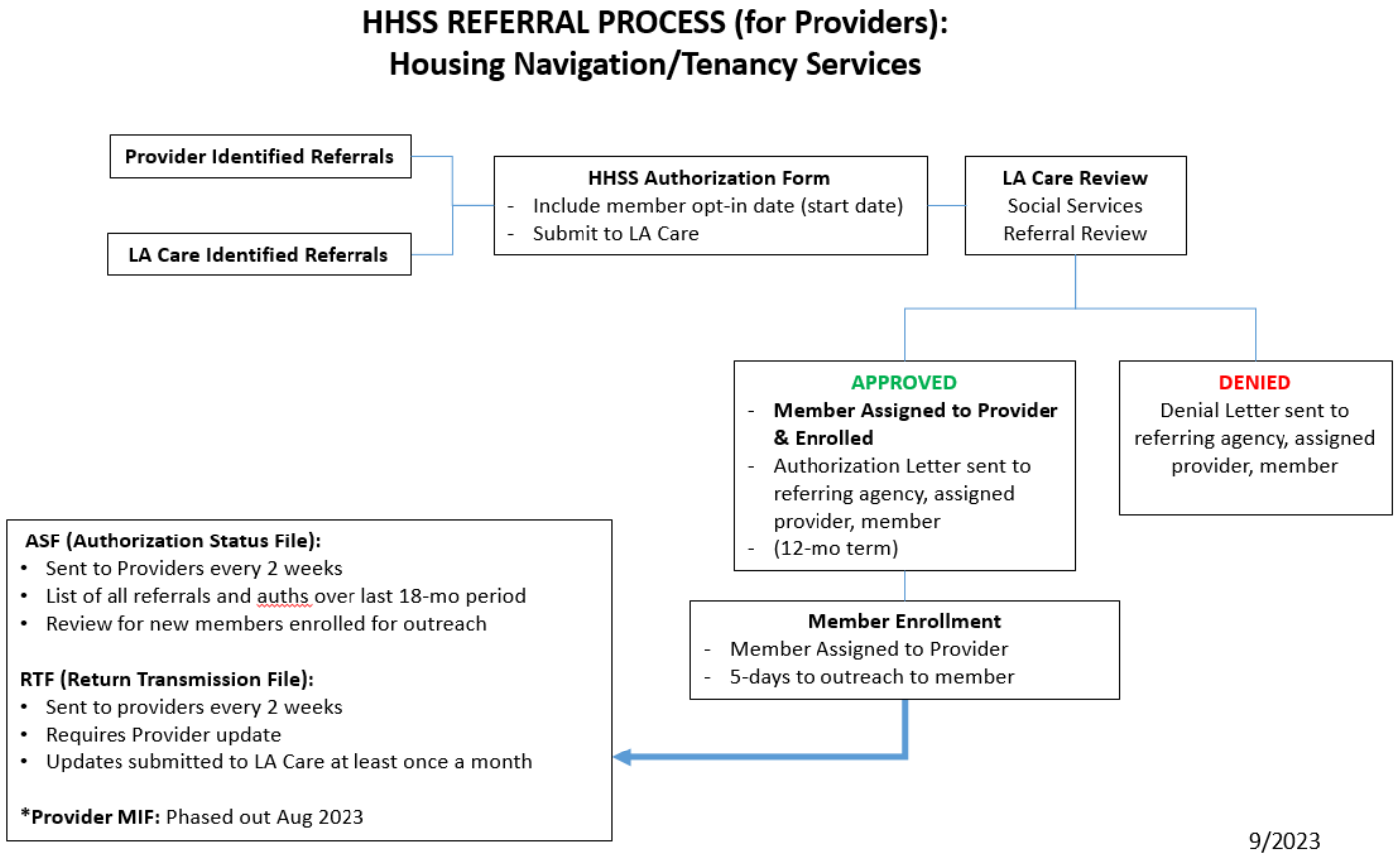
- Community Supports (CS) are part of a new state Department of Health Care Services (DHCS) initiative called California Advancing and Innovating Medi-Cal (CalAIM). CS are optional, non-traditional services that address social determinants of health.

- L.A. Care Housing CS:
  - Housing Navigation (launched 1/1/2022)
  - Tenancy Sustaining Services (launched 1/1/2022)
  - Housing Deposits (launched 7/1/2022)

- Homeless and Housing Support Services (HHSS) offers two housing services to eligible members:
  - **Housing Navigation (HN)** — helps homeless members find housing
  - **Tenancy Sustaining Services (TSS)** — helps formerly homeless members maintain safe and stable tenancy once housing is secured

New Referrals and Authorizations

Workflow



New Referrals and Authorizations

Overview

L.A. Care Identified

1. L.A. Care referred member
    - Referring party obtains Member opt-in to receive Housing Navigation or Tenancy Sustaining Services CS services

2. Assignment to contracted Provider
    - An Authorization Letter is sent to the referring agency, assigned Provider, and Member
        - Referring agency and assigned Provider will receive via fax
        - Member will receive via mail
    - Upon referral authorization/approval, Member automatically enrolled with assigned Provider
    - Provider must outreach to Member within **5-days** of assignment
        - Notification includes Member contact information for outreach
    - Providers must acknowledge notification email upon receipt within **48-hours**

New Referrals and Authorizations

Provider Identified

1. Provider submits HHSS Authorization Form for HN or TSS*
    - Provider must obtain member consent to CS services
    - Please submit (1) Form per secure fax (email if no secure fax available)
    - No bulk submissions
    - No more that 60 auth/re-auth requests per day

2. L.A. Care reviews and respond within 5-business days

3. Member will be assigned to referring provider (may be assigned to another provider based on Provider capacity, etc.)
    - An Authorization Letter is sent to the referring agency, assigned Provider, and Member
        - Referring agency and assigned Provider will receive via fax
        - Member will receive via mail
    - Provider must outreach to Member within **5-days** of assignment
        - Notification includes Member contact information for outreach
    - Providers must acknowledge notification email upon receipt within **48-hours**

* *If Member transitions from one housing CS to the other, new Auth Request is required*

ASF and RTF Overview

The ***Authorization Status File (ASF)*** and ***Return Transmission File (RTF)*** are required by DHCS and L.A. Care in order to track and monitor CS authorizations.

	Summary	Frequency	Action Required
ASF: Authorization Status File	Includes list of all referrals and authorizations over the last 18-mo period (including enrolled and denied).	Goes out beginning and middle of each month	For review. No return submission required. Providers should track "New" members for outreach. Received via /outfile/CS/HHSS/MIF
RTF: Return Transmission File	This is similar to the MIF Approved auths only Includes fields for Providers to complete/update	Goes out beginning and middle of each month	Providers must submit updates at least once a month • Preferred method: upload via Provider SFTP folder: **/infile/CS/HHSS/MIF** • If unable to access your agency's SFTP, please alert your L.A. Care Program Manager to troubleshoot. RTF may be submitted via secure email, until resolved.

Authorization Term

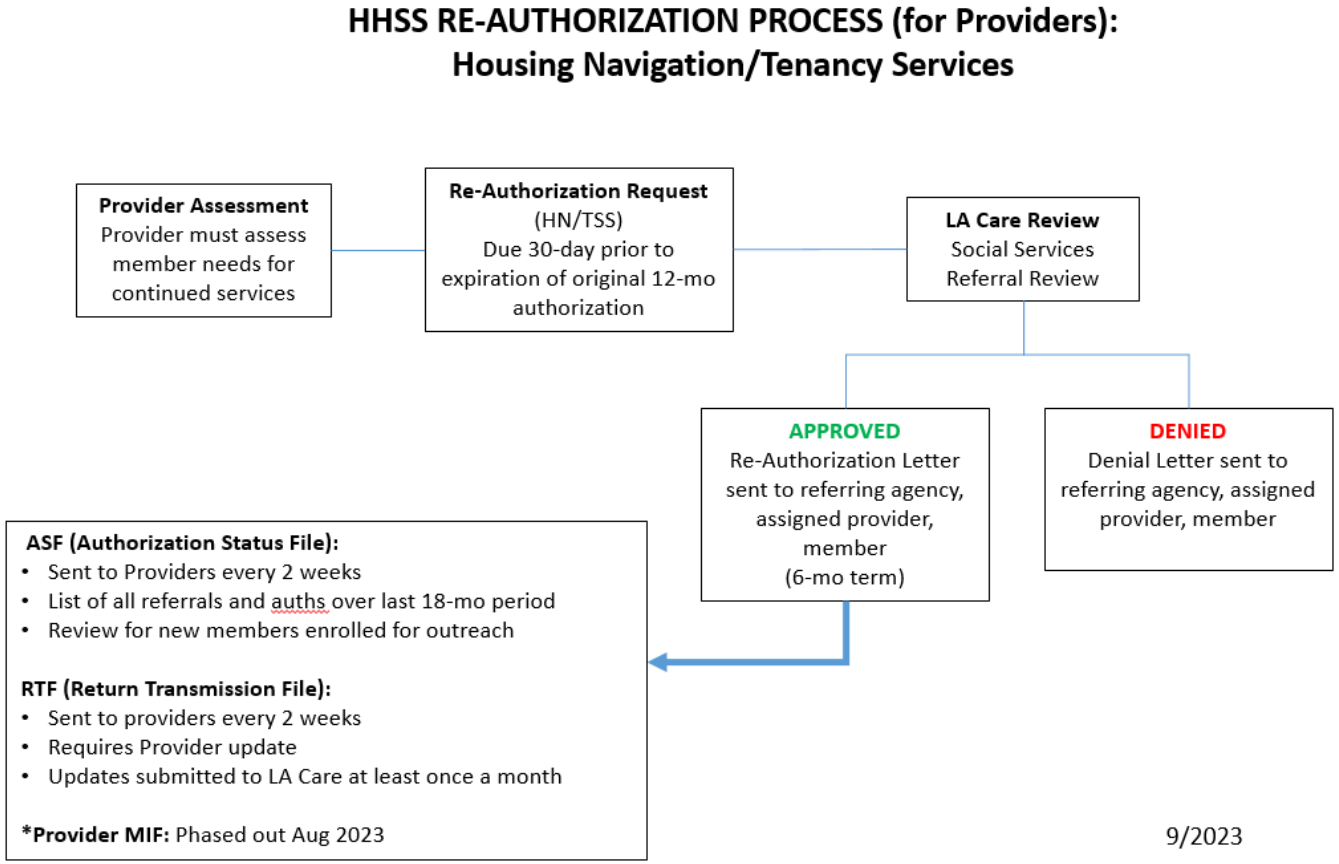
Length of Service for HN and TSS

- HN and TSS are initially approved for 12-months
  - Prior to month 11, providers must re-assess member's ongoing need for HHSS service and whether continued services are required
  - *TSS: During this period, members must remain enrolled in a housing program (e.g. PSH)

- After initial 12-mo authorization, providers may request additional 6-month re-authorization requests if assessed as reasonable and necessary
  - Updated HHSS form must be submitted **no later than 30-days prior** but **no sooner than 60-days prior** to the expiration of the initial 12-month authorization

HHSS Re-Authorizations

Workflow



Re-Authorizations

Overview

1. Re-Authorization Request
    - Provider can refer to RTF to confirm authorization expiration date (12-mos from opt-in/start date)
    - Provider must assess member need to continued services
    - Provider must update Housing Assessment and Individual Housing Support Plan

2. Provider submits Re-Authorization Form
    - Must be submitted 30-days prior to 12-mo authorization expiration (no earlier than 60-days prior to expiration)
    - Please submit (1) Form per secure fax (email if no secure fax available)
    - No bulk submissions

3. L.A. Care review and respond within 5-business days

Additional Resources

- **Provider Contract**
  - For terms and guidance
- **HHSS Quick Reference Guide**
- **HHSS Re-Authorization Training**
  - Providers may contact their HHSS Program Manager for a copy

Please contact your HHSS Program Manager for any additional guidance and information.

Contact Information

Authorizations/Re-Authorizations

- Submissions: Secure Fax (**213) 536-0630**
- Questions regarding authorizations: HHSS-Referrals@lacare.org

HHSS Provider Engagement Team

- Housing CS General Inbox: HHSS-program@lacare.org
- Shannon Keutzer, Program Manager II: skeutzer@lacare.org
- Nathalie Bedolla, Program Manager II: nbedolla@lacare.org
- Kevin Recinos, Program Manager II: krecinos@lacare.org
- Caroline Chung, Manager: cchung@lacare.org

Homeless and Housing Support Services Program (HHSS) Form

L.A. Care Health Plan's Homeless and Housing Support Services (HHSS) provides two services to eligible members: housing navigation and tenancy services. HHSS is a part of L.A. Care's health services called Community Supports. To submit an authorization request, all required fields in this form must be completely filled out and submitted via Secure Fax (**213.536.0630**). If the Secure Fax is not accessible, please submit via Secure Email (**HHSS-Referrals@lacare.org**).

This form is only for L.A. Care Medi-Cal and Dual Eligible Special Needs Plan members. This form is NOT for members from Anthem or Blue Shield Promise. Please refer to the L.A. Care HHSS Eligibility Criteria for more information.

Required responses are identified with an asterisk.*

Please check the type of service the member is requesting (choose one only):*

1. ☐ Housing Navigation – services to help homeless members and members at-risk of homelessness find housing
2. ☐ Tenancy Services – services to help homeless members and members at-risk of homelessness maintain housing

☐ Check this box if there has been a change in the member's service (must complete Section G)

Referral Source Information (Section A)

Date of Referral:* _____

Internal referring department* (select one): ☐ BH ☐ CM ☐ CRC ☐ ECM ☐ MLTSS ☐ SS ☐ Other: _____

External referral by* (select one): ☐ ECM provider ☐ Homeless Provider ☐ Hospital ☐ PCP/Clinic ☐ PPG ☐ Other:_____

Referring Individual Name:* _____

Referring Organization Name:* _____

Referring Organization Address:* _____

Referring Fax Number:* ( ) _____

Referrer Phone Number:* ( ) _____

Referrer Email Address:* _____

HHSS Provider NPI:* _____

For Referring Individual to complete (Section B)

☐ Check here if you have obtained "Member Consent" to enroll (Opt-In) into LA CARE HEALTH PLAN's Homeless and Housing Support Services (HHSS) Program and you will be able to present documentation substantiating this claim with dates, times, signature, voice capture, and/or phone records which will be required upon any prospective audit.*

Is the member transitioning their Housing Navigation or Tenancy Services due to a change in their health plan?*

☐ Yes ☐ No

If Yes, please confirm previous enrollment information below:

Housing Navigation or Tenancy Services provider name: _____

California Medi-Cal health plan name: _____

Last date the member worked with previous Housing Navigation or Tenancy Services Provider:_____

L.A. Care HEALTH PLAN®

Homeless and Housing Support Services Program (HHSS) Form

Member Information (Section C)

First Name:* _____ Last Name:* _____

Medi-Cal Client ID# (CIN):* _____ ☐ L.A. Care Medi-Cal:* ☐ Dual Eligible Special Needs Plans*

Gender:* ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other _____

Preferred Language:* _____ Date of Birth:* _____

Primary Phone Number:* ( ) _____ HMIS I.D. if available: _____

Authorized Representative Name: _____ Phone Number: ( ) _____

Elgibility Criteria (Section D)

☐ Member is prioritized for Permanent Supportive Housing (PSH); **OR**

☐ Member meets the homelessness criteria; **OR**

☐ Member meets the at-risk of homelessness criteria

Additional Eligibility Criteria [at least one box must be checked for approval] (Section E)

☐ Member has one or more serious chronic conditions (list below); AND/OR

☐ Member has serious mental illness (list below); AND/OR

☐ Are at-risk of institutionalization or overdose or are requiring residential services as a result of a substance use disorder (list below); AND/OR

☐ Are receiving Enhanced Care Management

List the serious chronic condition(s), mental illness(es), or substance use disorder(s): _____

_____

For more information on the eligibility criteria, please visit our website. Click Here

Member Housing Status Information (Section F)

Current living location:*

If you selected Other, please specify: * _____

Current SPA location:*

Mailing address or location:* _____

Change in Member's Housing Status (Section G)

If member has been permanently housed, please include the new address.

_____

Please indicate when the member moved in: _____ /_____ /_____

If member is no longer in PSH, please provide move out date: _____ /_____ /_____

Homeless and Housing Support Services Program (HHSS) Form

Please share any additional information on the member's housing status and housing needs:

By submitting this authorization request form, I attest that the information above is true and accurate to the best of my knowledge.

Note: Please complete the L.A. Care's Homeless and Housing Support Services (HHSS) Reauthorization Form for reauthorization of services