blue california
Promise Health Plan
3840 Kilroy Airport Way
Long Beach, CA 90806

January 24, 2024

Subject: **Notification of required regulatory updates and April 2024 updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual***

Dear Provider:

Blue Shield Promise is revising the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* (Manual). The changes in each provider manual section listed below are described either as a regulatory update, not subject to negotiation and effective January 31, 2024, or as a notice of an update effective April 1, 2024.

All updates included in this letter will appear in the April 2024 version of the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* posted by January 31, 2024 on the Blue Shield Promise Provider website at www.blueshieldca.com/en/bsp/providers in the *Provider manuals* section under *policies & guidelines* .

You may also request a PDF version of the revised *Blue Shield Promise Health Plan Medi-Cal Provider Manual* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *Blue Shield Promise Health Plan Medi-Cal Provider Manual* is included by reference in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Medi-Cal providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* and the agreement held by the provider and Blue Shield Promise, the agreement prevails.

If you have any questions regarding this notice or about the revisions that will be published in the April 2024 version of this Manual, please contact Blue Shield Promise Provider Customer Services at (800) 468-9935 [TTY 711] 6 a.m. to 6:30 p.m., Monday through Friday.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

Section 3: Benefit Plans and Programs

3.5: Enhanced Care Management

Added to the bullet list of mandatory Enhanced Care Management (ECM) "populations of focus," identified by the Department of Health Care Services (DHCS), as follows:

January 2022

- Individuals Transitioning from Incarceration ((post release **services for some Whole-Person Care (WPC) counties))**

January 2024

- Individuals Transitioning from Incarceration (post release services statewide, inclusive of the former WPC counties that already went live on January 1, 2022)

October 2024

- Individuals Transitioning from Incarceration (pre-release services)
    - Pre-release services will be phased in and completed by September 30, 2026

3.5.1: Enhanced Care Management for the Justice-Involved Population of Focus

Added a sub-section, which describes providers' responsibilities under The Justice-Involved (JI) Initiative. The JI Initiative allows eligible incarcerated Californians to enroll in Medi-Cal and receive a targeted set of services in the 90 days before their release. This initiative aims to ensure continuity of health care coverage and services between the time they are incarcerated and when they are released.

3.7: Doula Services

Updated language delineating doula qualifications, as follows:

Doula Qualifications

All doulas must be at least 18 years old, possess an adult/infant Cardiopulmonary Resuscitation (CPR) certification from the American Red Cross or American Heart Association, and attest they have completed basic Health Insurance Portability and Accountability Act (HIPAA) training.

Updated the following bullet points, in list of alternative methods, by which doulas can qualify, in boldface type below:

Training Pathway:

- **Attest that they have provided** support at a minimum of three births

Experience Pathway:

- Or all of the following:
    - **Attest that they have provided services in the capacity of a doula either a paid or volunteer capacity for** at least five years. The five years of active doula experience **occurred** within the previous seven years.

- Attestation to skills in prenatal, labor, and postpartum care as demonstrated by three written client testimonial letters or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven years. One letter must be from either a licensed provider, a community-based organization, or an enrolled doula. **"Enrolled doula" means a doula enrolled either through DHCS or through a Managed Care Plan (MCP)**

Doulas must complete three hours of continuing education in maternal, perinatal and/or infant care every three years. Doulas shall maintain evidence of completed training to be made available to DHCS **and Blue Shield Promise** upon request.

Added the following language, concerning doulas' recommendation requirement:

As a preventive benefit, doula services require a written recommendation from a physician or other licensed practitioner of the healing arts.

Added, under the heading of "**Documentation Requirements**," extensive language explaining the recommendation documentation, scope of recommendations and placement of recommendation in member records.

Added the following language, concerning doulas' claims:

All claims must be submitted with Modifier XP (separate practitioner: a service that is distinct because it was performed by a different practitioner), appended to the billing code. This is to distinguish the claim from the services by the medical provider.

Added the following language with guidance regarding providing doula services via telehealth:

Telehealth

Doulas should refer to the Telehealth section in Part 2 of the Provider Manual for guidance regarding providing services via telehealth for prenatal or postpartum visits, labor, and delivery support, and for abortion and miscarriage support. Doulas may bill for services provided by telehealth using either Modifier 93 for synchronous audio-only or Modifier 95 for synchronous video.

Section 6: Grievances, Appeals, and Disputes

6.4: Provider Disputes – Claims Processing

6.4.1: Provider Questions, Concerns, and Disputes

Updated information regarding the dispute process, as follows:

Providers can communicate questions and issues regarding their contract or that are not payment related to the Blue Shield Promise Provider Network Operations (PNO) Department.

All provider payment-related issues should be directed to the Provider Dispute Resolution (PDR) Department in writing, either online via Provider Connection at blueshieldca.com/provider-disputes, or via mail. A claim number is required for a dispute to be filed online. Examples of a payment related dispute are non-payment or underpayment of claims by IPA/medical groups.

All payment disputes are entered in the PDR database, investigated and a response will be provided in writing within the regulatory timeframe.

Disputes are acknowledged within two (2) working days for disputes submitted online via Provider Connection, and within 15 working days for disputes submitted via mail. A resolution letter will be sent within 45 working days.

If there is a dispute with the County Mental Health Plan, Providers can submit their provider dispute to the County Mental Health Plan. Should additional assistance be requested, providers can contact the PNO Department.

6.4.3: Provider Disputes Policy and Procedure

Updated language concerning written, formal provider disputes, as follows:

All written, formal disputes will be responded to in writing. Upon receipt of the written dispute specifying the issue of concern, the dispute will be entered into the provider dispute database. An acknowledgement letter will be sent to the provider within two (2) working days for disputes submitted online via Provider Connection, and within 15 working days for disputes submitted via mail.

6.4.4: First Level Dispute

Updated the following information explaining how a provider may appeal the decision made at Blue Shield Promise or one of its IPA/medical groups:

A provider may appeal the decision made at Blue Shield Promise or one of its IPA/medical groups.

1. The Provider shall be notified of receipt of written dispute within two (2) working days for disputes submitted online via Provider Connection, and within 15 working days for disputes submitted via mail, and a determination will be made within 45 working days from the date that Blue Shield Promise received the dispute.
2. A provider may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information. The amended dispute will be resolved within 45 working days of the receipt of the amended dispute.
3. All records shall be evaluated by the appropriate Plan personnel who will render a decision. The Blue Shield Promise Provider Dispute Department shall send a written determination letter outlining its conclusions with background information within 45 working days of receipt of the dispute. Language in the letter will include any available next steps the provider can take with the dispute.
4. The Provider Dispute Resolution process is available on Provider Connection at http://www.blueshieldca.com/provider-disputes.

Section 7: Utilization Management

Re-enumerated all sections, starting with Section 7.3 (Primary Care Physician Scope of Care), to accommodate the insertion of the new Section 7.3 (Transitional Care Services (TCS)).

7.3. Transitional Care Services (TCS)

Added, in support of the CalAIM Initiative, the entire new section, entitled "Transitional Care Services," which describes the Transitional Care Services (TCS) Program. The goal of the TCS Program is to ensure that Blue Shield Promise members receive the highest-level of care from the time of admission to post discharge until they have been successfully connected to all needed services and supports.

7.3.1 Admission, Discharge, and Transfer (ADT) Data

Added, in accordance with the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and the CalHHS Data Exchange Framework (DxF), this entire new sub-section, which describes the requirement of general acute care hospitals and emergency departments, as defined by California's Health & Safety Code §1250, (together "Participating Facilities"), to send admission, discharge, or transfer (ADT) notifications to other organizations that have signed the DxF Data Sharing Agreement, if requested in advance of the admission, discharge, or transfer event (ADT Event).

7.3.2 Requirements for High- vs. Lower-Risk Transitioning Members

Added this entire new sub-section, which describes the minimum TCS requirements for high-risk and lower-risk transitioning members.

7.3.2.a Notifying a Care Manager

Added this entire new sub-section which describes the process for assigning a Care Manager to a TCS member.

7.3.2.b Discharge Risk Assessment and Discharge Planning

Added this entire new sub-section which describes discharge planning for members experiencing a care transition.

7.3.3 Oversight and Monitoring

Added this entire new sub-section, which describes Blue Shield Promise's accountability for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning, as required by federal and state requirements.

7.4 Primary Care Physician Scope of Care

Added the following bullet point to list of PCP functions in the office/clinic setting:

Assessments:

- Screening for Adverse Childhood Experiences

7.6: Emergency Services and Admission Review

7.6.4 (Formerly 7.5.4): Discharge Planning

Removed the entire "Discharge Planning" subsection, as it is being replaced by Section 7.3, in support of a CalAIM initiative.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information

7.9.24: Community Supports

Updated the bullet points in a list of community supports, to the following:

Blue Shield Promise offers the following Community Supports to eligible Medi-Cal members in Los Angeles and San Diego Counties:

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

Providers may reference the Community Supports Referral form on the Blue Shield Promise provider website at http://www.blueshieldca.com/en/bsp/providers in the Forms section to determine a member's eligibility and submit a referral. Although these services are not Medi-Cal benefits, they are subject to Blue Shield Promise's grievance and appeals process in the event a concern arises regarding access to services.

For more information, refer to Appendix 10: DHCS Community Supports Categories and Definitions and Appendix 11: Community Supports Eligibility Criteria and Restrictions/Limitations Guide.

Section 9: Quality Improvement

9.5: Initial Health Appointment

Updated the following bullet points in the list of health assessments that, at a minimum, must be included for members under 21, in strikethrough and boldface type:

The Initial Health Appointment Services include:

A. Health Assessments for members under 21 years of age in accordance with the AAP/Bright Futures Periodicity Schedule must include, at a minimum:

- **Oral health risk assessment at 6, 9-, and 12-month visits. Continue with risk assessment at 12-, 18-, 24-, 30-month and 3- and 6-year visits if members do not have an established dental home after 12 months.**

- ~~Dental assessment to include inspection of the mouth, teeth, and gums beginning at 12 months of age and the a~~Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption and every 3 to 6 months thereafter in the primary care or dental office based on caries risk.
- HIV Screening, as appropriate. **Screen adolescents at least once between the age of 15 and 21. Those at increased risk of HIV should be retested annually or more frequently.**

Updated the following bullet points in the list of health assessments that, at a minimum, must be included for Asymptomatic members under 21, in strikethrough and boldface type:

B. The IHA Health ~~Assessments~~ **Appointments** for Asymptomatic members 21 years of age and older must include, at a minimum:

- Diabetic screening as part of cardiovascular risk assessment in adults ages ~~40~~ **35** to 70 who are overweight or obese.
- Hepatitis B and hepatitis C screening for all adults **and testing at least once in a lifetime, except when risk factors exist.**

Updated, in strikethrough and boldface type, the following items in the list of monitoring and oversight actions to ensure that newly enrolled members complete an IHA within 120 days of their enrollment date:

6. To ensure that newly enrolled Blue Shield Promise members complete an IHA within 120 days of their enrollment date, Blue Shield Promise will conduct the following monitoring and oversight actions:

    f. PCPs currently in the network that are issued CAPS and do not complete applicable CAP or CAPS within the established time frames may be referred to ~~the Credentialing Committee~~**Provider Relations** for further action, which may include but is not limited to immediate closure of panels to new membership, annual audit and/or termination from the network.

9.6: Facility Site Review

Updated and *moved* the following language, concerning the Facility Site Review process and the expectation that certified site reviewers will determine the most appropriate method(s) to ascertain the information needed to complete the review:

Certified Site Reviewers (CSRs) are expected to determine the most appropriate method(s) in each site to ascertain the information needed to complete the review. Review criteria shall be reviewed by approved clinical professionals only. CSRs will be, at a minimum, a registered nurse (RN) however, a nurse practitioner (NP), physician (MD), physician assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife may also be able to obtain a CSR certification.

9.7: Medical Records

9.7.2: Procedure

Updated, in strike-through and boldface, the following items in a list of procedures for reviewing medical records, as follows:

1. **Any CAP considered critical is due within 10 business days of the date of review. A non-critical CAP for remaining deficiencies will be due 30 days from the date of the issued CAP report.**
2. ~~**If the CAP is considered non-critical, the provider or designated person will have no greater than 120 days from the date the CAP report was provided to complete the corrective action plan and submit it to the Facility Site Review unit at Blue Shield Promise.**~~

9.13: Credentialing Program

9.13.4: Credentials Process for IPA/Medical Groups

Added "evaluations" to item 1, as a delegated credentialing activity.

Section 10: Pharmacy and Medications

10.2: Specialty Pharmaceuticals

Added the following language, regarding the policy for financial risk of specialty pharmaceuticals:

Covered medical benefit drugs that have historically been carved out of managed care health plans, include blood factor, HIV/AIDS drugs, antipsychotics, or drugs used to treat a substance disorder. As of January 1, 2022, these drugs continue to be carved out of the medical benefits for managed care plans and may be covered under Medi-Cal Fee For Service (FFS) Fiscal Intermediary (FI) via a Treatment Authorization Request (TAR) at (800)-541-5555.

10.3: Reporting

Deleted and replaced the following language, regarding the processing of Medi-Cal Pharmacy CALINX claim files:

Medi-Cal Pharmacy CALINX claim files are available by the 15th of each month and can be accessed via the Blue Shield of California Provider Portal. Participating Provider Groups that do not have access to these files should ask their Account Manager to create a user account. Once the account has been created, access instructions and additional information will be sent to the requestor.

Section 11: Health Education

Changed "Community and Provider Education Department" to "Growth and Engagement Department," throughout Section 11.

11.2: Scope of the Health Education Program

11.2.1: Member Education

Updated language to reflect that the Blue Shield Promise HE Department works with the Growth and Engagement Department to coordinate activities for Blue Shield Promise's involvement in community outreach efforts and health screening events.

Updated the website to https://blueshieldca.com/healtheducationlibrary, where brochures and handouts are available to providers and members and where providers may print materials from the Blue Shield Promise library.

Deleted and replaced the following language, regarding how Blue Shield Promise Health Plan develops Preventive Health Guidelines:

Blue Shield Promise Health Plan develops Preventive Health Guidelines for adults and children/adolescents. These guidelines represent a compilation of recommendations from various organizations including the American Academy of Pediatrics, American Academy of Pediatric Dentistry, Centers for Disease Control and Prevention, U.S. Preventive Services Task Force, and National Cancer Institute. Preventive Health Guidelines for Adults and Children/Adolescents are available in English and Spanish on the Blue Shield Promise member website at www.blueshieldca.com/en/bsp/medi-cal-members/health-wellness.

Members may also call Customer Care to request a printed copy of the guidelines. Providers are notified about updates to the guidelines via the Blue Shield Provider Connection website at www.blueshieldca.com/provider, provider visits, or blast fax. Members are notified about updates to the guidelines via member newsletters.

11.4: Tobacco Cessation Services Cessation Services

Updated language regarding Medi-Cal coverage for smoking cessation agents for adults who use tobacco products, as follows:

Tobacco Cessation Medications Available to Medi-Cal Patients

Smoking cessation agents for adults who use tobacco products are covered by the Medi-Cal RX program. Some of these medications may have quantity limits and are subject to change. Currently, none of the tobacco cessation medications require prior authorization. For additional information, please see the Medi-Cal RX Contract Drugs List here: medi-calrx.dhcs.ca.gov/home/cdl/. Some of the agents (i.e., patches, lozenges, and gum) are found in the over-the-counter list: medi-calrx.dhcs.ca.gov/home/cdl/.

Section 14: Claims

14.2: Claims Processing Overview

Updated/added the following items in the list of claim reimbursement rate processes, in boldface type:

C. Reimbursement Rates

3. Non-contracted providers are paid at Medi-Cal established rates. **If there are no Medi-Cal established rates, payment will be made at 15% of billed charges.**

4. **Miscellaneous drugs/supplies for non-surgical procedures are reimbursable with HCPC Z7610 when all the following criteria is met, and will be paid at $36.53 per Drug for Miscellaneous Drugs with Revenue Codes 25x or 63x, and $227.60 per Item for Miscellaneous Supplies with Revenue Code 27x:**
    i. **The item is billed by hospital outpatient departments, emergency rooms, surgical clinic, or community clinic;**
    ii. **The item being billed does not have a unique billing code/HCPCS code; and**
    iii. **The item is not related to a surgical procedure.**
5. **Effective June 1, 2021, home therapy hemodialysis HCPC Code S9335 and home therapy peritoneal disease HCPC S9339 became Medi-Cal benefits.**
    i. **HCPCs S9335 and S9339 do not have established Medi-Cal rates, therefore, per Medi-Cal guidelines published in bulletin 563, Blue Shield Promise will reimburse for these HCPCs equivalent to in-center dialysis code Z6004 at the rate of $141.31 until Medi-Cal establishes rates for one or both codes.**
    ii. **Contract specific rates for these codes will supersede the Medi-Cal allowable amount.**

Section 16: Regulatory, Compliance, and Anti-Fraud

Added the following item, in boldface type, to a list of ways in which providers can cooperate in anti-fraud and abuse efforts:

There are two ways in which providers can cooperate in Blue Shield Promise's anti-fraud and abuse efforts:

1. Review practices related to services to Blue Shield Promise members to ensure that:
    k. **Full cooperation is demonstrated with Special Investigations Unit (SIU) audits.**

Added the following section to comply with AB 133 which mandates the creation of the California Health and Human Services Data Exchange Framework for Medi-Cal providers. This update is effective 1/31/24:

Health Information Data and Record Sharing with Blue Shield Promise

Providers shall comply with State requirements regarding electronic health record data exchange, including without limitation those outlined in the California Health and Human Services Data Exchange Framework, and the compliance milestones established for Calendar Year 2022-2024 and other program policy and procedure requirements, and additional state and federal regulations as applicable, and as updated and amended from time to time. Such program requirements and State law, implementing regulations and regulatory guidance shall govern the sharing of electronic health record data beginning January 31, 2024. Blue Shield Promise is able to receive electronic health record data through the following platforms: (i) EPIC Payer platform, (ii) Manifest MedEx platform, and (iii) State Qualifying Health Data Exchange platform. Providers shall participate in and utilize one of the aforementioned options in providing electronic health record data to Blue Shield Promise within the timelines set forth in the State requirements as they may be amended from time to time. For informational purposes, as of January 1, the required timelines include:

On or before January 31, 2024, unless otherwise stated:

- General acute care hospitals, as defined by Section 1250. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Provider and physician organizations and medical groups. as defined by Section 127500.2. (Fewer than 25 physicians, and nonprofit clinics with fewer than 10 providers, the compliance date is 1/31/26.)
- Skilled nursing facilities, as defined by Section 1250, that currently maintain electronic records. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Clinical laboratories, as that term is used in Section 1265 of the Business and Professions Code, and that are regulated by the State Department of Public Health.
- Acute psychiatric hospitals, as defined by Section 1250. (Fewer than 100 beds and state-run acute psychiatric hospitals, the compliance date is 1/31/26.)
- Emergency medical services, as defined by Section 1797.72.

Appendices

Appendix 2: Delegation of Credentialing Responsibilities

Updated the IPA/Medical Group Responsibility for delegated activity **I. Credentialing Primary Source Verification – Credentialing and Recredentialing** in boldface type below:

Develop, implement, and submit to Plan the Credentialing Program/Policy and procedures outlining a well-defined credentialing process for evaluating and selecting licensed practitioners to provide care to its members that comply with the Plan, NCQA, state and federal components of credentialing, **including Mental Health Parity, as applicable**.

Appendix 9: Delegation Oversight Claims, Compliance, IT System Integrity - Auditing and Monitoring

Claims Oversight Audit Review Process

Updated language, in boldface type, concerning the process for conducting periodic audits of claims and provider disputes to ensure compliance with regulatory requirements, to the following:

Audits and Audit Preparation

…Also provided is a cover sheet that **is required** to be completed and attached to each claim sample. Note that the claim sample must include the following from the contract with the provider: the first and last page (signature) of contract, rate sheet from contract e.g., all documentation is required to be submitted with sample claim as noted on the cover sheet. **If the contract cannot be submitted including the rate sheet with the claims sample selection, you must show the rate sheet associated with each claim sample selected during the audit webinar**.

Blue Shield Promise will perform an annual audit for claims and compliance **program** oversight which includes internal controls. **Additionally, biennially an** IT system security **audit will be conducted**. Blue Shield Promise will provide a notification of the **oversight** audits that includes the scope of the audit along with interviews of appropriate departments within the Delegated Entity's organization.

Blue Shield Promise will require a walk through **(including responses to the audit assessment)** and demonstration of the Delegated Entity's operations…

Blue Shield Promise will provide the Delegated Entity with written results within 30 calendar days including an itemization of any deficiencies and whether or not the Delegated Entity must prepare and submit a formal, written corrective action plan to include root cause, remediation, and evidence of remediation within **14 business days** of receipt of audit results. If supporting documentation/evidence is not provided the CAP will be closed as non-compliant.

Payment Accuracy

Updated the following language regarding interest and penalties, in boldface type:

Interest is applicable for contracted and non-contracted provider claims paid later than the regulatory requirement. Interest must be paid beginning on the 46th working day which is the first day after the regulatory requirement of the 45th working day through **the day the check is mailed and/or electronic payment is issued**.

Deleted and replaced the following language, regarding timeframes for filing claims, pursuant to AB 1455 Regulations:

Timely Filing: The Department of Managed Health Care enacted regulations related to claims settlement and dispute resolution practices of health plans and their delegated IPA/medical groups ("AB 1455 Regulations"). Among other things, the AB 1455 Regulations provide timely filing limitations for Medi-Cal claims depending on the provider's status. Timeframes for filing claims for contracted and non-contracted providers are as follows (CCR Title 28 Section 1300.71(b)(1)).:

- Contracted – A deadline of less than ninety (90) days after the date of service may not be imposed.
- Non-contracted – A deadline of less than one hundred eighty (180) days after the date of service may not be imposed.

<u>Evidence of Payment (EOP)/Remittance Advice (RA)</u>

Added, to the "Check Clearing:" sub-title, language to reflect that Blue Shield Promise follows the audit process as described in the DMHC Financial Examiner Guide and will confirm the date the check or electronic transfer was cleared from the Delegated Entity's bank account during the audit process.

Newly Contracted Provider Training Oversight Audit

Added the following bullet point to new and biennial required training topics:

- Health Equity which includes the reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.

Added the following language, concerning monthly review audits on Specialized Health Plans:

Delegation Oversight performs monthly review audits on Specialized Health Plans requiring submission of monthly universe reports and signed attestations by the 15th of the following month to the dedicated email address BSCProviderTraining@blueshieldca.com. Blue Shield Promise Delegation Oversight Compliance team will review attestations, universe against what is in the Specialized Health Plan website provider directory.

Appendix 11: Community Supports Eligibility Criteria and Restrictions/Limitations Guide

Changed Appendix title from "Appendix 11: Community Supports Criteria and Exclusion Guide" to "Appendix 11: Community Supports Eligibility Criteria and Restrictions/Limitations Guide." ***Updated*** new title, throughout Appendix 11.

Deleted and ***replaced*** the charts and language in the entire Appendix 11.

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