Community Supports Oversight, Monitoring, and Auditing

Purpose: As part of the Department of Health Care Services' (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) initiative and the Community Supports (CS) benefit, Partnership HealthPlan of California is required to perform oversight of CS providers and hold them accountable to all CS requirements.

Process: Partnership will perform audits and oversight of CS providers to ensure their performance meets all CS requirements contained in the DHCS contract amendment, CS policy guide, and DHCS All Plan Letter (APL) 23-003. An internal oversight audit tool will be used to track each audit element and document compliance, comments, findings, if correction(s) are needed in a specific area, and date of correction(s) completed.

Frequency: Audits will occur every other year, or more frequently as needed, to evaluate CS provider performance and compliance to ensure State and contractual requirements are met. Additionally, onsite visits may be conducted as needed.

CS Record Selection: Providers with 10 or more enrolled CS members will be subject to CS oversight. Partnership will pull a sample of eight charts of the CS provider's assigned enrolled CS members. Partnership will review CS Treatment Authorization Record (TAR) records, as well as the provider's applicable CS folder for valid housing plans and/or other reporting files.

Scoring: The review score is based on a review standard of eight sample files of Partnership members enrolled with the CS provider. Partnership will review CS TAR records, as well as the provider's valid housing plans and/or other reporting files. Compliance levels are:

- 90% = Pass
- 80-89% = Conditional Pass
- 79% and below = Failure

The minimum passing score is 80%. A corrective action plan (CAP) is required for a total audit score below 80%.

Performance Improvement (PIPs) and Corrective Action Plans: If a provider scores below 80%, a PIP will be sent to the provider and the provider will have 90 days to correct action(s). Should a provider fail to correct action(s) within 90 days, they will receive a Corrective Action Plan (CAP) and will not be able to enroll new CS members nor submit authorizations until 100% compliant. The provider will have 30 days to correct action (s) and should a provider fail to correct action(s), the provider may be administratively terminated or de-credentialed and would not be able to provide services to nor bill for Partnership members.

Audit Tracking and Documentation: Designated Partnership staff will send the CS provider the Oversight Template. Partnership staff will conduct the CS audit using the CS Audit Tool. All oversight audits will be recorded for historical purposes and reference.

- **CS Provider Oversight Template**
- **Audit Scorecard**

Designated Staff: Auditing will be overseen by the Enhanced Health Services clinical manager. Both clinical (medical staff) and non-clinical (program staff) will conduct these CS audits.

CS File Review: **Information from the TAR, Housing Plans, CS Provider Reporting Files, Claims/Invoice Billing, and CS Provider materials such as program description, organizational charts, etc.**	
Housing Transition Navigation Services	
Tenant Screening and Housing Assessment *Source: TAR, CS referral, and provider's referral tracking system*	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.
Individualized Housing Support Plan *Source: TAR, CS referral, and provider's referral tracking system*	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.
Assisting in Securing Housing and/or Benefits Advocacy *Source: CS referral and provider's referral tracking system*	1. Searching for housing and presenting options. 2. Assisting in securing housing, including the completion of housing applications and required documentation (e.g., Social Security card, birth certificate, prior rental history). 3. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process. Such service can be subcontracted out to obtain needed specialized skillsets. 4. Identifying and securing available resources to assist with subsidizing rent (such as Housing and Urban Development's (HUD) Housing Choice Voucher Program [Section 8] or state and local assistance programs) and matching available rental subsidy resources to members. 5. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
Landlord Education *Source: Provider's referral tracking system*	Landlord education and engagement.

Supporting Move and Retention *Source: Provider's referral tracking system*	Assisting in arranging for and supporting the details of the move. 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.
Housing Deposits	
Deposits *Source: TAR, CS referral, and provider's referral tracking system*	The member's needs and the needs of their family should be documented in the individualized housing support plan. The services provided should utilize best practices for members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions, including Housing First, harm reduction, progressive engagement, motivational interviewing, and trauma-informed care. Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month of rent.
Housing Tenancy and Sustaining Services	
Tenancy and Sustaining Services *Source: TAR, CS referral, and provider's referral tracking system*	Services may include: 1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations. 2. Education and training on the role, rights, and responsibilities of the tenant and landlord. 3. Coaching on developing and maintaining key relationships with landlords/property managers with the goal of fostering successful tenancy. 4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability. 5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action, including developing a repayment plan or identifying funding in situations when the Member owes back rent or payment for damage to the unit. 6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

	7. Assistance with the annual housing recertification process. 8. Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. 9. Health and safety visits, including unit habitability inspections. 10. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.
Short Term Post Hospitalization	
Services *Source: CS referral and provider's referral tracking system*	This setting must provide individuals with ongoing supports necessary for recuperation and recovery, such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management, and beginning to access other housing supports like Housing Transition Navigation. This setting may include an individual or shared interim housing setting, where residents receive the services described above.
Recuperative Care	
Services *Source: CS referral, provider's referral tracking system, and program description*	Service will include interim housing with a bed, meals, and monitoring of the member's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include: 1. Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs). 2. Coordination of transportation to post-discharge appointments. 3. Connection to any other on-going services an individual may require including mental health and substance use disorder services. 4. Support in accessing benefits and housing. 5. Gaining stability with case management relationships and programs.

Standards for Recuperative Care *Source: CS referral, provider's referral tracking system, and program description*	Standard 1: Medical respite program provides safe and quality accommodations. Standard 2: Medical respite program provides quality environmental services. Standard 3: Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings. Standard 4: Medical respite program assists in health care coordination, provides wrap-around services, and facilitates access to comprehensive support services. Standard 5: Medical respite program facilitates safe and appropriate care transitions out of medical respite care. Standard 6: Medical respite care personnel are equipped to address the needs of people experiencing homelessness. Standard 7: Medical respite care is driven by quality improvement.
Respite Services	
Services *Source: CS referral, provider's referral tracking system, and program description*	May include: 1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals. 2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals. 3. Services that attend to the member's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of typical routines that would ordinarily be performed by those persons who normally care for and/or supervise them. 4. Respite services cannot be provided virtually, or via telehealth.

Day Habilitation	
Services *Source: CS referral, provider's referral tracking system, and program description*	Programs are designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. If possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management. Program services include, but are not limited to, training on: 1. The use of public transportation. 2. Personal skills development in conflict resolution. 3. Developing and maintaining interpersonal relationships. 4. Daily living skills (cooking, cleaning, shopping, money management). 5. Locating and choosing suitable housemates. 6. Managing personal financial affairs.
Personal Care and Homemaker Services	
Services *Source: CS referral, provider's referral tracking system, and program description*	Services provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with IADLs such as meal preparation, grocery shopping, and money management. Includes services provided through the In-Home Support Services program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes.

Medically Tailored Meals	
Minimum Nutrient and Energy *Source: CS referral, provider's referral tracking system, and program description*	The food provided to the member must meet at least two-thirds of the daily nutrient and energy needs of the individual for the course of the intervention, as estimated by the MTM/MSF provider. If offered in combination, MTM and MSF may be combined to meet the two-thirds requirement. This requirement is in place to ensure that members receive enough food to serve as a nutritional intervention.
Tailoring MTM/MSF Interventions *Source: CS referral, provider's referral tracking system, and program description*	MTM/MSF interventions must be tailored to a member's specific nutritional and clinical needs. Tailoring MTM/MSF interventions to the medical needs of a member should include determining appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes. Tailoring of MTM/MSF interventions must engage RDNs and/or clinical staff with relevant nutrition expertise.
Pairing of MSF with Education *Source: CS referral, provider's referral tracking system, and program description*	MSF must be authorized in conjunction with behavioral, cooking, and/or nutrition education. Behavioral, cooking, and/or nutrition education means health coaching, behavioral supports, and tools, including equipment and materials, that are delivered based on a member's medical conditions and needs. Nutrition education providers must have an RDN or clinician with relevant nutrition expertise to vet or oversee the medical appropriateness determinations. These nutrition supports can be provided in an individual or group setting. Education does not meet the MTM/MSF service definition if delivered as a standalone service.
Sobering Center	
Services *Source: CS referral, provider's referral tracking system, and program description*	Provides these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services. This service is covered for a duration of less than 24 hours.

Quality and Monitoring Reports	
CS Provider's Reporting Files	• Capacity • RTF
Referrals *Source: CS help desk trending*	Provider responds within 48 hours to referrals
Partnership Internal Monitoring Reports *Source: Revised CS dashboard*	Member-level outcomes related to utilization to evaluate CS benefit and in lieu of services.
Treatment Authorization Reports *Source: TAR reporting*	• TARs are submitted in a timely manner. Partnership Policy MCUP3041: TARs must be received by Partnership within 15 business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. Renewal TARs to be submitted at least 10 days prior to end of the prior approval. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.) • TARs are submitted correctly for payment purposes (i.e., correct codes, quantities, modifiers, dates, diagnosis codes.)
Member Experience	CS service provided with culturally and linguistically appropriate care
Program Narrative Description *Source: CS provider's program description and materials*	Review of provider program narrative as shared six months after first member enrolled and annually thereafter. Will include description of program, staffing, enrollment, barriers, challenges, successes, and recommendations for improvement of program.
Onsite Visits	
Onsite Visits	Onsite Visits

CS Review Tool

Provider Name: _____ Review Date: _____

Partnership No: _____ Site NPI: _____

Address: _____ Reviewer name/title: _____

City and Zip Code: _____

Phone: _____ Fax: _____

Contact person/title: _____

Email: _____

Provider Name	NPI

Number of Records Reviewed: _____

Visit Purpose	CS Services	
□ Initial Audit	□ HTNS	□ Respite Services
□ Monitoring	□ Deposits	□ Personal Care/Homemaker Services
□ Follow-up	□ HTSS	□ MTM
□ Technical Assistance	□ STPH	□ Day Habilitation
□ Other	□ Recuperative Care	□ Sobering Center

CS Record Scores				
	Yes	**No**	**N/A**	**Section Score %**
Housing Transition and Navigation				
Housing Deposits				
Housing Tenancy and Sustaining Services				
STPH				
Recuperative Care				
Respite Care				
Day Habilitation				
Personal Care/ Homemaker Services				
Medically Tailored Meals				
Sobering Center				
	Yes Points	**No Points**	**N/A**	

Scoring Procedure

Scoring is based on first 8 records pulled. If any of the first 8 pulled fails, another 8 records will be pulled for a total of 16 records.

1) Add points given for all sections applicable to CS services provided.
2) Divide total points given by total points possible.

Compliance Rate

Note: Any section score < 80% requires a PIP.

___ Pass: 90% or above
(Total score is ≥ 90% ***and*** all section scores are 80% or above)

___ Conditional Pass: 80-89%
(Total is 80-89% ***or*** any section(s) score is < 80%)

___ CAP: 79% and Below

___ Other follow-up

Next Review Due: _____

CS Records Reference:

CS Record	CIN	Age (Year/Month)	Gender	Member's Health Plan Code	Member's Enrollment Date or Effective Date Assigned to Member*
1					
2					
3					
4					
5					
6					
7					
8					

*More recent date should be noted in column.