An Introduction to Community Supports Billing for California Housing Services Providers

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Purpose

This guide is intended to help housing and homeless service organizations get ready for the billing processes that are required for Community Supports (CS) providers under Medi-Cal Managed Care in California. This introductory guide is a part of the CSH Medi-Cal Academy for Homeless Service Providers, a comprehensive training series funded by the California Health Care Foundation (CHCF). Training videos and additional resources are on the CHCF website here.

Housing-related CS programs, available through CalAIM, are treated much like other health care services when it comes to billing and payment. Unlike a lump sum grant or many government work orders, CS billing is usually done based on what services individual clients (called "members" by Medi-Cal Managed Care Plans, a.k.a. MCPs) received that month. For many homeless and housing service organizations, this means less certainty for cash flow, payment for services *after* they are provided rather than before, and the need for new billing systems and processes in order to get paid.

The information below focuses on three CS services that help move people experiencing homelessness into permanent housing placements:

Community Support	Brief Description (see the CS Policy Guide for more)
Housing Transition Navigation Services	Services to help members find and obtain housing, including assessment, development of an individual housing support plan, assistance with housing search and applications, communication with landlords, and arranging for logistics of the move.
Housing Deposits	Goods and services that assist with identifying, coordinating, securing, or funding one-time supports and modifications necessary to enable a person to establish a basic household, such as security deposits, utilities, first/last months' rent, pest eradication, cleaning, furniture, etc. Cannot include any ongoing payment of "room and board," or payment of ongoing rental costs.
Housing Tenancy and Sustaining Services	Services to help members maintain safe and stable tenancy once housing is secured, including identifying and addressing potential barriers to tenancy, education on tenant requirements, assistance communicating with landlords and the housing recertification process, updating the housing support and crisis plan, health and safety visits, and linkage to community resources.

Providers interested in other CS (e.g., day habilitation, recuperative care, short-term post-hospitalization housing, etc.) may find that most of this guide still applies, but differences in documentation of services, payment methodology and coding may exist that prospective CS providers should be attuned to.

While this guide is a good place to get started, it cannot and should not substitute for CS billing submission guidance provided by any MCPs with which your organization is contracted. Each MCP may have different timelines, formats, and processes for claims or invoice submission and payment for CS and will need to provide related guidance to all contracted providers. While the California State Department of Health Care Services (DHCS) mandates certain standardized processes, providers must always ensure that they are paying attention to the details required of them in their contractual obligations. Paying attention to these details will be critical for timely payment and long-term success.

Section One: Getting Started with Definitions and Key Questions

Housing and homeless service organizations intending to pursue contracts with local MCPs should come prepared with a basic understanding of the health care billing process as well as an understanding of their own ability to bill for services. This will help your organization know what questions to ask of the MCP during initial and ongoing discussions and make your organization more appealing as a potential provider. DHCS also offers some basic training resources on billing for Medi-Cal providers through the Medi-Cal Learning Portal[1], although each Medi-Cal Managed Care Plan will have some processes that differ from DHCS and from one another.

1.a. Billing & Payment Process Overview

In health care, the billing and payment process starts at the initial encounter with the member and has many steps before and after payments are requested and received. MCPs and other health care providers sometimes use the term "healthcare revenue cycle management" to describe what providers do from initial registration through documentation, coding, billing, and payment. For prospective CS providers, the five key steps to the billing process are:

1. initiating services;
2. providing and documenting services;
3. internal data review;
4. billing (also called claims submission); and
5. payment, reconciliation, correction, and resubmission.

These five key steps are described in Chart 1 on pages 3-, together with critical questions prospective and new CS providers should consider to successfully implement housing-related CS and ensure smooth billing and reimbursement processes. Section Two of this document provides additional detail and links to support for each step.

1.b. Internal Asset & Gap Analysis

For your organization to be successful as a CS provider, you will need to master the billing process. For each step above, you will need people to do the work, an electronic or paper-based system to use (electronic is recommended), and documented processes for how things are done (including training or instruction manuals for staff).

We recommend that prospective CS providers conduct an internal asset & gap analysis to identify where they will need financial resources, technical assistance, new staff, or other supports to be able to bill for CS. For example, does your organization already conduct Medi-Cal billing for any other services, such as mental health or substance use disorder services? Do you have a staff person with healthcare billing expertise or do you need a health care revenue cycle consultant? Do you already have a HIPAA compliant electronic documentation system you can use, or do you need a new system for CS? Does the MCP provide any tools to help you with documentation and billing?

Financial resources and free technical assistance to help with billing infrastructure development is available to prospective CS providers through several CalAIM programs. Prospective CS providers should consider applying for or participating in the following programs, although availability will vary over time and by MCP / region:

- Technical Assistance (Free)
  - PATH Technical Assistance Marketplace
  - MCP Technical Assistance (varies by MCP)
- Financial Support
  - Incentive Payment Program (IPP) funding through the MCP
  - Housing & Homelessness Incentive Program (HHIP) funding through the MCP
  - PATH CITED
  - Other grant programs (e.g. foundations, hospital community benefits)

[1] The user registration guide for the Medi-Cal Learning Portal outlines that users are required to enter their agency's National Provider Identifier (NPI) as well as the primary type of claim their agency submits. For housing-related CS providers, you should have registered and received an NPI before finalizing your MCP contract, and you will want to select CMS-1500 as the Primary Claim Type.

CHART 1: Understanding and Planning for Each Stage of the Billing Process

Step	Description	Key Questions to Think About
1) Initiating Services	Medi-Cal Coverage: When initiating services for CS, your organization will need to verify what Medi-Cal MCP the member is enrolled with, and that the coverage is active as of the current month. You will need to continue to verify Medi-Cal coverage and MCP for the member on an ongoing basis each month for the duration of services. Referral / Authorization: Depending on the MCP's requirements, you may also need to request an authorization to provide services, which involves submitting a referral or authorization request (often via an email or secure fax form or online platform) with key information about the member to show that they meet the criteria to receive the specific CS service. The MCP will provide a response back within no more than 72 hours for urgent requests or 5 days for routine requests. Depending on the service and the MCP, they may also provide an authorization number to submit with future billing. Opt-In: Because all CS are voluntary services, the MCP may ask your organization to document the member's agreement or "opt in" to receive services, which may be verbal or in writing. (Note: you may also secure a release to share information from the member at opt-in, although this is not strictly required for billing purposes.)	• Approximately what percentage of your current clients have active Medi-Cal coverage, and what percent are enrolled with the specific MCP you are contracting with? • Does your organization currently have a process to look up Medi-Cal coverage information for your clients? For example, if you already bill for another Medi-Cal service such as mental health or substance use disorder treatment, you likely do this already. If your agency does not have this process in place, you will need to develop one. See section 2.1 on Initiative Services below for information on the three ways to look this up. • Will most of the members receiving CS be referred to you by the MCP or are you expected to find and refer your own clients for services? Or both? If you refer clients whom you already serve, will the MCP honor the existing relationship your agency has with the client and assign that client to your agency for CS? Was this a part of your discussion during contracting? How will you identify your own clients to refer to CS (workflow, staff responsible, etc.)? • How long will it take for your organization to submit referrals and / or authorization requests? Who will be responsible for submission? Are there specific clients or instances where your agency will want to advocate for pre-authorization based on the acuity of need and client situation? • Do you have a method to get back in touch with the member quickly to provide services once approvals are received? Are there any time-sensitive services (e.g. landlords wanting housing deposits within 24 hours that may not align with MCP authorization timeframes)? See above question regarding pre-authorizations. • How will you explain the CS services to members and get their agreement to participate? Where will you document this agreement? Note: This may be a critical moment to get a release to share information with other providers signed as well.
2) Providing & Documenting Services	Documentation: For each CS service provided to an individual member, your organization will need to document key information to support billing. Key data elements for each CS are described below, but will include client demographics and	• Where do your staff document services they provide to clients? Do case notes include: ○ the date services were provided,

Step	Description	Key Questions to Think About
	Medi-Cal managed care coverage information as well as procedure codes that share services information. In addition to supporting submission of claims / invoices, more detailed documentation would need to be available to support any future audit requests, in order to verify that services billed were actually provided to the member on the specific date billed, during an authorized service period. Systems: While CS providers can use paper-based records, the vast majority use one or more electronic platforms. Documentation systems might include an electronic health record (EHR), care management platform, or Homeless Management Information System (HMIS). Systems might be owned by your agency or in some cases, provided by the MCP or hosted by the local Continuum of Care. All systems except those provided by the MCP will need to be configured to capture CS-specific data and share CS-specific data needed to submit billing and coordinate care.	○ if the service was face to face, telephonic, or another mode ○ which activity and service type was provided ○ the name of the staff member providing the service ○ which need the service was addressing (and that the need was included in the assessment and the service included in the service plan) • How often will staff need to document services (e.g. daily, weekly)? How much time will this documentation take from time serving clients? Does this additional documentation time impact staff members' ability to maintain current caseloads and provide excellent services? Will caseloads need adjustments? • Are documentation systems electronic or paper based? Is there web access for field-based staff? • Which fields will be standardized and which will be free text? • Can any fields be automatically populated to save time? • How will you train your staff to document CS services? Will staff use a standard case note format (e.g. SOAP)? • How will you ensure that staff document every CS service rendered (not just the minimum number required to achieve payment and/or contract compliance)? • How will you ensure that documentation and staff documentation processes are adhering to HIPAA privacy and security requirements?
3) Internal Data Review	Internal Data Review: On a regular basis, administrative staff should review the data entered by client-facing staff to ensure data quality and completeness. This may occur via manual or systematic review of all data for a recent time period (e.g. all CS encounters entered for the last month). Staff should monitor for any common errors (e.g. incomplete data, missing intake or assessment forms, or missing notes), as well as checking that frequency of contact is sufficient to meet or exceed the minimum requirements for the CS program.	• Who will review data? • How often will data be reviewed (e.g. weekly / biweekly / monthly)? • What constitutes "complete" data for billing purposes, i.e. what fields and / or forms or activities are the minimum required to submit a clean bill? • What are common staff errors or omissions to watch out for? • Are staff meeting CS program requirements (e.g. minimum monthly encounter frequency for payment)?
4) Billing: Data extraction, cleaning, and transmission / submission to MCPs	Extraction: In order to bill MCPs, your organization will need to extract the data from your system(s). It is important to create report formats that link all the necessary data elements of a CS claim or invoice in the correct format for	• Will my organization be using claims or invoices to bill MCPs for CS services? If claims, will my submissions be paper-based (CMS 1500 form) or electronic (837P)?

Step	Description	Key Questions to Think About
	billing. Most EHRs come with this function already standardized to produce data extracts in the "837P" (Professional) health care billing format for claims submission, but other systems will likely require customization. The 837P format is closely related to the "CMS 1500 form", which is the paper-based equivalent. This guide crosswalks data elements between the two layouts. The DHCS Invoice format for CS has many similar data elements to the 837P or CMS 1500 form. Data cleaning: If your organization uses an EHR, the data should be produced in a relatively clean 837P format. If your organization uses an electronic documentation system that does not automatically produce 837P files, you will likely need to clean the data to make sure that all of the data elements in your extract are correctly formatted to the claims or invoice specifications of the MCP you are working with. MCPs should have a "clean claim billing guide" or similar document available on their websites or by request, to show exactly how to format the data for submission. Transmission / Submission to MCPs: Once your organization has a clean claims file (837P) or invoice ready, you will need to submit it to the MCP. Many MCPs use "clearinghouses", which are institutions that electronically transmit different types of medical claims data to insurance carriers, in order to accept claims files from providers. In general, Medi-Cal claims must be submitted to insurers within no more than 180 days from the date of service in order to qualify for payment, but MCPs may have earlier deadlines in their CS contract language. NOTE: Some MCPs offer a software solution for CS providers to use for service documentation that assists with Steps 1-4.	• Does my electronic data system automatically produce extracts in the 837P format? Is any configuration required to meet the specifications for CS or for my specific MCP? • Who will be responsible for data extraction and cleaning? What systems or tools will they need to be successful? • What file formats and submission frequency does my MCP require for billing? If you are working with multiple MCPs, what are the similarities and differences between them? • What data cleaning or formatting needs to be done to ensure that my data extract meets MCP specifications? Can they be done systematically (i.e. programmed / automated) or do they require manual intervention and review? • Does my MCP use a clearinghouse? What is the process to register with and submit data to them?
5) Payment, Reconciliation, Correction, and Resubmission	Payment: Once an MCP receives a claim or invoice from your organization, they will process it in order to pay for CS services provided. MCPs must meet state required timelines by paying all claims as soon as practicable, but no later than	• How fast will payment occur? Will there be any anticipated cash-flow issues for your organization if payment is slower than expected or correction & resubmission is required?

Step	Description	Key Questions to Think About
	30 working days after receipt of the claim. MCPs are subject to interest payments if failing to meet the standards of paying at least 90% of "clean claims" (meaning claims without any errors, omissions, or other issues) within 30 days and at least 99% within 90 days. Payments may be delivered via paper check or electronic transfer (e.g. ACH), depending on the MCP and how your organization is set up. Reconciliation: Your organization will need to reconcile the payment from the MCP to ensure that it aligns with the amount you expected to receive based on the claim or invoice amount. In addition to providing the actual payment, the MCP will provide something called "remittance advice" (RA), which is an explanation from a health plan to a provider about a claim payment. The RA will include information on which claims were paid as expected, adjusted (i.e. paid at a different rate than you billed), or denied, along with different reason codes explaining why. Correction & Resubmission: Based on the RA, your organization may need to go back and correct some claims or invoices to add missing information, correct errors, or fix formatting issues. Once this is done, your organization will need to resubmit the claim to the MCP using the process in Step 4, potentially with a new data indicator that this is a resubmitted claim.	• Who will be responsible for reconciliation of payments to submitted claims / invoices? What tools or systems will they need to be successful? How often will you do reconciliation (e.g. monthly)? • Who will be responsible for correction & resubmission of claims or invoices? Based on the volume of CS services provided, does it make sense to do this manually or electronically? • Has the MCP provided guidance to your organization about the claims edit / reason codes they use, with information explaining what each edit / reason code means?

Section Two: Diving In & Staying Connected

In the next sections, we'll go into more detail on what you need to know for CS billing at each stage of the process. Please note that each part of the billing process is interconnected, so choices and changes made at one stage can affect others as well.

2.1. Initiating Services

Medi-Cal Coverage: When initiating services for CS, your organization will need to verify what Medi-Cal MCP the member is enrolled with, and that the coverage is active as of the current month. You will need to continue to verify Medi-Cal coverage and MCP for the member on an ongoing basis each month for the duration of services.

- In order to verify Medi-Cal coverage for an individual client, you will ideally need the individual's Medi-Cal Client Identification Number (CIN), a nine-character identification number assigned to each Medi-Cal member in the state.
    - This number stays the same no matter what Medi-Cal Managed Care Plan (MCP) the member is assigned to.
    - The CIN can be found on the member's Medi-Cal Beneficiary ID card (BIC) and / or their MCP ID card.
    - If you don't know the client's CIN, you can also use the client's name, date of birth, and other identifying information to look up the CIN using one of the below verification systems.
- Verification of active Medi-Cal coverage and the appropriate MCP should be done before serving the client and at least monthly thereafter.
    - Medi-Cal coverage and MCP can change up to once per month.
    - Starting in September 2023, DHCS is requiring that MCPs provide contracted CS providers with a regular file of all members they are serving and prospective members (the CS "member information file"), which will contain a "denial reason code" (see footnote 36) that indicates if a member is no longer enrolled in the MCP or in Medi-Cal. Talk with your MCP for information on how to interpret the denial reason codes.
- There are three main systems used to verify Medi-Cal coverage:
    - 1. The Automated Eligibility Verification System (AEVS) is a telephonic system that providers can use to verify Medi-Cal coverage for any Medi-Cal member statewide.
        - In order to use this system, you must have a valid Provider Identification Number (PIN), which is given to registered Medi-Cal FFS providers.
        - If your organization is only contracted with MCPs for CS and is not otherwise eligible to register as a Medi-Cal FFS provider, you will likely not have a PIN. However, DHCS has provided guidance in the draft Justice-Involved Reentry Initiative Guide that a new "Community Based Organization" provider type for Medi-Cal is under consideration; the timeline for implementation is TBD.
    - 2. The DHCS online provider transaction system is a site where Medi-Cal providers can verify Medi-Cal coverage as well as conduct other transactions for any Medi-Cal member statewide.
        - As with AEVS, a Medi-Cal PIN is required for this system.
        - Note: DHCS is in the process of transitioning to a new online provider portal, currently available by invitation only.
    - 3. Most MCPs also provide an online portal that contracted providers (including CS providers) can use to verify Medi-Cal coverage for current and prospective clients, although such portals are often limited only to that MCP's members.
        - Contact your MCP for information on how to access their online portal.
- Additional considerations for this activity:
    - Many people experiencing homelessness use aliases and may not have copies of physical ID cards to identify CIN; it may take several conversations to verify information needed to determine Medi-Cal coverage.
    - Electronic systems must have the ability to record Medi-Cal coverage and MCP history by month to link back to claims by date of service.

Referral / Authorization: Depending on the MCP's requirements, you may also need to request an authorization to provide services, which involves submitting a referral or authorization request (often via an email or secure fax form or online platform) with key information about the member to show that they meet the criteria to receive the specific CS service. The MCP will provide a response back within no more than 72 hours for urgent requests or 5 days for routine requests, and may provide an authorization number to submit with future billing.

- At this time, each MCP can decide whether authorizations will be required for a particular CS or whether contracted providers can provide the CS without a formal authorization approval.

    - Some MCPs may also offer presumptive eligibility or other provider leeway to determine which members should receive certain CS.
    - DHCS has indicated that they plan to have MCPs standardize authorization timeframes and processes for CS starting in 2024.
- Most MCPs will have a referral form, request for services form, or other similar document that CS providers can use to share key information about the member and how they meet the eligibility criteria for that specific CS service.
    - Detailed information on the eligible populations for each CS can be found in the CS policy guide. This guidance applies even if no authorization is required.
    - Some MCPs currently have different criteria approved by DHCS but according to the July 2023 revision of the CS Policy Guide, MCPs will need to standardize to align with statewide criteria by no later than 1/1/2024.
    - The actual forms and submission method differ by MCP.
- DHCS requires that MCPs accept provider referrals and member self-referrals for CS. MCPs cannot limit CS only to those members identified by the MCP (specified in the Finalized ECM and CS MCP Contract Template, CS section 1.E. and the July 2023 CS Policy Guide, p. 6)
- Once the MCP receives a referral request, they are required to evaluate it and provide back an authorization for services, denial, or modification.
    - Both the member and the provider must receive a letter describing the decision and the reasoning behind it.
- If an authorization is required, the provider's letter will include information on the initial timeframe or quantity for which the service is authorized (e.g. Individual Housing Transition Services are authorized for this member from January 1 – December 31, 2024, Housing Deposits are authorized for this member up to a limit of $5,000), and may also include a specific authorization number, which the provider should keep in order to submit it on the claim or invoice.
    - If services are needed beyond the initial timeframe or quantity authorized, the provider can request an extension later on.
    - The CS "member information file" will include aggregated information on member authorizations starting in September 2023.

Opt-In: Because all CS are voluntary services, the MCP may ask your organization to document the member's agreement or "opt in" to receive services, which may be verbal or in writing.

- If your organization provides CS in addition to other housing-related services covered by other funders, or provides CS services through a subcontract, you will still need to ensure that the member understands when they are being referred to and enrolled in the CS service.
    - Even if there is no change in the member's relationship with their direct service provider when switching from (for example) County-funded Housing Navigation to the Individual Housing Transition Services CS, member agreement is still required to ensure compliance from the Medi-Cal perspective. A brief conversation is required at minimum.

2.2. Providing & Documenting Services

To bill for the CS you provide to each MCP member, your organization will need to ensure that you have at least the minimum data elements to complete one of the three minimum formats to bill an MCP: (1) the CMS 1500 form, (2) the 837P file exchange format, or (3) CS Invoice template. The data elements needed between the three are very similar and fall into the following categories:

- WHO: the MEMBER
    - Demographics & insurance coverage information including the member's name, date of birth, address, and Medi-Cal CIN (verified as part of initiating services).
    - MCPs may have different guidelines re: what address information to include as part of billing for members experiencing homelessness; we recommend checking with your MCP.
- WHO: the PROVIDER
    - Your organization's information as a CS provider, including your National Provider Identifier (NPI).
    - For CS, all billing should be done at the organization level (i.e. use your organization's Type 2 NPI; do not use NPIs for individual licensed clinicians).
        - The organization is the "billing provider."
        - There are optional fields available to include a "rendering provider" as well, meaning the NPI and information for a specific individual who rendered the care. However, this is not necessary or appropriate for most housing-related CS and can be left blank.
    - It is critical to ensure that your organization name, address, and other information exactly match those on your NPI application and registration with the MCP.

        - Since nearly all MCP billing is processed automatically by electronic systems, tiny differences (e.g. "St." vs. "Street") can cause unwanted errors that result in denials.
- WHO: The MCP (a.k.a. PAYER)
    - Your bill will need to include information on which MCP is being billed for this member for this service for this month (or other appropriate timeframe). This is used to help avoid misdirected billing.
- WHAT: What SERVICES were provided to the member
    - DHCS has issued ECM and CS coding guidance with specific Healthcare Common Procedure Coding System (HCPCS) service codes and modifiers to be used for each CS:

Chart 2: Service Type, HCPCS Code, Description and Modifiers Used in Billing

Community Support	HCPS Level II Code	HCPCS Description	Modifier	Modifier Description
Housing Transition Navigation Services	H0043	Supported housing; per diem	U6	Used by Managed Care with HCPCS code H0043 to indicate Community Supports Housing Transition/Navigation Services
	H2016	Comprehensive community support services; per diem	U6	Used by Managed Care with HCPCS code H2016 to indicate Community Supports Housing Transition/Navigation Services
Housing Deposits	0044	Supported housing, per month. Requires deposit amounts to be reported on the encounter. Modifier used to differentiate housing deposits from Short-Term Post-Hospitalization Housing.	U2	Used by Managed Care with HCPCS code H0044 to indicate Community Supports Housing Deposit
Housing Tenancy and Sustaining Services	T2040	Financial management, self directed; per 15 minutes	U6	Used by Managed Care with HCPCS code T2040 to indicate Community Supports Housing Tenancy and Sustaining Services
	T2050	Financial management, self directed; per diem	U6	Used by Managed Care with HCPCS code T2050 to indicate Community Supports Housing Tenancy and Sustaining Services
	T2041	Support brokerage, self directed; per 15 minutes	U6	Used by Managed Care with HCPCS code T2041 to indicate Community Supports Housing Tenancy and Sustaining Services
	T2051	Support brokerage, self directed; per diem	U6	Used by Managed Care with HCPCS code T2051 to indicate Community Supports Housing Tenancy and Sustaining Services

    - For both Housing Transition Navigation Services and Housing Tenancy and Sustaining Services, there are two coding options.
        - Providers should pick the code that best describes their activities, unless there is specific MCP guidance to differentiate between the two codes.
    - For Housing Tenancy and Sustaining Services, there are both 15 minute and per-diem codes. Most providers prefer to use per-diem (i.e. daily) codes to minimize the amount of information they have to track, depending on MCP approval.
    - While some MCPs have used different modifiers in the past, DHCS has clarified that all MCPs must use the exact codes and modifiers in their guide going forward.
- WHEN: The DATES and FREQUENCY of services provided to members.
    - These will vary by CS.
    - For Individual Housing Transition Navigation Services and Housing and Tenancy Sustaining Services, services must be recorded by date (e.g. dates of each conversation or activity to help the member) for per diem codes, and must also include the number of units if 15 minute codes are used (e.g. 45 minutes = 3 units).
- WHERE: The PLACE of SERVICE (POS) where the service was provided
    - Use the appropriate code from the CMS POS code set.
    - Common POS codes for housing-related CS include:

        - 04: Homeless shelter
        - 12: Home
        - 15: Mobile Unit
        - 16: Temporary Lodging
        - 27: Outreach Site / Street (New code effective that will be 10/1/2023)
    - Note that there is currently no separate POS code for services provided via street outreach.
- WHY: The DIAGNOSIS code describing the member's condition and reason for services
    - For housing-related CS, providers should make sure to include at least one of the housing-related diagnosis codes that applies to the member, as outlined in APL 21-009:

Chart 3: Diagnostic Codes to Support Documentation and Service Need

Code	Description
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified

    - CMS guidance is that any member of a person's care team (including non-clinicians) can collect information on social determinants of health (SDOH) such as housing, that can then be recorded and reported as Z-codes.
    - In addition to codes related to housing status, please include any other relevant codes, which helps the MCP identify other services that the member qualifies for. For a list of priority SDOH codes from DHCS, see APL 21-009.
    - Diagnosis codes are a separate data point from the "member homelessness indicator" on the ECM / CS Invoice Format or CS Member Information File. MCPs generally use diagnosis code information from claims much more than either of those two fields, so including information in this section is critical for MCPs to identify other services that the member qualifies for.
- HOW MUCH: The RATE or REIMBURSEMENT for the services provided.
    - Each MCP will negotiate a different reimbursement rate for CS services, specified in your contract. Your organization should bill at the contracted rate.
- Other Fields of note on the CMS 1500 Form:
    - 22. Resubmission code (used for claims being resubmitted as part of step e)
    - 23. Prior Authorization number (used to enter the authorization number, if one was provided)

Not all fields are required for a clean claim / invoice (see links for guidance on optional fields for each form). In addition to the minimum data elements required for billing, your organization should make sure that you also have required documentation for audit purposes and to run a high-quality program (e.g. case notes, individual housing support plans).

2.3. Internal Data Review

Part of providing high quality health related social services, like Community Supports, means that your team will need to conduct regular quality reviews of the documentation and client records you create, collect and store- in order to:

1) provide high quality, consistent services to people served,
2) track these services and ensure that care is consistent and coordinated,
3) ensure that the documentation you create and collect complies with what your contracted payors, like Managed Care Plans, expect,
4) have the information you need to bill for services provided and demonstrate quality services to payors, and
5) be ready for an audit, should an MCP or payor ask to see files to check for quality compliance.

It is important that you begin to do regular reviews of client charts and documentation of services, in order to anticipate any issues that may arise related to delayed reimbursement because of missing data in an assessment or individualized service plan. You should plan to conduct regular internal reviews of the documentation collected by your teams at least quarterly to ensure that you have sufficient information to generate comprehensive, correct billing documents and will do well in an audit. Best practice is to review documentation at least monthly.

Currently there are no standard chart review guides created just for housing-related Community Supports, but there are several online that your team could tailor to support your internal quality improvement and quality assurance activities, including one internal chart record audit checklist included in the Medi-Cal Academy for Homeless Service Providers training[2] materials.

2.4. Billing: Data Extraction, Cleaning, and Transmission / Submission to MCPs

Since most CS billing will be processed electronically by MCPs, you should make sure you have a process for data cleaning and formatting that will match the exact claim or invoice file specifications needed. Exact address matching, date formatting (e.g. 4/12/2024 vs. 04/12/2024), and correct placement of each data element is required to ensure that the claim or invoice will be paid promptly.

Your organization's processes to extract, clean, and transmit data to MCPs will vary significantly based on the type of electronic documentation system that you use. Below, in Chart 4, is a non-exhaustive list of pros and cons that prospective housing-related CS providers might consider when looking at different systems, specifically with regards to billing:

Chart 4: Data Systems Pros and Cons for Billing Housing-related CS

System Solution	Pros	Cons
Certified Electronic Health Record (EHR)	• Can easily generate health care billing file formats • HIPAA compliant	• Can be expensive for smaller providers who don't offer for other health services • Generally not designed for housing-related services • May need some customization to create templates for CS documentation • Need to do double documentation in HMIS for any required CES activities
Electronic Case Management System	• Staff can document CS and non-CS housing-related services in one platform within the organization	• May not be HIPAA compliant • Can be expensive for smaller providers • Will need customization to generate health care billing file formats and to create templates for CS documentation • Need to do double documentation in HMIS for any required CES activities
Homeless Management Information System	• Staff can document CS and non-CS housing-related services in one platform within the organization and with the CoC • Can be lower cost / no cost	• May not be HIPAA compliant • Will need customization to generate health care billing file formats and to create templates for CS documentation • Controlled by the CoC, not your organization
MCP Documentation System	• HIPAA compliant • Free for contracted providers • Already configured to document CS activities per MCP specifications (but may not include all required billing functionality) • MCPs may offer documentation platforms to CS providers but may not require use of them.	• Need to do double documentation in HMIS for any required CES activities • Different MCPs have different platforms and some MCPs do not offer one

[2] All video recordings, slide decks and training materials from the CHCF funded Medi-Cal Academy for Homeless Service Providers can be found here: https://www.chcf.org/resource-center/medi-cal-academy-homeless-service-providers/training-sessions/

2.5. Payment, Reconciliation, Correction, and Resubmission

Payment: Once an MCP receives a claim or invoice from your organization, they will process it to pay for CS services provided. MCPs must meet state required timelines by paying at least 90% of "clean claims" (meaning claims without any errors, omissions, or other issues) within 30 days and at least 99% within 90 days. Payments may be delivered via paper check or electronic transfer, depending on the MCP and how your organization is set up.

- Your organization should be prepared for a significant delay from provision of services to receipt of payment – e.g. for Housing Transition Navigation Services provided in July, if your organization submits a claim in August, you would receive payment between September and November (2-5 months later). If it takes you more time to complete initial billing, then payment would be delayed further, which can create cash flow issues.
- Claims processing and payment tends to be faster for electronic claims and electronic transfer vs. paper-based.
- Electronically processed claims will have a claim status code indicating what happened with the claim.
- If your organization has questions about a specific claim or payment, the MCP will provide different ways to address your concerns, such as:
    - A provider liaison staff person specific to your organization
    - A provider call center
    - Claims status review on the online provider portal
- Note that, for any MCPs that offer prospective capitation, there may be additional capitation payment reports (different from claims payment reporting). Ask your MCP for more information.

Reconciliation: Your organization will need to reconcile the payment from the MCP to ensure that it aligns with the amount you expected to receive based on the claim or invoice amount. In addition to providing the actual payment, the MCP will provide something called "remittance advice" (RA), which is an explanation from a health plan to a provider about a claim payment. The RA will include information on which claims were paid as expected, adjusted (i.e. paid at a different rate than you billed), or denied, along with different reason codes explaining why.

- When reviewing a payment from an MCP, make sure you calculate how much you expected to receive based on 1) the volume of services provided to MCP members and 2) the contracted payment rate, so that you can compare it to the amount received and identify any differences. If there are differences, reach out to your MCP liaison to discuss the reason why.
- Your MCP should be able to provide information about their Claims Adjustment Reason Codes (CARC) and Remittance Advice Reason Codes (RARC), which will be returned by the MCP or clearinghouse. (Similar to this Medicare example)
- If you disagree with the amount paid to you by the MCP, you have options to address the issue:
    - You may need to correct and resubmit parts of the claim or invoice (see below).
    - Each MCP must offer a Provider Dispute Resolution (PDR) process where providers can file disputes in writing to challenge, appeal, or request reconsideration of a claim within 365 days of the date of service (or most recent action date).
    - If the PDR process does not resolve your issue, you can also file a complaint with the CA Department of Managed Health Care.
- Note that, for any MCPs that offer prospective capitation, the reconciliation process may differ because of the need to reconcile claims or encounter submission with capitation payments. Ask your MCP for more information.

Correction & Resubmission: Based on the RA, your organization may need to go back and correct some claims or invoices to add missing information, correct inaccuracies, or fix formatting issues. Once this is done, your organization will need to resubmit the claim to the MCP using the process in Step 4.

- There are many potential errors that can occur for claims, including: duplicate claims, inactive Medi-Cal coverage, wrong MCP for the member, coding errors, lack of prior authorization, incorrect place of service or HCPCS codes, incorrect member or provider information, lapse in authorization, or time not justified.
- Your organization should expect to have a learning curve for claims processing because it takes time to develop expertise in billing for any new service, even for experienced health care billers.
- This process is also new for many MCPs, and it will take time for both parties to develop workflows and systems that support everyone and ensure timely and accurate payment. It will be important to document and track these processes at your agency and keep track of any updated requirements from MCPs and policy updates from DHCS.

2.6. Access Free Technical Assistance through the PATH TA Marketplace

The housing and homeless service provider community is enduring significant change and system redesign as healthcare payors and partners acknowledge the tremendous impact housing-related community supports can have to support community members experiencing homelessness who are enrolled in Medi-Cal to access housing and remain successfully housed. With these new reimbursement mechanisms come many new workflow adjustments, staffing changes, compliance obligations and necessary additional financial oversight that can strain already challenged provider networks worn thin after the COVID-19 pandemic.

DHCS and MCPs are investing in a number of technical assistance and grant programs to support your agency and staff as you navigate these big changes. One important program to highlight is the PATH TA Marketplace, a website designed to help you identify your technical assistance (TA) needs, be matched to or select a TA vendor, and receive free TA that is paid for by DHCS. As you work through this billing guide, the key questions in Chart 1, and the many new processes and requirements to successfully be paid for housing-related CS, we encourage you to note each area that you'll need help with and request support through these free TA resources.

2.7. Ensure Your Agency is Connected to DHCS Updates and Provider Feedback Channels

As engagement in the health care sector is new to housing and homeless service provider organizations, your agency may not yet be plugged into the notification channels and feedback systems already in place for healthcare providers. It will be important that agency staff implementing CS sign up for any MCP provider listservs, the DHCS Stakeholder email listserv and the PATH Collaborative Planning and Implementation (CPI) group for your region(s). The PATH CPI groups provide opportunities to give feedback to DHCS and DHCS has made updates to CS policy guidance based on recent feedback from CPI groups. Listserv announcements from MCPs and DHCS often include news about new policy guidance or implementation updates and at times offer open comment periods related to CalAIM and other Medi-Cal initiatives. These will be important tools for tracking changes and advocating for improvements as Medi-Cal transformation efforts continue to better serve people experiencing homelessness and stabilizing in permanent housing.