

Health Plan   
of San Joaquin

 Mountain Valley  
Health Plan



**Enhanced Care Management  
and  
Community Support Services  
Bi-Monthly Meeting**

**September 12, 2024**

# Meeting Agenda

Topics	Facilitator
Introductions	Provider Services
Enhanced Case Management (ECM)	Tapinder Dhillon
Community Support Services (CSS)	Mike Shook
Transitional Care Services (TCS)	Andrea Smith
Compliance – Audit and Oversight	Arantxa Patino
CalAIM Program Updates	Niyati Reddy



# Enhanced Case Management (ECM)

**Tapinder Dhillon, RN**  
**Manager Case Management**



# ECM Authorization Process

## Authorization Submission

1. ECM provider submits the initial request using an authorization request\* along with [Eligibility Verification Form \(EVF\)](#)
2. Case management team reviews the authorization, EVF and verifies the information shared by ECM provider.
3. Case management communicates decision:
  - Approved for 12 months if member meets the criteria
  - Denial if does not meet the criteria
  - Deferral for additional information

\*To submit an authorization request, visit our online portal

<https://provider.hpsj.com/dre/default.aspx>

Authorization form also available at [Forms & Documents for HPSJ Providers](#)



# Authorization for continuation of ECM services

## ❖ Continuation of ECM services:

For continuation of ECM services, beyond 12 months:

- A prior auth is needed with care plan
- CM team will review the care plan to make determination.
- If member meets the criteria, then the auth is approved for **6-month** period.



# AUTHORIZATION TIMELINES

Authorization Type	Processing Time	Approval Time Period	Forms & Documents
Initial Authorization	Standard: 5 days Urgent: 72 Hours	12 Months	Authorization Request + ECM Eligibility Verification Form
Continuation	Standard: 5 days	6 Months	Authorization Request + care plan



# Community Support Services

**Mike Shook BSN, RN**  
**Director Utilization Management**



# Homeless Patients

Homeless patients, or those at risk of becoming homeless, could benefit from the following:

- **Housing Navigation** – assistance in finding housing
- **Housing Deposits** – assistance in securing housing
- **Housing Tenancy** - Once housing is secured, the goal is to keep the patient in their housing
- **Short Term Post-Hospitalization Housing** and recuperative care are for those homeless members who do not have a place to recover once discharged from the hospital





# Skill Development & Assistance

Are there patients who could use some assistance with improving self-help, social skills, or skills to be able to be successful in living in the environment they desire?

**Day Habilitation programs** may be the answer. These services can be provided in the patient's home or another location.

Some of your patients may need assistance with bathing, dressing, toileting, walking or feeding. Also, they may need assistance with making meals, grocery shopping or money management.

**Personal Care and Homemaker Services** are available for just that.



# Patients with Limitations

Some patients may have limitations due to illness or injury and may require special modifications, such as ramps and grab-bars to get into their home, patients in a wheelchair that may need doorways widened so they can independently get around in their home, stair lifts, or bathroom and shower changes to make it easier to bathe themselves.

**Home Modifications** are available to assist these patients.

These services do require an order from a doctor and the reasons why this patient needs such services/adaptations to their home. In addition, this will require a homeowner's consent to be signed prior to any changes made to the home.

Those who supply these services will assist with getting the order and homeowner consent, you do not need to worry.

If they are having problems obtaining these documents, Health Plan is here to help.



# Help for Patients with Asthma

Patients with Asthma who have had several visits to the emergency department or admission to the hospital for asthma attacks could benefit from **Asthma Remediation** to better manage their Asthma!

Similar to home modifications, this service will identify asthma triggers in the patient's living environment and adaptations to the home may be made to remove them.

This also requires an order from a doctor and a homeowner consent.

As with home modifications, the Asthma Remediation provider will obtain the order and consents, and we are here to help if it is needed!



# Patients with Chronic Conditions

Often times, patients with certain chronic conditions may be suffering from not getting enough of the right foods to eat to be healthy. These may be patients who have diabetes, heart disorder, heart failure, stroke, chronic lung disorders, HIV, Cancers and other conditions that impact the patient's nutrition.

**Medically Tailored Meals** are designed to help to help these individuals.

Please note these services are not for those who may not be able to get enough food due to their living circumstances, but for chronic conditions.



# Sobering Centers

**Sobering Centers** are available for members who need to sober up, as long as they are not rowdy or causing problems. These are safe spaces for these patients to rest and sober up.

Also, these services do not require authorization, so please reach out to one of the providers who provide this service following the steps below.

Currently we have 1 provider in San Joaquin and 1 in Stanislaus Counties.

We are working diligently to find providers in Alpine and El Dorado counties to help these patients.



# Family Help

Are there patients who have caregivers in their home that could use a break to take care themselves and keep them from burnout.

**Respite services** are intended to allow those caring for loved ones a break.



# How can I get these Services Patients

When you feel a patient could benefit from one of these services, what do you do?

1. Identify the specific need for the patient and refer to the referral form located below  
<https://www.hpsj.com/wp-content/uploads/2024/02/Community-Support-CS-Services-Referral-Form.pdf>
2. Locate the provider for the service that the member needs by looking in the other provider section of the provider directory located  
<https://www.hpsj.com/find-a-provider/>
3. Reach out to that provider with information on the patient's needs and they will handle the rest.



# Providers

Health Plan will work with community support providers who provide services to members and obtain the necessary information to get the services started.

Although, Medi-Cal has outlined specific requirements for each service that the patients must meet to receive them.





# In Closing....

Enhanced Care Management and Community Supports have been available since 2022

These services are designed to keep patients in the environment in which they choose

We are hoping that now that you have a better understanding of these services and how that can help, you can partner with Health Plan by submitting referrals for patients who would greatly benefit

We are here to support and help out anyway we can!



# Transitional Care Services (TCS)

**Andrea Smith, RN**  
**Manager Transition of Care**



# TOC team's role in referrals

- The TOC team is composed of non-clinically licenses **Patient Health Navigators** and **Transition of Care Nurses** (RNs) who are designated as Care Coordinators for members experiencing care transitions *when those members are not already connected to ECM/CCM*
- The team provides telephonic care coordination throughout a member's care transition including assessing the member's needs and barriers and making referrals and connections as needed
- TOC Start
  - As soon as Health Plan is notified that a member is experiencing a care transition
- TOC End
  - No sooner than 30 days from the date of discharge, or until the member is connected to all needed services and supports



# TOC team's role in referrals

- When a need for a referral is identified it may be initiated at any point in the care transition:
  - While the member is inpatient
  - Once the member discharges to home
  - During/after follow-up visits to providers
  - At any point during the 30+ days of a care transition period
  
- Considerations for referrals from the HPSJ TOC team:
  - Referrals are not authorizations
  - Referrals indicate that members have been identified as potentially qualifying for ECM/CSS
  - Currently the TOC team does not review or approve any services



# Compliance: Audit & Oversight

**Arantxa Patino, Manager  
Clinical Audit & Oversight**



# Audit & Oversight Audit Process

## I. What/Why?

Health Plan's Audit & Oversight (A&O) department is responsible for ensuring all contracted entities conduct the respective services in accordance with regulatory and contractual requirements. Oversight activities include, but are not limited to:

- **Readiness Assessment:** Conducted prior to contracting to assess an entity's ability to perform the contracted services in accordance all regulatory and contractual requirements.
- **Baseline Audit:** Conducted when a contract is executed without completing a Readiness Assessment to ensure the entity is performing services in accordance with all regulatory and contractual requirements.
- **Annual Audit:** Conducted annually with all contracted entities to ensure continued compliance and in consideration of risk.



# Audit & Oversight Audit Process

## II. Process

A&O will assess the entity's processes against the following standards:

- [DHCS Community Supports Policy Guide](#)
- [DHCS Enhanced Care Management Policy Guide](#)
- Compliance Program Requirements (HIPAA Privacy, Fraud, Waste, and Abuse, IT Security)

## III. What is needed

- Entity must provide policies and procedures that illustrate how the entity performs delegated functions in accordance with regulatory requirements.
- Supporting evidence such as, but not limited to, reports, tools, care plans, assessments, communication of referrals and coordination of care.



# CalAIM ECM/CSS Updates

## Provider Services Niyati Reddy





# Program Reminders

1. HPSJ-MVHP meets with County Correctional Facilities monthly. If you are a Justice-Involved (JI) provider for the Health Plan or would like to share your services with Correctional Facilities, please join us at the next collaborative.
2. Manatt-DHCS Justice-Involved Learning Collaboratives (August – December 2024).  
Registration Link:  
[https://manatt.zoom.us/meeting/register/tJMufuysqzMjHdA\\_mLQcfrog\\_8B63qS9vTnf#/registration](https://manatt.zoom.us/meeting/register/tJMufuysqzMjHdA_mLQcfrog_8B63qS9vTnf#/registration)
3. Congrats to the recent PATH JI Round 3 awardees:
  1. Adventist Health Physicians Network
  2. California Health Collaborative
  3. Pacific Health Group
  4. MedZed
  5. Modesto Gospel Mission
  6. St. Vincent Preventative Family Care
4. ECM-CS Coding Guidance V1.2 – updated as of June 2024: MCPs and ECM/CS Providers are expected to implement and adhere to the updates in the guidance by 03/31/24. The coding guidance applies to both encounter data MCPs submit to DHCS and claims/encounters ECM-CS providers submit to MCPs



# Program Reminders

5. Part of ECM standardization across all MCPs, DHCS published an updated guidance on: the ECM Referral and Authorization Guidance. MCPs are required to operationalize this by 01/01/25.
  - DHCS strongly encourages referrals to ECM come from the community and from those that have a trusted relationship with Members such as an ECM Provider, PCP, CCS provider, Community Partner, ED, school system, etc.
  
6. DHCS is revisiting and updating service definitions for the following Community Support services for a key 2024 objective due to significant feedback from stakeholders (more to share when we hear from DHCS):
  - Asthma Remediation
  - Housing Deposits
  - Medically Tailored Meals; Medically Supportive Foods
  - Community Transitions Home and Nursing Facility Transition/Diversion to Assisted Living Facilities
  
7. MVHP is looking for Asthma Remediation Community Support providers to join MVHP's network to support both El Dorado and Alpine Counties. If interested, please contact [contractingdepartment@hpsj.com](mailto:contractingdepartment@hpsj.com).
  
8. Justice-Involved Update



# ECM – Outreach and Engagement

To make ECM successful, ECM Providers receive a monthly Pursuit List from MVHP that lists out members that **MAY** be eligible for ECM services.

- ❖ Using the pursuit list, ECM Providers should conduct outreach.
- ❖ Determine other methods of outreach via provider engagement
- ❖ Outreach to members can be done by both **clinical** and **non-clinical staff**
- ❖ **Outreach = in-person or electronic (email, phone, text)**
- ❖ Both in-person and telephonic outreaches, **whether successful or unsuccessful**, can be submitted for reimbursement using the appropriate code(s) **AND** modifier(s) that are listed in DHCS's Coding Guidance.
  - ❖ <https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf>
  - ❖ [Refer to Outreach Toolkit \(aurrerahealth.com\)](http://aurrerahealth.com)



# ECM and CS – Utilization Open Forum

- Brainstorm on utilization efforts



# ECM-CS Service and/or Personnel Changes

If you need to modify (add/delete) an ECM Population of Focus or Community Support Service on your current contract, please contact your Provider Service Representative. This will require a Contract modification. You will be contacted by HPSJ-MVHP Contracting Team for next steps.

To keep key provider data, point of contacts, and services up-to-date in the HPSJ-MVHP systems and the Plan's Provider Directory, HPSJ-MVHP will be re-initiating the ECM-CS Directory Form 2 times a year (July and January).

If you have any questions on this process, please contact HPSJ-MVHP Provider Services Team at: 209-942-6340



# Resources

## CALAIM WEBPAGE

Referral forms and more information is available on our website under the CalAIM section.

## REFERRALS

Download Adult ECM Referral Form

Download Child ECM Referral Form

CS-Referral-Form.pdf  
([hpsj.com](http://hpsj.com))

## AUTHORIZATIONS

To submit an authorization request, visit our [online portal](#). Authorization form also available at Forms & Documents for HPSJ Providers

## QUESTIONS

Questions?  
Contact HPSJ/MVHP Case Management Dept.  
@ 209-942-6352



# Community Health Worker (CHW): DHCS Monitoring

Department of Health Care Services (DHCS) is closely monitoring and actively inquiring about CHW utilization.

It is important that Providers (including FQHCs) bill for CHW services to assure timely receipt of encounter data for reporting to DHCS.

The following CPT codes maybe used for all CHW services when submitting encounters (**CPT + U2 modifier**):

- 98960
- 98961
- 98962

Refer to DHCS's All Plan Letter (APL) 22-016 for more information

If you are a contracted entity with MVHP, and have CHWs, please ensure you complete MVHP's CHW Attestation Form



# Community Health Worker (CHW)

Supervising Provider must be a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO). If a CBO – must be a qualified 501 ( C ) (3) entity

Supervising Provider must be Medi-Cal enrolled, or have initiated Medi-Cal enrollment and credentialed by Health Plan

If you are ineligible for a pathway in PAVE/declined by DHCS or a for-profit, please complete the MVHP CHW Attestation Addendum

Complete the HPSJ-MVHP CHW Attestation Form for each CHW and submit one of the following forms of supporting documentation:

- 1) CHW Certificate Pathway
- 2) Work Experience Pathway Attestation Letter
- 3) Violence Prevention Professional Pathway

Submit the completed Attestation and include the proof and email the forms to: [providernetworks.verification@hpsj.com](mailto:providernetworks.verification@hpsj.com)

If you want more information on CHWs, please contact Health Plan's Provider Services Team at: 209-942-6340





# HPSJ MVHP Key Contacts

- Customer Services: 1-888-936-7526 (Monday-Friday from 8am – 5pm)
- Provider Services: 209-942-6340



# Questions



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Open Discussion



**Next ECM/CSS  
11/14/2024**

**Health Plan**   
of San Joaquin



**Mountain Valley**  
Health Plan

**Thank you!**