Health Plan of San Joaquin

Mountain Valley Health Plan

LOOK & LEARN

Quarter 2

June 18, 2025

Meeting Agenda

Topics	Facilitator
Introductions	Provider Services
Provider Updates	J'neen Abramjian
Total Fluoride Intake	Howard Pollick
Health Equity & Quality Improvement	Mae Cayetano
Community Supports	Mike Shook
Closing / Open Forum	All

Health Plan of San Joaquin

Mountain Valley Health Plan

OPERATIONS UPDATES

J'neen Abramjian MHA, Manager Provider Relations

Mandatory Annual Provider Training

Provider's Demographic Data

Provider Directory regulatory standards are in place to ensure Medi-Cal health plans publish and maintain accurate directories. As part of the man d regulations, **Health Plan must vali provider information at least every 6 months** and up the provider directory as often as necessary to ensure accurate information is available for our members. For a complete list of all the required data that needs validation, see slide *Provider Directory Maintenance*.

You can up your demographic information by:

- Emailing- providernetworks.verification@hpsj.com
- Fax -209-933-3700
- By selecting the Provider Verification link in DRE (Under Welcome Provider)
- Submitting the Health Plan Roster Template
- The **Health Plan Roster Template** is available on our website: https://www.hpsj.com/forms-documents/

  Attestation Form (1st Tab – required)
  Health Plan Roster Template (select the "Tab" that suits your provider type

Mandatory Annual Provider Training

Provider's Demographic Data Cont'd

In order to assure Members of timely and accurate information on the Providers available in the Health Plan network, it is important that Providers comply with Health Plan's policies regarding Provider Directory maintenance. Health Plan has a regulatory responsibility to publish an accurate Directory of all Providers. This Provider Directory will be maintained and up d in accordance with State and federal law, including but not limited to CA Health and Safety Code 1367.27.

Failure to up information may delay payment or reimbursement of claim(s). Once the provider data is vali d and corrected, Health Plan will restore and display your provider information in the directory.

Provider Directory Maintenance

Health Plan is required to have a current Provider Directory for the following changes:

- Provider is no longer accepting new Members
- Provider was previously not accepting new Members but is now open to new Members
- Provider is no longer contracted with Health Plan (contract termination has occurred)
- Provider has moved to a different location
- Provider has added a location
- Provider has changed its office hours
- A change in languages spoken in the office
- As a result of an error identified through a member complaint
- Any other information affecting the accuracy of the Provider Directory

Mandatory Annual Provider Training

In compliance with state and federal regulations, Health Plan has established and implemented mandatory training, including but not limited to Cultural Competency and Sensitivity Training. Health Plan network providers and their staff are required to complete the mandatory annual trainings and attest to having completed the trainings. Trainings and education are provided for all network providers and their staff. At least once a year, A Provider Alert is sent to all providers as a reminder to complete the required training.

The following trainings are available on Health Plan's website at https://www.hpsj.com/provider-trainings/:

The training includes:

1. Cultural Competency Training and Sensitivity Training.
2. Anti-Fraud. Waste and Abuse
3. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
4. Early Periodic Screening and Diagnostic Treatments (EPSDT)- Medi-Cal for Kids & Teens Training
5. Emergency Preparedness Training
6. Diversity, Equity, Inclusion (DEI) Training – *Coming Soon*

Health Plan of San Joaquin

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HEALTH EDUCATION GUEST SPEAKER

HOWARD POLLICK, BDS, MPH
CLINICAL PROFESSOR, UCSF
FLUORIDATION CONSULTANT, CDPH

Fluoride Intake

Why we don't need to be concerned and fluoride hesitancy.

Preface

These slides were created for the Stanislaus County Public Health Oral Health Program, Look & Learn Session

Howard Pollick is responsible for the content

The slides and comments made here do not necessarily reflect the position of the Office of Oral Health or the California Department of Public Health

Preamble

In California, we are much less concerned about over-exposure to fluoride because of the public health recommendations that are in place from the US EPA and California EPA and from the US Public Health Service.

Evidence from countries outside the USA show much greater exposure to fluoride from naturally occurring fluoride in water, salt, and coal burning.

Stanislaus County
No fluoride communities

Water Quality reports

Community	Population	Fluoride in Water
Modesto	218,000	0.01 ppm
Turlock	73,000	0.10 ppm
Ceres	45,000	0.05 ppm
Riverbank	25,000	None Detected
Recommended		0.70 ppm

In 2001, Modesto City Council was in favor of fluoridating the water but were concerned about the expense
(about $10 per household per year).
It was placed on the ballot and defeated — cost was the main reason cited for no votes.
Fluoridation has not been discussed by the council since.

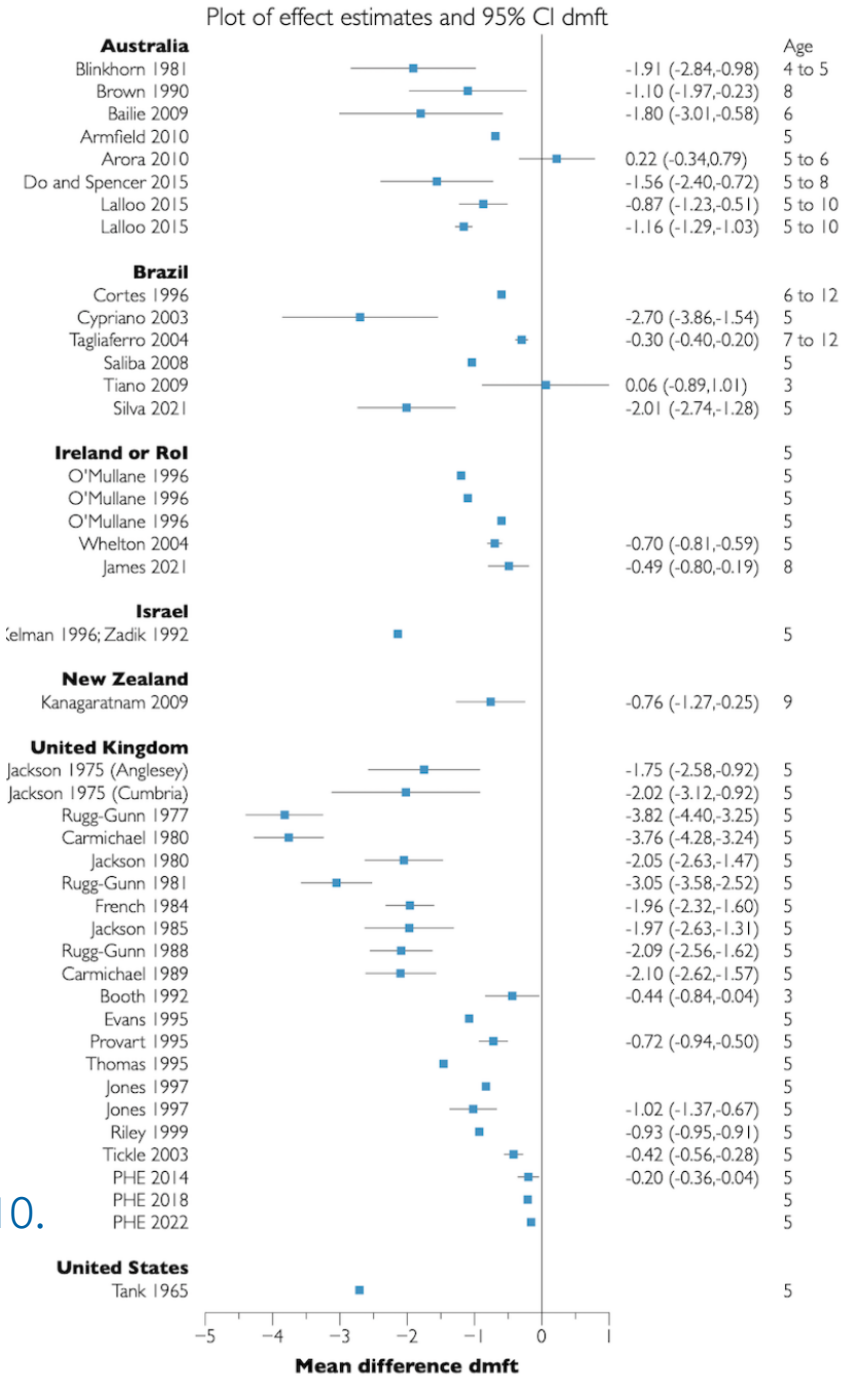
Benefits of Fluoridation

- Benefits equitably all members of a community
- Reduces cavities by about 25% in children and adults
- Reduces dental costs, root canal treatments and extractions and associated anesthesia https://pmc.ncbi.nlm.nih.gov/articles/PMC11414298/
- Reduces missed days of school and work
- Reduces oral health disparities
- Scientifically proven – cause and effect (not simply statistical association)
- Safe, effective and cost-effective for over 75 years.

https://www.cdc.gov/fluoridation/about/index.html

Cochrane 2024. Figure 5. Studies after 1975 Lower primary teeth decay in CWF areas

Single time point cross-sectional studies - mean difference and 95% confidence interval (CI) in decayed, missing and filled teeth (dmft) in the primary dentition between fluori d and low/ non-fluori d areas, with age (years) at time of measurement



Water fluoridation for the prevention of dental caries. Cochrane Database of Systematic Reviews 2024, Issue 10.

Joint statement on community water fluoridation - – March

Dr. Erica Pan, CDPH Director and State Public Health Officer and Dr. Shakalpi Pendurkar, CDPH State Dental Director

The California Department of Public Health (CDPH) supports optimal levels of fluoride in drinking water as a safe, effective and cost-saving public health intervention to improve the health and well-being of California's diverse people and communities.

Community water fluoridation is the single most cost-effective, equitable, and safe public health measure to prevent tooth decay and improve oral health.

One of the biggest benefits of water fluoridation is that it helps everyone in the community and especially those without access to regular dental care.

Optimal levels of fluoride in water are effective in preventing tooth decay throughout life, resulting in fewer and less severe cavities.

Furthermore, water fluoridation has been endorsed by every major health organization in the United States and many other countries, as well as every Surgeon General for the past 50 years.

There are four principal public health recommendations to limit exposure to excessive amounts of fluoride and protect the public's health from adverse health effects including tooth decay.

- **Drinking water:** To prevent severe dental fluorosis in developing teeth, follow the US EPA and California standard of informing the public to recommend that children under 9 years of age refrain from the regular ingestion of naturally occurring fluoride in drinking water from private and public wells that exceeds 2.0 mg/L (part per million – ppm).
- **Drinking water:** To optimize protection against tooth decay and minimize the chance of dental fluorosis, use drinking water at 0.7 mg/L (part per million – ppm), the US Public Health Service (2015) recommended concentration of fluoride in drinking water.
- **Toothpaste:** Use fluoride toothpaste as recommended and limit the amount of fluoride toothpaste for young children.
- **Infant formula:** Use low fluoride water at least some of the time for infants exclusively fed infant formula reconstituted with tap water.

Question:
What are other sources of Fluoride that children/the community may encounte
that could contribute to increased exposure or doses?
If the dose makes the poison, where/when do we need to be thinking about to
much?

Answer:

1. There are several sources of fluoride, with variation by age. The main sources are water, followed by beverages, then food and toothpaste.

2. The youngest age group under one year of age (infants), can be divided into 2 groups

    a) fed exclusively by infant formula

    b) exclusively breast fed

3. The NRC report (2006) found the average daily fluoride intake for infants exclusively fed by infant formula, when the fluoride concentration water used for reconstituting powdered infant formula was 1 mg/L (ppm), approximated 0.09 mg/kg body weight/day.

4. That level exceeded the recommended optimal fluoride intake for children to maximize caries prevention and minimize the occurrence of enamel fluorosis of between 0.05-0.07 mg/kg/day.

Question:
What are other sources of Fluoride that children/the community may encounter that could contribute to increased exposure or doses?
If the dose makes the poison, where/when do we need to be thinking about too much?

Answer:

5. With the current recommended fluoride concentration for fluori d water of 0.7 mg/L (ppm), the average daily fluoride intake for infants exclusively fed by infant formula, would be approximately 0.07 mg/kg body weight/day, within the recommended optimal fluoride intake.
6. The NRC report (2006) found the average daily fluoride intake for infants exclusively breast-fed, approximated 0.03 mg/kg body weight/day.
7. For young children ages 1-4 years, unintended toothpaste ingestion contributes an average of 20% of total fluoride exposure. Figure 2-8 shows a graph of average fluoride intake from all sources when there is 1 mg/L (ppm) of fluoride in drinking water.
8. The average child aged 1-5 years will not exceed the 0.07 mg fluoride/kg body weight/day with fluori d water at 0.7 ppm.

Question:
What are other sources of Fluoride that children/the community may encounter that could contribute to increased exposure or doses? (Or the lack there of?) If the dose makes the poison, where/when do we need to be thinking about too much?

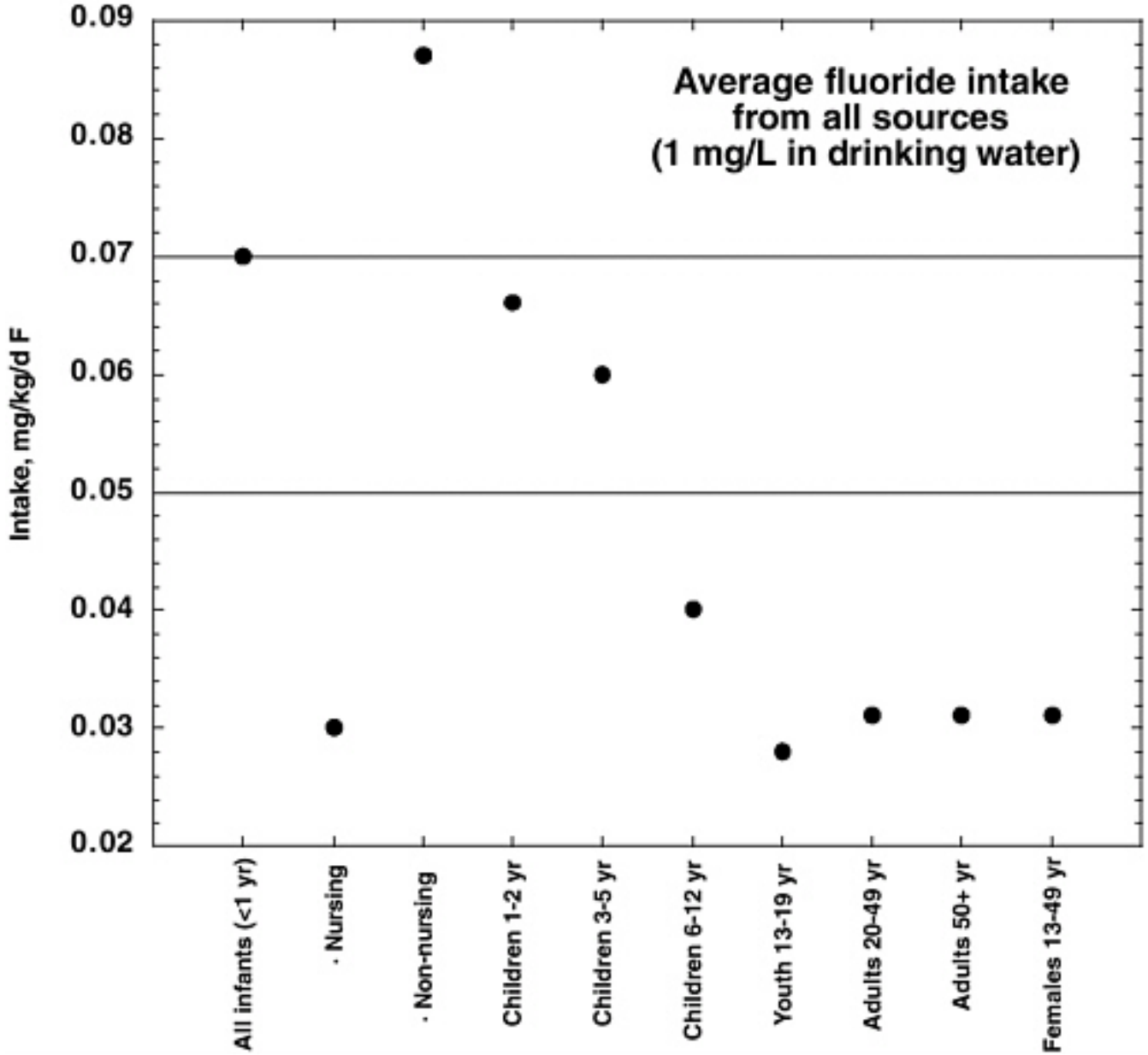
Answer:

9. The recommended optimal fluoride intake for children to maximize caries prevention and minimize the occurrence of enamel fluorosis is often stated as being 0.05-0.07 mg/kg/day.
10. National Academies of Sciences, Engineering, and Medicine. 2006. Fluoride in Drinking Water: A Scientific Review of EPA's Standards. Washington, DC: The National Academies Press. https://doi.org/10.17226/11571.
11. In 1997 and based on data collected in children and non-pregnant adults, the USA's Institute of Medicine recommended an adequate intake (AI) for F of 3 mg/d (0·05 mg/kg per d). Using a pre-pregnancy body weight for women >19 years of ~61 kg as a reference, the recommendation for both pregnant and non-pregnant women was also set as 3 mg F/d.
12. A study of pregnant women participating in the Early Life Exposures in Mexico to Environmental Toxicants (ELEMENT) project, from 2001 to 2003, found dietary F intake was below current AI (Adequate Intake).

This graph shows average daily fluoride intake by age group: all infants, nursing infants, non-nursing infants, children 1-2 years, 3-5 year, 6-12 years, 13-19 years, adults 20-49 years, adults 50+ years and females 13-49 years.

FIGURE 2-8 Estimated average intake of fluoride from all sources, at 1 mg/L in drinking water (based on Table 2-11). Horizontal lines indicate an intake of 0.05-0.07 mg/kg/day.

National Academies of Sciences, Engineering, and Medicine. 2006. Fluoride in Drinking Water: A Scientific Review of EPA's Standards. Washington, DC: The National Academies Press. https://doi.org/10.17226/11571.



Infant Formula

- Total dietary exposures of fluoride can exceed this threshold amount (0.07 mg F/kg/day) in infants exclusively fed formula reconstituted with optimally fluori d water or well or municipal water with high fluoride concentration above the recommended level of 0.7 ppm.

- Formula that must be mixed with water (e.g., powdered or liquid concentrates) may increase the chance of mild dental fluorosis if it is a child's main source of food and if the water used to mix the formula is fluori d or well or municipal water with high fluoride concentration above the recommended level of 0.7 ppm.

- Ready-to-feed formula contains little fluoride and does not cause dental fluorosis.

- CDC. Community Water Fluoridation Frequently Asked Questions. May 15, 2024. https://www.cdc.gov/fluoridation/faq/index.html#cdc_faqs_cat5-infant-formula

Infant Formula

What type of water can I use to mix infant formula?

- If your child is only consuming infant formula mixed with fluori d water or well or municipal water with high fluoride concentration above the recommended level of 0.7 ppm, there may be an increased chance for dental fluorosis.

- Bottled water labeled as de-ionized, purified, demineralized, or distilled contains no or only trace amounts of fluoride, unless they specifically list fluoride as an added ingredient.

- Parents can use low fluoride bottled water some of the time to mix infant formula to lessen this risk. Look for bottles labeled as de-ionized, purified, demineralized, or distilled. Additionally, some bottled waters are marketed for infants and for the purpose of mixing with formula.

- For more information, see the U.S. Food and Drug Administration's general Q&A about bottled water and infant formula.

Sources of Fluoride Intake

Water Food Beverages Sulfuryl fluoride Toothpaste Soils

Drinking water contributes the highest percentage of the total fluoride intake (70%) for infants six months to one year old.

However, the high percentage contribution of drinking water for this age group is partially a consequence of the use of the intakes for infants fed exclusively with powdered formula reconstituted with tap water containing 0.87 mg/L fluoride for this analysis.

EPA 820-R-10-015 Fluoride: Exposure and Relative Source Contribution Analysis. Health and Ecological Criteria Division Office of Water December 2010. https://nepis.epa.gov/Exe/ZyPDF.cgi/P100N49K.PDF?Dockey=P100N49K.PDF

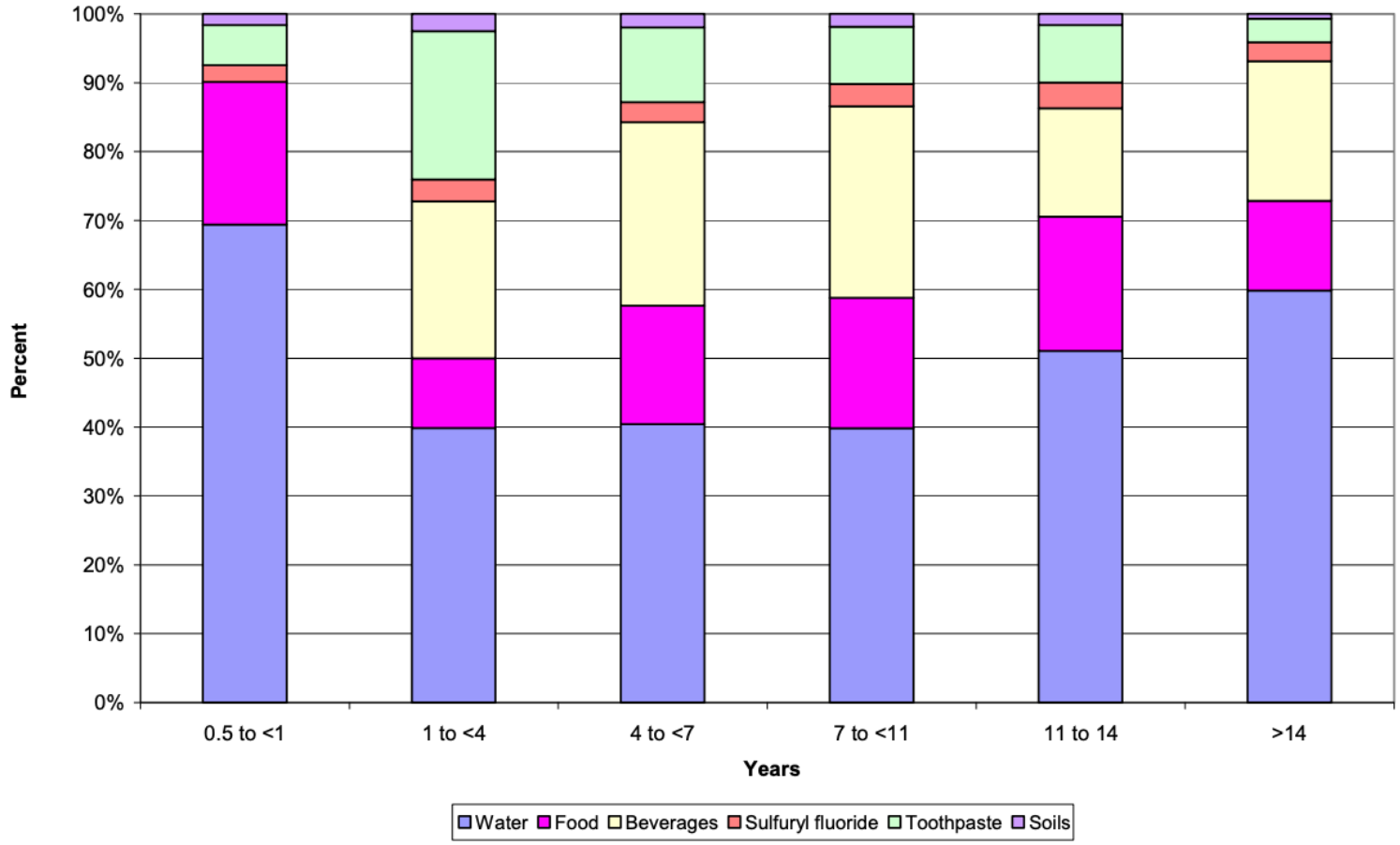


Figure 7-1. Percentage Media Contribution to Total Daily Fluoride Intake: 90th Percentile Drinking Water Intakes for Consumers Only and a Fluoride Concentration of 0.87 mg/L

Recommendations on fluoride toothpaste application for young children
Smear for the youngest (<3 years), pea-sized for children 3-6 years

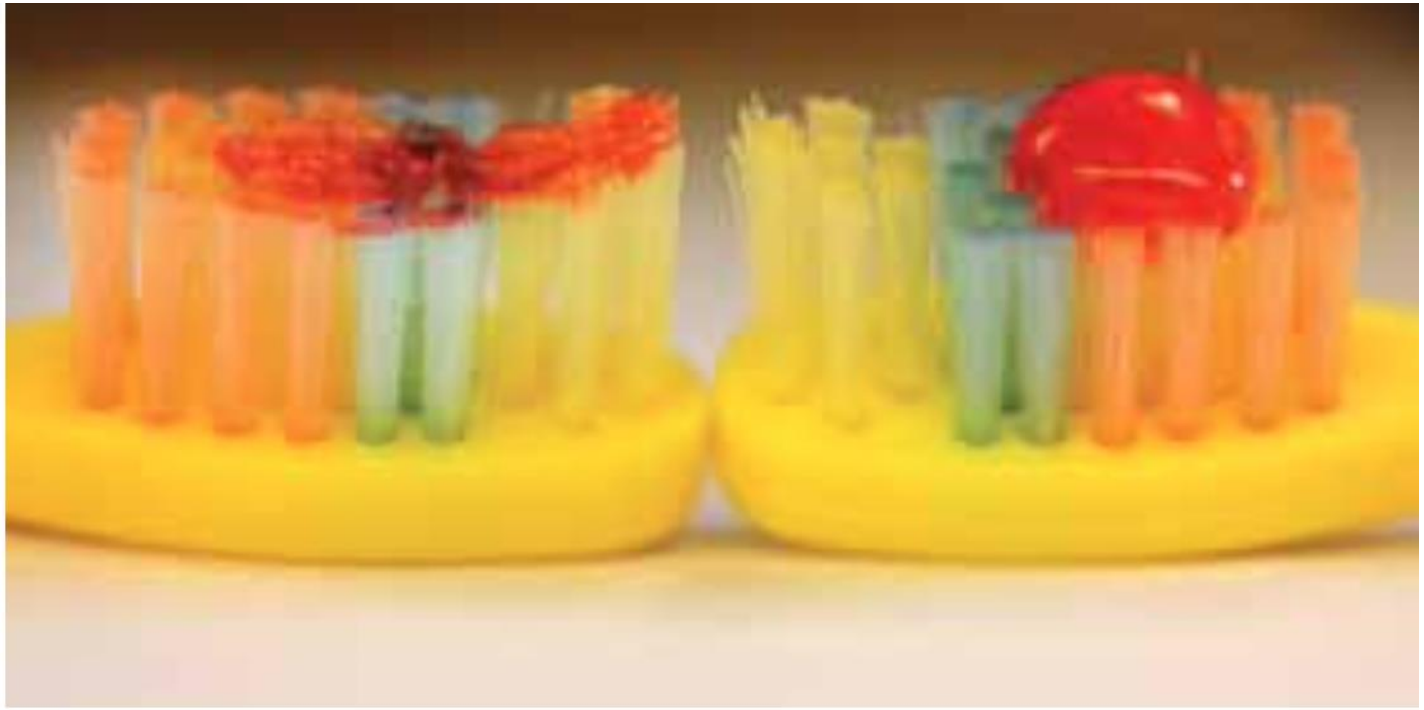


Figure. The toothbrush on the left shows a smear of toothpaste (0.1 milligram of fluoride) and the one on the right a pea-sized amount (0.25 mg of fluoride).

American Dental Association Council on Scientific Affairs. Fluoride toothpaste use for young childrer JADA 145(2)190-1. http://jada.ada.org February 2014

Recommendations on prescription dietary fluoride supplements

- Dietary fluoride supplementation by prescription for children at **high** caries risk who do not have access to optimally fluori d water is recommended by the American Academy of Pediatric Dentistry and the Centers for Disease Control and Prevention.
- In 2021, the USPSTF recommended primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride, *not based on risk assessment*.
- The American Academy of Pediatrics also recommends fluoride supplements age 6 months to 16 years of age for children whose water supply is deficient in fluoride, *not based on risk assessment*.

Recommendations on prescription dietary fluoride supplements

Child's Age	Water Fluoride Concentration		
	< 0.3 ppm	0.3 – 0.6 ppm	> 0.6 ppm
6 mos – 3 yrs	0.25 mg	None	None
3 yrs – 6 yrs	0.50 mg	0.25 mg	None
> 6 years	1.00 mg	0.50 mg	None

Dosages are in milligrams F/day

Guidelines on prescription dietary fluoride supplements

- If the fluoride content of the main water used for cooking and drinking cannot be determined, then supplemental fluoride should NOT be prescribed.
- In optimally fluori d communities where children drink bottled water, supplements should NOT be prescribed due to halo effect.
- Supplementation is not recommended for breast feeding infants or formula fed infants until age six months.
- All prescriptions for fluoride should specify a sugar-free preparation.

https://www.smilesforlifeoralhealth.org/topic/dietary-fluoride-supplementation/

Guidelines on prescription dietary fluoride supplements

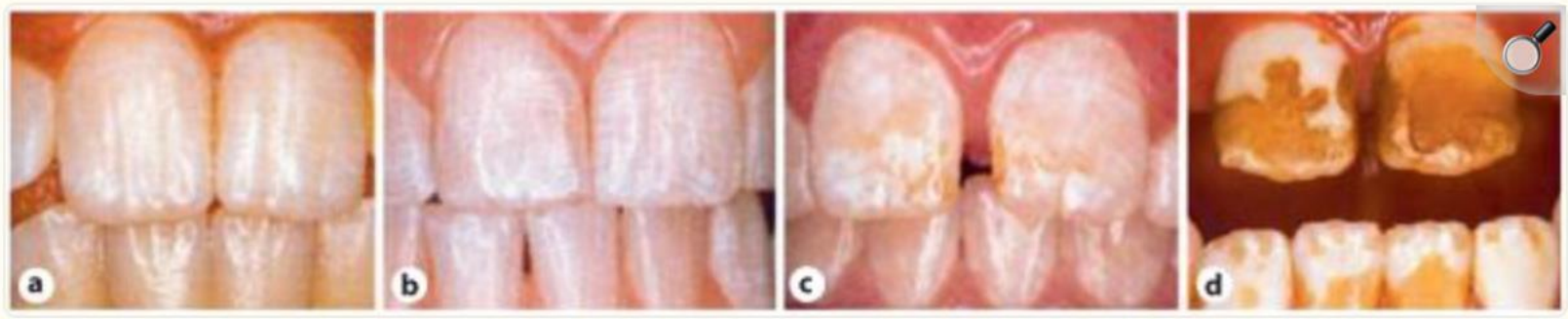
- If fluoride level is unknown, drinking water should be tested for fluoride content before supplements are prescribed. For testing of fluoride content, contact the local or state health department.
- All sources of fluoride should be evaluated with a thorough fluoride history.
- Patient exposure to multiple water sources may complicate proper prescribing.
- Ingestion of higher than recommended levels of fluoride by children has been associated with an increased risk of mild dental fluorosis in developing, unerupted teeth.
- To obtain the benefits from fluoride supplements, long-term compliance on a daily basis is required.

https://www.ada.org/resources/ada-library/oral-health-topics/fluoride-topical-and-systemic-supplemen

What to know about differences in US and non-USA studies and why we are much less concerned about fluoride exposure in the USA.

- There is a remarkable difference between US data and non-US data on **severe dental fluorosis**.
- In US studies, severe dental fluorosis does not occur where the water fluoride concentration is less than 2.0 mg/L (ppm). Note that the recommended level in the United States is 0.7 ppm.
- However, there are multiple studies from communities outside the United States where severe dental fluorosis occurs where the water fluoride concentration is less than 2.0 mg/L (ppm).
- This may be due to multiple additional sources of fluoride from salt and burning coal in some foreign countries.

Mild, Moderate and Severe Dental Fluorosis



MILD MODERATE SEVERE

Dental fluorosis. **a** Mild with slight accentuation of the perikymata. **b** Moderate, showing a white opaque appearance. **c** Moderate, white opaque enamel with some discoloration and pitting. **d** Severe.

DenBesten P, Li W. Chronic fluoride toxicity: dental fluorosis. Monogr Oral Sci. 2011;22:81-96. doi: 10.1159/000327028

Differences in fluoride exposure between US and non-USA studies

FIGURE 4-1 **Prevalence of severe enamel fluorosis** at the person level by water fluoride concentration, permanent teeth, age < 20 years, **U.S. communities**.

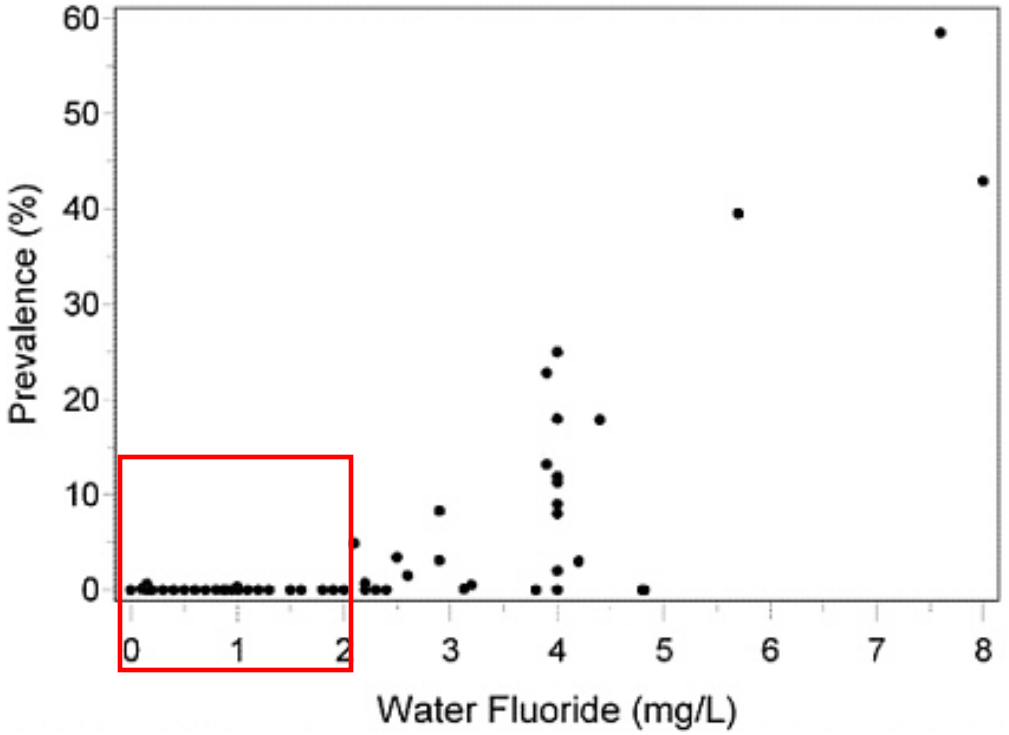
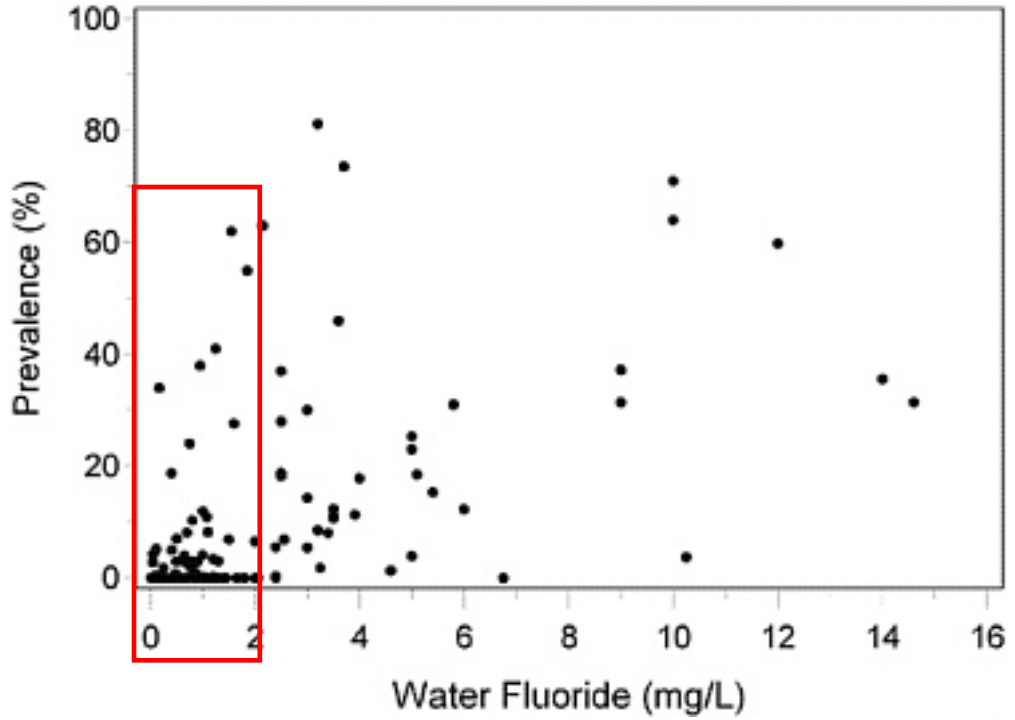


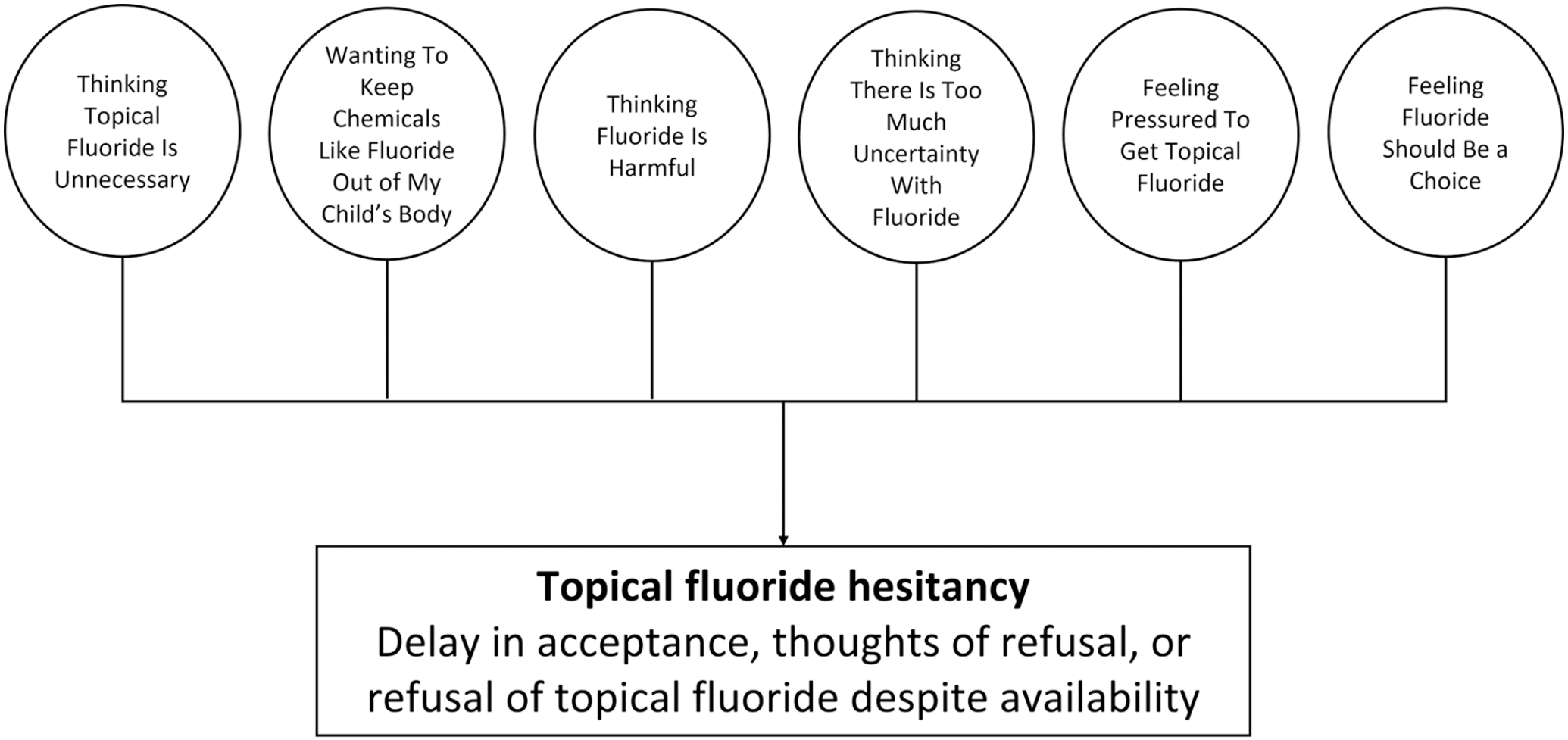
FIGURE 4-3 **Prevalence of severe enamel fluorosis** at the person level by water fluoride concentration, permanent teeth, age < 20 years, **communities outside the United States**



Fluoride Hesitancy

- Topical fluoride hesitancy and opposition are significantly and positively associated: A cross-sectional study. Lim J, Carle AC, Carpiano RM, Chi DL. PLoS One. 2025 Apr 30;20(4):e0322027. doi: 10.1371/journal.pone.0322027
- A conceptual model on caregivers' hesitancy of topical fluoride for their children. Chi DL, Kerr D, Nguyen DP, Shands ME, Cruz S, Edwards T, et al. PLOS ONE. 2023 Mar 22;18(3):e0282834
- Caregivers who refuse preventive care for their children: the relationship between immunization and topical fluoride refusal. Chi DL. Am J Public Health. 2014 Jul;104(7):1327–33

Fluoride Hesitancy



Additional References

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- Zohoori, F., Whaley, G., Moynihan, P. *et al.* Fluoride intake of infants living in non-fluori d and fluori d areas. *Br Dent J* 216, E3 (2014). https://doi.org/10.1038/sj.bdj.2014.35
- Levy SM, Guha-Chowdhury N. Total fluoride intake and implications for dietary fluoride supplementation. J Public Health Dent. 1999 Fall;59(4):211-23. doi: 10.1111/j.1752-7325.1999.tb03272.x. PMID: 10682326.
- Fluoride in Drinking Water: A Scientific Review of EPA's Standards (2006) National Academies of Sciences, Engineering, and Medicine. 2006. Fluoride in Drinking Water: A Scientific Review of EPA's Standards. Washington, DC: The National Academies Press. https://doi.org/10.17226/11571.
- Chapter: 2 Measures of Exposure to Fluoride in the United States. National Academies of Sciences, Engineering, and Medicine. 2006. Fluoride in Drinking Water: A Scientific Review of EPA's Standards. Washington, DC: The National Academies Press. https://doi.org/10.17226/11571.
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- CDC. Community Water Fluoridation Frequently Asked Questions. May 15, 2024. https://www.cdc.gov/fluoridation/faq/index.html#cdc_faqs_cat5-infant-formula
- Castiblanco-Rubio GA, Muñoz-Rocha TV, Cantoral A, Téllez-Rojo MM, Ettinger AS, Mercado-García A, Peterson KE, Hu H, Martínez-Mier EA. Dietary fluoride intake over the course of pregnancy in Mexican women. Public Health Nutr. 2021 Jun;24(9):2388-2396. doi: 10.1017/S1368980021000781.
- Ando M, Tadano M, Asanuma S, et al. Health effects of indoor fluoride pollution from coal burning in China. Environ Health Perspect. 1998 May;106(5):239-44. Available at https://ehp.niehs.nih.gov/doi/epdf/10.1289/ehp.98106239

Questions and Follow-Up

- Do you have questions on the science or why CWF should continue to be supported?
- Have you experienced fluoride hesitancy?
- Could there be efforts in to fluori your community?

- Contact the California Department of Public Health, Office of Oral Health
- California Oral Health Technical Assistance Center - oralhealthsupport@ucsf.edu

Health Plan of San Joaquin

Mountain Valley Health Plan

HEALTH EQUITY & QUALITY IMPROVEMENT

Mae Cayetano, Credentialing Supervisor

Behavioral Health Provider Credentialing

As of May 1st, 2025, Health Plan has started credentialing BCBA providers.

Frequently asked questions

I have questions about my credentialing application, whom do I contact?

Please contact your direct credentialing contact person if you have already connected with one, and if not email: Credentialing1@hpsj.com

What is Health Plan's credentialing approval timeframe?

The credentialing process for Behavioral Health providers is completed within 60 days of receipt of the completed credentialing application. Health Plan credentialing timeframe primarily hinges on the completeness of submitted applications. Health Plan will prioritize providers with 100% completed applications along with required paperwork.

How often are the providers being re-credentialed?

The providers are recredentialed every 1-3 years based on committee approval.

Behavioral Health Provider Credentialing

What is the process for credentialing Licensed QAS Providers?

Licensed Qualified Autism Service(QAS) Providers such as Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Psychologists will go through the credentialing process and application, including the need for Medi-Cal enrollment.

What is the process for credentialing BCBA's?

BCBA's will go through the credentialing process and application. BCBA must enroll with Medi-Cal within 6 months once credentialed by Health Plan.

What do I need to do if providers leave my group or new providers join?

When provider (BCBA or Licensed Provider) leaves your group, please notify Health Plan via providerservices@hpsj.com

When a new provider (BCBA/Licensed Provider) joins your group, they will need to be credentialed by Health Plan to begin seeing members, please contact your direct credentialing contact person if you have already connected with one, and if not email: Credentialing1@hpsj.com

Health Plan of San Joaquin

Mountain Valley Health Plan

COMMUNITY SUPPORTS REFERRAL PROCESS AND UP S

Mike Shook, Director BSN RN

Acronyms

ALF Assisted Living Facility

ALW Assisted Living Waiver

CS Community Support

LOC Level of Care

CCT California Community Transitions Program

TCS Transitional Care Services

APS Asthma Preventive Services Program

RDN Registered Dietician

HCBA Home& Community Based Alternatives

MSSP Multipurpose Senior Services Program

MTM Medically Tailored Meals

MTG Medically Tailored Groceries

MSF Medically Supported Food

P Page

Pp Pages

Community Supports Currently Offered

Volume 1	Volume 2
1. Respite Services	9. Housing Transition Navigation Services
2. Assisted Living Facility Transitions*	10. Housing Deposits
3. Community or Home Transition Services*	11. Housing Tenancy and Sustaining Services
4. Personal Care and Homemaker Services	12. Day Habilitation Programs
5. Environmental Accessibility Adaptations (Home Modifications)	13. Recuperative Care (Medical Respite)
6. Medically Tailored Meals/Medically Supportive Food	14. Short-Term Post-Hospitalization Housing
7. Sobering Centers	15. *New* Transitional Rent
8. Asthma Remediation	

**Names of these Community Supports have been updated*

Red Outline: Subject of today's training
Blue Outline: Effective 1.1.26 – Future training to be provided

Community Support	Change(s)	Eligibility Requirements

Assisted Living Facility (ALF) Transitions	• Includes (Pp. 13-14 Policy Guide):
	  • Time-limited transition services and expenses
	  • Ongoing assisted living services for members (**excludes room and board**)
	• Cannot receive CS and the ALW or CCT at the same time
	• May receive other CS as long as not duplicative
	• Members in private residence/public subsidized housing are eligible for ALF transition, must meet criteria for nursing facility LOC
	• Use this service when waiting on enrollment in the ALW utilize the time-limited transition services and expenses & the ongoing assisted living services until enrollment in ALW complete
		• Members in a nursing facility who:
		  • Have resided 60+ days in a nursing facility and
		  • Are willing to live in an assisted living setting as an alternate to a nursing facility; and
		  • Are able to reside safely in an ALF
		
		• Members residing in the community who:
		  • Are interested in remaining in the community; and
		  • Are willing to reside safely in an ALF; and
		  • Meet the minimum criteria to receive nursing facility LOC services and choose to remain in the community in lieu of going into a facility

Community Support	Change(s)	Eligibility Requirements

Community or Home Transition Services	• Clarification of two components:
	  • Time limited transition services and expenses (P. 19) should not duplicate/replace TCS
	  • Non-recurring set up expenses (P. 20)
	• Does not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are purely diversionary/recreational purposes.
	• Non-recurring set up expenses' total lifetime max of $7,500.
	  • Home modifications CS if eligible and available can be used.
	• May receive other CS as long as not duplicative
		Members who:
		• Currently receiving medically necessary facility LOC
		• Have lived 60+ days in nursing home and/or recuperative care setting
		• Are interested in moving back to the community
		• Are able to reside safely in the community with appropriate cost-effective supports and services
		
		NOTE: Can be eligible for CCT, HCBA waiver and/or MSSP and this community support, but cannot receive both at the same time are duplicative

Community Support	Change(s)	Eligibility Requirements

Medically Tailored Meals/Medically Supportive Foods	• Medically tailored meals (MTM) and Medically tailored groceries (MTG) are included (Pp. 32-34)
	• Use of evidenced-based nutrition guidelines specific for the condition
	  • Must meet at least 2/3 of daily nutrient and energy needs
	• Provider monitoring required
	  • Follow service definition
	  • Nutrition standards followed
	  • Ingredients in meals
	  • Location of service, meal preparation
		• Focus eligibility solely on whether the Member has a chronic or serous health condition that are nutrition-sensitive (P 35)
		• Include an individual nutrition assessment conducted or overseen by an RDN

Community Support	Change(s)	Eligibility Requirements

Asthma Remediation	• Supplement Asthma Preventive Services Medi-Cal State Plan Service (link provided)
	• January 1, 2026: Removal of In-home environmental trigger assessments and asthma self-management education (Provide through APS)
	• Encourage providers to transition to APS prior to 1/1/26
		• Includes through December 31, 2025:
		  • In home trigger assessments, self management education (P. 44)
		  • Must have poorly controlled asthma (ED or hospital visit, or 2 urgent care visits in the past 12 months, or score of 19 or lower on asthma control test)
		
		January 1, 2026:
		• Completed in-home environmental trigger assessment in past 12 months through APS benefit
		• Cover physical modification and supplies only (Pp. 43-44)
		• In home assessment when physical modifications needed

Community Support	Up d CS
Recuperative Care	• 6-month limit per rolling 12-month period (previously 90 continuous days)
Short-term Post Hospitalization Housing	• 6-month limit per rolling 12-month period (previously once in a lifetime benefit)

Community Supports (CS) Referral Process

Members or providers can initiate the referral process

Provider Referrals
Providers can submit referrals directly to the Community Support Provider using the CS Referral Fax Form, including supporting documentation.

The CS provider will:

- review the referral and identifies if the member meetings criteria for the CS requested
- will follow up with the member to obtain consent and all supporting documentation needed for the authorization request from the members provider.
- The HPSJ/MVP UM team is available to assist when the CS providers encounters challenges in receiving complete information.

Member Referrals
Members (Caregivers, family members) can call HPSJ/MVHP Customer Service at 1.888.936.7526 to initiate a CS referral. HPSJ/MVHP Staff will assist the member in identifying a CS provider as well as assist with submitting the referral using the CS Referral Fax Form

NOTE: Refer to the references slide for links to support information and forms mentioned throughout the presentation

CS Referral Process (cont'd)

HPSJ/MVHP UM Staff will review the request and evaluate based on the Medi-Cal Community Supports Policy Guide

- **Routine or Standard Requests:** Determination of the request will be made within 5 business days of receipt of all information necessary to vali the need for the service
- **Urgent Request:** Determination of the request will be made within 72 hours of receipt.
    - These requests are made when the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function)

The authorization request can be submitted via the Provider Portal (preferred)

- The provider portal is accessible to providers, 24 hours day/7 days per week, who have a contract with HPSJ/MVHP.
- Providers who need access assistance should contact their HPSJ Provider Representative
- Providers can also choose to complete the Medical Authorization Request form and submit via fax.

Provider Engagement

HPSJ/MVHP partners with providers to assist with member needs:

- Bi-Monthly ECM/CS meeting with those providers, community health clinics
- Provider Partnership meeting aimed at improving health care quality and addressing population needs
- Provider alerts posted on hpsj-mvhp.org to stay up to on the latest information impacting providers
- Participate in multiple forums, such as those provided by the county, Medical Centers, community business partners and many others

References

- COMMUNITY SUPPORT POLICY GUIDE (UP D APRIL 2025)
  - ✓ Volume 1: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf
  - ✓ Volume 2: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf

- DHCS FACT SHEET: HTTPS://WWW.DHCS.CA.GOV/CALAIM/DOCUMENTS/DHCS-MEDI-CAL-COMMUNITY-SUPPORTS-SUPPLEMENTAL-FACT-SHEET.PDF
- HPSJ-MVHP.COM CALAIM RESOURCE FOR PROVIDERS HTTPS://WWW.HPSJ.COM/PROVIDERS/CALAIM-2/
- REFERRAL FORM (TO CSS PROVIDER) HTTPS://WWW.HPSJ.COM/WP-CONTENT/UPLOADS/2025/04/COMMUNITY-SUPPORT-CS-SERVICES-REFERRAL-FORM-03172025.PDF
- CS PROVIDER CONTACT LIST: HTTPS://WWW.HPSJ.COM/WP-CONTENT/UPLOADS/2025/05/HPSJ-MVHP-CS-PROVIDER-CONTACT-LIST.PDF
- AUTHORIZATION REQUEST FORM (TO HPSJ/MVHP): HTTPS://WWW.HPSJ.COM/WP-CONTENT/UPLOADS/2024/07/HPSJ-MVHP_PRIOR-AUTHORIZATION-FORM_06032024E_FILLABLE-1.PDF
- ASTHMA PREVENTIVE SERVICES PROGRAM: HTTPS://MCWEB.APPS.PRD.CAMMIS.MEDI-CAL.CA.GOV/ASSETS/B30BA13C-7A4F-47B9-9403-760091E44ADC/ASTHPREV.PDF?ACCESS_TOKEN=6UYVKRRFBYXTZEWIH8J8QAYYLPYP5ULO

Open Discussion / Questions

Next Look and Learn

Date: 9/17/2025

Time: 12pm – 1:30pm

THANK YOU!

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