Health Plan of San Joaquin

Mountain Valley Health Plan

ENHANCED CARE MANAGEMENT (ECM) AND COMMUNITY SUPPORT SERVICES (CSS) BI-MONTHLY MEETING

July 10, 2025 - 8:30 am – 9:30 am

Meeting Agenda

Topics	Facilitator
Introductions	Provider Services
Provider Services	Christina Villar
Referral Process and Updates	Mike Shook
Transitional Care Services (TCS)	Andrea Smith
Closing / Open Forum	All

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PROVIDER SERVICES

Christina Villar

Provider Services Representative II

ECM and CSS Provider Network Contact List

Health Plan - Welcome to HPSJ/MVHP

Providers > CalAIM - CalAIM - HPSJ/MVHP

- **HPSJ/MVHP Enhanced Care Management Provider Network Contact List**

HPSJ-MVHP-ECM-Provider-Contact-List.pdf

- **HPSJ/MVHP Community Supports Provider Network Contact List**

HPSJ-MVHP-CS-Provider-Contact-List.pdf

Questions – Contact providerservices@hpsj.com

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COMMUNITY SUPPORTS

Referral process and updates

Mike Shook, BSN RN

Director Utilization Management

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	Updated 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 authorization 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 validate 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 date 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** (UPDATED 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

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TRANSITIONAL CARE SERVICES (TCS)

Andrea Smith

Manager, Transition of Care

TCS – ECM Responsibilities

❖ DHCS PHM POLICY GUIDE – MAY 2024 VERSION

1. Identify the Care Manager Responsible for TCS Pg. 53

Once a member has been identified as being admitted and as being high-risk, the MCP must identify a care manager, who is the single point of contact responsible for providing longitudinal support and ensuring completion of all TCS across all settings and delivery systems, and that members are supported in a culturally and linguistically appropriate manner from discharge planning until they have been successfully connected to all needed services and supports.

For members already enrolled in ECM or CCM at the time of the transition, the MCP must ensure that the member's assigned ECM Lead Care Manager or CCM care manager is that identified care manager and provides all TCS.

e. Care Manager Responsibilities Pg. 54

The care manager responsible for TCS is responsible for coordinating and verifying that high-risk members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. As set out above, the hospital/discharging facility's responsibility to perform discharge planning does not supplant the need for TCS, although the TCS responsibility may be fully contracted out to the hospital/facility to allow a single team to perform discharge and TCS. If MCPs contract with or delegate TCS to providers or facilities, MCPs must have a monitoring plan in place to ensure all required TCS are completed.

The care manager is responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, LTSS, physicians or advanced practice providers (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions.

DHCS PHM Policy Guide – May 2024 Version Link

TCS – ECM Responsibilities (cont.)

- **1. CONTACT MEMBER WHILE INPATIENT**
  - Introduce assigned Care Manager during hospital stay
  - Explain what Transitional Care Services (TCS) include
  - Begin care planning with member and family/supports

- **2. COLLABORATE WITH FULL CARE TEAM**
  - Communicate with hospital staff, PCPs, nurses, social workers, LTSS, and others
  - Ensure shared understanding of care plan

- **3. ASSESS RISK AND SUPPORT NEEDS**
  - Review hospital assessments & discharge plan
  - Identify member's eligibility for Benefits or Community Supports
  - Document risks and develop follow-up plan

- **4. FOLLOW-UP WITHIN 7 DAYS OF DISCHARGE**
  - Contact member to review instructions and care plan
    - Ensure needed services and supports for discharge were ordered and fulfilled
  - Confirm understanding and address new needs

TCS – ECM Responsibilities (cont.)

- **5. ARRANGE AND MONITOR POST-DISCHARGE SERVICES**
  - Schedule PCP/follow-up appointments within 7 days from discharge
  - Coordinate transportation and ensure appointments are kept

- **6. ENSURE MEDICATION AND BEHAVIORAL HEALTH CONTINUITY**
  - Confirm medication reconciliation completed
  - Support continuation/initiation of MH or SUD treatment

- **7. CONNECT TO COMMUNITY SERVICES/SUPPORTS**
  - Refer to appropriate supports for identified needs (ex: CSS, county resources/programs, etc.)
  - Coordinate safe SNF discharges or transitions

- **8. CONNECT TO COMMUNITY SERVICES/SUPPORTS**
  - TCS ends no sooner than 30 days from date of discharge

  OR
  - Once the member has been connected to all needed services and supports

TCS Flow

1 Inpatient Contact (🏥📞)

- Introduce Care Manager during stay
- Explain TCS and begin discharge planning

2 Discharge Coordination (📋)

- Review discharge summary, meds, risk level
- Identify post-discharge needs

3 Member Follow-Up (Within 7 Days) (📞)

- Contact member to review care and answer questions

4 Appointment Setup & Transport (📅🚗)

- Schedule PCP/follow-ups
- Arrange transport if needed

5 Medication & MH/SUD Treatment (💊🧠)

- Confirm medication reconciliation
- Support MH/SUD services continuation/initiation

6 Community and Home-Based Services (🏠🔗)

- Refer to appropriate supports for identified needs
- Coordinate SNF or LTSS transitions

7 Monitoring & Documentation (📁)

- Track task completion
- Confirm safety and member engagement

8 End of TCS (✅)

- TCS ends *no sooner than* 30 days from date of discharge

OR

- Once the member has been connected to all needed services and supports

Resources/References

- **CALAIM POPULATION HEALTH MANAGEMENT (PHM) POLICY GUIDE:** HTTPS://WWW.DHCS.CA.GOV/CALAIM/PAGES/POPULATIONHEALTHMANAGEMENT.ASPX
    - **TCS considerations begin on pg. 45 of the May 2024 Guide**

- **ECM PROVIDER TOOLKIT:** HTTPS://WWW.DHCS.CA.GOV/CALAIM/ECM/DOCUMENTS/ECM-PROVIDER-TOOLKIT.PDF
    - **Comprehensive Transitional Care is on pg. 15**

- **ECM & COMMUNITY SUPPORTS RESOURCES:** HTTPS://WWW.DHCS.CA.GOV/CALAIM/ECM/PAGES/RESOURCES.ASPX

HPSJ Specific Contacts:

- TOC: ANDREA SMITH, MANAGER TRANSITION OF CARE: ASMITH@HPSJ.COM OR TRANSITIONOFCARE@HPSJ.COM

Questions

Next Meeting

- September 11, 2025
- 8:30 am– 9:30am

THANK YOU!

Health Plan of San Joaquin

Mountain Valley Health Plan

www.hpsj-mvhp-org | 1-888-936-PLAN (7526)

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