Health Plan of San Joaquin

Mountain Valley Health Plan

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

September 10, 2026

Meeting Agenda

Topics	Facilitator
Introductions	Eveyln Terra
STPHH Sunsetting	Niyati Reddy
UIS Transition	Niyati Reddy
ECM/CS Provider Directory Form – Reminder ECM Justice-Involved Implementation Update • Go-Live Readiness (10/1/26)	Niyati Reddy
Community Supports Updates-High Level	Kimberly Glasby
Asthma Preventative Services vs Asthma Remediation	Kimberly Glasby
Closing / Open Forum	

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SHORT-TERM POST HOSPITALIZATION HOUSING

Niyati Reddy

Community Support Services: Short-Term Post Hospitalization Housing

- Short-Term Post Hospitalization Housing (STPHH) Sunsetting as of 12/31/2026 as California is seeking to transition federal authority for Recuperative Care from Section 1115 waiver to ILOS authority as of 1/1/27.
    - DHCS seeks to create a model for Recuperative Care that incorporates the both Recuperative Care and STPHH
    - For MCPs:
        - Released Provider Alert to network on 8/12/2026
        - Limiting the duration of STPHH authorizations as of 7/1/26 and authorizations cannot extend beyond 12/31/26.
        - State cutoff date: 12/1/26 after which no STPHH authorizations may be issued
        - 'Notice of Action' - notifying members via DHCS's member notification (week of 9/8/26)
        - Implement transition planning expectations
            - UM to meet with current/contracted STPHH providers to discuss transitions of care with **discharge date** status
        - Updating member handbooks and Evidence of Coverage to remove STPHH as a covered service
        - Amending provider contracts to remove STPHH (in process)
        - Sharing Transition Monitoring Report to DHCS (monthly basis)

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UNSATISFACTORY IMMIGRATION STATUS (UIS) TRANSITION UPDATE

Niyati Reddy

UIS Transition Update

- Federal rules require states to move all individuals with Unsatisfactory Immigration Status (UIS) out of managed care and into fee-for-service (FFS) by January 1, 2027
- Medi-Cal coverage does not end (**if they renew on time**); they will not longer be enrolled in a Medi-Cal MCP; claims will be billed directly to DHCS
- DHCS released Version 1.0 of their UIS Transition Policy Guide, outlining major changes to member experience, including loss of managed care-only services, care coordination and Primary Care Physician (PCP) assignments. V2 draft was released on 9/2/26 and expecting to release V3 later this year.
- Managed care plans must maintain care coordination through December 31, 2026, submit extensive data to DHCS, support provider FFS enrollment, and notify Enhanced Care Management (ECM) / Community Supports (CS) members of service discontinuations – **ECM and CSS will not be offered in FFS**
- DHCS aims to minimize disruption by expanding FFS provider capacity and issuing a single statewide member notice by December 1, 2026; members will continue using existing Benefit Identification Cards (BIC) instead of their health plan card
- Provider Alert was released earlier this month (August 12, 2026) and uploaded to Health Plan's public website
    - Medi-Cal FFS enrollment requirements
        - Provider must complete a provider enrollment application with the DHCS Provider Enrollment Division (PED)/PAVE and must be approved to enroll by 01/01/27 to receive reimbursement at FFS rates
        - Confirm all enrollment, screening and revalidation requirements are current
        - Review FFS billing requirements, including Treatment Auth Requests (TARs)
- The transition will require significant system, IT, provider enrollment and operational changes, with further guidance expected in the near term

Online Resources to Support Members, Providers and Community Partners

DHCS has published new online resources to support Medi-Cal members, providers, and community partners as we prepare for the January 1, 2027 transition of Medi-Cal members with unsatisfactory immigration status (UIS) from managed care to Fee-for-Service (FFS)

Fee-for-Service Transition | Medi-Cal

- Member-Focused Webpage
- Stakeholder Page
- Find Doctors and Services Tool
- Medi-Cal Changes Toolkit (Fact Sheet and FAQs)

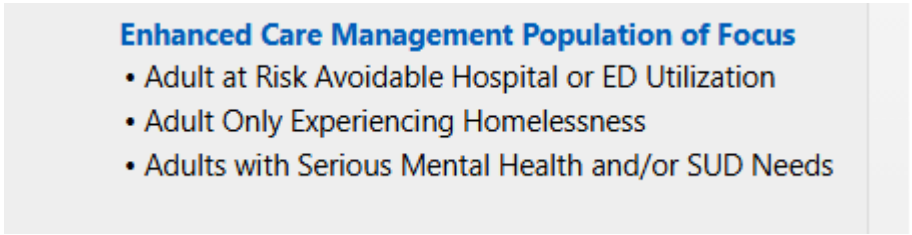
ECM-CS Provider Directory Form

To ensure Health Plan has your confirmed ECM Populations of Focus (POF) and Community Support Services (CSS) documented accurately under the CalAIM Website and in the Provider Directory (public facing): if you have any scope changes/updates, please complete the Provider Directory Form and submit accordingly

*For ECM, we do not document your POFs in the Provider Contract

*For CSS, these services will be listed in your Provider Contract Exhibit

We will share the ECM/CS Provider Directory Form after this call and post it to the CalAIM Website for easy access; please complete it and submit to: providernetworks.verification@hpsj.com and please copy your Provider Services Rep in the e-mail.



Example of what to look for in the Provider Directory

ECM Justice Involved (JI) Update

HPSJ is only live with ECM JI in San Joaquin County Adult/Sheriff as of 01/01/25

- To date, received and processed over 50 referrals from CF

HPSJ-MVHP will be using Manifest MedEx as the data sharing platform for referrals and care plan exchange between Correctional Facilities, MCP and ECM JI Providers

HPSJ-MVHP will be going live with the ECM Justice-Involved Implementation in the following Counties as of **10/1/26**

- San Joaquin County Probation/C&Y
- Stanislaus County Sheriff/Probation
- El Dorado County Sheriff/Probation
- Alpine County – no facilities/EDC Providers will support Alpine members/Alpine Sheriff attends EDC calls

ECM JI Provider Network

(aligned with Health Net, Kaiser and Anthem)

San Joaquin County	El Dorado County
Serene Health	Serene Health
Turning Point	Cal Voices
SJ Health Care Services Agency	Tahoe Family and Youth (pending Medi-Cal enrollment)
Friends Outside	
Stanislaus County	**Alpine County**
Serene Health	Serene Health
Turning Point	Cal Voices
La Familia	
Sierra Vista	

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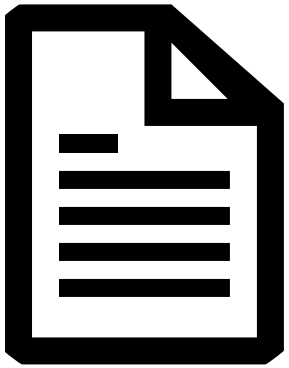
COMMUNITY SUPPORTS UPDATES

Kimberly Glasby

Community Supports Updates



Submit Required Documentation

Please ensure that all required documentation is submitted in support of the request. While we make every effort to follow up on missing information, this is not always possible due to regulatory turnaround times.

Minor Services

Services requested need to be age appropriate.

- MTM
- Housing Trio-only allowed if the parent/guardian is not an HPSJ member
- PCHS-not appropriate for iADL services

Questions?

Please reach out to your Provider Relations Representative with any questions or if you would like to schedule a meeting to discuss individual issues/concerns.

Asthma Preventative Services vs Asthma Remediation

Asthma Preventive Services (APS)

APS covers clinic-based asthma self-management education, homebased asthma self-management education, and in-home environmental trigger assessments that identify physical modifications to a home or supplies that would reduce the likelihood of acute asthma episodes.

Asthma Remediation

The Asthma Remediation Community Support consists of supplies and/or physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of a Member, or to enable a Member to function in the home with reduced likelihood of experiencing acute asthma episodes.

Asthma Remediation Items

- Allergen-impermeable mattress and pillow dustcovers
- High-efficiency particulate air (HEPA) mechanical filtered vacuums
- Integrated Pest Management (IPM) services
- De-humidifiers
- Mechanical air filters/air cleaners
- Other moisture-controlling interventions
- Minor mold removal and remediation services
- Ventilation improvements
- Asthma-friendly cleaning products and supplies
- Other interventions identified to be medically appropriate for the management and treatment of asthma

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ENHANCED CARE MANAGEMENT

Care Planning

Samantha Hansen, RN
Supervisor-Case Management

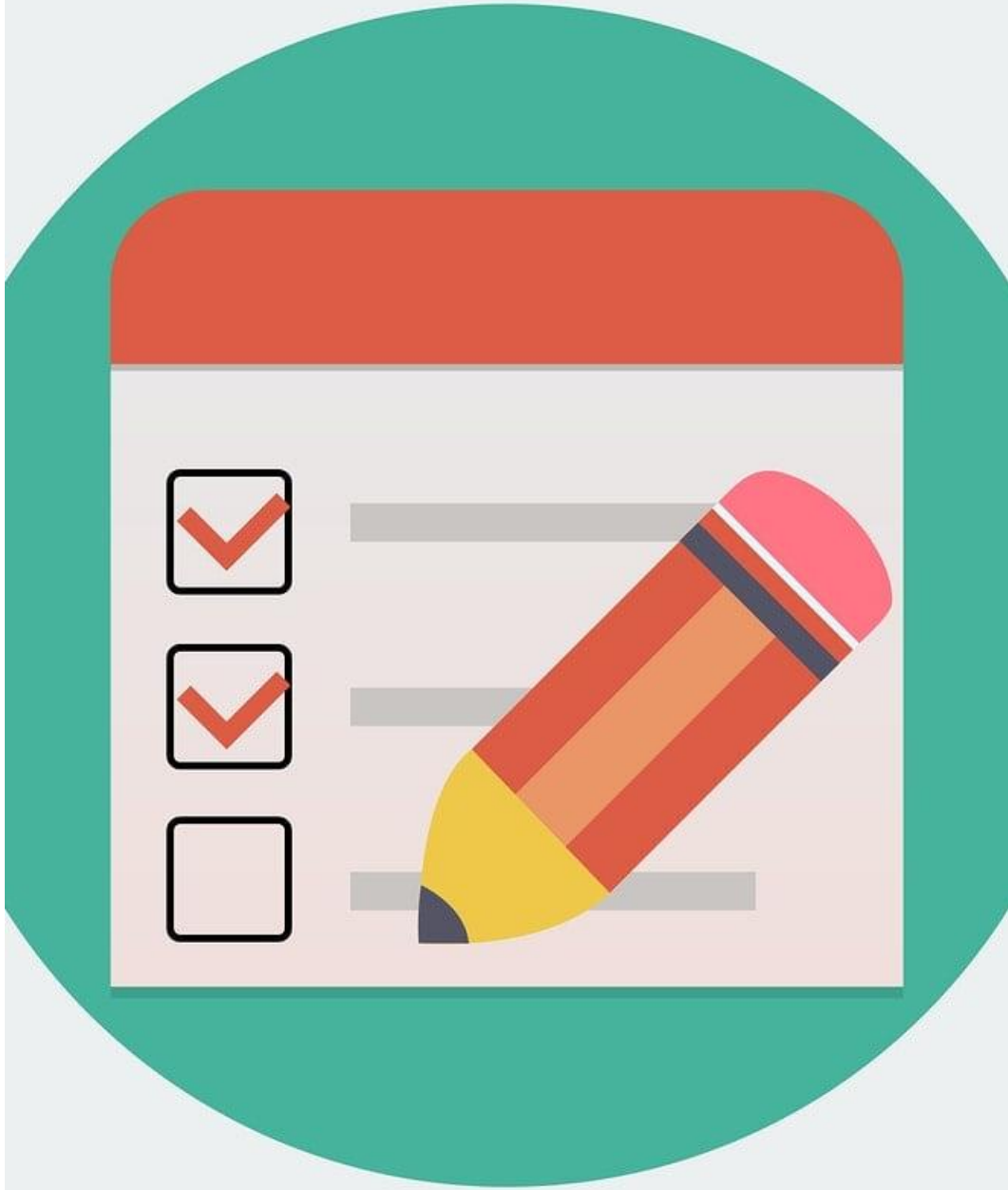
WHAT IS A CARE PLAN?
And why is it important?

A Care Plan is document that is created for each person that outlines their health or support needs, the goals of their care and the actions (interventions) required to achieve those goals.

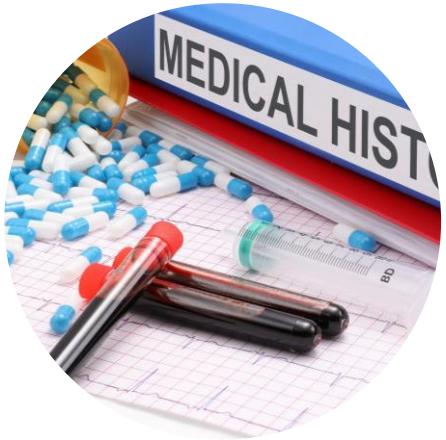
A Care Plan is important because it is the "roadmap" of the member's care. Without well defined problems, goals and interventions, how does a provider know when the member/client is ready for discharge/disenrollment from the program for which they were enrolled??

KEY COMPONENTS

- Assessment
- Goals and Outcomes
- Actions and Interventions
- Frequency of Services
- Review and Updates



Assessment/Evaluation



Medical

What does the member's medical history consist of??

- Past/Current Medical Diagnoses
- Medications
- Providers

Social

Evaluation of the member's social determinants of health.

- Living situation
- Family/Caregiver supports
- Community Support Services

Emotional/Behavioral

Evaluation of member's emotional and behavioral health conditions.

- SMI/SUD history
- Behavioral Healthcare Team
- Substance Use Team

Goals and Objectives

1. **What** are the specific problems the member is facing?

   Identifying these is the first step in developing the care plan.

2. **Why** is this particular problem important to the member?

   Is it meaningful/appropriate/achievable?

3. **How** can the problem be solved??

   What actions need to be taken to solve the problem.

4. **When** do you expect this problem to be solved?

   Timeframe in which actions need to be completed (think dates)

5. **What** are the member's strengths, abilities and barriers?

   Will these help or hinder their ability to solve the problem?

ACTIONS AND INTERVENTIONS

What **specific** actions are going to be taken to achieve the solution of the stated problem (goal)?

Who is responsible for each action?

- Member?
- Family member?
- ECM LCM/CHW?

What is the specific timeframe that these stated actions will be accomplished by?

- Within 1 year?
- Within 30 days?
- By a specific date? 12/31/2026

Frequency of Services

How often are you planning to interact with the member?

- Daily, Weekly, Monthly?

How often are you planning to review your care plan?

- Monthly, every 3 months, every 6 months?

Review and Updates

How effective has your care been?

- Did you achieve the goal as stated?
- Did you partially meet the goal? i.e some interventions/actions completed?
- Did you not meet the goal at all?

Are there goals still to be met at the end of this initial authorization period??

- Update the care plan to reflect which goals have been met and which goals are still unmet with updated target dates.

Care Plan Example

Problem: Homelessness

Goal: Member/client will secure stable housing within the next 12 months

Interventions:

1. Refer to CSS provider for housing trio
2. Provide community resources: 211, low-income housing providers
3. Gather required documents: Driver's license, social security card, birth certificate, etc
4. Assist with financial support: job search, employment resources, resume creation
5. Coordinate transition with landlord

Goals and interventions need to be age-appropriate

Example: a child/youth under the age of 18 cannot be the person applying for housing since they cannot legally sign a lease.

A child would not need assistance for "employment" as they cannot get a job.

If the parent is enrolled in ECM, then they should be the only participant receiving extension of services and have the care plan goals related to housing. If you solve the problem for the parent, you are solving the problem for the child.

INTERVENTIONS

For documentation purposes:

Your interventions should reflect the next steps and identify what you have completed and when.

1. Refer to CSS provider for housing trio:

--member referred to “CSS name” provider on [date].

--Application for housing completed on [date]

**Be specific on what tasks you have completed and when.

What are the next steps??

Constantly update you care plan and take credit for the work you have done.

This will tell you when the member is ready for discharge OR if they will need an extension of ECM services to complete all their goals; however, the goals must rise to the level of Enhanced Care Management.

If not, please refer them back to the plan to complete basic tasks: dental appt, annual well-check appointments.

Next Meeting

- November 12, 2026
- 8:30 am– 9:30am

THANK YOU!

Health Plan of San Joaquin

Mountain Valley Health Plan

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