COMMUNITY SUPPORTS POLICY GUIDE VOLUME 1

Updated April 2025

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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[1] This volume contains the service definitions for eight of the 15 Community Supports that address Members' health-related social needs. Volume 2 contains the service definitions for the seven Community Supports that address the needs of Members experiencing or at risk of homelessness, inclusive of Transitional Rent.

I. INTRODUCTION TO COMMUNITY SUPPORTS

(Updated April 2025)

This Community Supports Policy Guide Volume 1 is intended to serve as a resource for Medi-Cal Managed Care health plans (or "Managed Care Plans" (MCPs)) in the implementation of Community Supports.

As of Spring 2025, the Department of Health Care Services (DHCS) has reorganized the Community Supports Policy Guide into two volumes to accommodate new policies specific to Transitional Rent and other Community Supports related to supporting Members experiencing or at risk of homelessness.

- **Volume 1 contains the service definitions for eight of the 15 Community Supports that address Members' health-related social needs.**
- **Volume 2 contains the service definitions for the seven Community Supports that address the needs of Members experiencing or at risk of homelessness, inclusive of Transitional Rent.**

This Policy Guide provides a comprehensive overview of Community Supports, as well as operational guidance for MCPs. It is also intended to serve as a resource for Community Supports Providers.

Beginning in January 2022, DHCS launched California Advancing and Innovating Medi-Cal (CalAIM), with the goal of improving the quality of care and health outcomes of Medi-Cal Members by implementing delivery system, program, and payment reforms across the Medi-Cal program. A key feature of CalAIM was the statewide introduction, in January 2022, of the Enhanced Care Management (ECM) benefit and a menu of 14 Community Supports. Community Supports, at the option of the MCP and Member, can substitute for covered Medi-Cal services as cost-effective alternatives, potentially decreasing the need for hospital care, nursing facility care, and emergency department (ED) use. MCPs are responsible for administering both ECM and Community Supports in close collaboration with their network of community-based Providers. DHCS expects MCPs to source the majority of referrals for Community Supports from the community and prioritize contracting with locally-based providers who address equity gaps and are culturally responsive to their community.

ECM and Community Supports were developed from lessons learned, as well as MCP and Provider experience, in the Whole Person Care (WPC) Pilots and Health Homes Program (HHP). These initiatives pushed the boundaries of a traditional health care

delivery approach to begin formally considering the impact of social drivers of health (SDOH) on health outcomes and experience of care in Medi-Cal.

DHCS' adoption of ECM and Community Supports on a statewide scale supports the highest-need Medi-Cal Members enrolled in MCPs. ECM and Community Supports are anchored in the community, where services can be delivered in an in-person manner by community-based ECM and Community Supports Providers, to the greatest extent possible. As such, DHCS encourages MCPs to offer a robust menu of Community Supports services to Members who qualify for ECM—including those with the most complex challenges affecting health, such as homelessness, unstable and/or unsafe housing, food insecurity, and/or other social needs. Note, however, that ECM and Community Supports are separate initiatives, and some Medi-Cal Members may qualify for only ECM, or only Community Supports. For detailed information about ECM, refer to the separate ECM Policy Guide.[2]

The Medi-Cal ECM and Community Supports Quarterly Implementation Report[3] provides a comprehensive overview of ECM and Community Supports implementation to date. It is based on data submitted by MCPs to DHCS, and includes data at the state, county, and plan levels on total Members served, utilization, and provider networks. Since the launch of the program, Community Supports have served over 239,000 Medi-Cal Members.[4] As of Spring 2025, every county has at least eight Community Supports available for Members to access.

DHCS is committed to data-driven oversight of Community Supports and expects MCPs to have a data-driven approach to their implementation and monitoring of Community Supports. DHCS regularly reviews inbound MCP data as part of a comprehensive monitoring strategy for Community Supports, described in Section VIII of this Policy Guide. DHCS is in continuous communication about Community Supports with MCPs, Providers, and other implementation partners. MCPs and other stakeholders may direct their questions to DHCS using the following email address: CommunitySupports@dhcs.ca.gov.

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[2] DHCS. *ECM Policy Guide*. August 2024. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf. Accessed April 2025.

[3] DHCS. *Medi-Cal ECM and Community Supports Quarterly Implementation Report*. March 2025. Available at https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117. Accessed April 2025.

[4] Based on the data from Q2 2024.

II. COMMUNITY SUPPORTS OVERVIEW

(Updated April 2025) What are Community Supports?

Community Supports are services that help improve the health and well-being of MCP Members by addressing Members' health-related social needs; helping them live healthier lives; and avoiding higher, costlier levels of care. Community Supports—with the exception of Transitional Rent, which is mandatory for MCPs to offer beginning January 1, 2026—are optional for MCPs to offer and for Members to utilize. MCPs may not require Members to use a Community Support instead of a service or setting listed in the Medicaid State Plan.

Starting on January 1, 2022, MCPs in all counties have been strongly encouraged to offer the following 14 pre-approved Community Supports, which are defined fully in this Policy Guide or Community Supports Policy Guide Volume 2:

- Respite Services
- Assisted Living Facilities, formerly known as Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly and Adult Residential Facilities
- Community or Home Transition Services, formerly known as Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals/Medically Supportive Food
- Sobering Centers
- Asthma Remediation
- Housing Transition Navigation Services (Volume 2)
- Housing Deposits (Volume 2)
- Housing Tenancy and Sustaining Services (Volume 2)
- Day Habilitation Programs (Volume 2)
- Recuperative Care (Medical Respite) (Volume 2)
- Short-Term Post-Hospitalization Housing (Volume 2)

Effective July 1, 2025, DHCS is adding Transitional Rent as the fifteenth Community Supports service. MCP coverage of Transitional Rent is initially optional and becomes mandatory for MCPs to offer on January 1, 2026. Transitional Rent is defined in Volume 2.

Consistent with federal regulations,[5] DHCS has determined the preapproved Community Supports to be cost-effective and medically appropriate substitutes for covered Medi-Cal services or settings. MCPs do not need to actively assess or report on cost effectiveness for Community Supports at the MCP or individual level for the purposes of rate setting or compliance with federal requirements. Nothing prohibits MCPs from using utilization management techniques as applicable and as permitted by federal managed care regulations. DHCS is conducting statewide aggregate analyses of the cost effectiveness of each of the approved Community Supports services.

(Added April 2025) Federal Authorities for Community Supports

Short-Term Post-Hospitalization Housing, Recuperative Care, and Transitional Rent are authorized under Section 1115 waiver authority. Short-Term Post-Hospitalization Housing and Recuperative Care are authorized under the CalAIM waiver,[6] and Transitional Rent is authorized under the BH-CONNECT waiver.[7] These services are each subject to the Special Terms and Conditions (STCs) of their respective waivers. The requirements and limitations set forth in the waiver STCs are reflected in the policies provided in this Guide. The other 12 Community Supports are "in lieu of services"

[5] National policy continues to evolve; the latest guidance from CMS can be found in the *State Medicaid Director Letter (SMDL)* from January 2023. (Centers for Medicare and Medicaid Services. *SMDL 23-001*. January 2023. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf. Accessed April 2025.)

[6] Medicaid. *CalAIM Demonstration Approval Technical Correction Attachment*. January 2025. Available at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list. Accessed April 2025.

[7] Medicaid. *Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration*. January 2025. Available at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list. Accessed April 2025.

established and implemented in accordance with California's Section 1915(b) waiver and 42 CFR section 438.3(e)(2).[8]

Each Community Support is additionally subject to the requirements of DHCS' MCP contract.[9] The MCP Contract sets forth the eligibility criteria and clinically oriented service definition for each Community Support. Greater detail, additional requirements, and limitations for each Community Support are provided in this Guide.

All Community Supports must supplement and not supplant services received by the Medi-Cal Member through other state, local, or federally-funded programs, in accordance with applicable federal waiver authorities, MCP Contract, APLs, and DHCS guidance.

All Plan Letter (APL) Governing Community Supports

MCPs are responsible for ensuring that all Community Supports Providers, Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, APLs, and other DHCS guidance including, but not limited to, Policy Letters and this Community Supports Policy Guide (inclusive of Volumes 1 and 2) as outlined in APL 21-017 or subsequent updates or superseding APLs.

ECM and Community Supports Action Plan

DHCS is committed to adjusting Community Supports program design to reduce administrative burden, promote market awareness, and improve access and uptake of Community Supports across the state. DHCS conducts regular stakeholder feedback on ongoing implementation of Community Supports, which resulted in an ECM and Community Supports Action Plan[10] summarizing areas for standardization and efforts to

[8] All in lieu of services are subject to the requirements of 42 CFR section 438.3(e)(2). This means that they must be a cost-effective substitute for a service or setting covered under the Medicaid State Plan, voluntary for an MCP to cover and for a Member to utilize, and taken into account in developing the component of the capitation rate that represents the covered State Plan services and settings.

[9] DHCS. *Medi-Cal Managed Care Boilerplate Contracts*. 2024. Available at https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. Accessed April 2025.

[10] DHCS. *ECM Community Supports Action Plan Updates*. December 2024. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx. Accessed April 2025.

streamline access to both services. Since 2023, DHCS has updated select Community Supports service definitions to improve eligibility alignment across the Community Supports and/or clarify eligibility policies. In the spirit of continuous improvement, DHCS updates the Action Plan on a regular basis.

Brief descriptions of the service definition refinements made in February 2025 are included in Appendix B.

III. COMMUNITY SUPPORTS – SERVICE DEFINITIONS

The Community Supports service definitions for the following services are detailed in the section below:

- Respite Services
- Assisted Living Facility Transitions[11]
- Community or Home Transition Services[11]
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals/Medically Supportive Food[11]
- Sobering Centers
- Asthma Remediation[11]

Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Day Habilitation Programs, Recuperative Care (Medical Respite), Short-Term Post-Hospitalization Housing, and Transitional Rent service definitions can be found in Volume 2 of the Community Supports Policy Guide.

[11] These Community Supports service definitions have been updated as of February 2025, and are effective July 2025. Select updates to the Asthma Remediation service definition go into effect on January 1, 2026, rather than July 2025. See the Asthma Remediation section of this document for additional details.

Respite Services

Description/Overview

Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite Services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the Member's basic self-help needs and other activities of daily living (ADL), including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite Services are provided to the Member in his or her own home or another location being used as the home.

Facility Respite Services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to pre-empt caregiver burnout to avoid institutional services for which the Medi-Cal MCP is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program, and Members with Complex Care Needs.

Restrictions/Limitations

In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal MCP authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid Member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal MCP would be responsible.

Respite services cannot be provided virtually, or via telehealth.

Licensing/Allowable Providers for Respite Services

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal MCPs may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
  - Providers contracted by county behavioral health
- Other community settings that are not a private residence, such as:
  - Adult Family Home/Family Teaching Home
  - Certified Family Homes for Children
  - County Agencies
  - Residential Care Facility for the Elderly (RCFE)
  - Child Day Care Facility; Child Day Care Center; Family Child Care Home
  - Respite Facility; Residential Facility: Small Family Homes (Children Only)
  - Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)

- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)
- Short-term Residential Therapeutic Program Providers or other care providers who are serving youth with complex needs
- Community-Based Adult Services (CBAS) Facilities/Providers

HCPCS Codes for Respite Services

Listed below are the Healthcare Common Procedure Coding System (HCPCS) code and modifier combinations that must be used for Respite Services. See Section VII for more information about Billing & Payments for Community Supports.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
H0045	Respite care services, not in the home; per diem	U6	Used with HCPCS code H0045 to indicate Community Supports Respite Services
S5151	Unskilled respite care, not hospice; per diem	U6	Used with HCPCS code S5151 to indicate Community Supports Respite Services
S9125	Respite care, in the home; per diem	U6	Used with HCPCS code S9125 to indicate Community Supports Respite Services

Assisted Living Facility (ALF) Transitions

(Updated February 2025)[12]

Description/Overview

Assisted Living Facility Transitions (formerly known as "Nursing Facility Transition/Diversion to Assisted Living Facilities such as Residential Care Facilities for the Elderly and Adult Residential Facilities") is designed to assist individuals with living in the community and avoid institutionalization, whenever possible. The goal of the service is to facilitate nursing facility transition back into a home-like, community setting, and/or to prevent nursing facility admissions for Members living in the community. This Community Support is intended for Members with an imminent need for nursing facility level of care (LOC) and is intended to provide a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility.

For the purposes of this service definition, the term assisted living facility (ALF) includes a Residential Care Facility for the Elderly (RCFE), or an Adult Residential Care Facility (ARF). This service includes two components, as follows:

Time-limited transition services and expenses to enable a person to establish a residence in an ALF. Transition services end once the Member establishes residency in the ALF.[13] The transitional period will vary in length and services provided based on a Member's unique circumstances. Allowable expenses are those necessary to enable a person to establish ALF residence (except room and board), including, but not limited to:

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[12] The name of this Community Support has been abbreviated for ease of use and to clarify intended purpose of the service. Stakeholders have indicated that the term "nursing home/facility" may inadvertently discourage individuals residing in the community from utilizing this Community Support. This service definition was updated and published in February 2025 in a document titled *Community Supports: Select Service Definition Updates*. This section incorporates all refinements made in February 2025 and is effective July 1, 2025. For additional detail on the refinements, see Appendix B.

[13] MCPs are required to provide Transitional Care Services (TCS), including transitional care management, for high and lower-risk transitioning Members, as specified in the *DHCS PHM Policy Guide* (May 2024). Members who are eligible for this Community Supports service would receive it in addition to TCS. The DHCS PHM Policy Guide is available at https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf. Accessed April 2025.

a. Assessing the Member's housing needs and presenting options.
b. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the ALF, so the Member can be safely and stably housed.
c. Assisting in securing an ALF residence, including the completion of facility applications, and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
d. Moving expenses to support a Member's transition, such as movers/moving supplies and necessary private/personal articles to establish an ALF residence.
e. Communicating with facility administration and coordinating the move.
f. Establishing procedures and contacts to retain housing at the ALF.

Ongoing assisted living services are provided to Members on an ongoing basis after they transition into the ALF. Members can receive these services indefinitely, as long as the Member can maintain residency in the ALF. These services include:

a. Assistance with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs)
b. Meal preparation
c. Transportation
d. Medication administration and oversight
e. Companion services
f. Therapeutic social and recreational programming provided in a home-like environment
g. 24-hour direct care staff onsite at the ALF to meet unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security
h. Care coordination services to screen for eligibility and support enrollment of Members in Enhanced Care Management (ECM) and other Community Supports

MCPs may not limit their offering of this service to only component 1 (time-limited transition services and expenses) or component 2 (ongoing assisted living services) and must offer both to the extent that they are appropriate for the Member. However, individual Members may require only one or only the other component (e.g., Members already in the ALF will require only component 2 since they are not transitioning;

Members enrolled in a waiver program that covers similar wraparound services may require only component 1).

Eligibility (Population Subset)

Members residing in a nursing facility who:

1. Have resided 60+ days in a nursing facility and
2. Are willing to live in an assisted living setting as an alternative to a nursing facility; and
3. Are able to reside safely in an ALF.

Members residing in the Community who:

1. Are interested in remaining in the community; and
2. Are willing and able to reside safely in an ALF; and
3. Meet the minimum criteria to receive nursing facility LOC services[14] and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF.

"Members residing in the community" includes Members living in a private residence or public subsidized housing and Members already residing in an ALF who are at risk of institutionalization.

Members who are receiving facility level health care services on an acute or post-acute care basis (such as hospitalization or a short-term skilled nursing facility stay) may be eligible for this Community Support, provided they otherwise meet the eligibility criteria.

Interface with the Assisted Living Waiver and California Community Transitions Program

A Member can be eligible for both the Assisted Living Waiver[15] and California Community Transitions (CCT) program[16] and this service; however, they cannot receive

[14] Nursing facility level of care as defined in Section 51124 of Title 22 of the California Code of Regulations.

[15] For more information, see the *DHCS ALW webpage*. Available at https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx. Accessed April 2025.

[16] For more information, see the *DHCS CCT webpage*. Available at https://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx. Accessed April 2025.

both at the same time. MCPs are encouraged to assist Members with enrollment in eligible and available waiver programs, such as the ALW, as appropriate.

MCPs must ensure coordination with ALW providers to avoid overlapping service delivery and to facilitate seamless transitions when Members move between the two programs. For example, Members transitioning out of a nursing facility who are awaiting enrollment in the ALW may utilize the time-limited transition component of this Community Support to support their transition to the ALF. Members may then utilize the ongoing assisted living services component of this Community Support to support their services received from the ALF until their enrollment in the ALW is completed. DHCS encourages MCPs to offer the Community Support to Members on the ALW waitlist.[17]

MCPs should work collaboratively with ALW Care Coordination Agencies to align care planning and ensure appropriate referrals. Additional guidance on ALW services and eligibility criteria is available on the DHCS ALW website.[18]

Restrictions/Limitations

Room and board expenses are not included in this service. Members may receive assistance with room and board from other sources at the same time as receiving this service. Additional details on how Members can obtain assistance for payment of room and board when residing in an ALF can be found on the DHCS ALW website.[18]

ALF Transitions: Delivery with Other Community Supports, ECM, Transitional Care Services, and Population Health Management

The time-limited transition services and ongoing assisted living services offered through ALF Transitions are designed to complement Enhanced Care Management (ECM).[19] The

[17] To determine whether a Member is on the ALW waitlist, MCPs may contact DHCS directly at the email address provided on the DHCS ALW webpage. Effective April 2025, DHCS will make available to MCPs a list of their Members who are also on the ALW waitlist, and the associated Care Coordination Agency, to facilitate delivery of this Community Support service for Members who are likely to benefit from the service. These lists will be uploaded monthly and available in each MCP's secure file transfer protocol (SFTP) data folder.

[18] DHCS. *Assisted Living Waiver*. Available at https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx. Accessed April 2025.

[19] Refer to the DHCS *ECM Policy Guide* for additional details on scope of services available through ECM. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf. Accessed April 2025.

Community Support does not replace ECM services for Members who are eligible for or receiving ECM, and ECM should be used for the ongoing care management of Members receiving this Community Support.[20] For Members already enrolled in ECM during the time of transition, the MCP must ensure that the ECM Care Manager provides all necessary Transitional Care Services (TCS) and coordinates referrals to Community Supports like ALF Transitions on the Member's behalf. Regardless of whether the Member is enrolled in ECM, ALF Transitions is not intended to replace TCS, which MCPs are required to provide for Members transitioning from one setting or level of care to another under Population Health Management.[21]

Members receiving this service may also be eligible for other Community Supports. MCPs should ensure Members are appropriately screened and referred for services for which they may be eligible. For example, Members can be connected to Housing Transition Navigation Services[22] at the same time as the time-limited transition component of this service (if they meet eligibility criteria and the MCP has made them available) as long as the activities provided are distinct between the Community Supports.

Licensing/Allowable Providers for ALF Transitions

For the purposes of this service definition, the term ALF includes a RCFE, or an ARF. RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing Division.

The below list is provided as an example of the types of providers MCPs may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case Management agencies
- Home Health agencies
- ARF/RCFE Operators

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[20] Refer to the *ECM Populations of Focus Spotlight for Long-Term Care POFs* for additional details on integrating ECM and Community Supports for Members. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-POF-Spotlight-LongTermCarePopulation.pdf. Accessed April 2025.

[21] Refer to the *Population Health Management Policy Guide*. Available at https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf. Accessed April 2025

[22] The Housing Transition Navigation Services service definition is located in Volume 2 of the Community Supports Policy Guide.

- 1915c Home & Community Based Alternatives (HCBAs)/ALW providers
- CCT/Money Follows the Person providers

Additionally, MCPs must consider factors such as the availability of clinical staff, staff training, emergency response systems and procedures, licensing, and adequate home and community-based setting characteristics within their vetting processes.

The ALW is **not** considered a state-level enrollment pathway for the purpose of enrolling these operators as Medi-Cal Providers offering Community Supports. The ALW is a distinct program authorized under the 1915(c) Waiver and is available to Medi-Cal managed care Members, with restrictions as a Medi-Cal FFS benefit, and is carved out of the Medi-Cal managed care program authority. If an entity is already enrolled as an ALW provider, MCPs may consider this enrollment when vetting the Community Supports Provider and must document this consideration in their Policies and Procedures.

HCPCS Codes for ALF Transitions

Listed below are the HCPCS code and modifier combinations that must be used for ALF Transitions. See Section VII for more information about Billing & Payments for Community Supports.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Community or Home Transition Services	U4	Used with HCPCS code T2038 to indicate Community Supports Assisted Living Facility Transitions
H2022 ***(Updated January 2024)***	Community wrap-around services, assisted living services, per diem. Requires billed amount(s) to be reported on the encounter.	U5	Used with HCPCS code H2022 to indicate Community Supports Assisted Living Facility Transitions

Community or Home Transition Services

(Updated February 2025)[23]

Description/Overview

Community or Home Transition Services (formerly known as "Community Transition Services/Nursing Facility Transition to a Home") helps individuals to live in the community and avoid further institutionalization in a nursing facility.

Community or Home Transition Services support Members in transitioning from a licensed nursing facility to a living arrangement in a private residence or public subsidized housing where the Member is responsible for identifying funding for their living expenses. This service also covers set-up expenses necessary for a Member to establish a basic household.

This service includes two components, as follows:

1. **Time-limited transition services and expenses**[24] to enable a Member to transition from a licensed facility to a private residence or public subsidized housing. Each transitional period will vary in length and services provided based on a Member's unique circumstances. Includes services such as:
    a. Assessing the Member's housing needs and presenting options.
    b. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

[23] The name of this Community Support has been abbreviated for ease of use and to clarify intended purpose of the service. Stakeholders have indicated that the term "nursing home/facility" may inadvertently discourage individuals residing in the community from utilizing this Community Support. This service definition was updated and published in February 2025 in a document titled Community Supports: Select Service Definition Updates. This section incorporates all refinements made in February 2025 and is effective July 1, 2025. For additional detail on the refinements, see Appendix B.

[24] MCPs are required to provide Transitional Care Services (TCS), including transitional care management, for high and lower-risk transitioning Members, as specified in the PHM Policy Guide. Members who are eligible for this Community Supports service would receive it in addition to TCS.

c. Communicating with the landlord (if applicable) and coordinating the move.

d. Establishing procedures and contacts to retain housing.

e. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

f. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

2. **Non-recurring set-up expenses** are those necessary to enable a Member to establish a basic household that does not constitute room and board and include:

   a. Security deposits required to obtain a lease on an apartment or home. Security deposits should be in alignment with AB-12,[25] enacted in 2024;

   b. Set-up fees for utilities or service access and up to six months' payment in utility arrears, as necessary to secure the unit;

   c. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, and necessary repairs to meet Housing Choice Voucher program quality standards where those costs are not the responsibility of the landlord under applicable law;

   d. Air conditioner or heater;

   e. Adaptive aids designed to preserve an individual's health and safety in the home, such as hospital beds, Hoyer lifts, bedside commode, shower chair, traction, or non-skid strips, etc., that are necessary to ensure access and safety for the individual upon move-in to the home, when they are not otherwise available to the Member under Medi-Cal (e.g., State Plan, HCBS waiver, etc.).

MCPs may not limit their offering of this service to only component 1 or component 2 and must offer both to the extent that they are applicable to each Member.

[25] *AB-12 Tenancy: Security Deposits*. 2023-2024. Available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB12. Accessed April 2025.

Eligibility (Population Subset)

Members who:

1. Are currently receiving medically necessary nursing facility Level of Care (LOC) services[26] and in lieu of remaining in the nursing facility or Recuperative Care setting are choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
2. Have lived 60+ days in a nursing home and/or Recuperative Care setting; and
3. Are interested in moving back to the community; and
4. Are able to reside safely in the community with appropriate and cost-effective supports and services.

A Member can be eligible for both the California Community Transitions (CCT) program,[27] Home & Community Based Alternatives (HCBA) Waiver,[28] and/or the Multipurpose Senior Services Program (MSSP) and this Community Support;[29] however, they cannot receive both at the same time. MCPs are encouraged to assist Members with enrollment in eligible and available waiver programs, as appropriate.

Restrictions/Limitations

- Community Transition Services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Non-recurring set-up expenses are payable up to a total lifetime maximum amount of $7,500.00. The transitional coordination cost is excluded from this total lifetime maximum. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence or public subsidized housing through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, without which the Member would be unable to move

[26] Nursing facility level of care as defined in Section 51124 of Title 22 of the California Code of Regulations.

[27] For more information, see the DHCS CCT webpage.

[28] For more information, see the DHCS HCBA Waiver webpage.

[29] For more information, see the DHCS MSSP webpage.

to the private residence or public subsidized housing and would then require continued or re-institutionalization.

A Member can be eligible for relevant waiver/demonstration programs (e.g., CCT, Home & Community Based Alternatives, etc.) and this Community Support; however, they cannot receive both at the same time if activities provided under each program are duplicative. MCPs are encouraged to assist Members with enrollment in eligible and available waiver/demonstration programs, as appropriate.

Community or Home Transition Services: Delivery with Other Community Supports, ECM, Transitional Care Services, and Population Health Management

Members receiving this Community Support may also be eligible for other Community Support services. MCPs should ensure Members are appropriately screened and referred for services for which they may be eligible. For example, Members can also be connected to Housing Deposits[30] and/or Housing Transition Navigation Services,[31] if eligible and available. Members may receive these Community Supports at the same time as Community Transition Services if the activities provided are distinct.

To fund home modifications, Members should first be connected to the Environmental Accessibility Adaptations (Home Modifications) Community Support if eligible and available. If a Member reaches their lifetime maximum of the Environmental Accessibility Adaptions Community Support, funds for non-recurring set-up expenses may be used for similar modifications.

The time-limited transition services offered through Community Transition Services are designed to complement ECM.[32] The Community Support does not replace ECM

[30] Refer to the Housing Deposits service definition located in Volume 2 of the Community Supports Policy Guide.

[31] Refer to the Housing Transition Navigation Services service definition located in Volume 2 of the Community Supports Policy Guide.

[32] Refer to the *ECM Policy Guide* for additional details on scope of services available through ECM. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf. Accessed April 2025.

services for Members who are eligible for or receiving, and ECM should be used for the ongoing care management of Members receiving this Community Support.[33]

Additionally, Community Transition Services is not intended to replace Transitional Care Services (TCS), which MCPs are required to provide for Members transitioning from one setting or LOC to another under Population Health Management.[34] For Members already enrolled in ECM during the time of transition, the MCP must ensure that the ECM Care Manager provides all necessary TCS and coordinates referrals to Community Supports like this one on the Member's behalf.

Licensing/Allowable Providers for Community or Home Transition Services

The list is provided as an example of the types of providers Medi-Cal MCPs may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- County-operated or county-contracted behavioral health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

HCPCS Codes for Community or Home Transition Services

Listed below are the HCPCS code and modifier combinations that must be used for Community or Home Transition Services. See Section VII for more information about Billing & Payments for Community Supports.

[33] Refer to the *ECM Populations of Focus Spotlight for Long-Term Care POFs* for additional details on integrating ECM and Community Supports for Members. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-POF-Spotlight-LongTermCarePopulation.pdf. Accessed April 2025.

[34] Refer to the *Population Health Management Policy Guide* for full DHCS requirements under TCS. Available at https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf. Accessed April 2025.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Assisted Living Facility Transitions.	U5	Used with HCPCS code T2038 to indicate Community Supports Community or Home Transition Services

Personal Care and Homemaker Services (PCHS)

Updated April 2025[35]

Description/Overview

Personal Care Services and Homemaker Services (PCHS) can be provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

Includes services as similarly provided by the In-Home Supportive Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

PCHS aid individuals who could otherwise not remain in their homes.

The PCHS Community Support can be utilized:

- During the IHSS application process, including during any waiting period after a referral has been made. PCHS may be authorized prior to, and up until, IHSS services are in place.
- In addition to any approved county IHSS hours when additional support is required, including when IHSS benefits are exhausted.
- For Members who are ineligible for IHSS, PCHS can be put in place to help prevent a short-term stay in a skilled nursing facility (not to exceed 60 days). In order to receive short term PCHS, Members are not required to apply for IHSS, but the authorization request should include information about the need for short term stay in a skilled nursing facility in the absence of PCHS being available.

[35] This service definition has been updated in April 2025 and is effective July 1, 2025. These refinements clarify provision of this Community Support with the In-Home Supportive Services program and clarify that Members cannot receive Waiver Personal Care Services provided through the HCBA waiver at the same time as PCHS.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or
- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Interface with IHSS and the Home and Community Based Alternatives (HCBA) Waiver

While IHSS must be the primary source of support for eligible Members, PCHS may be provided when additional support is needed beyond authorized IHSS hours or when IHSS allocations are insufficient. In such cases, PCHS can supplement IHSS and extend care to ensure the Member's needs are fully met.

Waiver Personal Care Services (WPCS) provided through the HCBA Waiver must be coordinated separately from IHSS to ensure there is no duplication of authorized hours.[36]

Individuals enrolled in the HCBA Waiver and eligible for or receiving WPCS are not eligible to receive Personal Care and Homemaker Services (PCHS). However, individuals who are on the waitlist for HCBA Waiver may receive PCHS while they are awaiting HCBA waiver approval.

Restrictions/Limitations

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

[36] Any WPCS hours granted must supplement, rather than overlap with, the IHSS-approved hours to prevent duplication of services.

Licensing/Allowable Providers for PCHS

This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

HCPCS Codes for PCHS

Listed below are the HCPCS code and modifier combinations that must be used for Personal Care and Homemaker Services. See Section VII for more information about Billing & Payments for Community Supports.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
S5130	Homemaker services; per 15 minutes	U6	Used with HCPCS code S5130 to indicate Community Supports Personal Care/Homemaker Services
T1019	Personal care services; per 15 minutes	U6	Used with HCPCS code T1019 to indicate Community Supports Personal Care/Homemaker Services

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab bars to assist Members in accessing the home
- Doorway widening for Members who require a wheelchair
- Stair lifts
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower)
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member
- Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed)

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as a Community Support, the MCP must receive and document an order from the Member's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice to show the purpose and efficacy of the equipment; however, a brief written evaluation specific to the Member describing how and why the equipment or service meets the needs of the Member will still be necessary.

The MCP must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the MCP determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
    A. An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;
    B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member *and reduces the risk of institutionalization*. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and
    C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.
2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and
3. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

- If another State Plan service such as Durable Medical Equipment (DME), is available and would accomplish the same goals of independence and avoid institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the MCP must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.

Licensing/Allowable Providers for EAA

The Medi-Cal MCP may manage these services directly or may coordinate with a provider to manage the service.

This list is provided as an example of the types of providers Medi-Cal MCPs may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments

- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License except for a PERS installation, which may be performed in accordance with the system's installation requirements.

HCPCS Codes for EAA

Listed below are the HCPCS code and modifier combinations that must be used for EAA. See Section VII for more information about Billing & Payments for Community Supports.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
S5165	Home modifications; per service. Requires billed amount(s) to be reported on the encounter.	U6	Used with HCPCS code S5165 to indicate Community Supports Environmental Accessibility Adaptations/Home Modifications

Medically Tailored Meals (MTMs)/Medically Supportive Food (MSF)

(Updated February 2025)[37]

Description/Overview

Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address individuals' chronic or other serious conditions that are nutrition-sensitive, leading to improved health outcomes and reduced unnecessary costs.

Medically Tailored Meals and Groceries: MTMs and Medically Tailored Groceries (MTGs) are covered by this service, defined as follows:

a. **MTMs:** Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

b. **MTG:** Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

The provision of MTMs/MTGs must include an individual assessment of the Member's nutrition-sensitive condition and nutritional needs conducted or supervised by Registered Dietitian Nutritionist (RDN) to inform the development of a nutritional plan and connection to the appropriate MTM or MTG services.

The design of each of the MTM/MTG services (e.g., uncontrolled diabetes meal plan, congestive heart failure grocery plan) must be tailored by an RDN or other appropriate clinician to ensure the food provided adheres to established, evidence-based nutrition guidelines to prevent, manage, or reverse the targeted nutrition-sensitive health condition(s).[38]

The MTM and/or MTG assistance provided (singularly or in a combination of meals and groceries) must meet at least two-thirds of the daily nutrient and energy needs of an average individual, as estimated by the RDN/clinician overseeing the design of the MTM/MTG services. "Medically tailored" interventions must be provided in specified

[37] This service definition was updated and published in February 2025 in a document titled Community Supports: Select Service Definition Updates. This section incorporates all refinements made in February 2025 and is effective July 1, 2025. For additional detail on the refinements, see Appendix B.

[38] MTM/MTG services include (but are not limited to) pregnancy nutrition plans and gestational diabetes meal or grocery plans.

quantities to constitute the majority of the Member's diet over the course of the intervention to have the intended impact on health outcomes. MTM/MTG must not contain ultra-processed foods nor foods with excessive sugar or salt.

Medically Supportive Food (MSF): MSFs are packages of foods that adhere to national nutrition guidelines to prevent, manage, or reverse nutrition-sensitive conditions of referred Members. Unlike MTM or MTG, MSF is intended to supplement, rather than replace, all or most of the Member's diet. The design or selection of foods or food options in MSF services must be overseen and signed off on by an RDN or another appropriate clinician. RDNs do not need to oversee the assembly of each grocery box or produce prescription, but, for example, should provide or review the nutrition parameters of the types of foods to be included or approved for the food packages for the targeted conditions. Though MSF food packages do not need to meet minimum nutrient and energy requirements, MSF Community Supports Providers should design food packages to support participants to meet minimum recommendations for fruit, vegetable, or other targeted daily servings for nutrients. MSF must not contain ultra-processed foods nor foods with excessive sugar or salt.

Terms within the category of MSF are defined as follows:

1. **Medically Supportive Groceries:** Preselected foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the nutrition-sensitive health conditions of the recipients to whom they are prescribed.[39]
2. **Produce Prescriptions:** Fruits and vegetables, typically procured in retail settings, such as grocery stores or farmers' markets, obtained via a financial mechanism such as a physical or electronic voucher or card.
3. **Healthy Food Vouchers:** Vouchers used to procure pre-selected foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the nutrition-sensitive health conditions of the recipients, via retail settings such as grocery stores or farmers' markets.
4. **Food Pharmacy:** A model that specifically combines MSF and nutrition supports to remove barriers to healthy eating and build the knowledge and skills of participants to cook and eat foods appropriate for their nutrition-sensitive

[39] More information on the *Dietary Guidelines for Americans* can be found here: https://www.dietaryguidelines.gov/. Accessed April 2025.

conditions.[40] Food pharmacies are often housed within (or managed by) a health care setting, providing a patient cohort with coordinated clinical, food, and nutrition education services targeted at specific nutrition-sensitive health conditions. The healthy food "prescription" includes access to a selection of specific whole foods appropriate for the specific chronic or serious health condition(s) that follow the federal Dietary Guidelines for Americans and meet recommendations for the targeted health condition(s). The food is typically paired with peer supports, nutrition education, counseling, and/or culinary classes to build cooking and healthy eating skills and habits.

MCPs must require and oversee that their MTM/MSF Providers produce MTM/MSF meal and food packages that follow national nutrition guidelines and that are appropriate for the nutrition-sensitive conditions identified by the MCP for MTM/MSF services. MTM/MTG and MSF service packages must be tailored or designed at the service level for the identified target chronic or serious health conditions (e.g., MSFs recommended and tailored for Members with chronic heart failure, or the Dietary Approaches to Stop Hypertension (DASH) diet for Members with hypertension who may benefit from a low sodium diet).[41] Meals, groceries, produce prescriptions, or nutritional intervention packages do not need to be individually customized for each Member, but must be appropriate based on evidence-based guidelines for the targeted nutrition-sensitive health conditions(s) for which the MTM/MSF service is intended to improve. MCPs and their MTM/MSF Community Support Providers must consider the cultural preferences/needs (e.g., halal or kosher meals) and food preparation and storage capabilities (e.g., ability to store frozen meals) of each individual Member when determining the appropriate MTM/MSF intervention for the Member.

Nutrition Education: Health coaching, counseling, classes, behavioral supports, and tools, including equipment and materials, that are based on a Member's health conditions and needs.[42] DHCS strongly encourages, but does not require, MCPs to work with their Community Supports Providers to offer behavioral, cooking, and/or nutrition

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[40] Donohue, J. A., Severson, T., & Martin, L. P. 2021. The food pharmacy: Theory, implementation, and opportunities. *American Journal of Preventive Cardiology*. Available at https://www.sciencedirect.com/science/article/pii/S2666667720301458. Accessed April 2025.

[41] These service packages include, but are not limited to, dietary recommendations for pregnant Members including those with gestational diabetes.

[42] These health conditions and needs can include, but are not limited to, pregnancy and pregnancy-related conditions such as gestational diabetes.

education as part of this service alongside the MTM/MSF services offered. Nutrition education provided as a standalone service is not sufficient to be considered delivery of this Community Support.

- Any nutrition education offered must adhere to nationally-established, evidence-based nutrition guidelines and be vetted by an RDN or other appropriate clinician. The education must be appropriate to the Member's chronic or serious health condition and the MTM/MSF intervention the Member is receiving. Nutrition education can be provided in an individual or group setting. Nutrition education classes do not need to be delivered by an RDN. The organization delivering nutrition education may be the same as the organization providing the MTM/MSF but is not required to be the same organization. An MCP may choose to provide nutrition education directly.
- Nutrition education provided as part of this service does not supplant other Medi-Cal services. MCPs are encouraged to identify and refer Members who are receiving MTM/MSF Community Support services to other Medi-Cal covered services for which they may be eligible such as Medical Nutrition Therapy and Diabetes Self-Management Education.[43]

Eligibility (Population Subset)

Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

[43] See the *Medi-Cal Provider Manual* for further information about Medical Nutrition Therapy and Diabetes Self Management Education services. Available at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/A4A4CF11-DFAE-4958-B95F-4DB14D2CEB18/medne.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO. Accessed April 2025.

Restrictions/Limitations

- Service covers up to two (2) meals and/or meal packages per day using a combination of MTMs and MSF interventions.
- MTM/MSF can be authorized for up to 12 weeks and may be reauthorized thereafter if medically necessary. MCPs and their MTM/MSF providers are encouraged to check in with Members who are receiving this Community Supports at a more frequent cadence to assess whether Members are obtaining and eating the foods/meals provided through this Community Support, and whether any changes need to be made to improve the effectiveness of the MTM/MSF.
- Meals, food, payments, and nutrition services that are eligible for or reimbursed by alternate programs for the Member cannot be funded or counted by MCPs as an MTM/MSF Community Support.

Since MTM/MSF services are delivered as part of the Member's clinical care to address or mitigate nutritional needs from a chronic or serious health condition, they are not covered to respond solely to food insecurities. Given the coexistence of food and nutrition insecurity in populations afflicted by chronic and other serious health conditions, DHCS encourages screening and facilitating access to additional resources (e.g., SNAP, WIC, local food pantries) to combat food insecurity and enhance physical and mental well-being. DHCS considers food assistance benefit programs such as SNAP or WIC not to be duplicative of MTM/MSF services because both benefits are designed to mitigate food insecurity for a household, while MTM/MSF services are provided to the authorized Member as part of a clinical care plan to address their specific, eligible chronic or serious health condition(s).

Licensing/Allowable Providers for MTM/MSF

Types of providers Medi-Cal with whom MCPs may choose to contract include (non-exhaustive):

- MTM providers
- MSF and nutrition providers such as produce prescription services providers
- Medically tailored or supportive grocery providers (e.g., food banks)
- Home delivered meal providers
- Area Agencies on Aging

- Nutrition services providers with expertise serving pregnant and postpartum individuals
- Nutritional education providers to help sustain healthy cooking and eating habits

Monitoring of MTM/MSF Community Supports Providers by MCPs

MCPs are responsible for ensuring and documenting that their MTM/MSF Community Supports Providers are providing MTM/MSF services that follow this service definition, via their provider contracts and ongoing monitoring.

As part of their compliance oversight, MCPs should collect and regularly refresh information about programs and services from MTM/MSF Community Supports providers. Suggested domains to ensure compliance with the Community Support service definition include:

- Nutrition standards used by the provider, including the processes, qualifications of the clinical staff and/or RDN staff, and guidelines used to develop standards;
- Nutritional information of MTMs or grocery services, including specific macro- and/or micro-nutrient thresholds utilized to ensure that the meals or food packages are tailored for the targeted chronic or serious conditions;
- Average energy content and ingredients used in the meals and food packages;
- Providers' food preparation licensure, recent inspection records, and/or food safety violations with the relevant food safety regulatory agency;
- Service locations, meal production location, and transparency in units of meals, groceries or produce distributed (e.g., number of servings provided).

In addition, MCPs should routinely audit their MTM/MSF providers including validating, through review of case files, whether each provider adheres to the criteria outlined above and demonstrates ongoing compliance. To the extent the MCP identifies concerns or violations, the MCP should take any necessary enforcement actions, including corrective action or contract terminations as needed.

Finally, to identify opportunities for ongoing quality improvement and effectiveness of this Community Support, MCPs are encouraged to routinely collect information regarding Member adherence with the MTM/MSF intervention and assessing whether Members with strong adherence had improved health outcomes and whether those Members with low adherence could have modified interventions to support MTM/MSF service adherence, and thereby improved health outcomes.

HCPCS Codes for MTM/MSF

Listed below are the HCPCS code and modifier combinations that must be used for MTM/MSF. See Section VII for more information about Billing & Payments for Community Supports.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
S5170	Home delivered prepared meal	U6	Used with HCPCS code S5170 to indicate Community Supports Medically Tailored Meals/Medically Supportive Food
S9470	Nutritional counseling, diet	U6	Used with HCPCS code S9470 to indicate Community Supports Medically Tailored Meals/Medically Supportive Food
S9977	Meals; per diem, not otherwise specified	U6	Used with HCPCS code S9977 to indicate Community Supports Medically Tailored Meals/Medically Supportive Food

Sobering Centers

Description/Overview

Sobering Centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are experiencing homelessness or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering Centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and, for those experiencing homelessness, care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnerships with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering Centers must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

Individuals ages 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

This service is covered for a duration of less than 24 hours.

Licensing/Allowable Providers for Sobering Centers

This list is provided as an example of the types of providers Medi-Cal MCPs may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal MCPs should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal MCPs must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal MCPs shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

HCPCS Codes for Sobering Centers

Listed below are the HCPCS code and modifier combinations that must be used for Sobering Centers. See Section VII for more information about Billing & Payments for Community Supports.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
H0014	Alcohol and/or drug services; ambulatory detoxification	U6	Used with HCPCS code H0014 to indicate Community Supports Sobering Centers

Asthma Remediation

(Updated February 2025)[44]

Description/Overview

Asthma Remediation can prevent acute asthma episodes that could result in the need for emergency services and hospitalization. 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.[45]

Asthma Remediation should supplement the Asthma Preventive Services (APS) Medi-Cal State Plan service.[46] APS covers clinic-based asthma self-management education, home-based 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.

Effective January 1, 2026: Removal of In-Home Environmental Trigger Assessments and Asthma Self-Management Education from the Asthma Remediation Community Support
DHCS launched the APS benefit in July 2022, six months after the Asthma Remediation Community Support. The CalAIM Special Terms and Conditions[47] require that

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[44] This service definition was updated and published in February 2025 in a document titled Community Supports: Select Service Definition Updates. This section incorporates all refinements made in February 2025 and is effective January 1, 2026. For additional detail on the refinements, see Appendix B.

[45] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided, and Community Supports should be complementary. (See the U.S. Department of Housing and Urban Guide to Sustaining Effective Asthma Home Intervention Programs; Appendix B. Available at https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf. Accessed April 2025.)

[46] For additional information, see the Medi-Cal Provider Manual for Asthma Preventive Services. April 2025. Available at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=clinics-and-hospitals. Accessed April 2025.

[47] DHCS. *CalAIM Special Terms and Conditions.* August 2023. Available at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-ManagedCare-Amendment-Approved.pdf. Accessed April 2025.

Community Supports must supplement and not supplant services received by the Medi-Cal Member through other State, local, or federally funded programs. To implement this requirement, DHCS is updating Asthma Remediation Community Support effective January 1, 2026: asthma self-management education and in-home environmental trigger assessments must be covered by MCPs under the APS benefit and will no longer be covered under this Community Support.

MCPs and Community Supports Providers are strongly encouraged to implement this policy sooner than January 1, 2026, and ensure Members utilize the APS benefit for asthma self-management and in-home trigger assessments, as appropriate. The remaining updates to the service definition are effective July 1, 2025.

DHCS is providing a phase-out period for asthma self-management education and in-home environmental trigger assessments from the Asthma Remediation Community Support to allow Community Supports Providers that are not currently enrolled with the Medi-Cal program to enroll and seek reimbursement under APS. Throughout 2025, MCPs may still cover asthma self-management education and in-home environmental trigger assessments under the Asthma Remediation Community Support as long as the Member meets eligibility criteria as outlined below.

Supplies and physical modifications for Asthma Remediation covered under this Community Support include, but are not limited to:

- Allergen-impermeable mattress and pillow dustcovers
- High-efficiency particulate air (HEPA) mechanical filtered vacuums
- Integrated Pest Management (IPM) services[48]
- De-humidifiers
- Mechanical air filters/air cleaners[49]

[48] For additional information about Integrated Pest Management, visit https://www.cdpr.ca.gov/docs/pestmgt/ipminov/overview.htm. Accessed April 2025.

[49] Air cleaners that are listed as "Mechanical" are those that only use physical filtration, such as pleated or HEPA-style filters, and do not generate ozone or ions and are not classified as "electronic" which can generate ozone and other reactive compounds that harm health. For California Air Resources Board's list of certified air cleaners, see: https://ww2.arb.ca.gov/list-carb-

- 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

The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver. Services provided to a Member need not be carried out at the same time but may be spread over time, subject to lifetime maximums below.

From January 1, 2025 to December 31, 2025, MCPs should transition coverage for in-home environmental trigger assessments and asthma self-management education to the APS benefit but may cover the following under the Community Support, as medically necessary, through December 31, 2025:

- In-home environmental trigger assessments are defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants. This assessment guides the supplies, home modifications, and asthma self-management education about actions to mitigate or control environmental exposures offered to the Member.
- Asthma self-management education can include, but is not limited to:
    - Teaching Members how to manage their asthma, including how to use inhalers
    - Teaching Members how to identify environmental triggers commonly found in their own home, including allergens and irritants
    - Informing Members about various options for reducing environmental triggers such as using dust-proof mattresses and pillow covers, asthma-friendly cleaning products, air filters, etc.

certified-air-cleaning-devices. (Accessed April 2025) Note the list includes both mechanical and electronic cleaners; for the purposes of Asthma Remediation, only mechanical options are permitted.

Eligibility (Population Subset)

- Members with a completed in-home environmental trigger assessment within the last 12 months through the Asthma Preventive Services benefit that identifies medically appropriate Asthma Remediations and specifies how the interventions meet the needs of the Member. Effective January 1, 2026, MCPs must cover in-home environmental trigger assessments through the APS benefit, as described above.

  When authorizing physical modifications and supplies for Asthma Remediation as a Community Support, MCPs must receive and document that an assessment is completed, as outlined above. An in-home trigger assessment within the last 12 months, assuming no change in the Member's residence, provided under the APSs benefit suffices as a medical appropriateness determination for Asthma Remediation. No further documentation of medical appropriateness is required for the MCP to authorize Asthma Remediation.

- *From January 1, 2025 to December 31, 2025 only,* if the Member is receiving the in-home environmental trigger assessment or asthma self-management education through the Asthma Remediation Community Support, they must:

  - Have poorly controlled asthma (defined as an emergency department visit or hospitalization or two sick or urgent care visits due to asthma in the past 12 months, or a score of 19 or lower on the Asthma Control Test), or otherwise have a recommendation from a licensed health care provider (e.g., physician, nurse practitioner, or physician assistant) that the service will likely avoid asthma-related hospitalizations, emergency department visits, and/or other high-cost services.

Payments to Providers

MCPs and Community Supports Providers are also reminded that payments to providers for the APS benefit under managed care do not have to mirror the Fee Schedule for Fee-For-Service APS reimbursement. Network agreements with Community Supports Providers should include Community Supports Provider payment rates, which may differ from the FFS rates.

Restrictions/Limitations

- If another State Plan service beyond the APS, such as Durable Medical Equipment (DME), is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, the State Plan service should be accessed first.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.
- Asthma Remediation home modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the MCP must provide the owner and Member with written documentation that the modifications are permanent and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable mattress and pillow dust covers, high-efficiency particulate air (HEPA) filtered vacuum, de-humidifiers, portable air filters, and asthma-friendly cleaning products and supplies.

Licensing/Allowable Providers for Asthma Remediation

This list is provided as an example of the types of providers MCPs may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Lung health organizations
- Healthy housing organizations

- Local health departments
- Community-based providers and organizations

Physical adaptation to a residence covered by Asthma Remediation must be performed by an individual holding a California Contractor's License.

- Medi-Cal MCPs must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal MCPs shall monitor the provision of all the services included above.
- All allowable providers must be approved by the MCP to ensure adequate experience and appropriate quality of care standards are maintained.

Asthma Remediation Providers must enroll in the Medi-Cal program to continue providing in-home trigger assessments and asthma self-management education under the APS benefit.[50]

HCPCS Codes for Asthma Remediation

Listed below are the HCPCS code and modifier combinations that must be used for Asthma Remediation. See Section VII for more information about Billing & Payments for Community Supports.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
S5165	Home modifications; per service	U5	Used with HCPCS code S5165 to indicate Community Supports Asthma Remediation

[50] For additional information, see the *Medi-Cal Provider Manual for Asthma Preventive Services*. April 2025. Available at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=clinics-and-hospitals. Accessed April 2025.

IV. ENGAGING MEMBERS IN COMMUNITY SUPPORTS

As previously outlined, **DHCS expects MCPs to source the majority of referrals for Community Supports from the community**—i.e., from the MCP's network of providers (including ECM and Community Supports Providers) and other clinical and community-based partners, regardless of whether those partners directly deliver Community Supports.

Referrals to Community Supports

MCPs are required to use a variety of methods to identify Members who may benefit from Community Supports. One important method for Member identification is through referrals. DHCS expects MCPs to establish strong referral relationships with Community Supports Providers and a wide broad range of organizations in the community, including developing a process for receiving and responding to referral requests from a wide range of sources.

MCPs are required to inform Members and their networks of providers about Community Supports and what the process is to request authorization of Community Supports. MCPs must consider requests for Community Supports from Members and on behalf of Members from their families, guardians and caregivers, ECM Providers, Community Supports Providers, other providers and Community-Based Organizations (CBOs). MCPs must also train their call centers about how to manage referrals for Community Supports.

(Added April 2025) **Closed-Loop Referral (CLR) Requirements:** In addition to the guidance provided in this Policy Guide, the DHCS CLR Implementation Guidance[51] details MCP requirements for tracking, supporting, and monitoring referrals made to ECM and Community Supports.[52] Community Supports CLR requirements take effect on

[51] DHCS. *CLR Implementation Guidance*. Available at https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx. Accessed April 2025.

[52] Due to the real-time nature of the provision of services via Sobering Centers, CLR requirements do not apply to the Sobering Centers Community Support. For additional details on MCP and Provider data exchange to support CLR tracking, also see the *DHCS Community Supports Member Information Sharing Guidance*. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx. Accessed April 2025.

July 1, 2025, and apply to community referrals—including those from Members and caregivers—and referrals generated by MCP data-driven practices.

Under CLR requirements, MCPs must track referral source mix in pursuit of having a majority of Community Supports referrals originate from community-based sources, rather than from the MCP itself.

Requirement to Publish Information about Offered Community Supports

To promote access to Community Supports, MCP websites must be updated to include the following for ECM and Community Supports:

- Up-to-date Member and provider facing information about ECM and Community Supports and how to request authorization of ECM and Community Supports.
- As required in A.B. 133 14184.206(e), Cal Assembly, 2021 Reg. Sess. (CA 2021):[53] Up-to-date information about all the Community Supports being offered by the MCP, including, at minimum:
    - A short description of each available service that is consistent with the service definitions listed in the DHCS Community Supports Policy Guide. Terminology should not differ from DHCS' terminology.
    - All populations they have optionally elected to cover for Transitional Rent, as well as the associated eligibility requirements. (See additional detail on the Transitional Rent populations of focus in Volume 2.)
    - Member and provider facing information about how to refer and request authorization for the Community Supports offered by the MCP.

Authorization Process

To support Members' access to any offered Community Supports, MCPs must have nondiscriminatory authorization processes in place to determine Member eligibility for

[53] California Assembly Bill 133. *Committee on Budget. Health, Chapter 143, Statutes of 2021*. Available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133. Accessed April 2025.

each Community Support, in accordance with the service definitions and the MCP's contract with DHCS.

As part of the authorization process, MCPs must clearly outline their process for ensuring documentation of the medical appropriateness of the Community Support. This process must detail that provision of the Community Support, recommended by a provider at the MCP or network level using their professional judgment, is likely to reduce or prevent the need for acute care or other Medi-Cal services, including, but not limited to, inpatient hospitalizations, skilled nursing facility stays, or emergency department visits.[54] Thus, the Community Support is medically appropriate for that Member.

This process may be incorporated into the MCP's utilization management process or may include provider-level documentation in a Member's care plan or other record. The service definitions for several Community Supports already require this documentation. For example:

- When authorizing Environmental Accessibility Adaptations as a Community Support, MCPs must receive and document an order from the Member's current primary care physician or other health care professional specifying the requested equipment or service and a description of how the equipment or service meets the medical needs of the Member with supporting documentation describing the efficacy of the of the equipment or service, where appropriate.
- Effective January 1, 2026, when authorizing Asthma Remediation Services, MCPs must receive and document an in-home environmental trigger assessment through the Asthma Preventive Services benefit that identifies medically appropriate Asthma Remediation and specifies how the interventions meet the needs of the Member. No additional documentation of medical appropriateness from a provider is necessary.

In addition to these specific examples, most Members who receive Community Supports will also qualify for either ECM or Complex Case Management (CCM). In these instances, MCPs may use ECM or CCM care plans to document Member needs that qualify them for a Community Support and ensure it is a medically appropriate substitute for a State

[54] When authorizing a Community Support for a Member who has disclosed experiencing intimate partner violence (IPV), MCPs must ensure that their process for documenting the medical necessity of that Community Support is in accordance with federal, state, and local privacy and confidentiality laws.

Plan service. This process may apply to any Community Support provided to a Member who is also engaged in one of these care/case management programs.

Requirement for Expedited Authorization Timeframes

MCPs must have Policies and Procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate. MCPs are required to submit their Policies and Procedures for situations that may be appropriate for expedited authorization of a Community Support (e.g., for sobering center visits with a 48-hour+ authorization timeline would preclude effective use of the service). DHCS determined the following Community Supports are inherently time sensitive and therefore must be subject to expedited authorization if offered:

- Recuperative Care[55]
- Short-Term Post-Hospitalization Housing[55]
- Sobering Centers

MCPs are encouraged to consider working with Community Supports Providers to define a process and appropriate circumstances for streamlined authorization of all Community Supports offered.

Prime and Subcontracted MCP Authorization Alignment

For each Community Support commonly offered across a Prime MCP and its Subcontractor(s), the Prime MCP is responsible for ensuring alignment of all standards and Policies and Procedures related to authorizations for the Community Support, including both the adjudication standards and the documentation used for referrals and authorizations. The Prime MCP is also responsible for ensuring that Community Supports are equitably available to all Members in the counties where those Community Supports are offered. As such, if a Member of a Prime MCP or a Subcontracted MCP requests or is referred to a Community Support that is offered by the Prime MCP **or** any of its Subcontractors in the county where the Member resides, and if the Member meets the eligibility criteria for that Community Support, then the Prime MCP must ensure the Member has access to that Community Support. To accomplish this, the Prime MCP has the following options, provided there are sufficient Community Supports Providers in the given service area(s)/counties in which the Prime MCP and Subcontracted MCP operate:

[55] This service definition is located in Volume 2 of the Community Supports Policy Guide.

- The Prime MCP requires its subcontractor to offer the Community Support;
- The Prime MCP directly facilitates access to the Community Support, even though the Member remains enrolled in the Subcontracted MCP; or
- The Prime MCP helps facilitate the transition from the Member's current MCP to a MCP that offers the Community Support, which could be the Prime MCP or another Subcontractor MCP that offers that Community Support.

The Prime MCP must describe in its Model of Care (MOC) submitted to DHCS which of the approaches above it will implement to ensure equitable access for all its Members to Community Supports in a given county.

The Prime MCP must ensure that all Community Supports it elects to offer are also offered by its Subcontracted MCP to ensure all Members can access the same set of Community Supports.

Continuity of Care for Authorizations for Members Receiving Community Supports Moving to Another MCP

If a Member transitions to a new MCP and the new MCP offers the same Community Support(s) that the Member received under their previous MCP, then the new MCP must honor the Community Support authorization for that Member. Where the new MCP offers the same Community Supports(s) as the previous MCP, the new MCP must:

- Automatically authorize newly enrolled Members who were receiving a Community Support through their previous MCP, adapting the specifications (e.g., amount and duration) to be consistent with the parameters of the new MCP's offered Community Support.
- Have a process for engaging the previous MCP, Member, and/or Community Supports Provider to mitigate gaps in care.
- Have a process for reviewing historical utilization data using a 90-day look-back period to identify Members receiving Community Supports.

The MCP is also encouraged to bring in network new Members' out-of-network Community Supports Providers.

For Community Supports with a lifetime maximum, or with other maximums (such as during the demonstration period; or 6-month maximums during a rolling 12-month period as is applicable for Community Supports services with a Room and Board component), MCPs must track and apply Continuity of Care if Members have not reached their applicable maximums.

Graduation/Deauthorization Process

MCPs must have processes in place for "graduating" or discontinuing Community Supports for Members who no longer qualify for, no longer require, or no longer want to receive Community Supports services.

A Notice of Action letter is necessary to inform the Member when the Community Support service is ending or discontinuing. However, NOAs are not needed if the Member was informed at the beginning of service delivery (i.e., when a Medically Tailored Meal service is authorized for three months, the Member is informed at the beginning of the authorized period of service). It is also not necessary if the Member has opted out of the Community Support service.

(Updated April 2025) Grievances and Appeals

Requests for authorization of Community Supports via referral are subject to state and federal requirements for grievances, appeals, and noticing outlined in APL 21-011.[56] Members always retain the right to file appeals and/or grievances if they request one or more Community Support offered by the MCP but were not authorized to receive the requested Community Support because of an adverse service determination (i.e., that it was not medically appropriate; the Member did not meet eligibility criteria; or the provider requesting the service was not eligible to deliver the Community Support). Community Supports are also subject to the State Hearings process.

[56] DHCS. *Grievance and Appeal Requirements, Notice and "Your Rights" Templates*. August 2022. Available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf. Accessed April 2025.

V. PROVIDER CONTRACTING, ENROLLMENT, CREDENTIALING, AND VETTING REQUIREMENTS

Contracting with Local Community Supports Providers with Specialized Skills or Expertise

CalAIM has challenged MCPs to work and contract with a new set of "non-traditional" Providers that offer services and supports that historically have not been well integrated into the health care system. These Providers include, but are not limited to, housing service providers, home modification companies, sobering centers, intimate partner violence (IPV) and domestic violence shelters and organizations (including those serving pregnant and postpartum Members and families), and organizations that prepare and deliver medically-tailored food and nutrition. While many MCPs and Community Supports Providers have some experience working together, particularly in former WPC Pilot counties, CalAIM is designed to encourage and support broader contracting and partnerships throughout the state. **MCPs should contract with organizations that have experience delivering Community Supports services and an existing footprint in the communities they serve**, working with the populations eligible to receive Community Supports. Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. MCPs are encouraged to be innovative in exploring new partnerships.

DHCS expects MCPs to prioritize contracting with qualified, locally-based providers who can work to close existing equity gaps and are culturally responsive to their community. DHCS expects MCPs to vet entities as part of their credentialing and contracting processes to ensure Community Supports Providers, as Network Providers, can deliver services in accordance with the guidelines described below.

DHCS encourages MCPs to leverage community care hubs, which are organizations that centralize administrative functions for Medi-Cal providers of Community Supports, ECM, and other Medi-Cal services, acting as intermediaries between MCPs and community-based providers.[57]

[57] Donnelly, J., Nielson, B., & Owens, B. October 2024. *Exploring Emerging Medi-Cal Community Care Hubs*, *California Health Care Foundation*. Available at https://www.chcf.org/publication/exploring-emerging-medi-cal-community-care-hubs/. Accessed April 2025.

(Updated April 2025) Community Supports Providers as Medi-Cal Enrolled Providers

MCP Network Providers (including those operating as Community Supports Providers) are required to enroll as Medi-Cal Providers **if there is a state-level enrollment pathway available**. For more information on Medi-Cal enrollment pathways and processes, see the Provider Application and Validation for Enrollment (PAVE)[58] portal.

Requirements where a state-level enrollment pathway is in place: For those Community Supports Providers with a state-level Medi-Cal enrollment pathway, the Provider must enroll through the DHCS Provider Enrollment Division, or the MCP may choose to implement a separate enrollment process.

DHCS has created enrollment pathways for certain Community-Based Organizations (CBOs) including Community Health Worker (CHW), Asthma Preventive Services (APS), and justice-involved (JI) services. Local Health Jurisdictions (LHJs) and County Children and Families Commissions that provide CHW or AP services may also apply to enroll in the Medi-Cal program by submitting an electronic application through the PAVE online enrollment portal, along with all supporting documentation.[59]

The CHW enrollment pathway is intended for providers delivering the CHW Benefit and is not a required state-level enrollment pathway for all organizations that employ CHWs as staffing for their service models (e.g., Community Supports Providers with CHWs on staff who don't contract to provide the CHW Benefit).

Requirements when a state-level enrollment pathway is not in place: Other Community Supports Providers without a state-level enrollment pathway (e.g., housing agencies, medically tailored meal providers) are not required to enroll in the Medi-Cal program. Instead, these Providers must be vetted by the MCP to participate as Community Supports Providers. To include a Community Supports Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs must vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to serve as a Community Supports Provider. This vetting may extend to individuals employed by or delivering services on behalf of the

[58] DHCS. *Provider Application and Validation for Enrollment Portal.* Available at https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx. Accessed April 2025.

[59] For more details, see *CBO LHJ Application Information.* Available at https://www.dhcs.ca.gov/provgovpart/Pages/CBO-LHJ-CCFC-Application-Information.aspx. Accessed April 2025.

Community Supports Provider, ensuring they can meet the capabilities and standards required to serve as a Community Supports Provider. MCPs must submit Policies and Procedures in their MOC submissions detailing how they will vet the qualifications of ECM and Community Supports Providers. MCPs must create and implement their own processes to do so. Factors MCPs should consider as part of their process include, but are not limited to:

- Ability to receive referrals from MCPs for the authorized Community Supports;
- Sufficient experience in providing services similar to the specific Community Supports for which they are contracted to provide within the service area;
- Ability to submit claims or invoices for Community Supports using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste, and/or abuse;
- Recent history of criminal activity, including any criminal activities that endanger Members and/or their families; and
- History of liability claims against the Provider.

MCPs should consider the evolving landscape of Community Supports Providers and requirements they have voluntarily enacted to credential and/or accredit service providers. Examples include the Food is Medicine Coalition MTM Intervention Accreditation Criteria[60] for MTM agencies and the Requirements and the National Institute for Medical Respite Care Certification for Medical Respite Programs.[61]

[60] For additional information see *Food is Medicine Coalition MTM Intervention Accreditation* Criteria. Available at https://fimcoalition.org/programs/fimc-accreditation/. Accessed April 2025.

[61] For additional information see *Requirements and the National Institute for Medical Respite Care Certification for Medical Respite Programs*. Available at https://nhchc.org/medical-respite/nimrc/certification/. Accessed April 2025.

VI. DATA SYSTEMS AND DATA SHARING

The vision of Community Supports is to embrace and integrate a diverse range of Providers in the delivery of whole-person care, beyond traditional health care Providers. DHCS acknowledges the significant investment required of both MCPs and Provider organizations to realize this from an information technology infrastructure and data sharing perspective. To that end, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and Community Supports Providers.

Data System Requirements

MCPs must have an IT infrastructure and data analytic capabilities to support Community Supports, including the following capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in Community Supports Contract Template Section 7: Identifying Members for Community Supports;
- Assign Members to Community Supports Providers;
- Maintain records of Members receiving Community Supports and their consent;
- Securely share data with Community Supports Providers;
- Receive, process, and submit encounters and invoices from Community Supports Providers to DHCS in accordance with DHCS standards;
- Receive and process supplemental reports from Community Supports Providers;
- Submit Community Supports supplemental reports to DHCS; and
- Open, track, and manage referrals to Community Supports Providers.[62]

Community Supports Providers and MCPs may need to reconfigure their existing systems to meet these requirements.

(Updated July 2023) To mitigate administrative burden on Community Supports Providers who contract with more than one MCP in particular, MCPs **may not require** Community Supports Providers to utilize their MCP portal for documentation of all services and day-to-day work, such as notes and care plans. MCPs **may** rely on portals

[62] DHCS. *Community Supports Member Information Sharing Guidance*. December 2024. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx. Accessed April 2025.

for sharing the information contained in the Member Information Sharing Guidance document (below). Furthermore, MCPs may still offer access to MCP's care management documentation system for all functions, and Providers may still choose to take this option. MCPs who may be unsure of how to strike the required balance between robust data sharing with providers and mitigating administrative burden on providers, should contact DHCS for a discussion.

VII. CODING, BILLING, AND PROVIDER PAYMENTS

DHCS' vision is that Community Supports Providers will submit compliant 837P encounters to MCPs for submission to DHCS. Providers that do not have these capabilities can submit invoices to MCPs using a standardized format, and MCPs will then convert the invoices to encounters for submission to the DHCS.

Procedure Coding Guidance

Each service definition provided in this Policy Guide and Volume 2 of the Community Supports Policy Guide lists the procedure codes, using the HCPCS codes that must be used for Community Supports services. The HCPCS code and related modifier combined define the service as Community Supports. MCPs must use the HCPCS codes and modifiers listed in DHCS' guidance, including the ECM and Community Supports HCPCS Coding Guidance,[63] to report Community Supports services. For example, HCPCS code "H0043" by itself does not define the service as a Housing Transition Navigation Services Community Supports service for billing purposes; it must be reported with modifier "U6" for the supported housing services to be defined and categorized as a Community Supports service.

DHCS expects MCPs to support their Community Supports Providers in reporting and translating their delivered Community Supports to these required HCPCS codes.

(Added January 2024) MCPs may not require or allow Community Supports Providers to report codes or modifiers for Community Supports services beyond those included in this guidance, even if the MCP and Community Supports Provider mutually agree to the additional codes/modifiers. MCPs may utilize alternative payment approaches with Community Supports Providers, as long as service records continue to be reliably reported using the included HCPCS codes and modifiers. For example, an MCP might opt to pay a Provider for Housing Transition Navigation Services in a per Member per month (PMPM) payment. However, that MCP must still require the Provider to report the HCPCS codes and modifiers below, which are on a standard per diem basis.

[63] DHCS. *ECM and Community Supports HCPCS Coding Guidance*. June 2024. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx. Accessed April 2025.

(1) If a Community Supports service is provided through telehealth, the modifier "GQ," must be used.[64]

(2) Some Community Supports services have more than one coding option. For these services, MCPs may determine which codes to require their Community Supports Providers to use. For example, MCPs may require their Community Supports Providers to bill short-term post-hospitalization housing on **either** a per diem (H0043, U3) **or** per month (H0044, U3) basis.

(3) For the Community Supports services that allow for billing in 15-minute increments, MCPs should work with their Community Supports Providers to adhere to the "Rule of Eights": at least eight minutes of treatment must occur to bill for the first 15-minute increment, and for each subsequent 15-minute increment thereafter.

(Updated April 2025) Place of Service (POS) Codes

MCPs and Community Supports Providers must use appropriate Place of Service (POS) codes when submitting claims and encounter data for Community Supports. The accurate use of POS codes is necessary to ensure proper documentation, adjudication, and reporting of services delivered in various settings.

DHCS aligns POS code expectations with existing Medi-Cal billing policies. MCPs must follow the applicable guidance outlined in the Medi-Cal Provider Manual, Medi-Cal Billing Manual, and any APLs issued by DHCS. This includes using POS codes that accurately reflect the physical or virtual setting in which the Community Support was provided.

MCPs are responsible for ensuring that contracted Providers understand and apply the correct POS codes in accordance with DHCS policy. For Community Supports delivered in non-traditional settings (e.g., in the field, in temporary housing sites), MCPs should refer Providers to the Medi-Cal Billing Manual for additional specificity on POS code selection and application.

Additionally, accurate POS code reporting is essential for identifying services subject to Electronic Visit Verification (EVV) requirements. MCPs and Providers must ensure

[64] All telehealth services must be provided in accordance with DHCS policy. For more information, refer to DHCS' *Medi-Cal Provider Manuals*. Available at https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Medi-CalProviderManuals.aspx. Accessed April 2025.

alignment between POS coding and EVV reporting, where applicable, in accordance with federal and state EVV policies. For more information on EVV requirements, MCPs should refer to DHCS EVV guidance[65] and applicable APLs, including APL 22-014.[66]

MCPs must also ensure that the POS codes used are compatible with DHCS-approved HCPCS codes and modifiers for Community Supports, as outlined in this Policy Guide.

Community Supports Billing and Invoicing Guidance

DHCS has developed comprehensive guidance that describes the minimum set of data elements required to be included in an invoice submitted to MCPs, available from the CalAIM Data Guidance: Billing and Invoicing between ECM/Community Supports Providers and MCPs.[67]

As established in the ECM and Community Supports Billing and Invoicing Guidance, MCPs must require their contracted Community Supports Providers to submit claims for the provision of Community Supports services using the national standard specifications and DHCS-established code sets contained in this document. MCPs must require their contracted Community Supports Providers to submit claims for the provision of Community Supports services using the national standard specifications and DHCS-established code sets contained in this document.

Community Supports Provider Payments

DHCS does not set Provider rates for Community Supports. Community Supports Payments rates as well as payment arrangements are negotiated between MCPs and Community Supports Providers and should be clarified in the Network Agreement between the MCP or their Subcontractor and the Community Support Provider.

In recognition that MCPs and Community Supports Providers are required to engage in new contracting and payment relationships, DHCS published a **Non-Binding Community Supports Pricing Guidance** document in 2022. It offers historical information on potential rates for each of the 14 optional Community Supports,

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[65] DHCS. *California Electronic Visit Verification*. Available at https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx. Accessed April 2025.

[66] DHCS. *Electronic Visit Verification Implementation Requirements*. July 2022. Available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-014.pdf. Accessed April 2025.

[67] DHCS. *ECM and Community Supports Billing and Invoicing Guidance*. April 2023. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx. Accessed April 2025.

including historical mid-point benchmarks and a discussion of key cost drivers that MCPs and Community Supports Providers may want to consider as they establish their own contracting and payment arrangements. The Non-Binding Community Supports Pricing Guidance can be accessed from the Community Supports Resource Directory.[68] DHCS intends to update this resource in 2025.

Transitional Rent has a unique payment model with MCP payments being made outside capitation rates to MCPs, explained in Volume 2.

Community Supports are subject to the same standard reimbursement timelines as other Medi-Cal services. These requirements **pertain to both invoices and claims submitted by Community Supports Providers**. MCPs are required to train their contracted network of Community Supports Providers on how to submit a clean claim and must have personnel available to troubleshoot issues with Community Supports providers. Please refer APL 23-020[69] or any updated or superseded APL for related requirements.

[68] DHCS. *Community Supports Resource Directory*. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx. Accessed April 2025.

[69] DHCS. *APL 23-020*. October 2023. Available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-020.pdf. Accessed April 2025.

VIII. MONITORING, REPORTING, AND ENFORCEMENT

(Updated April 2025)

Consistent with the Special Terms and Conditions (STCs) of California's Section 1115 and Section 1915(b) waivers,[70] DHCS has implemented a multi-pronged, data-driven approach to monitor and report on MCP implementation of Community Supports. As described in this section, this approach includes:

- MCP's Model of Care and ongoing data submissions to monitor Community Supports implementation;
- Monitoring of MCP compliance and performance, including oversight of Subcontractors;
- Public reporting through the Quarterly Implementation Report;;
- Annual reports to CMS;
- An independent evaluation of Community Supports; and
- Enforcement for non-compliance.

MCP Model of Care and Ongoing Data Submissions to Monitor Community Supports

To support the STCs outlined above, DHCS requires MCPs to submit a range of data prior to and during the provision of Community Supports that are further outlined in the sections that follow. MCPs are required to submit the following to DHCS:

- A Community Supports Model of Care; and
- Ongoing and regular data:
    - Encounter Data,
    - Provider 274 Files,
    - Quarterly Implementation Monitoring Reports (QIMRs), and

[70] Per the STCs of California's Section 1915(b) waiver, DHCS "must monitor ILOS, using appropriate quantitative and qualitative measures, no less than annually, to ensure compliance with federal requirements, including that each ILOS remains a medically appropriate and cost effective substitute for the service(s) or setting(s) covered under the state plan."

- JavaScript Object Notation (JSON) Reports.

Model of Care (MOC) Template and Approval Process

MCPs are required to detail their Community Supports offerings in their Community Supports Model of Care (MOC) Template submissions to DHCS. DHCS has also developed a separate Transitional Rent MOC Template that MCPs are required to submit to DHCS (see below for details).

Standard Community Supports MOC Template: Each Community Supports MOC must include the specific Community Supports elected and the expected launch date for each. Each MOC must also demonstrate the MCPs' operational readiness to go live with each of the Community Supports they have opted to elect by including responses to questions across a range of areas such as:

- Policies and procedures for operationalizing the services;
- Detailed Policies and Procedures regarding Community Supports Provider (including non-traditional Provider) contracting and oversight;
- Provider network capacity for each elected Community Support

MCPs submitted their initial Community Supports MOCs to DHCS for review and approval prior to initial Community Supports implementation in 2022. MCPs must update their Community Supports MOCs to reflect any changes to their Community Supports offerings and must submit an updated Community Supports MOC with each new election. MCPs may add Community Supports every six months and may choose to offer different Community Supports in different counties.[71]

MCPs may terminate any optional[72] Community Support upon notice to DHCS once annually at the end of the calendar year, except in cases where the Community Support

[71] Prior to the launch of Community Supports in 2022, MCPs may have offered similar services that address Members' Social Drivers of Health needs (e.g., meals) through "value-added services." MCPs that are continuing to deliver such services but who are not considering them to be Community Supports must evaluate and determine the feasibility of transitioning them into the Community Supports program, engaging with DHCS for technical assistance as necessary. Per 42 CFR section 438.3(e)(1), MCPs may continue to provide such services even if it is determined that the services cannot transition to the Community Supports program.

[72] Effective January 1, 2026, MCP coverage of Transitional Rent is mandatory for the Transitional Rent Behavioral Health Population of Focus. (See additional detail in Community Supports Policy Guide Volume 2.)

is terminated due to Member health, safety, or welfare concerns. If an MCP terminates a Community Support, it must publicize the service end date, provide at least 30 days' notice to its Members, and implement a plan for continuity of care for Members receiving that Community Support.

Transitional Rent MOC Template: MCPs who opt to offer Transitional Rent starting on July 1, 2025, must submit a Transitional Rent MOCs by May 16, 2025. In advance of the mandatory coverage of the Behavioral Health POF on January 1, 2026, all MCPs are required to submit Transitional Rent MOCs by September 1, 2025. MCPs must update their Transitional Rent MOCs to reflect any additional Transitional Rent POFs covered and must submit an updated Transitional Rent MOC with each new election. MCPs may add Transitional Rent POFs every six months and may choose to cover different optional Transitional Rent POFs in different counties. Upon receiving approval, MCPs are required to continue offering Transitional Rent for each of the POFs they elect to cover for the duration of the BH-CONNECT waiver demonstration. (See additional details on the Transitional Rent Populations of Focus in Community Supports Policy Guide Volume 2.)

MCPs must use the DHCS-developed Community Supports MOC Template and Transitional Rent MOC Template to complete these submissions. The templates are available on the ECM and Community Supports Resource Webpage.[73]

The MOC review process is iterative. MCPs should anticipate feedback and potential requests from DHCS for clarification, revisions, or supplemental materials to support alignment with DHCS requirements.

Oversight of Subcontractors

For MCPs that delegate any functions to Subcontractors or Downstream Subcontractors, DHCS reminds MCPs of the following related requirements:

- MCPs will maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting.
- MCPs will be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors and Downstream Subcontractors meet required responsibilities and functions.

[73] DHCS. *ECM and Community Supports: Resources*. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx. Accessed April 2025.

- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services.
- MCPs will remain responsible for ensuring the Subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members.
- MCPs will report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served.[74]
- MCPs will make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, excluding method and amount of compensation unless otherwise specified in specific circumstances by DHCS.

As required in the MCP Contract (*Section 3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*), MCPs are required to flow down applicable MCP Contract provisions to the Subcontractor in particular as it pertains to delegated functions. MCPs are required to ensure Subcontractors and Downstream Subcontractors meet requirements through their Compliance Program, which would include monitoring and regular auditing. For example, if the MCP delegates payments of invoices to a Subcontractor, such as a Community Support hub, then the MCP must establish a sufficient oversight mechanism to ensure the hub is adjudicating and paying the invoices or claims of the contracted Community Supports Providers in a timely manner.

In addition, MCPs are encouraged to collaborate with their Subcontractors on the approach to Community Supports to minimize variance in implementation and to ensure a streamlined, seamless experience for Community Supports Providers and Members.

[74] Please refer to Section: 3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan of the MCP Contract.

Encounter Data Submission Requirements

DHCS requires Medi-Cal MCPs to submit claims and encounter data in accordance with MCP contract requirements, APL 14-019, and any subsequent updates or superseding APL.[75]

MCPs must submit encounter data for Community Supports through existing encounter reporting mechanisms for all covered services. MCPs are responsible for complete, timely and accurate data submissions including for their Network Providers and Subcontractors. Submissions must use the ASC X12 837 version 5010 x223 (Institutional and Professional transactions) or NCPDP 2.2 or 4.2, along with the applicable Community Supports coding requirements, and be submitted to the Post Adjudicated Claims and Encounters System (PACES).

DHCS reviews Community Supports encounter data to monitor program performance and integrity, and to assess the health and service needs of Medi-Cal Members.

Encounter data submission is also a requirement under the Special Terms and Conditions of California's Section 1115 and Section 1915(b) waivers. DHCS reports to CMS on the timeliness and accuracy of MCP-submitted encounter data as part of its Annual Report on ILOS. (See Annual Reports to CMS below for more detail.)

Community Supports Provider Reporting in 274

To enable ongoing monitoring of Community Supports Providers, DHCS requires MCPs to report Community Supports Providers in the Medi-Cal Provider Enrollment (274) file on an ongoing basis. This reporting ensures DHCS can assess network adequacy, monitor service delivery, and support quality improvement for Community Supports across the state.

MCPs must submit updated 274 files to DHCS quarterly, reflecting current information for all contracted Community Supports Providers, including any additions, terminations, or changes in provider status, in accordance with DHCS reporting standards and

[75] DHCS. *Encounter Data Submission Requirements*. December 2014. Available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-019.pdf. Accessed April 2025.

deadlines outlined in the MCP Contract and applicable APLs.[76] The 274 file must include, at a minimum, the provider's name, National Provider Identifier (NPI), contracted Community Supports services, and service area(s).

Submissions must be made through the DHCS Provider Enrollment Portal, with additional guidance available in the Medi-Cal Provider Enrollment Manual.

DHCS may conduct audits to verify compliance, and non-compliance may result in corrective action plans as outlined in the MCP Contract.

Quarterly Implementation Monitoring Report (QIMR)

Until otherwise directed, MCPs must submit data on the following using an Excel-based report, called the Quality Implementation Monitoring Report (QIMR):

- Members receiving Community Supports;
- Requests for Members to receive Community Supports; and
- Providers contracted to deliver Community Supports.

For further details see *ECM and Community Supports Quarterly Implementation Monitoring Report Requirements, (Selectively Updated in April 2023).*[77]

JavaScript Object Notation (JSON) Transition

By December 2025, DHCS intends to transition ECM and Community Supports monitoring from the QIMR Excel Reports to a monthly JSON file submission process. JSON, or JavaScript Object Notation, is an open standard file format that streamlines the collection and transmission of implementation data.

The transition from QIMR to JSON began in January of 2024 and is occurring in several phases:

[76] DHCS. *Medi-Cal Managed Care Health Plan Guidance on Network Provider Status*. January 2019. Available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-001.pdf. Accessed on April 2025.

[77] DHCS. *ECM and Community Supports Quarterly Implementation Monitoring Report Requirements*. April 2023. https://www.dhcs.ca.gov/Documents/MCQMD/Quarterly-Implementation-Monitoring-Report-Guidance.pdf. Accessed on April 2025.

- **Phase 1** (beginning January 2024): Limited data elements specific to Enhanced Care Management (ECM) and Complex Care Management (CCM) enrollment status.
- **Phase 2** (beginning July 2024): ECM Populations Of Focus, Eligibility, Outreach, Authorizations, and Provider Networks.
- **Phase 3** (beginning January 2025): New ECM data fields.
- **Phase 4** (beginning July 2025): All remaining QIMR data elements specific to Community Supports, including Member-level details, utilization, authorizations, provider networks, and Closed Loop Referrals data for ECM and Community Supports.

During the transition to JSON—anticipated to continue through at least the end of 2025—MCPs must continue submitting data via both the Quarterly Implementation Monitoring Report process and the monthly JSON file submission process. Dual reporting will remain in place until DHCS determines the JSON data are sufficiently robust to replace QIMR Excel reporting entirely.

DHCS has developed a Technical Assistance Companion Guide that includes all necessary technical specifications, including file layouts, JSON Schemas, response file details, and data dictionaries. A comprehensive Data Dictionary—describing required data values and associated validation logic—is also available. Both resources can be accessed through DHCS' Documentation Center.

DHCS Monitoring of MCPs

Throughout the year, DHCS monitors MCP performance of implementation activities of Community Supports and engages with MCP leadership to review progress.

DHCS monitors each MCP's implementation of Community Supports through ongoing review of:

- Required submissions described in the prior section, along with information shared during meetings and ad hoc requests;
- Member grievances and appeals; and
- Qualitative input from Members, providers, and stakeholders.

DHCS takes timely action to address issues identified through any of these sources, including through:

- Meetings with MCPs: DHCS holds regular and ad hoc meetings with MCP leadership to review Community Supports implementation and address emerging concerns.
- Technical Assistance: DHCS offers technical assistance through monthly MCP CalAIM Technical Assistance meetings and by publishing tools and resources on the DHCS website.
- Compliance Actions: MCP contracts outline specific Community Supports implementation requirements. DHCS may take compliance actions—consistent with APL 23-012[78]—to address contract violations. These may include, but are not limited to, Corrective Action Plans.

Annual Monitoring Measures and Priorities

In 2025, DHCS launched a new monitoring approach to assess MCP implementation of Community Supports through the use of monitoring measures. This approach is grounded in a central goal and a set of key priorities needed to achieve that goal:

- **Monitoring Goal:** Ensure MCPs provide Community Supports to Members who need them, engaging with community based providers to address Members' health-related social needs.
- **Key Priorities to Achieve the Goal:**
    1. Engage appropriate community based partners building and maintaining sufficient capacity to meet the varied needs of Members with health related social needs;
    2. Increase availability and uptake of Community Supports statewide; and
    3. Reduce barriers to providers and improve timely access to Community Supports services, as appropriate.

Across these priorities, DHCS identified measures in three categories based on data availability and the Department's readiness to set quantifiable minimum performance expectations:

[78] DHCS. *Enforcement Actions: Administrative and Monetary Sanctions*. December 2023. Available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-012.pdf. Accessed April 2025.

- Primary Measures: Evaluate compliance with DHCS policy, with specific minimum performance thresholds defined.
- Secondary Measures: Assess performance where quantitative data are available but minimum thresholds have not yet been established.
- Feedback and Event Priorities: Capture qualitative input and event-based insights from Members, providers, media, and other stakeholders.

Each calendar year, DHCS will identify measures in each category. The measures are calculated primarily using data already submitted to DHCS. In some cases, MCPs may be required to submit additional supplemental data.

Public Reporting

DHCS publishes quarterly data on Community Supports in the ECM & Community Supports Implementation Report.[79] The report summarizes data at the state, county, and MCP levels, covering indicators such as Community Support rate of offering by MCP and county; utilization rates; and type and counts of providers participating in MCP's provider networks. Data are from the most recent prior Quarterly Implementation Monitoring Report submissions from MCPs of the most recent completed JSON submissions.

DHCS expects to transition the data source for this report to JSON following the completion of the QIMR-to-JSON transition.

Annual Reports to CMS

As required by the Special Terms and Conditions of California's Section 1115 and Section 1915(b) waivers, DHCS submits an annual report on ILOS to CMS that includes the following:

- A description of programmatic or operational changes;
- Annual oversight and monitoring activities;
- Utilization data;
- Grievances and appeals data;
- Data related to health outcomes and quality metrics;

[79] DHCS. *ECM & Community Supports Implementation Report*. March 2025. Available at https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117. Accessed April 2025.

- Data on the timeliness and accuracy of MCP encounter data submitted to DHCS and T-MSIS data submitted to CMS; and
- Analyses on cost effectiveness of the services.

An Independent Evaluation of Community Supports per STCs

Consistent with the Special Terms and Conditions of California's Section 1115 and Section 1915(b) waivers, DHCS must conduct and submit to CMS an evaluation of Community Supports no later than 24 months after the completion of the first five MCP contract years to include Community Supports.

DHCS engaged the University of California Los Angeles-RAND Center for Law & Public Policy to conduct the independent evaluation of Community Supports.[80]

Enforcement of Non-Compliance

DHCS is obligated to enforce compliance with contractual provisions of the DHCS Contracts with MCPs including the requirement to comply requirements pertaining the delivery of Community Supports as outlined in this Policy Guide, related APL, MCP Contract requirements, and related federal and state requirements. DHCS may take corrective action plans or additional enforcement actions for contractual violations including non-payment of Community Supports Provider claims as outlined in APL 23-020 or any subsequent updated or superseded APL.

Please refer to APL 23-012 or any subsequent updated or superseded APL.[81]

[80] UCLA-RAND. *Community Support Evaluation Design*. October 2024. Available at https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx. Accessed April 2025.

[81] DHCS. *Enforcement Actions: Administrative and Monetary Sanctions*. December 2023. Available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-012.pdf. Accessed April 2025.

IX. APPENDICES

Appendix A: Community Supports to State Plan Service Crosswalk

Table 1 below summarizes potential state plan services or settings for which each of California's pre-approved Community Supports may substitute. Community Supports may represent an immediate substitute for a State Plan-covered service/setting or a substitute for a State Plan-covered service/setting over a longer timeframe. Additional historical detail on the cost-effectiveness and medical appropriateness of each service/setting is available in the CA ILOS Evidence Library Executive Summary document.[82] This document is for historical reference only.

Table 1. Community Supports to State Plan Service Crosswalk

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
1	**Respite Services**	Home Health Agency
		Home Health Aide
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Personal Care Services
		Skilled Nursing Facility Stay
		Targeted Case Management and Services
2	**Assisted Living Facility Transitions**	Emergency Transportation Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative

[82] DHCS. *CA ILOS Evidence Library Executive Summary document*. 2021. Available at https://www.dhcs.ca.gov/Documents/MCQMD/CA-ILOS-Evidence-Library-Executive-Summary-August-2021.pdf. Accessed April 2025.

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
3	**Community or Home Transition Services**	Emergency Transportation Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Intermediate Care Facility Services for the Developmentally Disabled – Nursing
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
4	**Personal Care and Homemaker Services**	Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
5	**Environmental Accessibility Adaptations (Home Modifications)**	Emergency Transportations
		Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Personal Care Services
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
6	**Medically Tailored Meals/Medically Supportive Foods**	Emergency Department Services
		Emergency Transportation Services
		Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Outpatient Hospital Services
		Personal Care Services
7	**Sobering Centers**	Emergency Department Services
		Emergency Transportation Services
		Inpatient Services
		Emergency Transportation Services
8	**Asthma Remediation**	Asthma-related primary care and specialty visits
		Emergency Department Services
		Home Health Aide
		Home Health Agency
		Inpatient Stay
		Outpatient Hospital Services
		Personal Care Services
		Emergency Transportation Services

Appendix B: Summary of February 2025 Service Definition Refinements

(Added February 2025) The following sections summarize the process DHCS engaged throughout 2024 to clarify and standardize key components of four Community Supports. DHCS originally released these descriptions in February 2025 and resulted in the final, updated service definitions included in the April 2025 version of this policy guide. The summary is provided here for reference for stakeholders, providers and MCPs in need of additional description of the clarifications made in February 2025.

DHCS will continue to solicit stakeholder feedback on further standardization for Community Supports in 2025 and 2026, including Respite Services.

Assisted Living Facility Transition

Summary of February 2025 Refinements

This service aims to divert and support Members who otherwise would receive skilled nursing facility (SNF) level of care (LOC) to an assisted living facility (ALF) both by providing support during the transition and by providing ongoing assisted living services during their tenancy. For the purposes of this service, the term "ALF" includes Residential Care Facilities for the Elderly (RCFEs) and Adult Residential Facilities (ARFs).

Since the initial launch of Community Supports, stakeholders have requested that DHCS clarify several aspects of this service definition, including eligibility criteria, service components, and overlapping enrollment with other Community Supports, 1915(c) waivers, and the California Community Transitions (CCT) demonstration.

In September 2024, DHCS released for stakeholder comment a set of clarifications and updates to this service definition and received 19 comments from a range of MCPs, providers, counties, and advocacy organizations. In response to these comments and other stakeholder discussions, DHCS is finalizing the following clarifications and updates:

- **Eligibility Criteria:** DHCS proposed clarifying that Members residing in a private residence are eligible for this service as long as they are transitioning to an ALF and meet the criteria for needing a nursing facility LOC. DHCS is finalizing these clarifications. In response to feedback, DHCS is also clarifying that Members transitioning from public subsidized housing to an ALF (not just from a "private residence" to an ALF) can receive this service. Finally, in response to stakeholder feedback, DHCS is finalizing that Members currently residing in an ALF can receive the ongoing assisted living services component

of this Community Support as a means of diversion from a SNF, if they meet the criteria for nursing facility LOC.

- **Service Components:** DHCS proposed clarifying that there are two distinct components of this Community Support:
  - Time-limited transition services and expenses, including one-time moving expenses such as movers/moving supplies; and
  - Ongoing assisted living services for the Member after transitioning into an ALF (excludes room and board). This component of the Community Support does not have a time limit.

DHCS proposed clarifying that MCPs may not limit their offering of this service to only one component or the other. DHCS is finalizing this clarification.

- **Overlap Principles with Other Community Supports:** DHCS proposed clarifying that Members may receive other Community Supports (in particular, the time-limited transition services/expenses component of this service and Housing Transition Navigation Services) at the same time as long as the services provided are nonduplicative, distinct, and necessary. DHCS is finalizing this clarification.
- **Overlap Principles with Waivers:** DHCS proposed clarifying that while a Member may be eligible for both the ALF Transitions Community Support and the ALW[83] or CCT,[84] they may not receive both at the same time due to the similar services funded under each program. DHCS is finalizing this clarification.
- **Allowable Settings:** DHCS received feedback that it should consider transitions to (1) rehabilitation facilities and/or (2) public housing combined with home care as alternatives to ALFs under this service. DHCS is not expanding the scope of this service definition to these settings at this time. DHCS is aware of current pilot efforts under the ALW that combine public housing with home care as an alternative to an ALF setting and may explore expansion to this setting in future iterations of this service definition.

[83] DHCS. *Assisted Living Waiver*. Available at https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx. Accessed April 2025.

[84] DHCS. *California Community Transition Program*. Available at https://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx. Accessed April 2025.

Community or Home Transition Services

Summary of February 2025 Refinements

The Community Transition Services Community Support aims to support Members transitioning out of a skilled nursing facility back to a residence (whether a private residence or public subsidized housing). Individuals transitioning back to a home need distinct support in identifying housing and may encounter one-time costs in updating their homes to meet their clinical and mobility needs. Community Transition Services covers both the transitional care coordination and one-time costs necessary for a Member to transition to a home.

DHCS received similar feedback regarding Community Transition Services as described in Assisted Living Facility Transitions above (including clarifications of the service components and overlapping enrollment with other Community Supports and the 1915(c) waivers/CCT).

In September 2024, DHCS released for stakeholder comment a set of clarifications and updates to this service definition and received 19 comments from a range of MCPs, providers, counties and advocacy organizations. In response to these comments and other stakeholder discussions, DHCS is finalizing the following clarifications and updates:

- **Service Components:** DHCS proposed clarifying there are two components of this Community Support available to Members:
  - Transitional coordination services to identify and support a Member in transitioning to a private residence or public subsidized housing, including efforts to assess the Member's housing needs and communicate with landlords. DHCS is clarifying that this service is not intended to duplicate or supplant MCPs' obligation to provide PHM Transitional Care Services (TCS)[85] for Members transferring from one level of care to another, under Population Health Management.
- One-time set-up expenses to establish or reestablish a household, such as security deposits, utility set up fees, one-time cleaning fees, and other medically necessary services. DHCS has made clarifications to the list of services and finalized the clarification that these expenses may include Durable Medical Equipment to the extent that these services are not available to the Member from another Medi-Cal Benefit. DHCS is also finalizing the clarification that the lifetime maximum of $7,500 that applies to this service

[85] DHCS. *PHM Policy Guide.* May 2024. Available at https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf. Accessed April 2025.

applies only to the one-time set-up expenses, not to the cost of transitional coordination services. This interpretation of the maximum aligns with similar limits in CCT (Money Follows the Person) as was the original intent of this service.

- **Overlap Principles with Other Community Supports:** DHCS proposed clarifying that Members may receive Housing Transition Navigation Services, Housing Deposits, and/or Environmental Accessibility Adaptations (Home Modifications) at the same time as the Community Transition Services Community Support as long as the services provided are nonduplicative, distinct, and necessary. DHCS is finalizing this clarification.
- **Waivers:** DHCS proposed clarifying that while a Member may be eligible for both Community Transition Services and other relevant waiver/demonstration programs such as CCT and HCBA,[86] they cannot receive both at the same time if the activities provided under each program are duplicative. DHCS is finalizing this clarification.

Medically Tailored Meals/Medically Supportive Food

Summary of February 2025 Refinements

The Medically Tailored Meals/Medically Supportive Food (MTM/MSF) Community Support provides targeted food and nutrition services to Members with nutrition-sensitive health conditions. The meals, food, and nutrition education provided through this service are specific to the Member's eligible health conditions and are a critical part of the Member's treatment plan to improve or maintain their health status.

Since the initial launch of Community Supports, stakeholders have requested that DHCS clarify several aspects of this service definition that were leading to disparate interpretations and implementation across the state. Stakeholders requested more detailed, standardized definitions for each of the service components; clearer eligibility criteria; and more explicit DHCS expectations for how MCPs should oversee MTM/MSF providers and services.

Nationally, the integration of nutrition supports into the health care delivery system (including, but not limited to, Medicaid programs) is a rapidly evolving field. States, payers, MTM/MSF providers, and the federal government are continuing to identify

[86] DHCS. *Home & Community Based Alternatives Waiver.* Available at https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx. Accessed April 2025.

and refine best practices as organizations and individuals gain more experience and evidence delivering the services. Based on stakeholder feedback, this service definition update establishes more specific expectations for the quality of MTM/MSF services and MCP oversight of MTM/MSF providers.

In September 2024, DHCS released for stakeholder comment a proposed set of clarifications and updates to this service definition and received nearly 50 comments from a range of stakeholders including MCPs, MTM/MSF provider organizations, health care providers, researchers and advocates. In response to these comments and other stakeholder discussions, DHCS is finalizing the following clarifications and updates:

- **Streamlining Eligibility Criteria:** Stakeholders provided feedback that the original eligibility criteria were broad, allowing disparate interpretations. MCPs and MTM/MSF providers also reported that they found the "at risk of hospitalization or SNF placement" and "extensive care coordination needs" criteria ambiguous. In the September 2024 draft issued for stakeholder comment, DHCS proposed to require eligible Members to have a nutrition-sensitive health condition and an additional complicating factor (e.g., at risk of hospitalization or extensive care coordination needs). Stakeholders overwhelmingly voiced that this proposal would restrict eligibility too far and be challenging to operationalize. In the finalized updates below, the eligibility criteria have been refined to focus eligibility solely on whether the Member has a nutrition-sensitive health condition appropriate for MTM/MSF services. The updates reflect stakeholder feedback to streamline the eligibility criteria, including expanding and refining the list of example health conditions. Throughout the service definition below, DHCS emphasizes that MTM/MSF services must address the Member's eligible nutrition-sensitive health condition to assist them to regain or maintain their health status related to their specific condition and that these services are not solely to address food insecurity. If Members meet the refined, more specific eligibility criteria, DHCS considers delivery of MTM/MSF services to be medically appropriate without the need for a separate step to consider medical appropriateness.
- **"Medically Tailored" and "Medically Supportive" Service Specifications:** The original service descriptions did not assert a distinction between "medically tailored" and "medically supportive" services within the definition, leading to disparate interpretations and delivery across the state. The proposed September 2024 draft for public comment sought to expand the descriptions of the allowable services. Stakeholders, including Food is Medicine experts and MCPs with implementation experience, provided valuable feedback and input informing the descriptions for each service. These

updates also seek to align with evolving national best practices and service descriptions in other state Medicaid programs. Per feedback on the proposed September 2024 draft, DHCS is clarifying that MTM and MSF service packages can be designed at the service level for the identified target chronic or serious health conditions. To ensure that the interventions are provided in sufficient quantity to impact health outcomes, the proposed September 2024 refinements also specified that meals and food packages must meet two-thirds of the daily nutrient and energy needs of an average individual. Based on stakeholder feedback, the two-thirds requirement has been clarified to only apply to MTMs and MTGs, and not MSF services.

MSF services, such as medically supportive groceries or produce prescriptions, are intended to be supplemental to the Member's diet, whereas "medically tailored" interventions must be provided in specified quantities to constitute the majority of the Member's food for a period of time to have the intended impact on health outcomes. The final refinements establish clearer overall expectations for what it means for services to "medically tailored" vs. "medically supportive" and the roles of Registered Dietician Nutritionists (RDNs) or other appropriate clinicians in their design:

- Medically tailored services must include an individual nutrition assessment conducted or overseen by an RDN to inform the development of a nutritional plan and connection to the appropriate medically tailored services for the Member. Additionally, the development of medically tailored meal or food packages must be tailored by an RDN or other appropriate clinician based on established, evidence-based nutrition guidelines for the targeted nutrition-sensitive condition.
- MSFs packages provide access to preselected whole foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the targeted health condition(s). The design or selection of foods or food options in MSF services must be overseen and signed off on by an RDN or another appropriate clinician.

» **Nutrition Education:** The updates clarify that nutrition education provided as a standalone service is not sufficient to be considered delivery of this Community Support. In the September 2024 draft for public comment, DHCS proposed that all MSF services must be paired with nutrition education. However, stakeholders provided feedback that this requirement would present an access barrier and cited literature that MTM/MSF can be evidence-based even if not paired with education. As such, the service definition no longer

includes the requirement that MSF services must be paired with nutrition education. MCPs and their Community Supports Providers are still strongly encouraged to offer behavioral, cooking, and/or nutrition education in parallel with MTM/MSF services and refer eligible individuals to Medi-Cal covered nutrition counseling services (e.g., diabetes self-management education, medical nutrition therapy).

- **Provider and Meal/Food Package Oversight:** As the MTM/MSF sector grows, it is more important for MCPs to provide robust oversight of providers and the food itself. In the finalized serviced definition, DHCS outlines MCP requirements for reviewing the quality and safety of MTM/MSF interventions. These requirements apply for MTM/MSF services delivered by potential and current MTM/MSF Community Supports Providers to ensure Members receive high quality meals/food tailored to their clinical needs.

Asthma Remediation

Summary of February 2025 Refinements

Asthma Remediation is designed to reduce acute asthma episodes that can lead to hospitalization or emergency department use. The support covers physical modifications to a home environment and/or supplies that are necessary to ensure the health, welfare, and safety of a Member.

DHCS received feedback on several opportunities to further clarify the supplies and modifications covered under the Community Support and increase utilization by simplifying eligibility criteria and reducing documentation requirements.

In September 2024, DHCS released for stakeholder comment a set of clarifications and updates to this service definition and received seven comments from a range of MCPs, providers, counties and advocacy organizations. In response to these comments and other stakeholder discussions, DHCS is finalizing the following clarifications and updates:

- **(Effective January 2026) Phase Out of In-Home Environmental Trigger Assessments and Asthma Self-Management Education Under Asthma Remediation:** As originally launched, the Asthma Remediation Community Support included assessment, self-management education, and home remediations. DHCS launched the Asthma Preventive (APS) benefit under its State Plan in July 2022, six months after the launch of this Community Support. As a State Plan service, MCPs are required to cover this benefit. Two of the three components of APS were also included in the original Asthma Remediation service definition, namely (1) asthma self-management education

and (2) in-home environmental trigger assessments. In line with the general principle that Community Supports supplement rather than supplant State Plan services, DHCS intends APS and the Asthma Remediation Community Support to be complementary and non-duplicative. Thus, DHCS' revisions clarify that these two components should be covered through the APS benefit, and these components are being removed from the Community Support definition. Given the addition of the APS benefit, DHCS' vision is that the Asthma Remediation Community Support will become a wraparound service relative to the APS, covering the supplies and physical modifications for Members' homes, based on the results of the APS in-home environmental trigger assessment, to reduce acute asthma episodes.

  - In September 2024, DHCS proposed a transition period through January 1, 2026, during which network providers will continue to be able to be reimbursed for the overlapping components under either the APS benefit or the Community Support. However, MCPs and Providers are strongly encouraged to transition to reimbursement under the APS benefit prior to January 1, 2026. DHCS proposed a transition period because billing the APS benefit requires Medi-Cal provider enrollment. DHCS recognizes that some Community Supports Providers may not be enrolled in Medi-Cal. The transition period will allow any such providers to enroll if they wish to continue providing services under the APS benefit. DHCS is finalizing the transition period for the phase-out of service components overlapping with the APS benefit in this guidance.

- **Eligibility Criteria:** DHCS received feedback that existing eligibility criteria were unintentionally leading to multiple rounds of clinician review and sign off for services covered under the Community Support. In response, in September 2024, DHCS proposed simplifying eligibility criteria for the physical modifications and supplies that will continue to be covered under the Asthma Remediation Community Support. DHCS is further clarifying documentation requirements in this final version of the service definition by stating MCPs need only to document an in-home trigger assessment that was completed in the last 12 months under the APS benefit to authorize physical modifications or supplies as medically appropriate. No further documentation of medical appropriateness is required for the MCP to authorize Asthma Remediation.
- **Covered Supplies:** In response to feedback that electronic air filters rely on technology that can produce ozone or other byproducts harmful to health, DHCS proposed clarifying that the provision of air filters under this Community Support should be narrowed to mechanical air filters. DHCS is

finalizing this clarification and integrating additional resources on Integrated Pest Management into the list of covered supplies.

- **Timeframe:** DHCS received stakeholder questions on whether all physical modifications and supplies needed to be delivered at the same time for a Member. DHCS is finalizing a clarification that the Asthma Remediation Community Support need not be delivered at a single point in time as long as modifications and supplies comply with the $7,500 total lifetime maximum.