

COMMUNITY SUPPORTS POLICY GUIDE VOLUME 2 ADDENDUM

Recuperative Care and Short-Term Post- Hospitalization Housing (STPHH) Sunset

October 2026

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I. INTRODUCTION

In 2022, as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Department of Health Care Services (DHCS) launched 14 Community Supports that, at the option of a Medi-Cal Managed Care health plan (or “Managed Care Plan” (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. As of January 1, 2026, MCPs are additionally required to cover Transitional Rent as a fifteenth Community Support for Members meeting the Behavioral Health Population of Focus.

As part of its commitment to continuous improvement, DHCS is making updates to Community Supports based on data and feedback from implementors and stakeholders and in response to changes at the federal level. To safeguard program integrity and drive appropriate utilization, it is critical that MCPs take an active approach in establishing clear protocols to manage covered Community Supports as is expected of all covered benefits. DHCS expects MCPs to monitor Network Provider activity to ensure Community Supports Providers are actively assessing appropriateness and engaging Members during service authorization periods.

The finalized updates described in this Policy Guide Addendum take effect January 1, 2027. As described in DHCS’ CalAIM Section 1115 waiver renewal application,¹ California plans to transition federal authority for Recuperative Care from Section 1115 waiver authority to Medicaid managed care in lieu of services and settings (ILOS) authority and sunset Short-Term Post-Hospitalization Housing (STPHH) as a separate Community Support.

Because Medicaid policy does not permit the coverage of room and board outside of 1115 authority, DHCS has updated the Recuperative Care service definition to align with federal requirements. Additionally, DHCS is using this transition as an opportunity to strengthen and standardize service delivery statewide. Since becoming a Community Support, Recuperative Care has been delivered through a diverse range of provider and facility models. While this flexibility has supported innovation and local adaptation, it has also created variation in how the service has been implemented. The updated

¹ California Office of the Governor. *Request for Amendment and Five-Year Renewal of the California Advancing and Innovating Medi-Cal Section 1115 Demonstration*. Available at: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calAIM-renwl-sect-1115-app-05112026.pdf>

service definition seeks to provide greater standardization in service delivery, provider oversight, and quality expectations. This includes more fully articulating the care coordination and case management activities that must be provided onsite to Members during a Recuperative Care stay, helping ensure service quality, accountability, and cost-effectiveness.

This addendum includes both the updated Recuperative Care service definition and the STPHH sunset plan. Also included is updated language about the global cap on coverage of room and board services that will be carried into the Community Supports Policy Guide, Volume 2. Because the current state Recuperative Care service definition in the Community Supports Policy Guide Volume 2 remains in effect through December 31, 2026, DHCS is issuing the updated service definition as a standalone addendum to the Community Supports Policy Guide, Volume 2. DHCS will incorporate the updated service definition into the Community Supports Policy Guide, Volume 2, as part of a broader forthcoming update and will make updates to the Managed Care Plan (MCP) contract.

DHCS released the contents of this addendum in [draft form](#) for public comment in July 2026. DHCS received 46 public comments from providers, MCPs and MCP Associations, advocates, and other stakeholders. Finalized policies reflect feedback received during the public comment period as well as extensive stakeholder engagement with providers, MCPs, and the National Institute for Medical Respite Care (NIMRC),² conducted from Q4 of 2025 through Q3 2026.

Since releasing the draft policy for public comment, DHCS has made several targeted refinements to the finalized Recuperative Care service definition in response to stakeholder feedback. Key updates include additional clarification regarding Member eligibility, including the circumstances under which Members with a behavioral health condition, but without a co-occurring physical condition, may qualify for Recuperative Care. The finalized policy also more clearly specifies that Members who require support with activities of daily living (ADLs), immediate skilled nursing services, or residential treatment are not appropriate for Recuperative Care. Additionally, DHCS updated supervisor staffing requirements to provide greater operational flexibility, including

² The National Institute for Medical Respite Care (NIMRC) is a special program of the National Health Care for the Homeless Council (NHCHC) whose primary focus is on expanding medical respite care programs in the U.S.

permitting supervisors to be contracted by the Recuperative Care facility rather than directly employed.

Stakeholder comments also raised questions regarding whether aspects of the updated service definition could implicate California Department of Social Services (CDSS) Community Care and Licensing (CCL) requirements. While DHCS is not requiring licensure by January 1, 2027, DHCS is continuing to evaluate applicable regulatory and licensure considerations and will provide additional guidance as that review progresses.

Next Steps

- » DHCS will incorporate this Addendum into the Community Supports Policy Guide Volume 2 by early January 2027.
- » DHCS aims to provide clarification pertaining to licensure through stakeholder meetings and update to the Community Supports Policy Guide Volume 2 by early January 2027.

II. RECUPERATIVE CARE UPDATES AND SHORT TERM POST-HOSPITALIZATION HOUSING (STPHH) SUNSET

1. Recuperative Care: Summary of Updates to Service Definition

Since the fall of 2025, DHCS has engaged in a robust stakeholder engagement process to inform the updated Recuperative Care service definition, guided by the following key program requirements and policy objectives:

- » **Eliminate coverage of room and board.** Consistent with the transition from Section 1115 waiver authority to ILOS authority, the updated service definition eliminates Medi-Cal coverage of room and board. While Recuperative Care Providers must continue to furnish 24-hour access to a bed and three meals per day—as well as meet other facility-specific requirements outlined in Section II.2. of this Addendum—MCPs will not be permitted to reimburse for these components as covered Medi-Cal services.
- » **Establish greater precision, standardization, and quality in service delivery.** The updated service definition more clearly articulates DHCS' expectations for Recuperative Care and establishes greater standardization of the core service components relative to the [current service definition](#). These refinements are intended to support more consistent implementation across the State while maintaining cost-effectiveness and improving the quality of service delivery for Members. The updated service definition emphasizes that the support available at the Recuperative Care facility always includes care coordination and case management, provides a standardized definition of these activities, and requires these activities to be supervised by a qualified professional. The updated Recuperative Care service definition was also informed by NIMRC's nationally recognized standards while establishing certain Medi-Cal-specific requirements to strengthen accountability, consistency, and quality across providers.³
- » **Establish an achievable standard that mitigates attrition of today's Recuperative Care Providers.** DHCS seeks to establish enhanced standards for

³ NHCHC. Standards for Medical Respite Care. 2026. Available at: https://nhchc.org/wp-content/uploads/2025/03/Standards-for-Medical-Respite-Programs_2025.pdf

Recuperative Care that strengthen accountability and standardize service delivery while remaining operationally attainable. Preserving provider capacity and mitigating attrition of today's existing Recuperative Care Providers is a priority for DHCS. In addition, DHCS recognizes that STPHH Providers play a critical role in the housing continuum and strongly encourages these providers to prepare for transition by aligning their service models and capabilities to participate as Recuperative Care Providers going forward.

The summary below highlights the major changes DHCS is implementing in 2027 relative to today's service definition.

- » **Eligibility Criteria:** DHCS made minor updates to the eligibility criteria to improve specificity.
- » **Service Components:** DHCS made comprehensive updates to the service components, establishing more prescriptive and detailed requirements that apply for all Recuperative Care programs for the duration of service delivery. In addition to removing the coverage of room and board, these changes clarify that the key function of Recuperative Care is to provide the care coordination and case management needed to ensure Members are connected to Medi-Cal covered services as well as appropriate social services available to all communities, but is not responsible for providing the care directly to Members.
- » **Supervision and Staffing Requirements:** To ensure all Members are appropriately connected to health care services and social supports, DHCS established a new requirement that all care coordination and case management activities in a Recuperative Care setting be supervised by a qualified professional—specifically, a Master of Social Work (MSW), Licensed Clinical Social Worker (LCSW), Licensed Vocational Nurse (LVN), Registered Nurse (RN), or individual holding a higher qualification—who is employed or contracted by and regularly available onsite at the facility. DHCS has also defined the specific activities supervisors are expected to perform.
- » **Concurrent Delivery of Recuperative Care and ECM:** DHCS will maintain the current policy permitting concurrent delivery of Enhanced Care Management (ECM) services during a Recuperative Care stay. MCPs are responsible for actively coordinating the two services when covered and ensuring non-duplication of payment for overlapping services. As part of the refined service definition, if a Member is not already receiving ECM, MCPs must ensure that Recuperative Care Providers connect all Members to ECM as part of the discharge planning process.

DHCS may revisit this policy position following the transition of Recuperative care to the updated service definition.

- » **Service Duration:** The Recuperative Care Community Support will continue to maintain the current coverage limit of six-months per rolling 12-month period. Given the exclusion of room and board, the global cap on coverage of room and board services that currently applies to Recuperative Care and Transitional Rent, no longer applies. (Note: Any room and board services received prior to December 31, 2026 must still be included in the global cap calculation. See Section II.5 "Update on Global Cap on Coverage of Room and Board Services" for more information)

2. Updated Recuperative Care Service Definition Effective January 1, 2027⁴

Description/Overview

Recuperative Care, also referred to as medical respite care, is short-term residential care that allows an individual experiencing or at risk of homelessness to recover from an injury or illness while receiving onsite and supervised care coordination, case management, and access to medical and social services. It is for Members who have medical and/or behavioral health needs significant enough to result in emergency department (ED) visits, hospital admissions, or other institutional care.

Members living with a behavioral health condition who do not have a co-occurring medical need can qualify for Recuperative Care, provided they meet both components of the eligibility criteria and that the facility is equipped to meet their needs.

Importantly, Recuperative Care is not appropriate for Members who require support with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who require immediate skilled nursing care or residential treatment.

Eligibility (Population Subset)

Members are eligible for Recuperative Care if they meet **both** of the following criteria:

- (1) Requiring recovery in order to heal from an injury or illness, including recovery from an acute exacerbation of a chronic condition.⁵

AND

- (2) Experiencing or at risk of homelessness.⁶

⁴ See Page 48 of the [Community Supports Policy Guide Volume 2](#) for the current Recuperative Care service definition.

⁵ Members requiring recovery from both significant physical and/or behavioral health conditions are eligible for Recuperative Care.

⁶ The definition of an individual experiencing or at risk of homelessness is based on U.S. Department of Housing and Urban Development's (HUD's) definitions with three modifications as detailed in Appendix C of the [Community Supports Policy Guide Volume 2](#).

An individual need not be exiting an institution to qualify provided they meet the eligibility criteria.

MCPs may accept an attestation by the Member or the provider on behalf of the Member of the need for housing to satisfy any documentation requirements regarding the Member's housing status.

Recuperative Care Requirements

Service Components

All Recuperative Care programs must provide the following services for the duration of a Member's stay in the Recuperative Care facility:

1. Onsite care coordination and case management that includes, but is not limited to:
 - a. Confirming the Member's medical and behavioral health needs and goals which includes reviewing the Member's discharge instructions and/or care plan when available or connecting the Member to a clinician who can complete an individual needs assessment.
 - b. Providing ongoing monitoring of the Member's medical or behavioral health condition to avoid unnecessary ED utilization, keeping the Member's providers informed of their progress, and ensuring timely clinical consultation when a Member's condition changes.
 - c. Conducting wellness checks (which may be performed by non-clinical staff) at least once every 24 hours.
 - d. Coordinating onsite access to the health care services a Member needs (see also Service Component number 5 below).⁷
 - e. Supporting the Member's health care goals for the Recuperative Care period.
 - f. Working with the MCP to connect the Member to an existing or new primary care provider (PCP) upon their entry into Recuperative Care.

⁷ Onsite access must be made available to Members who need it; however, Members may access services offsite if clinically appropriate and feasible.

- g. Connecting the Member to any other health care services and/or social supports they may require, including referral, as needed, to mental health and substance use disorder services and dental services.
 - h. Coordinating transportation to health care appointments, diagnostic procedures, and the pharmacy.
 - i. Conducting case conferencing and communicating health care needs with community-based medical providers.
 - j. Conducting discharge planning to support the Member in successfully transitioning out of the Recuperative Care facility, including transitioning the Member to other Community Supports such as Housing Navigation and Transition Services (HTNS), Housing Tenancy and Sustaining Services (HTSS), and Housing Deposits.
 - k. Connecting the Member to Enhanced Care Management (ECM), which includes submitting a referral to the Member's MCP for ECM; working with the MCP, as necessary, to identify the ECM Provider; and facilitating a warm handoff with the ECM Provider prior to discharge from Recuperative Care (see *Delivery with Other Community Supports and ECM* subsection of Section II.2. for additional information).⁸
2. Providing access to equipment (e.g., phone, computer), as needed, for any telehealth visits during the stay.
 3. Providing access to a safe space for storage (including refrigeration) of the Member's own medications.
 4. Providing access to a secure space for storage of personal items.
 5. Providing onsite access to appropriate health care services (including basic nursing care; wound care; and medication prescribing, dispensing, administration, and management as may be needed) through established relationships with qualified medical or Home Health Providers.
 6. Providing 24 hours a day/7 days a week access to onsite staff (may be non-clinical) who are trained in first aid, basic life support, and de-escalation techniques and can coordinate access to on-call medical support that includes 24/7 nursing hotlines through the Member's MCP.

⁸ Members always have the right to decline ECM referral or services at any time.

Onsite Team Supervision Requirement

All Recuperative Care programs must have a supervisor to conduct programmatic oversight of the care coordination and case management activities set forth above in the *Service Components* subsection of Section II.2. Supervisors are responsible for ensuring care coordination and case management decisions reflect Members' medical and behavioral health needs and facilitate timely access to appropriate services. Key supervisory responsibilities include:

- » Providing structured oversight and guidance to care coordination and case management staff to ensure Member engagement is occurring consistently and appropriately;
- » Ensuring care coordination activities align with Members' documented needs and goals, including discharge instructions, care plans, and referrals;
- » Ensuring Members receive timely access to required health care (including medical and behavioral) and social services through effective coordination, monitoring, and follow-up;
- » Overseeing quality and accountability for care coordination and case management functions, including consistency and adherence to applicable service requirements; and
- » Establishing clear escalation pathways to ensure medical, behavioral health, or safety concerns are referred to appropriately licensed providers in a timely manner.

The supervision required does not constitute licensed clinical supervision; medical decision-making authority remains with the licensed providers delivering clinical services.

Supervisor Qualifications

The supervisor must be employed by or contracted with the Recuperative Care facility and be regularly available onsite.⁹ Supervisors are not required to be hired on a full-time basis. Recuperative Care facilities may utilize a shared supervision model, under which a qualifying supervisor supports multiple facilities operated by the same organization.

⁹ Supervisors must be regularly available in-person and cannot be solely on-call or based virtually.

Supervisors must also have experience managing staff and/or a team and hold one of the following licenses or degrees, acting within their applicable scope of practice:¹⁰

- » Registered Nurse (RN); or
- » Licensed Vocational Nurse (LVN); or
- » Licensed Clinical Social Worker (LCSW) with at least two years of experience in a health care delivery setting;¹¹ or
- » Master of Social Work (MSW) with at least five years of experience in a health care delivery setting.¹²

LCSWs and MSWs serving in the supervisory role **must also** demonstrate experience in a health care delivery setting, defined as:

- » Working with patients, or supervising staff working with patients, who have complex medical, behavioral health, and social needs;
- » Interpreting and executing care plans, and/or overseeing staff execution of care plans;
- » Coordinating patient care activities and/or supervising staff coordinating patient care activities with other members of the healthcare team, patient representatives, and community partners;
- » Routine collaboration with interdisciplinary healthcare teams that include licensed professionals; and
- » Escalating care as needed to other qualified professionals.

Qualifying experience in health care delivery settings does not include the following:

- » Working exclusively with patients on social needs care with no experience coordinating medical needs; or

¹⁰ Licensed supervisors must operate within their applicable scope of practice, which may limit who they can supervise and the activities subject to supervision.

¹¹ The required years of experience in a health care delivery setting may have been obtained at any time, including prior to or during degree attainment.

¹² The required years of experience in a health care delivery setting may have been obtained at any time, including prior to or during degree attainment.

- » Serving solely in an administrative or non-patient-facing function (e.g., human resources, billing oversight, or facilities management).

Recuperative Care Facility Requirements

While Medi-Cal does not cover room and board, facilities must meet the standards below to qualify as a Recuperative Care setting:

- » Provide 24-hour access to a bed
- » Provide 24-hour access to a bathroom with a shower, sink, and toilet (shared facilities are permissible)
- » Provide three meals a day

Restrictions/Limitations

Recuperative Care is an allowable Community Supports service if it prevents unnecessary utilization of the ED, hospital admission or readmission, and/or nursing facility admission or readmission.

Recuperative Care cannot exceed a duration of six months per rolling 12-month period (but may be authorized for a shorter period based on individual needs). While MCPs have the discretion to determine a medically appropriate duration, MCPs are advised to make determinations about authorization timelines based on Members' documented recovery needs and ongoing medical necessity, rather than fixed authorization intervals.

Delivery with Other Community Supports and ECM

During a stay in a Recuperative Care setting, Members may be referred to HTNS and Transitional Rent, as well as other Community Supports that are medically appropriate. As noted above, discharge planning from Recuperative Care should ensure warm handoffs to Community Support Providers so that Members who qualify can be authorized for appropriate services and connected with providers as soon as feasible.

If already receiving ECM when entering a Recuperative Care setting, Members can continue receiving it during their stay.¹³

MCPs are responsible for actively coordinating the service delivery and management of these services when covered, including ensuring non-duplication of payment for

¹³ DHCS may revisit this policy position following the transition of Recuperative Care to the updated service definition.

overlapping services. If there are overlapping services during the Recuperative Care stay, MCPs must adjust payments accordingly to avoid double payment during the stay.

If the Member is not already receiving ECM when entering a Recuperative Care setting, consistent with existing Transitional Care Services Requirements,¹⁴ MCPs must ensure that Recuperative Care Providers connect all Members to ECM as part of the discharge planning process, as described in the *Service Components* subsection of Section II.2.

Whenever possible, applicable Community Supports and ECM should be provided to Members onsite in the Recuperative Care setting.

Licensing/Allowable Providers for Recuperative Care

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

- » Interim housing facilities with additional on-site support
- » Shelter beds with additional on-site support
- » Converted homes with additional on-site support
- » Peer respite setting¹⁵
- » County-operated or contracted Recuperative Care facilities

For Members who are pregnant and up to 12-months postpartum, DHCS also strongly encourages MCPs to contract with Recuperative Care facilities that offer rooming in (i.e., the practice where a postpartum Member and their newborn stay in the same room

¹⁴ Under Population Health Management, MCPs are accountable for providing Transitional Care Services (TCS) to all Members transitioning out of Recuperative Care, which include ensuring Members are supported from discharge planning through connection to needed services and supports. See full TCS requirements in the Population Health Management (PHM) Policy Guide. DHCS. *PHM Policy Guide*. May 2024. Available at: <https://www.dhcs.ca.gov/wp-content/uploads/2025/10/PHM-Policy-Guide.pdf>.

¹⁵ The peer respite setting must be staffed with Certified Peer Support Specialists and be capable of transporting its residents to an emergency room or urgent care facility 24 hours a day, 7 days a week. If a peer respite setting identifies a need for monitoring services that fall outside the scope of practice of a Certified Peer Support Specialist, the setting must have policies and procedures in place to facilitate timely referral to, and coordination with, an appropriately licensed behavioral health provider.

together) and have the requisite capabilities to contract as Community Supports Providers to deliver Recuperative Care.¹⁶

MCPs remain responsible for conducting provider screening, enrollment, credentialing, revalidating and recredentialing in accordance with the Community Supports Policy Guide, MCP Contract, and the forthcoming DHCS APL on Provider Screening, enrollment, credentialing, and recredentialing (which will supersede APL 22-013), as well as monitoring the delivery of Recuperative Care services.

Although Recuperative Care facilities are not currently required to obtain NIMRC certification, DHCS encourages MCPs to consider NIMRC certification as part of their screening, enrollment, and credentialing processes. MCPs should verify compliance with both the DHCS service definition and any applicable NIMRC standards¹⁷ incorporated into their provider oversight processes.

HCPCS Codes for Recuperative Care

Listed below are the Healthcare Common Procedure Coding System (HCPCS) code and modifier combinations that must be used for Recuperative Care. See Section XI of the [Community Supports Policy Guide Volume 2](#) for more information about Billing & Payments for Community Supports.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
T2033	Residential care, not otherwise specified (NOS), waiver; per diem	U6	Used with HCPCS code T2033 to indicate Community Supports Recuperative Care (Medical Respite)

¹⁶ In alignment with DHCS' goals to address the physical, behavioral, and health-related social needs of pregnant and postpartum Members via its [Birthing Care Pathway work](https://www.dhcs.ca.gov/CalAIM/Pages/BirthingCarePathway.aspx). (Available at <https://www.dhcs.ca.gov/CalAIM/Pages/BirthingCarePathway.aspx>. Accessed June 2026.)

¹⁷ NHCHC. Standards for Medical Respite Care. 2026. (Available at: https://nhchc.org/wp-content/uploads/2025/03/Standards-for-Medical-Respite-Programs_2025.pdf. Accessed August 2026)

3. Short-Term Post-Hospitalization Housing Sunset Plan

As described in Section I of this Addendum, DHCS is sunsetting STPHH as a standalone Community Support on December 31, 2026. DHCS is committed to implementing this change in a manner that minimizes disruption for Members while remaining operationally clear and administratively feasible for MCPs and STPHH Providers. DHCS will closely monitor this transition to ensure Members' needs remain at the center and that they are appropriately transitioned to comparable medically necessary services. In accordance with applicable federal and State requirements, MCPs are responsible for the following actions to support the transition.

Authorization Limits

Effective July 1, 2026, MCPs must limit new STPHH authorizations; specifically, for Members requesting the maximum six-month service duration, authorizations must be adjusted to ensure they do not extend beyond December 31, 2026, the end of the State's coverage authority for the service.

Consistent with federal Medicaid rules,¹⁸ when an MCP authorizes a shorter duration of STPHH than requested, the decision constitutes an Adverse Benefit Determination (ABD) and triggers applicable Member appeal rights. However, if a Member's requested authorization period for STPHH does not extend beyond December 31, 2026 or if it is not shorter than what was requested, an ABD is not triggered, as the MCP is not reducing or denying the service request.

To minimize ABDs and related appeals, MCPs are strongly encouraged to proactively educate STPHH, Recuperative Care and other referring providers within their networks about the December 31, 2026, coverage end date and the resulting limits on authorization periods for STPHH. Educating providers on these requirements may help to reduce referrals that request STPHH beyond the allowable coverage period.

For Members requesting service durations of STPHH that extend beyond December 31, 2026, DHCS also encourages MCPs to assess whether the Member may be appropriate for transition to the updated Recuperative Care service.

In addition, DHCS is establishing a statewide cutoff date of December 1, 2026, after which no new STPHH authorizations may be issued. MCPs are responsible for evaluating

¹⁸ CMS. Title 42 of the Code of Federal Regulations Part 438, Subpart F—Grievance and Appeal System. Available at <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-F>.

Members requesting STPHH after this date for eligibility for Recuperative Care and other available Community Supports. The established cutoff date for STPHH ensures adequate time to allow for transition planning. For Members who will be transitioning from managed care enrollment to the Medi-Cal Fee For Service (FFS) delivery system as part of the Unauthorized Immigration Status (UIS) transition, effective January 1, 2027, the cutoff date is December 31, 2026 (see the *Transition Planning* section below for additional information).

Notify Members

As part of the STPHH wind down, MCPs must notify Members of the changes to coverage and maximum service duration; specifically:

- » The STPHH service will sunset on January 1, 2027; and
- » Beginning on July 1, 2026, the maximum duration of STPHH authorizations will be reduced as necessary to ensure that no authorization extends beyond December 31, 2026.

MCPs are required to notify the following groups:

1. **All Members requesting the maximum service duration of STPHH authorizations (on or after July 1, 2026):** MCPs must embed the standardized language received from DHCS within the notice of action or notice of adverse benefit determination (NOA) letters that MCPs are required to send to Members when communicating the authorization decision as part of the utilization management process.
2. **All other Medi-Cal Members:** MCPs currently offering STPHH must send the standardized language received from DHCS to all Members notifying them of the changes to coverage and maximum service duration outlined above. Notices must be sent no later than December 1, 2026.¹⁹ DHCS has provided standardized Member noticing language for MCPs to use. Accordingly, MCPs are not required to submit Member notices for DHCS review and approval.
3. **Member Handbook/Evidence of Coverage and Provider Directories.** MCPs that currently offer STPHH must update their Member Handbook/EOCs and Provider Directories for January 1, 2027, to no longer include STPHH services as a

¹⁹ DHCS. *Medi-Cal Managed Care Contract*. Exhibit A, Att: III, Section 5.2.9. Available at: <https://www.dhcs.ca.gov/wp-content/uploads/2025/12/Managed-Care-Boilerplate-Contract.pdf>.

covered benefit. Provider Directories should be reviewed to remove explicit reference to STPHH Providers.

MCPs are also strongly encouraged to coordinate with STPHH Providers to communicate this change directly to Members residing in their respective facilities.

Notify Providers

As part of sunseting STPHH, MCPs must notify Network Providers and update or terminate Network Provider contracts in accordance with the MCP Contract. DHCS encourages MCPs to update Network Provider Agreements to transition STPHH Providers to Recuperative Care Providers, provided such Providers also meet all applicable requirements established in the DHCS Recuperative Care service definition, and the Providers are able to meet provider screening, enrollment, credentialing, revalidation, and recredentialing requirements.

Transition Planning

MCPs are required to ensure that any Member with an active STPHH authorization approaching the December 31, 2026, sunset date receives appropriate transition planning support. Consistent with existing Transitional Care Services requirements,²⁰ MCPs are responsible for supporting Members through their transition out of STPHH facilities from discharge planning until successful connection to comparable medical services and other needed supports. This may include linkage to Recuperative Care, Transitional Rent (provided the global cap on the coverage of room and board has not been exceeded), other Community Supports, and ECM, based on the Member's needs.

DHCS is committed to monitoring MCPs' Member-level transition planning efforts as part of the STPHH sunseting. MCPs must complete and submit a STPHH Transition Monitoring report monthly through December 31, 2026, with the last December report due January 10, 2027, as instructed by DHCS via separate communications. DHCS will review monitoring reports and work with MCPs as needed to ensure Members receive appropriate transition planning.

²⁰ See requirements for Transitional Care Services in the Population Health Management (PHM) Policy Guide. DHCS. *PHM Policy Guide*. May 2024. Available at: <https://www.dhcs.ca.gov/wp-content/uploads/2025/10/PHM-Policy-Guide.pdf>.

Considerations for Members with Unauthorized Immigration Status (UIS) Transitioning from Managed Care to FFS (“UIS Transitioning Members”)

For Members who will be transitioning from managed care enrollment to the Medi-Cal FFS delivery system as part of the UIS transition, please refer to the [Policy Guide for Transition of Unsatisfactory Immigration Status Population from Managed Care to Medi-Cal FFS](#). This guidance will include ensuring transitioning Members are identified, and the MCP and/or the Community Supports Provider work with Members to support transitions to Medi-Cal covered benefits (such as the Community Health Worker benefit) or other non-Medi-Cal services available in the community.

Remove References to STPHH in Member and Provider-Facing Materials

Given STPHH will sunset as a Community Support on December 31, 2026, MCPs must remove references to STPHH as a covered Medi-Cal service across all Member Information documents, as well as Provider-facing materials, including those available on active Member- and Provider-facing websites, including:

- » Member Handbook / Evidence of Coverage
- » Provider Directory
- » Welcome packets
- » Marketing materials
- » Provider-facing education materials, including those available on Provider Portals

5. Update on Global Cap on Coverage of Room and Board Services

STPHH and Recuperative Care are authorized under California’s [CalAIM 1115 waiver](#) through December 31, 2026, and Transitional Rent is authorized under the [BH-CONNECT Section 1115 waiver](#) through December 31, 2029. Under these waivers, STPHH, Recuperative Care, and Transitional Rent are classified as “Room and Board” services and are subject to a “global cap” that limits coverage to a combined six months of room and board services per Member within any rolling 12-month period.

Effective December 31, 2026, STPHH will sunset as a Community Support and Recuperative Care will no longer be classified as a “Room and Board” service. As a result, Transitional Rent will be the only remaining “Room and Board” service and will continue

to be subject to a stricter limit of six months of services per household, per BH-CONNECT demonstration.

However, because the global cap is calculated on a rolling 12-month basis, MCPs must continue to account for any STPHH or Recuperative Care months received prior to December 31, 2026, when determining Transitional Rent eligibility during the applicable runout period. Specifically, if Members receive Recuperative Care or STPHH in 2026, MCPs must count those months toward the six-month limit throughout the remainder of the associated rolling 12-month period, including months that extend into 2027. These months apply toward the six months of service per household, per BH-CONNECT demonstration period.

Example:

A Member is authorized for Recuperative Care from November 1, 2026 through March 31, 2027. The Member will have used two months of room and board services during that timeframe; specifically:

- » From November 1 to December 31, 2026, Recuperative Care is a "Room and Board" service under the CalAIM waiver and the time spent in Recuperative Care counts toward the global cap.
- » From January 1, 2027, to March 31, 2027, Recuperative Care is no longer a "Room and Board" service and the time does not count towards the global cap.
- » Having used 2 months of room and board services, the Member in this example may be authorized for Transitional Rent for a maximum of four months before November 1, 2027.

MCPs must continue to track and enforce this limitation in accordance with Section VII of the [Community Support Policy Guide Volume 2](#).