# COMMUNITY SUPPORTS PRICING RESOURCE — RECUPERATIVE CARE

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# INTRODUCTION

## Background

Beginning in January 2022, the Department of Health Care Services (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 through delivery system, program, and payment reforms. A key feature of CalAIM was the statewide introduction of Community Supports, which managed care plans (MCPs) may offer as medically appropriate, cost-effective alternatives to covered Medi-Cal services or settings.

To support contracting and payment arrangements between MCPs and Community Supports providers, DHCS released the Non-Binding Community Supports Pricing Resource. The resource was designed to provide non-binding pricing information, including benchmarks and key cost drivers, for each Community Support and was intended to assist MCPs and providers in negotiating contracting and payment arrangements.

Since the launch of Community Supports, MCPs and providers across California have gained substantial experience delivering these services and developing payment and contracting arrangements to support them. As the Community Supports delivery system has matured, sustainable pricing and informed contracting remain essential to supporting successful MCP-provider partnerships.

DHCS is updating the Community Supports Pricing Resource to better reflect current service delivery requirements and cost structures. **This document is a stand-alone update focused on Recuperative Care.**

## Context for Recuperative Care Pricing Update

In October 2026, DHCS released the "Community Supports Policy Guide Volume 2 Addendum," which contains the updated service definition for Recuperative Care. The updated service definition, which **goes into effect January 1, 2027**, includes revised service components, enhanced supervision requirements, and removes room and board from the covered service. It is grounded in the National Institute for Medical Respite Care's (NIMRC) nationally recognized standards for high-quality Recuperative Care, while incorporating additional DHCS requirements to promote consistency, accountability, and quality across Medi-Cal and to ensure compliance with federal Medicaid requirements.

To reflect the resources and costs associated with the updated Recuperative Care service definition, including enhanced service components and supervision requirements, as

well as changes in wages and inflation, DHCS is updating the pricing benchmark for Recuperative Care.

## Scope of Update

This targeted update provides pricing information specific to the updated Recuperative Care service definition. Specifically, this document includes:

- Guidance about how MCPs and providers may use this resource to support contracting discussions
- A high-level overview of the pricing methodology
- A midpoint service price benchmark
- The applicable pricing unit and Healthcare Common Procedure Coding System (HCPCS) code
- The primary cost drivers and assumptions underlying the benchmark
- Supplemental benchmark information from related programs and other states

## How MCPs and Providers Should Use This Resource

The Community Supports Pricing Resource is intended to support, not replace, negotiations between MCPs and Community Supports providers. This resource is one tool that MCPs and providers may use when establishing payment arrangements for Recuperative Care.

The pricing benchmark presented in this document is **non-binding and should not be interpreted as a required** rate, rate floor, or rate ceiling. DHCS does not require MCPs and providers to use the benchmark or mandate any particular payment rate. The benchmark included in this publication is based on a fee-for-service methodology. MCPs and providers may negotiate payment rates above or below the benchmark and may utilize alternative payment methodologies such as capitated, value-based, or outcome-based payment arrangements. For example, MCPs may consider utilization benchmarks, outcome measures or performance benchmarks as part of the payment arrangements they establish with Community Support providers.

DHCS is providing a single **midpoint service benchmark** to support contracting discussions for Recuperative Care. The benchmark reflects a modeled Recuperative Care program based on the updated service definition that goes into effect on January 1, 2027, and a defined set of assumptions regarding staffing, supervision, caseloads, employee-related expenses, and indirect costs. Rather than providing a benchmark range, as was provided in previous guidance, DHCS is providing a midpoint benchmark

to serve as a common reference point for negotiations while recognizing that payment rates will reasonably vary based on provider-specific costs and operational considerations.

When using this Pricing Resource, MCPs and providers are expected to evaluate how patient acuity and realistic caseload assumptions compare to the modeled benchmark. The midpoint benchmark considers programs with staffing models designed for Members with higher medical and/or behavioral health needs, including lower caseload ratios and increased clinical touchpoints. Programs serving higher-acuity Members usually require smaller caseloads and more intensive staffing than providers operating less-intensive models, and MCPs and providers should adjust rates accordingly.

Conversely, programs serving lower-acuity Members may operate with larger caseloads and different staffing structures. As a result, a single uniform rate deployed widely across an MCP's delivery system is unlikely to be commensurate with the cost of delivering Recuperative Care that addresses specific needs of Members being served across all program types. MCPs and providers should assess where programs fall along the Member acuity and caseload continuum and establish rates that appropriately reflect those differences and support safe and clinically appropriate service delivery.

**When evaluating payment rates, MCPs and providers should consider the following factors:**

- **Program Size and Caseload:** The midpoint benchmark assumes a specific staffing ratio and average caseload (see Table 2 – Cost Drivers and Assumptions). Program size and the number of individuals supported by each Recuperative Care Team Member materially affect per diem costs. Lower caseloads and smaller program sizes generally increase per diem costs, while larger programs will generally achieve lower per diem costs.
- **Staffing Model and Member Acuity:** Variation in staffing models and patient acuity will result in different costs. For example, some Recuperative Care programs may operate a specialized or intensive model with lower caseloads and higher staff and facility costs relative to those modeled in the Recuperative Care assumptions below, while others may utilize a less intensive staffing model with higher caseloads, lower staff, and lower facility costs.
- **Geographic Variation:** Providers in higher-cost areas generally face higher labor, facility, and operating expenses, which should be considered when MCPs and providers are negotiating payment rates.

# PRICING RESOURCE SERVICE SUMMARIES

## Recuperative Care (T2033 U6)

The information included in this Pricing Resource was principally informed by updates to the service definition, pricing inputs collected via a provider survey in June 2026, input from NIMRC and various stakeholders, review of other states' Recuperative Care models, and other publicly available data.

To align with federal requirements, the benchmark excludes room and board costs. Despite this change, the updated service definition establishes more prescriptive, enhanced service components and new supervision requirements that may require a more intensive service delivery model. Accordingly, the benchmark incorporates staffing assumptions designed to reflect these requirements, including 24/7 staffing and relief coverage, lower caseload ratios, dedicated supervisory capacity, and greater clinical consultant involvement. The specific staffing ratios and caseload assumptions used to develop the benchmark are modeling assumptions and are not requirements of the Recuperative Care service definition.

Specifically, for the purposes of the benchmarking exercise, DHCS makes the following assumptions:

- **Staffing model:** Continuous 24/7 coverage by a Recuperative Care Team Member. This assumption uses a standard 24/7 relief factor FTE of 4.2. A supervisor (1.0 FTE) is employed or contracted with a staffing ratio of 1 supervisor to 4.2 Recuperative Care Team Members. A 0.4 FTE Clinical Consultant is available per caseload of 10 Members.
- **Caseload:** Average caseload of 10 patients.
- **Indirect costs:** Includes administrative, supply and security costs.

### Table 1 — Recuperative Care Service Pricing Benchmark

| Service Type | Recuperative Care |
|---|---|
| Midpoint Service Benchmark | $216.86 |
| Unit of Service | Per diem |
| HCPCS Billing Code | T2033 U6 |

**Table 2 — Cost Drivers and Assumptions**

| Cost Drivers and Assumptions Informing Midpoint Service Benchmark | |
|---|---|
| **Cost Drivers** | **Assumptions** |
| Frequency (if applicable) | As Needed |
| Duration (if applicable) | No more than six months per rolling twelve-month period |
| Setting | In-Person |
| Provider Staffing Qualifications and Hourly Salaries | Recuperative Care Team Member: $30.09<br>Recuperative Care Team Supervisor: $50.86<br>Recuperative Care Clinical Consultant: $94.67 |
| Staffing Ratio/Caseload | 1 24/7 Recuperative Care Team Member (4.2 FTE): 10 Patients<br>1 Recuperative Care Team Supervisor (1.0 FTE): 4.2<br>Recuperative Care Team Members |
| Additional Staffing Considerations | 0.4 FTE Clinical Consultant per caseload of 10 |
| Other Pricing Inputs | Non-Billable Time per FTE (all positions):<br>» Training: 40 hours/year<br>» PTO: 27 days/year<br>Indirect Expenses: 25%<br>All standard Employee-Related Expenses (ERE) components included:<br>» Federal Insurance Contributions Act: 7.65% of wages<br>» Federal Unemployment Tax Act/State Unemployment Tax Act: 1.8% and 3.4% of the first $7,000 in wages, respectively<br>» Retirement Benefits: 5.4% of wages<br>» Workers' compensation: 1.4% of wages<br>» Long Term Disability/Short Term Disability/life insurance: 0.60% of wages |

| Cost Drivers and Assumptions Informing Midpoint Service Benchmark | |
|---|---|
| **Cost Drivers** | **Assumptions** |
| | » Employer-paid healthcare: $727.86 per employee per month<br>» Supplemental Pay: 6.4% of wages |

**Table 3 — Supplemental Benchmark Information**

| Supplemental Information on Related Benchmarks |
|---|
| *North Carolina Healthy Opportunities Pilots Fee Schedule (2024)[1]:<br>» Medical Respite<br>*Washington Health-Related Social Needs Fee Schedule (2025)[2]:<br>» Medical Respite<br>**Please note that it is assumed that room and board costs are included in both the North Carolina and Washington benchmarks.* |

[1] North Carolina Department of Health and Human Services. (July 2024) *Updated Health Opportunities Pilots Fee Schedule.* Available at: https://www.ncdhhs.gov/healthy-opportunities-pilot-fee-schedule-and-service-definitions/open

[2] Centers for Medicare & Medicaid Services. (January 2025). *WA MTP HRSN payment methodology approval* [PDF]. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-mtp-hrsn-payment-methodology-approval01162025.pdf