COMMUNITY SUPPORTS POLICY GUIDE VOLUME 1

Updated July 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

[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 July 2026) 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.

The Community Supports Policy Guide is organized into two volumes:

- Volume 1 contains the service definitions for eight Community Supports that address Members' health-related social needs that are not related to housing supports specifically.
- Volume 2 contains the service definitions for the seven Community Supports that address the needs of Members experiencing or at risk of homelessness, including Transitional Rent.

This Policy Guide provides a comprehensive overview of Community Supports, as well as guidance for MCPs. This Policy Guide serves as an extension of the MCP Contract, and the All Plan Letter 21-017[2]: *Community Supports Requirements* (or subsequent APLs). 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 at the time. 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 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

[2] All Plan Letter 21-017: *Community Supports Requirements* available at APL 21-017 (https://www.dhcs.ca.gov/wp-content/uploads/2025/10/APL21-017.pdf)

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.[3]

The Medi-Cal ECM and Community Supports Quarterly Implementation Report[4] 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, over 521,000 Medi-Cal Members have utilized Community Supports.[5] As of January 2026, every California county has available at least eight Community Supports across one or more MCPs; availability varies by plan, and Members' access depends on the plan in which they are enrolled.

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 expects MCPs to regularly perform oversight and robust benefit management of covered Community Supports to ensure delivery of services with fidelity to the guidance presented in this Policy Guide, program integrity and quality. MCPs are expected to deliver data to DHCS as part of a comprehensive monitoring strategy for Community Supports, described in Section VIII of this Policy Guide. MCPs, Community

[3] DHCS. *ECM Policy Guide*. August 2024. Available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf. January 2026.

[4] DHCS. ECM and Community Supports Quarterly Implementation Report. June 2026. Available at https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117. July 2026.

[5] Based on the data from January 1, 2022 through June 30, 2025.

Supports Providers, and other stakeholders may direct their questions to DHCS using the following email address: CommunitySupports@dhcs.ca.gov.

II. COMMUNITY SUPPORTS OVERVIEW

(Updated July 2026) **What are Community Supports?**

Community Supports are services that help improve the health and well-being of Members by addressing Members' health-related social needs, avoiding higher, costlier levels of care, and ultimately helping them live healthier lives. Community Supports—with the exception of Transitional Rent, which is mandatory for MCPs to offer as of 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.

Since 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[6]:

- Caregiver Respite, formerly known as Respite Services
- 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
- 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)

[6] The Community Supports Policy Guide: Volume 2 is available at: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf

- Day Habilitation Programs (Volume 2)
- Recuperative Care (Medical Respite) (Volume 2)
- Short-Term Post-Hospitalization Housing (Volume 2)

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

Cost-Effectiveness

Consistent with federal regulations,[7] 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. DHCS is conducting statewide aggregate analyses of the cost effectiveness of each of the approved Community Supports services. DHCS has published the most recent statewide cost-effectiveness analysis for Community Supports under California's Section 1915(b) waiver. The current report is available on the DHCS 1915(b) Reports webpage.[8] Future reports will be accessible on the same webpage, once they become available.

Benefit Management and Program Integrity

- Utilization Management: MCPs must apply utilization management techniques as they do for other benefits, as applicable and as permitted by federal managed care regulations, including authorization timelines, reassessment schedules, and service duration standards. Once MCPs choose to offer Community Support, they must manage the service as they do other health care benefits, subject to Policy Guide, APL, MCP Contract and related guidance.
- Provider Screening, Enrollment Credentialing, Revalidation, and Recredentialing: As MCPs do for all other covered benefits, MCPs must conduct provider

[7] 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 January 2026.

[8] See the DHCS 1915(b) Reports webpage for the most recent cost-effectiveness report: https://www.dhcs.ca.gov/providers-partners/calaim-1915b-reports/

screening, enrollment credentialing, revalidation, and recredentialing for Community Supports providers and comply with all federal and state screening requirements under APL 22-013, the MCP Contract, and federal law.

- Community Supports providers with a state-level Medi-Cal enrollment pathway must enroll through that pathway.[9] At this time, Community Support Providers generally do not have a state-level enrollment pathway.
- **Therefore, MCPs are responsible for the screening, enrollment, credentialing, revalidation, and recredentialing for all Community Support Providers in order to contract with the Community Support provider as a Network Provider**.
- Payments made by the MCP to a Community Support provider – including for those that are not considered a Network Provider (i.e., the MCP has a letter of agreement or single case agreement) must only be made to those providers who have gone through the screening, enrollment, and revalidation process in accordance with APL 22-013.
- During the provider screening, enrollment, credentialing, revalidation and recredentialing process and on a regular basis, MCPs are required to determine the exclusion and/or enrollment status. MCPs must do so in accordance with APL 22-013 and APL 21-003, by verifying federal and State exclusion lists, no less than monthly.
- **Please see Section V below on Provider Contracting, Screening, Enrollment, Credentialing, Revalidation, and Recredentialing for more details**.

» Program Integrity: MCPs are required to ensure that Community Supports services are delivered in a manner that adheres to program integrity requirements. An MCP may immediately terminate its agreement with Network Provider when the MCP conducts an internal investigation and determines there is credible evidence that the individual or entity has committed Fraud, Waste, or Abuse (FWA).[10] The MCP must notify DHCS and all impacted members of the termination and coordinate care.

- MCPs must notify DHCS Program Integrity Unit of all identified FWA as directed. Although MCPs may immediately terminate an individual or

[9] Provider Types Supported in PAVE available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/Provider_Types_Supported_in_PAVE.pdf

[10] The definitions for "fraud," "waste," and "abuse" are separately defined in the MCP Contract, Exhibit A, Attachment I, Article 1.0 (Definitions). See also MCP Contract, Exhibit A, Attachment III, Subsection 1.3.2.D (Fraud Prevention Program); and See APL 21-003 "Medi-Cal Network Provider And Subcontractor Terminations"

entity for this reason prior to notifying DHCS, MCPs must still ensure they have a sufficient provider network to delivery covered Community Supports services and ensure impacted Members are transferred to alternate Network Providers as appropriate to avoid delays in care. If MCPs cannot ensure access using Network Providers, they must authorize out-of-Network care for Members as appropriate.

- MCPs should also apply pre-payment and other analytics to support program-integrity monitoring and prevent potentially fraudulent or abusive activities. MCPs and Community Supports Providers should routinely flag and report anomalies or patterns to support effective oversight.

Federal Authorities for Community Supports

Short-Term Post-Hospitalization Housing, Recuperative Care, and Transitional Rent are currently authorized under Section 1115 waiver authority. Short-Term Post-Hospitalization Housing and Recuperative Care are authorized under the CalAIM waiver until December 31, 2026,[11] and Transitional Rent is authorized under the BH-CONNECT waiver until December 31, 2029.[12] 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 Policy Guide. Short-Term Post-Hospital Stabilization is being phased out after December 31, 2026 and Recuperative Care is being transitioned to "in lieu of services" under California's Section 1915(b) waiver and 42 CFR section 438.3(e)(2). The other 12 Community Supports are "in lieu of services" established and implemented in accordance with California's Section 1915(b) waiver and 42 CFR section 438.3(e)(2).[13]

[11] Medicaid. *CalAIM Demonstration Approval Technical Correction Attachment*. January 2025. Available at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list. Accessed January 2026.

[12] 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.

[13] 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

Each Community Support is additionally subject to the requirements of DHCS' MCP Contract.[14] 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 Policy 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.

(Updated July 2026) 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* summarizing areas for standardization and efforts to 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 will update the Action Plan on a regular basis to enhance program elements to support more consistent and efficient delivery statewide.

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.

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

III. COMMUNITY SUPPORTS – SERVICE DEFINITIONS

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

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

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.

Brief descriptions of the service definition refinements made in February 2025 and July 2026 are included in Appendices B and C of this Policy Guide.

Caregiver Respite

(Updated July 2026)[15]

Description/Overview

Caregiver Respite is 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.

Caregiver Respite 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 Members.
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 Members.
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 Caregiver Respite services are provided to the Member in his or her own home or another location being used as the home.

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

Caregiver 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 Medi-Cal is responsible.

Eligibility (Population Subset)

Members 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.

[15] This Community Support has been renamed from "Respite Services" to "Caregiver Respite" to avoid confusion with "Recuperative Care (Medical Respite)". This service definition was updated in May 2026 and is effective July 1, 2026. These refinements include clarifications to the list of allowable providers for Caregiver Respite and ensuring non-duplication with Foster Family Agency funds.

Eligible managed care Members may include, but are not limited to, children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, children/youth in foster care, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program, and Members with Complex Care Needs.

Caregiver Respite: Interface with Foster Family Agency Funding

Caregiver Respite may be provided to Members in child welfare foster care placements who otherwise meet eligibility criteria when support is needed beyond respite services funded by Foster Family Agencies (FFAs) via the California Department of Social Services. The Caregiver Respite Community Support must not duplicate coverage already provided through other state funded services, but may be additive and used to fill coverage gaps.[16]

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.

This service is limited to up to 336 hours per calendar year, including in-home and 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 Member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only allowable to avoid placements for which Medi-Cal is the payer.

Respite services cannot be provided virtually or via telehealth.

Licensing/Allowable Providers for Caregiver Respite

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 that provide services in:
  - Private residence

[16] California Department of Social Services. Foster Family Agencies. Available at: https://www.cdss.ca.gov/inforesources/foster-care/foster-family-agencies.

- Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)

- 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)
  - Community-Based Adult Services (CBAS) Facilities/Providers
- Providers contracted by county behavioral health agencies

MCPs remain responsible for conducting provider screening, enrollment, credentialing, revalidation and recredentialing for Community Supports Providers per the Community Supports Policy Guide, MCP Contract, and APL 22-013.

HCPCS Codes for Caregiver Respite

Listed below are the Healthcare Common Procedure Coding System (HCPCS) code and modifier combinations that must be used for Caregiver Respite. 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 Caregiver Respite
S5151	Unskilled respite care, not hospice; per diem	U6	Used with HCPCS code S5151 to indicate Community Supports Caregiver Respite
S9125	Respite care, in the home; per diem	U6	Used with HCPCS code S9125 to indicate Community Supports Caregiver Respite

Assisted Living Facility (ALF) Transitions

(Updated July 2026)

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.[17] 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:

1. Assessing the Member's housing needs and presenting options.
2. 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.

[17] 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. 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.

3. 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).
4. Moving expenses to support a Member's transition, such as movers/moving supplies and necessary private/personal articles to establish an ALF residence.
5. Communicating with facility administration and coordinating the move.
6. 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 receive these services indefinitely, as long as the Member resides in the ALF. These services include:

1. Assistance with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs)
2. Meal preparation
3. Transportation
4. Medication administration and oversight
5. Companion services
6. Therapeutic social and recreational programming provided in a home-like environment
7. 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
8. 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 the first service component).

Eligibility (Population Subset)

Members residing in a nursing facility who:

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

Members residing in the Community who:

- Are interested in remaining in the community; and
- Are willing and able to reside safely in an ALF; and
- Meet the minimum criteria to receive nursing facility LOC services[18] 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.

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

Interface with the Assisted Living Waiver and California Community Transitions Program

A Member can be eligible for the Assisted Living Waiver (ALW)[19], the California Community Transitions (CCT) program[20], and ALF Transitions; however, they cannot receive the same services at the same time, as that would be considered duplicative.

MCPs are encouraged to assist Members with enrollment in eligible and available waiver programs, such as the ALW, as appropriate. In addition, MCPs should assist eligible Members who are interested in applying for the ALW with joining the ALW waitlist, and inform Members that the ALF Transitions Community Support service can be used while ALW enrollment is pending. Members can submit the ALW Waitlist Request Form to the Care Coordination Agency (CCA) serving their county. The ALW Waitlist Request Form can be accessed online.[21]

DHCS encourages MCPs to offer this Community Support to Members on the ALW waitlist.[22] For example, Members transitioning out of a nursing facility who are awaiting enrollment in the ALW may use the time-limited transition component of ALF Transitions to support their transition to an assisted living facility. Members may then utilize the ongoing assisted living services component of ALF Transitions to support the services received from the assisted living facility until their enrollment in the ALW is completed.

While ALF Transitions may be used by Members when their ALW enrollment is pending and for those on the waitlist, the service is not limited only to Members on the waitlist. Eligibility for, or enrollment in, the ALW is not a prerequisite for being eligible for the

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[19] For more information, see the DHCS ALW webpage. Available at: www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx.

[20] For more information, see the DHCS CCT webpage. Available at: www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx.

[21] The Assisted Living Waiver (ALW) Waitlist Request Form. Available at: www.dhcs.ca.gov/wp-content/uploads/2025/10/ALW_Waitlist_Request_Form_5_17_17.pdf

[22] 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 January 2026, 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.

ALF Transitions Community Support. Thus, MCPs should not require Members to join or already be on the ALW waitlist as a condition of approving ALF Transitions services.

MCPs must ensure no duplication of payment. When a Member is actively enrolled in the ALW, MCPs must not pay for services covered under the ALW or other Medi-Cal covered benefits.

DHCS provides MCPs with a monthly file of their specific Members who are on the ALW waitlist to support care planning and timely coordination and delivery of ALF Transitions services. MCPs should use this file as a primary resource when planning transitions, monitoring Member status, and ensuring non-duplication of services.[23] MCPs and their contracted ALW Transitions provider should ensure smooth transition to the ALW provider and ALW services once a Members is enrolled in the ALW.

Specifically, MCPs should work collaboratively with ALW Care Coordination Agencies to align care planning and ensure appropriate referrals.[24] As a best practice, MCPs should establish written protocols for warm handoffs between Community Supports Providers and ALW case managers, including timelines, documentation packages, and Member communications that explain benefit transitions.

Upon enrollment in the ALW, Members must transition to an ALW provider. An ALW provider is one that is participating in the ALW program. See the *Assisted Living Waiver Participating Facilities* list for the most current list of participating RCFE/ARFs.[25]

MCPs should review and ensure sufficient claims adjudication processes, service authorization processes, and related policies and procedures are in place to prevent

[23] DHCS makes these ALW waitlist files available to MCPs monthly via each plan's secure SFTP folder. DHCS has initially provided all MCP primary and secondary compliance contacts with access to the files. MCPs may contact their DHCS contract manager to add other individuals. MCPs may contact DHCS at ALWP.IR@dhcs.ca.gov or the assigned Care Coordination Agency for questions related to the ALW waitlist process and policy or general questions about the program.

[24] List of participating CCA agencies can be found at: https://www.dhcs.ca.gov/services/long-term-care-alternatives-home-and-community-based-service-options/participating-care-coordination-agencies/

[25] DHCS. Assisted Living Waiver Program Participating Facilities. Available at: https://www.dhcs.ca.gov/services/long-term-care-alternatives-home-and-community-based-service-options/assisted-living-waiver-program-participating-facilities/

duplicate payments if and when Members transition from the ALF Transitions Community Support to the ALW.

Additional guidance on ALW services and eligibility criteria is available on the DHCS ALW website.[26]

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, including the ALW Reimbursement Rate Sheet.

Many ALW participants use income supports such as Social Security Income/State Supplementary Payment (SSI/SSP)[27] to pay for room and board. MCPs may assist Members, as appropriate, with referrals or applications for SSI/SSP.

MCPs should strive to keep Members in the setting that is clinically appropriate while respecting the Member's choice of setting and freedom from coercion and restraint.[28] In counties where the ALW is available, MCPs may direct ALF Transitions placements in ALW providers (i.e. RCFE/ARFs enrolled in the ALW program), provided there is sufficient capacity and the ALW provider is able to accept the Member, and consistent with the governing authorities for In-Lieu-of Services.

The MCP is not compelled to authorize the ALF Transitions Community Support if the MCP can coordinate an alternative care plan that is clinically appropriate, including, but not limited to, leveraging In-Home Supportive Services, home health, and/or other supports, to keep the Member within their current housing, and the Member chooses this alternative.

[26] DHCS. Assisted Living Waiver. Available at: https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx.

[27] For more information on federal SSI benefits, Living Arrangements, and personal needs allowance, visit: https://www.ssa.gov/ssi/text-living-ussi.htm.
For more information on California's SSP, visit: https://www.cdss.ca.gov/inforesources/ssi-ssp.

[28] 42 CFR 441.530(a)(1)(iii)

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).[29] The 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.[30] 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.[31]

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[32] 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.

[29] 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.

[30] 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.

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

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

Licensing/Allowable Providers for ALF Transitions

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

The list below 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
- 1915(c) 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 screening, enrollment, credentialing, revalidation, and recredentialing processes.

Interface with Assisted Living Waiver (ALW) Providers

MCPs are encouraged to contract with ALW providers as Community Support Providers. DHCS conducts enrollment for ALW providers in certain counties and MCPs may leverage the state-enrollment pathway for ALF Transitions Community Support provider screening and enrollment where it is available. If MCPs leverage the state-enrollment pathway, they must document this in their Policies and Procedures.

However, MCPs are required to conduct credentialing, revalidation and recredentialing in accordance with APL 22-013.

DHCS also encourages MCPs to consider non-ALW RCFE/ARFs for enrollment and contracting as an ALF Transitions provider. MCPs should not restrict their ALF Transitions networks to ALW-enrolled providers only, as the ALW is not available statewide and there are currently delays in ALW provider enrollment. Non-ALW RCFE/ARF operators who meet DHCS qualifications and program standards may be well-qualified to deliver ALF Transitions services and should be considered for contracting upon provider screening, enrollment, credentialing, revalidation and recredentialing.

MCPs should review their Community Supports ALF Transitions network composition to assess current access and network capacity against their Members' needs. Again, MCPs

should consider contracting with qualified providers including RCFE/ARF that are not currently enrolled in the ALW program but can pass the MCPs' screening, enrollment, credentialing, revalidation, and credentialing process in accordance with APL 22-013.

HCPCS Codes for ALF Transitions

Listed below are the HCPCS code and modifier combinations that must be used for ALF Transitions. The modifier descriptions have been updated to clarify the appropriate HCPCS code and modifier combinations for billing Transition Services and Expenses versus Ongoing Assisted Living Services. 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.	U4	Used with HCPCS code T2038 to indicate Community Supports Assisted Living Facility Transitions: Transition Services and Expenses. Modifier used to differentiate from Community or Home Transition Services ***(Updated January 2026)***
H2022	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: Ongoing Assisted Living Services ***(Updated January 2026)***

Community or Home Transition Services

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**[33] 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:
   - Assessing the Member's housing needs and presenting options.
   - 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).
   - Communicating with the landlord (if applicable) and coordinating the move.
   - Establishing procedures and contacts to retain housing.
   - 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.
   - Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

[33] 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.

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 includes:
    - Security deposits required to obtain a lease on an apartment or home. Security deposits should be in alignment with AB-12,[34] enacted in 2024;
    - Set-up fees for utilities or service access and up to six months' payment in utility arrears, as necessary to secure the unit;
    - 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;
    - Air conditioner or heater;
    - 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.

Eligibility (Population Subset)

Members who:

- Are currently receiving medically necessary nursing facility Level of Care (LOC) services[35] 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
- Have lived 60+ days in a nursing home and/or Recuperative Care setting; and
- Are interested in moving back to the community; and

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

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

- 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,[36] Home & Community Based Alternatives (HCBA) Waiver,[37] and/or the Multipurpose Senior Services Program (MSSP) and this Community Support;[38] 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.

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

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 Supports services. MCPs should ensure Members are appropriately screened and referred for services for which they may be eligible. For example, Members can also be

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

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

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

connected to Housing Deposits[39] and/or Housing Transition Navigation Services,[40] 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.[41] The Community Support does not replace ECM 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.[42]

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.[43] 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.

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

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

[41] Refer to 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.

[42] Refer to DHCS' ECM Populations of Focus Spotlight for Long-Term Care POF*s* 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.

[43] Refer to DHCS' Population Health Management Policy Guide for full DHCS requirements under TCS. Available at https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf.

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

MCPs remain responsible for conducting provider screening, enrollment, credentialing, revalidation and recredentialing for Community Supports Providers per the Community Supports Policy Guide, MCP Contract, and APL 22-013.

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.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter.	U5	Used with HCPCS code T2038 to indicate Community Supports Community or Home Transition Services: Transition Services and Expenses. Modifier used to differentiate from Assisted Living Facility Transitions
H0044 ***(Updated January 2026)***	Supported housing; per month.	U5	Used with HCPCS code H0044 to indicate Community Supports - Community or Home Transition Services: Non-recurring Set-Up Expenses. Modifier used to differentiate from Housing Deposits and Short-Term Post-Hospitalization Housing

Personal Care and Homemaker Services (PCHS)

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. However, if upon assessment, the MCP finds that it would be clinically appropriate for a member to go to a higher level of care, the MCP should work with the Member to transition to that higher level of care instead of authorizing PCHS.

The PCHS Community Support can be utilized:

- During the IHSS application process, including during any waiting period after an application 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 and a request for increased hours is pending, and 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.

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 an IHSS application is pending, additional support is needed beyond authorized IHSS hours and a request for increased hours is pending, 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.

To be approved for this Community Support, Members must:

1) Demonstrate willingness and cooperate with the IHSS application process including the initial application process, or the application request for additional IHSS hours, beyond the hours that have been initially approved. This means responding to inquiries in a timely manner, providing required documentation in a timely manner, and cooperating with the case manager; or
2) Demonstrate a need for hours beyond the maximum number of hours IHSS authorized and proof that the member is already authorized for the maximum amount of IHSS hours.

If the Member is not already enrolled in the IHSS program, it is important that there is timely progression through the initial IHSS application process unless there is proof that the Member is not eligible for IHSS. Delays resulting from county-level IHSS processing—both for the initial application or for authorization of additional hours—should not be deemed as lack of timely progression through the IHSS application process.

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.[44]

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

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

Restrictions/Limitations

The eligibility criteria for this Community Supports remain the same as those used for IHSS. PCHS may only be authorized in the specific circumstances described above and cannot be utilized in lieu of applying to the In-Home Supportive Services program. The Member must apply to the In-Home Supportive Services program when the program criteria are met.

Members requesting PCHS must demonstrate a completed initial application for IHSS (if applicable) or a completed request for additional hours (if applicable) as part of the request for PCHS.

Members approved for PCHS must provide proof of application status (if applicable) and application progress (if applicable) every 90 days to the MCP to remain eligible for PCHS. Members must make a good faith effort to address any information requests or other requests in support of completing the IHSS application process or request for more hours.

If a Member receiving PCHS has any change in their current condition, they must be referred to IHSS for reassessment and determination of additional hours. Members may continue to receive PCHS during this reassessment waiting period.

MCPs are responsible for conducting the appropriate medical necessity determination based on level of care needs for the member. MCPs may deny authorization requests for PCHS if Members require higher levels of care needs than can be safely furnished by PCHS alone. MCPs are encouraged to refer Members to Transitional Care Services when appropriate. Please see the *Transitional Care Services for Members with Long-Term Services and Supports Needs: A Technical Assistance Resource for Medi-Cal Managed Care Plans*[45] for additional information.

In accordance with APL 22-14,[46] MCPs are required to implement electronic visit verification for all personal homemaker services that are delivered by a Community Supports provider. Validation of hours of service provided by the personal homemaker

[45] Available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/TCS-TA-Resource-for-LTSS-Transitions.pdf

[46] DHCS APL 22-014. Available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/APL22-014.pdf

service worker is a federal requirement necessary to ensure program integrity and delivery of authorized hours.

Licensing/Allowable Providers for PCHS

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

MCPs remain responsible for conducting provider screening, enrollment, credentialing, revalidation and recredentialing for Community Supports Providers per the Community Supports Policy Guide, MCP Contract, and APL 22-013.

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 and Homemaker Services
T1019	Personal care services; per 15 minutes	U6	Used with HCPCS code T1019 to indicate Community Supports Personal Care and 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, Member-specific written evaluation 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. Examples of items typically covered under DME include portable ramps, shower chairs, etc.

- 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.

MCPs remain responsible for conducting provider screening, enrollment, credentialing, revalidation and re-credentialing for Community Supports Providers per the Community Supports Policy Guide, MCP Contract, and APL 22-013.

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 (MTM)/Medically Supportive Food (MSF)

(Updated July2026)

Description/Overview

Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address Members' chronic or other serious nutrition-sensitive conditions, through treating, managing, and preventing the worsening of these conditions by addressing underlying disease mechanisms to improve health outcomes and reduce unnecessary costs.

As these interventions are designed to address nutrition-sensitive conditions, referrals must come from a member of the Member's established healthcare team or MCP (as described further below) and include clinical documentation of a member's nutrition sensitive conditions.

Medically Tailored Meals (MTM):

MTM consists of nutritionally complete meals designed in accordance with evidence-based nutrition guidelines for targeted nutrition-sensitive conditions and tailored to the Member following appropriate nutrition assessment. Subtypes include:

1. **Medically Tailored Meals (MTMs):** Nutritionally complete meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.
2. **Medically Tailored Groceries (MTGs):** Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

After the MCP determines an individual is eligible for MTM or MTG and authorizes the service, the Member must receive an individual nutritional assessment conducted or supervised by a Registered Dietitian Nutritionist (RDN) to inform the development of a Member-specific nutritional plan and confirm the appropriateness of the MTM or MTG intervention unless the MCP has staff that has conducted this assessment as part of its eligibility determination.

The design of each MTM/MTG service (e.g., diabetes meal plan, heart failure grocery plan) must be tailored by an RDN (or another appropriate clinician under RDN

oversight) to ensure adherence to evidence-based nutrition guidelines aimed at preventing, managing, or reversing the targeted nutrition-sensitive health condition(s).[47]

The MTM and/or MTG assistance provided (alone or in combination) must meet at least two-thirds (2/3) of the Member's estimated daily nutrient and energy needs, as determined by the overseeing RDN/clinician, and must constitute the majority of the Member's diet during the intervention period. MTM/MTG must not contain ultra-processed foods or foods with excessive added sugar or salt.

Medically Supportive Food (MSF):

MSF consists of supplemental foods that adhere to national nutrition guidelines to support management of nutrition-sensitive conditions. Subtypes include:

1. **Medically Supportive Groceries:** Preselected foods that follow the federal Dietary Guidelines for Americans and meet condition-specific recommendations.[48]
2. **Produce Prescriptions:** Fruits and vegetables procured via electronic vouchers, cards, or similar mechanisms in retail or farmers' market settings.
3. **Healthy Food Vouchers:** Electronic vouchers for pre-selected foods that follow the federal Dietary Guidelines for Americans and meet condition-specific recommendations.
4. **Food Pharmacy:** A model combining MSF with nutrition supports (e.g., education, counseling, culinary classes) in or coordinated with a healthcare setting to remove barriers to healthy eating and build the knowledge and skills required for sustained healthy eating.[49]

After MCP authorization of MSF, DHCS recommends (but does not require) a clinical review or assessment by an RDN or appropriate clinician to inform the development of a nutritional plan and to ensure receipt of the appropriate MSF service. The design or selection of foods or food options in MSF services must be overseen and signed off on

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

[48] More information on the Dietary Guidelines for Americans can be found at: https://www.dietaryguidelines.gov/.

[49] 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.

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.

For Produce Prescriptions and Healthy Food Vouchers, the financial mechanism must be electronic (e.g., reloadable restricted-use card, digital voucher, QR code, or direct point-of-sale credit) unless the MCP documents that no viable electronic option exists in the Member's service area. Paper vouchers are strongly discouraged and require prior MCP approval with enhanced controls.

Unlike MTM/MTG, MSF is supplemental and does not need to meet minimum daily nutrient and energy thresholds, but services should support recommended intakes of fruits, vegetables, or other targeted nutrients. MSF must not contain ultra-processed foods or foods with excessive added sugar or salt.

Applicable to All MTM/MSF Services:

MCPs must require providers to deliver meal and food services that follow national evidence-based nutrition guidelines and are appropriate for the identified nutrition-sensitive condition(s). Interventions must be tailored at the service level for the identified target chronic or serious health conditions (e.g., Dietary Approaches to Stop Hypertension (DASH) diet for Members with hypertension).[50] MCPs and providers must consider each Member's cultural preferences/needs (e.g., halal or kosher meals) and food preparation/storage capabilities (e.g., ability to store frozen meals) when determining the appropriate intervention for the Member.

Nutrition Education:

Nutrition education, health coaching, counseling, classes, behavioral supports, and related tools (including equipment and materials) must be based on the Member's condition(s) and the MTM/MSF intervention provided.[51] DHCS strongly encourages MCPs to work with their Community Supports Providers to offer behavioral, cooking,

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

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

and/or nutrition education alongside the MTM/MSF services offered, but standalone nutrition education is not sufficient to qualify as delivery of this Community Support.[52]

Any nutrition education offered must adhere to evidence-based nutrition guidelines, be vetted by an RDN or appropriate clinician, and may be provided in an individual or group setting by qualified staff. MCPs may choose to provide nutrition education directly.

Nutrition education provided as part of this service does not supplant other Medi-Cal services. MCPs must refer Members to other Medi-Cal covered services for which they are eligible (e.g., Medical Nutrition Therapy, Diabetes Self-Management Education, etc.).[53]

Utilization Management (UM) Protocols:

MCPs retain full authority and responsibility for UM of MTM/MSF consistent with DHCS guidance. Services may be authorized only for Members with documented nutrition-sensitive conditions. MCPs may establish clinical thresholds (e.g., biomarkers, disease severity) in their UM protocols to ensure services are directed to Members most likely to benefit.

- Authorization periods must be time-limited and based on the Member's clinical needs. Initial authorizations are generally expected to be up to 12 weeks. Reauthorizations may be granted for additional periods only when there is documented evidence of ongoing engagement with the Member's healthcare team, adherence to the care plan, and clinical benefit. MCPs may choose to authorize for longer periods when supported by the evidence to reduce administrative burden.

[52] MCPs will not be reimbursed for providing MTM/MSF if only the nutrition education subcomponent is delivered. It must be offered in conjunction with another MTM/MSF nutrition intervention.

[53] See the DHCS 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/B486BEE7-E730-44DE-BA05-A7525FED99D1/mednenutri.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

- MCPs must define evidence-based and clinically appropriate graduation/exit criteria[54] based on progress, member stability, and care plan alignment. These graduation criteria cannot override a treating clinician's documentation of ongoing medical necessity.
- In practice, MCPs will determine whether a treating clinician has documented ongoing medical necessity through the reauthorization process, which requires submission of clinical documentation from the Member's primary care, specialty care team, or other clinical care team (e.g., hospital inpatient team) confirming continued benefit and adherence to the care plan. If such documentation is provided and supports ongoing need, the MCP must not deny reauthorization solely based on internal graduation timelines. In addition, MCPs may also independently determine ongoing medical necessity by using available medical record information and Medi-Cal Connect (MCC) data available to them, consistent with their Population Health Management[55] responsibilities, when the evidence supports continuing the service.

For service denials , a qualified clinical professional (e.g., RDN, physician, or other clinician with relevant experience) at the MCP (or through a Subcontractor delegated to conduct UM for MTM/MSF) must conduct the review. MCPs must require documentation of the nutrition-sensitive condition, clinical appropriateness, and (for continuation) response to the intervention.

As part of program integrity requirements, MCPs must have processes to validate that Members authorized for this Community Supports are receiving the foods/meals as authorized. In addition, MCPs should ensure their MTM/MSP providers regularly contact Members to assess whether Members are 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.

[54] Food Is Medicine Coalition (FIMC) – Medically Tailored Meal Accreditation Criteria & Requirements (ACR), Version 1.1 (March 2024). Available at: https://fimcoalition.org/wp-content/uploads/2024/03/Food-is-Medicine-Coalition-Medically-Tailored-Meal-Intervention-Accreditation-Criteria-and-Requirements.pdf

[55] DHCS' Population Health Management Policy Guide. Available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/PHM-Policy-Guide.pdf

Eligibility (Population Subset)[56]

Individuals who have chronic conditions that are nutrition sensitive or other serious health conditions that are nutrition sensitive, including, but not limited to: cancer(s), , chronic kidney disease (stages 2-5), heart failure, diabetes or other nutrition-sensitive metabolic conditions, elevated lead levels, end-stage renal disease, human immunodeficiency virus, hypertension, high cholesterol/dyslipidemia, fatty liver, malnutrition, obesity, stroke, high-risk perinatal conditions (including, but not limited to: gestational diabetes, abnormal glucose in pregnancy, gestation hypertension, pre-eclampsia), anxiety conditions with moderate to severe distress, depression conditions with moderate to severe distress, and other mental/behavioral health disorders with moderate to severe functional impacts.

Restrictions/Limitations

- Service is limited to a maximum of two (2) meals or meal-equivalent packages per day (using any combination of MTM/MSF).
- Authorization periods:
  - Initial authorizations are generally expected to be up to 12 weeks. MCPs may choose to authorize for a longer period of time to minimize administrative burden based on their review of the evidence.
  - Reauthorizations beyond the initial 12 weeks may be granted only when the Member has demonstrated ongoing active engagement with their primary care or specialty care team. Please note a missed appointment or other one-off incidents in the context of overall ongoing engagement are not grounds for denying reauthorization or termination of this community support. Documentation must include:
    - Certification or documentation from the treating clinician(s) in the Member's individualized care plan.

[56] The following conditions appeared in the prior MTM/MSF service definition but were removed or refined in this updated version: cardiovascular disorders; chronic lung disorders, including asthma/COPD; gastrointestinal disorders; and the broader category of chronic or disabling mental/behavioral health disorders (now refined to specify conditions presenting with moderate to severe functional impacts).

    - Evidence of meaningful care coordination between the MTM/MSF provider and the Member's healthcare team (e.g., shared progress notes, joint care planning, or confirmed warm handoffs).

- MCPs may choose to reauthorize for a period of time longer than 12 weeks to minimize administrative burden based on their review of the evidence.
    - All authorizations and reauthorizations must remain tied to documented medical necessity and clinical benefit.
- Meals, food, payments, or nutrition services that are eligible for or reimbursed by alternate programs cannot be funded or claimed as MTM/MSF.
- MTM/MSF is not covered to address food insecurity.

Referrals for MTM/MSF

- Referrals for MTM/MSF must originate from a member of the Member's established health care team or from the MCP. This includes, but is not limited to, primary care providers, specialists, inpatient providers, dietitians, clinic care managers, hospital social workers, or other members of the Member's clinical care team. Referrals must include clinical documentation of the Member's nutrition-sensitive condition. Clinicians employed solely by MTM/MSF providers do not satisfy the health care provider referral requirement unless they also hold a separate contract with the MCP for clinical services outside of MTM/MSF. If Members, family members, friends, community partners, or MTM/MSF vendors request MTM/MSF, they should be directed to the Member's clinical care team unless the MCP determines that it has sufficient information to initiate the referral. MTM/MSF vendors should also direct Members to their health care team to initiate a referral when needed. If additional documentation is needed, Community Supports providers may assist MCPs in obtaining the documentation needed from the Member's established health care team.
- In addition to accepting referrals from the Member's clinical care team, MCPs may also initiate referrals based on their Population Health Management (PHM) responsibilities. MCPs are expected to use available data analytics—including claims and encounter data, EHR or QHIO information, and MCC data—to conduct risk assessments, identify Member needs, and determine which Members may benefit from MTM/MSF. As part of a comprehensive PHM program, MCPs should proactively identify Members with nutrition-sensitive conditions or other indicators suggesting that MTM/MSF may improve health outcomes, and may initiate referrals when sufficient information is available.

- MCPs and/or their providers must screen for and facilitate access to longer-term resources (e.g., SNAP, WIC, food pantries) to support food security and enhanced physical and mental well-being.

Additional Controls for Produce Prescriptions, Healthy Food Vouchers, and Other Retail-Based MSF Mechanisms:

- Benefits must be non-transferable, non-cash-equivalent, and restricted to eligible items only (fruits, vegetables, and other RDN-approved whole foods consistent with the Member's nutritional plan).
- Redemption must include Member (or authorized representative) identity verification, using methods appropriate to the delivery channel (e.g., electronic token, PIN, digital voucher linked to the Member's record, or photo ID at point of sale where feasible).
- MCPs must work with providers to ensure they receive sufficient information (such as regular redemption data and other relevant analytics) to support program-integrity monitoring and help prevent trafficking of delivered services. MCPs and providers should routinely flag and report anomalies (for example, zero or unusually low redemption rates or other irregular patterns suggestive of trafficking[57]) to support effective oversight.
- Any unused benefit value expires at the end of the authorization period and cannot be carried over or converted to cash.
- Providers must maintain fraud-prevention policies, including staff training on trafficking detection and immediate reporting to the MCP of suspected misuse.

Licensing/Allowable Providers for MTM/MSF

The types of providers MCPs may contract with include (non-exhaustive):

- MTM providers
- Produce prescription programs
- Medically tailored or supportive grocery providers (e.g., food banks)
- Home-delivered meal providers

[57] Trafficking refers to the unauthorized sale, exchange, transfer, or misuse of an MTM/MSF voucher, card, or food package by anyone other than the authorized Member or their designated representative.

- Area Agencies on Aging
- Perinatal nutrition providers with expertise serving pregnant and postpartum individuals
- Qualified nutrition education providers to help sustain healthy cooking and eating habits

MCPs remain responsible for conducting provider screening, enrollment, credentialing, revalidation and recredentialing for Community Supports Providers per the Community Supports Policy Guide, MCP Contract, and APL 22-013.

Monitoring of MTM/MSF Community Supports Providers by MCPs

MCPs must ensure ongoing compliance with all requirements through provider contracts and monitoring. Required elements include:

- Nutrition standards, RDN/clinical staff qualifications, and condition-specific guidelines;
- Nutritional content details, including available specific macro- and/or micro-nutrient thresholds, energy (calories), and ingredients;
- For retail-based MSF (Produce Prescriptions and Healthy Food Vouchers): detailed redemption reports, including utilization rates, item-level purchase data, and any flagged anomalies or suspected misuse.
- Providers' food safety licensure, inspection records, and violation history;
- Transparency on service volume and locations.

MCPs must conduct regular audits of case files and redemption/transaction data to verify MTM/MSF providers are delivering and Member are receiving the services in accordance to the service authorization and validate Member adherence. Corrective action or contract termination is required for violations. MCPs are encouraged to track Member adherence and health outcomes data to support quality improvement.

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 MTM/MSF: Medically Tailored Meals (Per Meal) ***(Updated January 2026)***
S9452 ***(Updated January 2026)***	Nutrition classes, non-physician provider; per session.	U5	Used with HCPCS codes S9452 to indicate Community Supports MTM/MSF: Nutrition Education - Individual Session (Per 15 Minutes)
S9452 ***(Updated January 2026)***	Nutrition classes, non-physician provider; per session.	U6	Used with HCPCS codes S9452 to indicate Community Supports MTM/MSF: Nutrition Education - Group Session (Per 15 Minutes)
S9470	Nutritional counseling, diet	U6	Used with HCPCS code S9470 to indicate Community Supports MTM/MSF: Nutritional Assessment (Per 15 Minutes) ***(Updated January 2026)***
S9977 ***(Updated January 2026)***	Meals; per diem, not otherwise specified	U4	Used with HCPCS code S9977 to indicate Community Supports MTM/MSF: Produce Prescription – Box (Per Week)

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
S9977 ***(Updated January 2026)***	Meals; per diem, not otherwise specified	U5	Used with HCPCS code S9977 to indicate Community Supports MTM/MSF: Produce Prescription – Retail (Per Month)
S9977	Meals; per diem, not otherwise specified	U6	Used with HCPCS code S9977 to indicate Community Supports MTM/MSF: Medically Tailored Groceries (Per Week) ***(Updated January 2026)***
S9977 ***(Updated January 2026)***	Meals; per diem, not otherwise specified	U7	Used with HCPCS code S9977 to indicate MTM/MSF: Medically Supportive Groceries (Per Week)
S9977 ***(Updated January 2026)***	Meals; per diem, not otherwise specified	U8	Used with HCPCS code S9977 to indicate MTM/MSF: Food Pharmacy (Per Session)
S9977 ***(Updated January 2026)***	Meals; per diem, not otherwise specified	U9	Used with HCPCS code S9977 to indicate MTM/MSF: Healthy Food Vouchers (Per Month)

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 must 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.

MCPs remain responsible for conducting provider screening, enrollment, credentialing, revalidating and recredentialing for Community Supports Providers per the Community Supports Policy Guide, MCP Contract, and APL 22-013.

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

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.[58]

Asthma Remediation is an optional supplement to the Asthma Preventive Services (APS) Medi-Cal State Plan service.[59] 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. APS must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Although Community Health Workers (CHWs) can also deliver high-level health education that touches on asthma management through the CHW benefit, the APS benefit covers a distinct set of targeted asthma education services delivered by providers with specialized asthma prevention training. *See asthprev.pdf for further details about APS service components and provider qualifications.*

As set out below, it is a requirement for Asthma Remediation that the Member's needs have been assessed under the APS benefit.

As of January 1, 2026: asthma self-management education and in-home environmental trigger assessments must be covered by MCPs under the APS benefit and is no longer covered under this Community Support as required by the CalAIM Special Terms and

[58] 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://nchh.org/resource-library/hud_guide-to-sustaining-effective-asthma-home-intervention-programs.pdf.

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

Conditions[60], which specify that Community Supports must supplement and not supplant services received by the Medi-Cal Member through other State, local, or federally funded programs.

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[61]
- De-humidifiers
- Mechanical air filters/air cleaners[62]
- 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.

[60] DHCS. CalAIM Special Terms and Conditions. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-ManagedCare-Amendment-Approved.pdf.

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

[62] 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-certified-air-cleaning-devices.
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.

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. MCPs should additionally cover any administrative costs necessary to secure, deliver, and install any applicable physical home modification(s) and supplies authorized through this service.

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.
- Asthma Remediation is provided as part of a Member's clinical asthma management and is not intended to address general housing or environmental concerns. Entry into this service is always though APS. Thus, all referrals must be routed to APS, including Member self-referrals and MCP-generated referrals. Referrals for Asthma Remediation(s) must always be supported by information from an APS in-home environmental trigger assessment completed within the past 12 months, which identifies the asthma-related environmental triggers and appropriate remediation activities.
- MCPs may obtain the APS assessment directly to complete the authorization process.
- Reauthorizations should reflect that the Member continues to have asthma-related needs, including a current APS assessment or an updated assessment if the Member's home environment has changed.

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, and must 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.[63]

MCPs remain responsible for conducting provider screening, enrollment, credentialing, revalidation and recredentialing for Community Supports Providers per the Community Supports Policy Guide, MCP Contract, and APL 22-013.

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

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

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 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 provider networks 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.

Exception for Medically Tailored Meals/Medically Supportive Food (MTM/MSF):

Referrals for MTM/MSF must originate from the Member's established healthcare team (primary care, medical home, specialist, or inpatient team) or the MCP and must include clinical documentation of the Member's nutrition-sensitive condition.

Members, family members, friends, community partners, or MTM/MSF providers/ vendors who inquire about or request this service should be directed (via warm handoff where possible) to the Member's healthcare team to initiate the formal referral.

Exception for Asthma Remediation:

As noted above, Asthma Remediation referrals must be routed to the APS benefit for approportionate assessment, documentation, and service authorization.

Closed-Loop Referral (CLR) Requirements:

In addition to the guidance provided in this Policy Guide, the DHCS CLR Implementation Guidance[64] details MCP requirements for tracking, supporting, and monitoring referrals made to ECM and Community Supports.[65] Community Supports CLR requirements took effect on 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):[66] 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.

[64] DHCS. CLR Implementation Guidance. Available at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.

[65] 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 January 2026.

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

- 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 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.[67] 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.

[67] 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.

- 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 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[68]
- Short-Term Post-Hospitalization Housing[68]
- 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.

Utilization Management Authority for Community Supports

MCPs retain full utilization management (UM) authority for all covered Community Supports services, consistent with federal managed care regulations, the Medi-Cal MCP Contract, and DHCS policy guidance to ensure clinically appropriate utilization of Community Supports as cost-effective substitutes for applicable Medi-Cal covered

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

services. MCPs are responsible for establishing and applying UM criteria, including on authorization timelines, service duration standards, and reassessment schedules, to ensure Community Supports are delivered in a cost-effective, medically appropriate, and outcomes-oriented manner that ensures program integrity. MCPs may apply UM protocols and make determinations regarding authorization, reassessment, service duration, and termination for sustained lack of engagement or when a service is no longer appropriate, so long as these processes align with DHCS guardrails and do not create impermissible barriers to access.

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 compliance for 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:

- 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, or when there is sustained lack of engagement or safety concerns, consistent with existing DHCS policy.

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.

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.[69] 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.

[69] DHCS. Grievance and Appeal Requirements, Notice and "Your Rights" Templates. Available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf.

V. PROVIDER CONTRACTING, SCREENING, ENROLLMENT, CREDENTIALING, REVALIDATION, AND RECREDENTIALING 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 screen 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. If MCPs use community care hubs as an intermediary and delegates any functions to these entities, certain Subcontracting requirements apply.[70]

Screening, Enrollment, Credentialing, Revalidation and Recredentialing Community Supports Providers

Screening and Enrollment

Under federal Medicaid regulations, all enrolling and currently enrolled Medi-Cal providers must comply with federal disclosure, screening, monitoring, reporting and enrollment requirements outlined in 42 CFR Part 455. These requirements apply uniformly to all provider types, including those enrolled by DHCS, via another state-level enrollment pathway, or by the MCP.

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[71]. For more information on Medi-Cal enrollment pathways and processes, see the Provider Application and Validation for Enrollment (PAVE)[72] portal. It should be emphasized that, except for Assisted Living Waiver Providers[73] available in some counties for the ALF Transition Community Support, there are no existing state-level enrollment pathways for Community Support Providers at this time.

DHCS has created enrollment pathways for certain Community-Based Organizations (CBOs) including, but not limited to, 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 APS services may also apply to enroll in the Medi-Cal program by submitting an electronic

[70] DHCS. The MCP-Hub Toolkit: A Resource for MCPs and CalAIM Providers. Available at: https://www.dhcs.ca.gov/services/the-mcp-hub-toolkit-a-resource-for-mcps-and-calaim-providers/

[71] DHCS. Provider Enrollment Options. Available at: https://www.dhcs.ca.gov/providers-partners/provider-enrollment-options/.

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

[73] DHCS. Assisted Living Waiver Provider Enrollment. Available at: https://www.dhcs.ca.gov/services/long-term-care-alternatives-home-and-community-based-service-options/assisted-living-waiver-provider-enrollment/

application through the PAVE online enrollment portal, along with all supporting documentation.[74]

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:

Community Supports Providers without a state-level enrollment pathway (e.g., housing agencies, medically tailored meal providers) are not required to enroll through the state-level enrollment pathway since such a pathway does not currently exist.

Therefore, MCPs are responsible for the screening, enrollment, credentialing, revalidation, and recredentialing for all Community Supports Providers in order to contract with the Community Support provider as a Network Provider in accordance with 42 CFR Part 455, the Community Supports Policy Guide, the MCP Contract and APL 22-013.

Payments made by the MCP to a Community Support provider – including for those that are not considered a Network Provider (i.e., the MCP has a letter of agreement or single case agreement) must only be made to those providers who have gone through the screening, enrollment, and revalidation process in accordance with APL 22-013.

Credentialing

As per the MCP Contract, credentialing means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure, and professional association membership. APL 22-013 gives details on MCP credentialing requirements. MCPs must take any actions, as needed, in addition to the steps listed above under screening and enrollment to credential all Community Supports Providers, as appropriate to meet the requirements of APL 22-013. MCPs may align screening and enrollment efforts with their credentialing efforts to reduce duplication of activities.

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, MCPs must ensure all providers resubmit and recertify the accuracy of their enrollment information as part

[74] For more details, see DHCS' CBO LHJ Application Information. Available at: https://www.dhcs.ca.gov/provgovpart/Pages/CBO-LHJ-CCFC-Application-Information.aspx.

of the revalidation process. As per APL 22-013, MCPs must revalidate the enrollment of each of their Network Providers at least every 5 years. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs are not required to revalidate providers that were enrolled through DHCS (i.e., the state-level enrollment pathway) or another MCP within the required timeframes. However, MCPs are required to ensure that the files demonstrate timeframes of screening, enrollment, revalidation, and recredentialing activities and indicate files are up to date.

Recredentialing

As per APL 22-013, DHCS requires each MCP to verify every three years that each Network Provider continues to possess valid credentials, as applicable. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of APL 22-013, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, Member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCP Policies and Procedures

MCPs must submit Policies and Procedures in their MOC submissions for DHCS approval detailing how they will conduct screening, enrollment, credentialing, revalidation, and recredentialing of ECM and Community Supports Providers without a state-level enrollment process. In addition to all federal requirements, MCP Contract requirements, and APL 22-013 requirements, MCPs must ensure that their process considers:

- Ability to receive referrals from MCPs for the authorized Community Supports;
- Sufficient experience in providing services similar to the specific Community Supports 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 also consider national accreditation and/or certification standards. Examples include the Food is Medicine Coalition MTM Intervention Accreditation

Criteria[75] for MTM agencies and the Requirements and the National Institute for Medical Respite Care Certification for Medical Respite Programs.[76]

[75] For additional information see the Food is Medicine Coalition's MTM Intervention Accreditation Criteria. Available at: https://fimcoalition.org/programs/fimc-accreditation/.

[76] 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/.

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.[77]

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

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 for sharing the

[77] DHCS. Community Supports Member Information Sharing Guidance. January 2026. Available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/Community-Supports-Member-Information-Sharing-Guidance.pdf.

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.

(Added July 2026) The HCPCS codes and modifiers included in DHCS' guidance will remain in use until permanent codes are established. Because modifiers may be used differently across DHCS programs, the guidance in this document defines modifier use specifically for Community Supports.

MCPs must use the HCPCS codes and modifiers listed in DHCS' guidance, including the ECM and Community Supports HCPCS Coding Guidance,[78] 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.

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)

[78] DHCS. ECM and Community Supports HCPCS Coding Guidance. January 2026. Available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/Coding-Options-for-ECM-and-Community-Supports.pdf.

payment. However, the MCP must still require the Provider to report the HCPCS codes and modifiers below, which are on a standard per diem basis.

- If a Community Supports service is provided through telehealth, the modifier "GQ," must be used.[79]
- 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.
- 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.

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.

[79] 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.

Additionally, accurate POS code reporting is essential for identifying services subject to Electronic Visit Verification (EVV) requirements. MCPs and Providers must ensure 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[80] and applicable APLs, including APL 22-014.[81]

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.[82]

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 payment 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.

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

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

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

MCPs are encouraged to consider Community Supports provider payment structures that reflect variation in service intensity and population risk.

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 Resource** document in 2022, which was updated in December 2025. It offers historical information on potential rates for each of the 14 optional Community Supports, 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 Resource can be accessed from the Community Supports Resource Directory.[83]

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[84] or any updated or superseded APL for related requirements.

Community Supports Provider Disputes

As with any other Provider dispute, Community Supports Providers should reach out to their MCP to resolve their dispute via the MCP's Provider Dispute Resolution Mechanism. Community Supports Providers can submit a dispute to MCPs for disputes pertaining to the following:

- The authorization or denial of a service;
- The processing of a payment or non-payment of a claim by MCPs;

[83] DHCS. Community Supports Resource Directory. Available at: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx.

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

- The processing of retroactive rate or payment adjustments pursuant to the terms of a State Directed Payment or other payment policy that is contractually required; or
- The timeliness of the reimbursement on an uncontested Clean Claim and any interest MCP is required to pay on claims reimbursement.

VIII. MONITORING, REPORTING, AND ENFORCEMENT

Consistent with the Special Terms and Conditions (STCs) of California's Section 1115 and Section 1915(b) waivers,[85] 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 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
  - JavaScript Object Notation (JSON) Reports.

[85] 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."

Beginning July 1, 2026, DHCS will sunset the Quarterly Implementation Monitoring Report (QIMR) as a required reporting mechanism for ECM and Community Supports. The final QIMR submission will be for Q2 2026 (reporting period ending June 30, 2026). Starting in Q3 2026, JavaScript Object Notation (JSON) submissions will serve as the primary source of ECM and Community Supports program data, consistent with DHCS' transition to more frequent, machine-readable, and standardized data exchange.

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.[86]

[86] 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.

MCPs may terminate any optional[87] Community Support upon notice to DHCS once annually at the end of the calendar year, except in cases where the Community Support 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.

MCPs must use the DHCS-developed Community Supports MOC to complete these submissions. The templates are available on the ECM and Community Supports Resource Webpage.[88]

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.
- 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.

[87] 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.)

[88] DHCS. ECM and Community Supports: Resources. Available at: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx.

- 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.[89]
- 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.

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.[90]

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

[89] 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.

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

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 deadlines outlined in the MCP Contract and applicable APLs.[91] 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.

[91] DHCS. Medi-Cal Managed Care Health Plan Guidance on Network Provider Status. Available: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-001.pdf.

Quarterly Implementation Monitoring Report (QIMR)

MCPs must continue submitting data through the Excel-based Quality Implementation Monitoring Report (QIMR) report through the end of the Q2 2026 reporting period (submission due August 14, 2026). MCPs are required to report quarterly on:

- 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).*[92]

Beginning July 1, 2026, DHCS will sunset the QIMR as a required reporting mechanism. The final submission will be for Q2 2026 (reporting period ending June 30, 2026). Starting in Q3 2026, MCPs will report ECM and Community Supports data exclusively through monthly JSON submissions, which will become the primary and authoritative reporting source following DHCS validation of JSON completeness and quality.

JavaScript Object Notation (JSON) Transition

DHCS is transitioning ECM and Community Supports monitoring from the QIMR Excel format to a monthly JSON file submission process. JSON, or JavaScript Object Notation, is an open-standard, machine-readable format that supports more frequent, efficient, and scalable data exchange.

The transition from QIMR to JSON began in early 2024 and has proceeded through multiple phases, expanding from limited ECM enrollment data to comprehensive member-level details for ECM and Community Supports. Monthly JSON submissions now include all required data elements, such as enrollment, eligibility, authorizations, provider networks, utilization, and closed-loop referrals.

Through June 30, 2026, MCPs must continue dual reporting—submitting both QIMR Excel Reports and monthly JSON files—while DHCS completes validation of JSON data against QIMR and 837 encounter data. This dual-reporting period ensures continuity in internal dashboards, public reporting, and data quality assessments as JSON submissions mature.

[92] DHCS. ECM and Community Supports Quarterly Implementation Monitoring Report Requirements. April 2023. Available at: https://www.dhcs.ca.gov/Documents/MCQMD/Quarterly-Implementation-Monitoring-Report-Guidance.pdf.

Beginning July 1, 2026, JSON submissions will replace QIMR as the primary and authoritative source of ECM and Community Supports program data. JSON-based reporting will support ongoing monitoring functions, including performance metrics, utilization trends, member eligibility and enrollment tracking, and analysis of contracted provider networks. This transition reflects DHCS' move towards more timely, standardized, and comprehensive data exchange for program oversight.

Technical specifications—including JSON Schemas, file layouts, response file details, validation logic, and data dictionaries—are available through the DHCS Documentation Center. MCPs should continue referencing the latest Technical Assistance Companion Guide and Data Dictionary to maintain compliance with all reporting requirements.

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[93]—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 who are 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:

- 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.

[93] DHCS. Enforcement Actions: Administrative and Monetary Sanctions. Available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-012.pdf.

Public Reporting

DHCS publishes quarterly data on Community Supports in the ECM & Community Supports Implementation Report.[94] 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;
- 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.

[94] DHCS. ECM & Community Supports Implementation Report. Available at: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117.

DHCS engaged the University of California Los Angeles-RAND Center for Law & Public Policy to conduct the independent evaluation of Community Supports.[95]

Enforcement of Non-Compliance

DHCS is obligated to enforce compliance with contractual provisions of the DHCS Contracts with MCPs including the requirement to comply with requirements pertaining to 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.[96]

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

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