Proposed Updates to Select Housing-Related Community Supports

Recuperative Care

Short-Term Post-Hospitalization Housing (STPHH)

Housing Transition Navigation Services (HTNS)

Housing Tenancy and Sustaining Services (HTSS)

Proposals Released for Public Comment

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

I. INTRODUCTION

In 2022, the California Department of Health Care Services (DHCS) launched 14 Community Supports that, at the option of a Medi-Cal Managed Care health plan (or "Managed Care Plan" (MCP)) and Member, can substitute for covered Medi-Cal services as cost-effective alternatives, potentially decreasing the need for hospital care, nursing facility care, and emergency department (ED) use. As of January 1, 2026, MCPs are additionally required to cover Transitional Rent as a fifteenth Community Support for Members meeting the Behavioral Health Population of Focus.

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

To reflect these commitments and expectations, DHCS proposes updates to select housing-related Community Supports in this document. The proposals described herein reflect distinct policy objectives and are at different stages of development. As a result, the level of detail provided varies across sections.

This document contains:

- **Recuperative Care and Short-Term Post-Hospitalization Housing (STPHH) Policy Guide revisions ("Addendum").** As described in DHCS' California Advancing and Innovating Medi-Cal (CalAIM) 1115 waiver renewal application,[1] California plans to transition federal authority for Recuperative Care from Section 1115 waiver authority to Medicaid managed care in lieu of services and settings (ILOS) authority and sunset STPHH as a separate Community Support.

  As Medicaid policy does not permit the coverage of room and board outside of 1115 authority, DHCS is updating the Recuperative Care service definition to align

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

with federal requirements. DHCS is also using this transition as an opportunity to strengthen and clarify the service definition to more fully articulate the nature of the care coordination and case management that is required to be provided onsite to all Members during their Recuperative Care stay, driving cost-effectiveness of this service. DHCS anticipates the updated service definition will take effect at the conclusion of the current 1115 CalAIM demonstration period, which is set to conclude on December 31, 2026.

The addendum includes both the proposed future-state Recuperative Care service definition and the STPHH sunset plan. Also included is updated language about provider oversight and the global cap on coverage of room and board services that will be carried into the policy guide.

- **Proposed, targeted updates for Housing Transition Navigation Services (HTNS) and Housing Tenancy and Sustaining Services (HTSS).** To promote program integrity, appropriate utilization, and ultimately long-term sustainability and effectiveness of these services, DHCS is proposing targeted updates to HTNS and HTSS. These updates are intended to drive MCPs to strengthen their utilization management (UM) and oversight approaches, reduce inappropriate or low-value utilization, improve management of health care costs by enhancing the economy and efficiency of payments for these services, and establish clearer, consistent expectations for service delivery statewide.

DHCS seeks stakeholder feedback on the Recuperative Care service definition and STPHH sunset plan described in the Addendum and the proposed service definition updates for HTNS and HTSS.

Please submit written feedback to CommunitySupports@dhcs.ca.gov by July 31, 2026, using the following subject lines: "*Feedback on the Community Supports Housing-Related Updates*"

All proposals remain subject to revision based on a variety of inputs including comments from MCPs and Providers, stakeholder feedback, ongoing policy deliberations, fiscal considerations, and, where indicated, federal review and approval.

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

1. Recuperative Care: Summary of Updates to Revised Service Definition

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

- **Eliminate coverage of room and board**. Consistent with the transition from Section 1115 waiver authority to ILOS authority, the future-state revised service definition eliminates Medi-Cal coverage of room and board. While Recuperative Care Providers must continue to furnish 24-hour access to a bed and three meals per day—as well as meet other facility-specific requirements outlined in Section II.2. of this Addendum—MCPs will not be permitted to reimburse these components as covered Medi-Cal services.
- **Establish greater precision, standardization, and quality in service delivery**. The revised service definition more clearly articulates DHCS' expectations for Recuperative Care and establishes greater standardization of the core service components, with the goal of maintaining cost effectiveness and improving the quality of service delivery for Members statewide. The revised service definition emphasizes that the support available at the Recuperative Care facility always includes care coordination and case management, provides a standardized definition of these activities, and establishes that care coordination and case management must be supervised by a qualified professional.
- **Establish an achievable standard that mitigates attrition of today's Recuperative Care Providers**. DHCS seeks to establish enhanced standards for Recuperative Care that strengthen accountability and standardize service delivery while remaining operationally attainable. Preserving provider capacity and mitigating attrition of today's existing Recuperative Care Providers is a central priority for DHCS. In addition, DHCS recognizes that STPHH Providers play a critical role in the housing continuum and strongly encourages these providers to prepare for transition by aligning their service models and capabilities to participate as Recuperative Care Providers going forward.

The summary below highlights the major changes DHCS intends to implement relative to today's service definition. These changes reflect feedback DHCS received from Recuperative Care Providers, MCPs, and the National Institute for Medical Respite Care (NIMRC)[2] in the Spring of 2026.

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

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

process. DHCS may revisit this policy position following the launch of Recuperative Care as an ILOS.

- **Service Duration**: DHCS has maintained the existing six-month time limit per rolling 12-month period for Recuperative Care. Given the exclusion of room and board, the global cap on coverage of room and board services that currently applies to Recuperative Care and Transitional Rent, will no longer apply.

Understanding the Connection Between DHCS' Future-State Service Definition & NIMRC's Standards

In developing the future-state service definition, DHCS drew upon the standards established by NIMRC,[3] which provide a national framework for safe, high-quality, person-centered Recuperative Care programs that can be applied across facility types, staffing models, and local delivery systems.

In certain areas, however, DHCS has established more specific and standardized requirements to support consistent implementation, accountability, and quality across Medi-Cal. For example, DHCS proposes requiring that care coordination and case management activities be supervised by specific, appropriately qualified professionals.

Accordingly, the proposed service definition reflects both nationally recognized best practices codified by NIMRC and DHCS' specific policy priorities for the Medi-Cal program.

[3] NHCHC. *Models of Medical Respite Care*. 2025. Available at: https://nhchc.org/wp-content/uploads/2025/03/Models-of-Medical-Respite-Care_2025_final.pdf.

2. Revised Future-State Service Definition[4]

Description/Overview

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

Eligibility (Population Subset)

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

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

AND

(2) Experiencing or at risk of homelessness.[6]

An individual need not be exiting an institution to qualify but must have been determined by a provider (at the MCP or Network Provider level) to have medical needs significant enough to result in ED visits, hospital admissions, or other institutional care.

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

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

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

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

Recuperative Care Requirements

Service Components

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

1. Providing onsite care coordination and case management that includes, but is not limited to:
    a. Confirming the Member's medical and behavioral health needs and goals which includes reviewing the Member's discharge instructions and/or care plan when available, or connecting the Member to a clinician who can complete an individual needs assessment.
    b. Providing ongoing monitoring of the Member's medical or behavioral health condition to avoid unnecessary ED utilization, keep the Member's providers informed of their progress, and ensure timely clinical consultation when a Member's condition changes.
    c. Conducting wellness checks (which may be performed by non-clinical staff) at least once every 24 hours.
    d. Coordinating onsite access to the clinical services a Member needs (see also Service Component number 5 below).[7]
    e. Supporting the Member's clinical goals for the Recuperative Care period.
    f. Connecting the Member to a primary care provider (PCP) upon their entry into Recuperative Care, and working with the MCP as necessary to identify the PCP.
    g. Connecting the Member to any other clinical services and/or social supports they may require, including referral, as needed, to mental health and substance use disorder services and dental services.
    h. Coordinating transportation to medical appointments, diagnostic procedures, and the pharmacy.
    i. Conducting case conferencing and communicating medical/clinical needs with community-based medical providers.

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

j. Conducting discharge planning to support the Member in successfully transitioning out of the Recuperative Care facility.

k. Connecting the Member to ECM, which includes submitting a referral to the Member's MCP for ECM; working with the MCP, as necessary, to identify the ECM Provider; and facilitating a warm handoff with the ECM Provider prior to discharge from Recuperative Care (see *Delivery with Other Community Supports and ECM* subsection of Section II.2. for additional information).[8]

2. Providing access to equipment (e.g., phone, computer), as needed, for any telehealth visits during the stay.
3. Providing access to a safe space for storage (including refrigeration) and administration of the Member's own medications.
4. Providing access to a secure space for storage of personal items.
5. Providing onsite access to appropriate clinical services (including basic nursing care; wound care; and medication prescribing, dispensing, administration, and management as may be needed) through established relationships with qualified medical or Home Health Providers.
6. Providing 24 hours a day/7 days a week access to onsite staff (may be non-clinical) who are trained in first aid, basic life support, and de-escalation techniques and can coordinate access to on-call medical support that includes 24/7 nursing hotlines through the Member's MCP.

Onsite Team Supervision Requirement

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

- Providing structured oversight and guidance to care coordination and case management staff to ensure Member engagement is occurring consistently and appropriately;

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

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

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

Supervisor Qualifications

The supervisor must be employed by the Recuperative Care facility and regularly available onsite.[9] The supervisor is not required to be employed full-time. To qualify, supervisors must have experience managing staff and/or a team and hold one of the following licenses or degrees, acting within their applicable scope of practice:[10]

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

---

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

[10] Each supervising clinician must operate within their applicable scope of practice, which may limit who they can supervise and the activities subject to supervision.

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

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

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

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

Health care delivery setting experience does not mean experience such as:

- Working exclusively with patients on social needs care with no experience coordinating medical needs; or
- Serving solely in an administrative or non-patient-facing function (e.g., human resources, billing oversight, or facilities management).

Recuperative Care Facility Requirements

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

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

Restrictions/Limitations

Recuperative Care is an allowable Community Supports service if it is necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions.

Recuperative Care cannot exceed a duration of six months per rolling 12-month period (but may be authorized for a shorter period based on individual needs).

Delivery with Other Community Supports and ECM

During a stay in a Recuperative Care setting, Members may be referred to HTNS and Transitional Rent, as well as other Community Supports that are medically appropriate.

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

MCPs are responsible for actively coordinating the service delivery and management of these services when covered, including ensuring non-duplication of payment for overlapping services. If there are overlapping care management functions during the Recuperative Care stay, MCPs must adjust payments accordingly to avoid double payment during the stay.

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

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

Licensing/Allowable Providers for Recuperative Care

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

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

[13] DHCS may revisit this policy position following the transition of Recuperative Care to an ILOS.

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

- Peer respite setting[15]
- County-operated or contracted Recuperative Care facilities

For Members who are pregnant and up to 12-months postpartum, DHCS also strongly encourages MCPs to contract with Recuperative Care facilities that offer rooming in (i.e., the practice where a postpartum Member and their newborn stay in the same room together) and have the requisite capabilities to contract as Community Supports Providers to deliver Recuperative Care.[16]

Facilities may be unlicensed. MCPs must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. MCPs must monitor the provision of all the services included above.

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 All Plan Letter (APL) 22-013.

Although Recuperative Care facilities are not required to obtain NIMRC certification at this time, DHCS encourages MCPs to consider NIMRC certification as part of their screening, enrollment and credentialing processes. At a minimum, MCPs should evaluate the applicable standards under the NIMRC certification to incorporate those, as applicable, in their screening processes, while also verifying compliance with all requirements set forth in the DHCS Recuperative Care service definition.

HCPCS Codes for Recuperative Care

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

---

[15] The peer respite setting must be staffed with Certified Peer Support Specialists and be capable of transporting its residents to an emergency room or urgent care facility 24 hours a day, 7 days a week. If the peer respite setting opts to deliver ongoing monitoring services that fall outside the scope of practice of a Certified Peer Support Specialist, then the setting must have a qualified alcohol and other drug (AOD) counselor or licensed practitioner of the healing arts (LPHA), as applicable, onsite to conduct monitoring.

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

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

3. 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.[17]

[17] 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/

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.[18] For more information on Medi-Cal enrollment pathways and processes, see the Provider Application and Validation for Enrollment (PAVE)[19] portal. It should be emphasized that, except for Assisted Living Waiver Providers 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 may also apply to enroll in the Medi-Cal program by submitting an electronic application through the PAVE online enrollment portal, along with all supporting documentation.[20]

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

---

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

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

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

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 credentialing, and recredentialing for all Community Support 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 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 credentialing 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[21] for MTM agencies and the Requirements and the NIMRC Certification for Medical Respite Programs.[22]

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

[22] 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/.

4. Short-Term Post-Hospitalization Housing Sunset Plan

A note regarding public comments for this section: Certain aspects of the STPHH sunset plan are necessary to comply with federal requirements and are not subject to revision. DHCS welcomes feedback on operational considerations and opportunities to minimize disruption for Members regarding the implementation of this sunset plan.

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

Authorization Limits

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

Consistent with federal Medicaid rules,[23] when an MCP authorizes a shorter duration of STPHH than requested, the decision constitutes an Adverse Benefit Determination (ABD) and triggers applicable Member appeal rights. However, if a Member's requested authorization period for STPHH does not extend beyond December 31, 2026 or if it is not shorter than what was requested, an ABD is not triggered, as the MCP is not reducing or denying the service request.

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

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

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

In addition, DHCS is recommending a statewide cutoff date of December 1, 2026, after which no new STPHH authorizations may be issued. Members requesting STPHH after this date should be evaluated for eligibility for Recuperative Care and other available Community Supports. DHCS is establishing a cutoff date for STPHH to ensure adequate time to allow for transitioning planning. For Members who will be transitioning from managed care enrollment to the Medi-Cal Fee For Service (FFS) delivery system as part of the Unauthorized Immigration Status (UIS) transition, effective January 1, 2027, DHCS recommends a later cutoff date of December 31, 2026 (see the *Transition Planning* section below for additional information).

Notify Members

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

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

MCPs are required to notify the following groups:

1. **All Members requesting the maximum service duration of STPHH authorizations (on or after July 1, 2026):** MCPs must embed the standardized language received from DHCS within the notice of action (NOA) letters that MCPs are required to send to Members when communicating the authorization decision as part of the utilization management process.
2. **All other Medi-Cal Members:** MCPs currently offering STPHH must send the standardized language received from DHCS to all Members notifying them of the changes to coverage and maximum service duration outlined above. Notices must be sent no later than December 1, 2026.[24]

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

DHCS has provided standardized Member noticing language for MCPs to use. Accordingly, MCPs are not required to submit Member notices for DHCS review and approval.

In addition to sending the required Member notices, MCPs are strongly encouraged to coordinate with STPHH Providers to communicate this change directly to Members residing in their respective facilities.

Notify Providers

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

Transition Planning

MCPs are required to ensure that any Member with an active STPHH authorization approaching the December 31, 2026, sunset date receives appropriate transition planning support. Consistent with existing Transitional Care Services requirements,[25] MCPs are responsible for supporting Members through their transition out of STPHH facilities from discharge planning until successful connection to comparable medical services and other needed supports. This may include linkage to Recuperative Care, Transitional Rent (provided the global cap on the coverage of room and board has not been exceeded), other Community Supports, and ECM, based on the Member's needs.

DHCS is committed to monitoring MCPs' Member-level transition planning efforts as part of the STPHH sunsetting. The Department will provide additional guidance in advance of December 31, 2026, outlining the MCP reporting requirements necessary to support these monitoring activities.

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

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

For Members who will be transitioning from managed care enrollment to the Medi-Cal FFS delivery system as part of the UIS transition, DHCS will be issuing guidance separately through a forthcoming Guide. The guidance will include ensuring transitioning Members are identified, and the MCP and/or the Community Support Provider work with Members to support transitions to Medi-Cal Covered benefits (such as CHW benefit) or other non-Medi-Cal services available in the community.

Remove References to STPHH in Member and Provider-Facing Materials

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

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

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

STPHH and Recuperative Care are authorized under California's CalAIM waiver[26] until December 31, 2026, and Transitional Rent is authorized under the BH-CONNECT waiver[27] until December 31, 2029. Under these waivers, STPHH, Recuperative Care, and Transitional Rent are categorized as "Room and Board" services, and are subject to a "global cap." Under the global cap, coverage is limited to a combined six months of room and board services per Member within any rolling 12-month period.

At the end of the CalAIM waiver, which is set to conclude on December 31, 2026, STPHH will sunset as a Community Support and Recuperative Care will no longer be classified as a "Room and Board" service.

Transitional Rent will therefore be the only "Room and Board" service and is subject to a stricter limit of six months of services per household, per BH-CONNECT demonstration.

However, because the global cap is applied on a rolling 12-basis, it will continue to apply during a runout period. Specifically, if Members receive Recuperative Care or STPHH in 2026, MCPs must count those covered months toward the six-month limit within the applicable rolling 12-month period, including months that extend into 2027.

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

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

[27] 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.

III. HOUSING TRANSITION NAVIGATION (HTNS) AND HOUSING TENANCY AND SUSTAINING SERVICE (HTSS) DEFINITION UPDATES

Housing Transition Navigation Services (HTNS) and Housing Tenancy and Sustaining Services (HTSS) are Community Supports authorized under Medicaid managed care ILOS authority. HTNS assist Members with finding, applying for, and obtaining housing, while HTSS help a Member maintain safe and stable tenancy once housing is secured.

MCPs are responsible for ensuring that Community Supports are provided in accordance with State and federal requirements, including that services are sufficient in amount, duration, and scope to achieve their intended purpose. Consistent with the goals under the CalAIM initiative, utilization of these services has increased significantly over time. While this growth reflects expanded access to housing-related services, DHCS has identified limited patterns of utilization that are consistent with low-value utilization such as overuse, misuse, and lack of fidelity to service definitions or other policy guardrails.

To promote program integrity, appropriate utilization, and ultimately long-term sustainability and effectiveness of these services, DHCS is proposing targeted updates to HTNS and HTSS. These updates are intended to drive MCPs to strengthen their utilization management (UM) and oversight approaches, reduce inappropriate or low-value utilization, improve management of health care costs by enhancing the economy and efficiency of payments for these services, and establish clearer, consistent expectations for service delivery statewide.

DHCS seeks stakeholder feedback on the proposed updates described below. To help inform feedback, specific stakeholder questions are included at the end of the section. These proposed updates remain subject to revision based on a variety of inputs including comments from MCPs and Providers, stakeholder feedback, and fiscal considerations.

1. HTNS-Specific Proposal

The current HTNS service definition is detailed in Community Supports Policy Guide Volume 2, pages 25-30. DHCS proposes establishing a standardized initial authorization and reauthorizations timeframes for the HTNS service definition. The proposed effective date for this update is January 1, 2027, although MCPs have discretion to implement changes sooner as part of their Utilization Management protocols as long as they are clearly communicating to Network Providers at least 30 days prior to effective dates.

Standardized Initial Authorization and Reauthorizations Timeframes for HTNS:

DHCS expects MCPs to monitor the quality of HTNS delivery and Member progress towards obtaining housing on a consistent and ongoing basis. To safeguard program integrity and ensure that Members who need HTNS are receiving appropriate support, it is critical MCPs take an active approach in monitoring Network Provider activity, and ensure they are actively engaging with Members as needed.

To promote oversight of service delivery and assessment of ongoing need, for all Members authorized to receive HTNS by their MCP, the initial authorization period will be six (6) months, with reauthorization every six (6) months after that.

At the conclusion of each authorization period, MCPs must determine whether Members require a reauthorization for HTNS or meet one or more of the graduation/discontinuation criteria outlined below and are therefore ready to discontinue services.

Throughout each authorization period, DHCS expects MCPs to oversee Network Providers to assess Members' potential for graduation/discontinuation prior to the conclusion of the authorization.

As a condition of reauthorization, MCPs must ensure that Providers confirm that the service is still needed and progress has been made towards the Member obtaining housing, such as gathering identification documents and records of housing history, obtaining verification of income or benefits, applying for housing, touring units, securing available resources to assist with attaining or moving into housing, or signing a lease. The Member's housing support plan should be updated to reflect such progress (see additional detail on the housing support plan in Section V.B of the Community Supports Policy Guide Volume 2). MCPs have discretion to determine whether progress is sufficient to justify reauthorization.

MCPs must discontinue services when any of the following graduation/discontinuation criteria are met:

- Member has obtained housing, whether through support from the HTNS Provider or through their own means;[28]
- Member indicates to the HTNS Provider that they no longer wish to receive HTNS or is unwilling to engage; ***or***
- The HTNS Provider has not been able to connect with the Member after multiple attempts.

[28] DHCS encourages Members to transition to HTSS, when appropriate, to support housing stability.

2. HTSS-Specific Proposal

The current HTSS service definition is detailed in Community Supports Policy Guide Volume 2, pages 37-42. DHCS proposes establishing a standardized initial authorization and reauthorizations timeframes for the HTSS service definition. The proposed effective date for this update is January 1, 2027, although MCPs have discretion to implement changes sooner as part of their Utilization Management protocols as long as they are clearly communicating to Network Providers at least 30 days prior to effective dates.

Standardized Initial Authorization and Reauthorizations Timeframes for HTSS:

DHCS expects MCPs to monitor the quality of HTSS delivery and Members' progress towards housing stability on a consistent and ongoing basis. To safeguard program integrity and ensure that Members who need HTSS are receiving appropriate support, it is critical MCPs take an active approach in monitoring Network Provider activity, and ensure they are actively engaging with Members as needed.

Evidence indicates that a minimum of 12 months of housing tenancy services is often needed to help Members achieve housing stability and shift health care utilization patterns. Accordingly, DHCS expects that most Members receiving HTSS will likely require additional months of services beyond the initial authorization period and may require one or more reauthorizations. In some instances, Members may achieve housing stability in fewer than six months. DHCS also recognizes that Members' tenancy support needs can fluctuate over time due to changes in life circumstances, behavioral health acuity, or aging.

To promote oversight of service delivery and assessment of ongoing need, for all Members authorized to receive HTSS by their MCP, the initial authorization period will be six (6) months, with reauthorization every six (6) months after that.

At the conclusion of each authorization period, MCPs must determine whether Members require a reauthorization for HTSS or meet one or more of the graduation/discontinuation criteria outlined below and are therefore ready to discontinue services.

Throughout each authorization period, DHCS expects MCPs to oversee Network Providers to assess Members' potential for graduation/discontinuation prior to the conclusion of the authorization.

Members who do not meet graduation/discontinuation criteria may continue to receive HTSS based on their ongoing needs and circumstances and subject to service re-authorization.

MCPs must discontinue services when any of the following graduation/discontinuation criteria are met:

- Member has access to permanent rental subsidies and is able to receive similar tenancy services through an alternative program;
- Member indicates to the HTSS Provider that they no longer wish to receive HTSS or is unwilling to engage;
- The HTSS Provider has not been able to connect with the Member after multiple attempts;
- Member has met all housing support plan goals; ***or***
- Member remained stably housed without incident for the standardized authorization period and is not expected to experience a disruption to housing stability in the near future. For example, they demonstrate:
    - No lease violations,
    - No landlord or neighbor disputes/complaints,
    - Sustained tenancy skills such as maintaining the unit, and
    - Member meets, and can continue to meet, lease obligations

3. HTNS/HTSS Payment Approaches Proposal

DHCS proposes to include best practice information regarding MCP payment approaches to HTNS and HTSS Providers as part of the updated Community Supports Non-Binding Pricing Resource, set to be released later in 2026. This information is intended to support MCPs and Community Support Providers in developing payment arrangements that promote appropriate service delivery and program goals. DHCS is ***not*** *proposing to standardize HTNS or HTSS payment methodologies nor the rates that MCPs pay providers. MCPs and Community Supports Providers will continue to have discretion to negotiate payment arrangements, including rates.*

Because this update consists of best practice information, no specific effective date is proposed. In alignment with existing requirements, DHCS continues to expect that MCPs utilize Provider payment approaches that are economic, efficient and support achievement of the MCP's obligations under its contract with DHCS including Members' timely access to high-quality services.

To the extent appropriate, MCPs should consider adjusting payment levels to HTNS/HTSS Providers to be commensurate with service intensity or Member outcomes including discontinuing or otherwise reducing payments to HTNS/HTSS Providers during months when no services are delivered. MCPs are encouraged to rely on Members' housing support plans to monitor service delivery and inform these approaches.

Potential payment approaches MCP may consider include, but are not limited to:

- Providing payments for completion of key HTNS activities (e.g., completing the housing support plan, obtaining necessary lease-up documentation, securing a housing unit/executing a lease).
- Requiring providers to have a minimum number of contacts with the Member for reimbursement.
- Adjusting payment based on Member acuity or population mix.
- Adjusting payment based on progress towards securing housing.
- Adjusting payment to meet Member's housing stability support needs.
- A pay-for-performance framework.

Stakeholder Questions for HTNS and HTSS Proposals:

HTNS-Specific Proposal

1. Please comment on the proposed updates to HTNS, including any potential benefits, implementation considerations, or unintended consequences.
2. Based on your experience, how long do Members typically receive HTNS? Please describe any factors that influence duration of service.
3. Please comment on the proposed 6-month standardized initial authorization and reauthorization periods for HTNS. Is six months an appropriate timeframe for reassessing Member need and progress toward obtaining housing? Why or why not?
4. Please comment on the proposed graduation/discontinuation criteria for HTNS, including whether they are clear, appropriate, and operationally feasible to implement consistently across MCPs and providers. Are there additional criteria or standardized assessment tools that DHCS should require or encourage MCPs and Providers to adopt?
5. Please comment on any operational or administrative considerations associated with the proposed reauthorization and graduation/discontinuation processes. What approaches could help minimize administrative burden?
6. What tools, information, or guidance would support consistent implementation of the proposed HTNS initial authorization period while promoting program integrity, improved cost-effectiveness, and appropriate utilization by Members who need the service?

HTSS-Specific Proposal

1. Please comment on the proposed updates to HTSS, including any potential benefits, implementation considerations, or unintended consequences.
2. Based on your experience, how long do Members typically receive HTSS? Please describe any factors that influence duration of service.
3. Please comment on the proposed 6-month standardized initial authorization period for HTSS. Is six months an appropriate timeframe for reassessing Member need and progress toward housing stability? Why or why not?
4. Please comment on the proposed graduation/discontinuation criteria for HTSS, including whether they are clear, appropriate, and operationally feasible to

implement consistently across MCPs and providers. Are there additional criteria or standardized assessment tools that DHCS should require or encourage MCPs and Providers to adopt?

5. Following graduation from HTSS, what services, supports, or care coordination activities are most important to helping Members maintain long-term housing stability?
6. Please comment on any operational or administrative considerations associated with the proposed reassessment, reauthorization, and graduation/discontinuation processes. What approaches could help minimize administrative burden?
7. What tools, information, or guidance would support consistent implementation of the proposed HTSS initial authorization period while promoting program integrity, improved cost-effectiveness, and appropriate utilization by Members who need the service?
8. For Providers, is your organization employing evidence-based practices like Critical Time Intervention in delivering HTSS?

HTNS/HTSS Payment Approaches Proposal

1. Please comment on the proposed payment approaches updates to HTNS/HTSS, including potential benefits, implementation considerations, or unintended consequences.
2. Please comment on the example payment approaches described above, including which may be most feasible to implement in practice and any other considerations for DHCS, including options to mitigate administrative burden.
3. Are there additional payment approaches or best practices that DHCS should consider highlighting?
4. Please comment on considerations associated with payment approaches that vary based on Member acuity, service intensity, and milestones attained.
5. How might variable payment approaches affect provider operations, staffing, financial sustainability, and service delivery?
6. How might performance-based payment models affect provider behavior, service delivery, and outcomes? What benefits, risks, or unintended consequences should be considered?

7. What are key factors and considerations for MCPs when designing payment approaches for these services?
8. What factors should MCPs consider to promote provider participation, maintain access to services, and ensure providers are able to serve Members with varying levels of housing-related needs?