

# **COMMUNITY SUPPORTS, OR IN LIEU OF SERVICES (ILOS) ANNUAL REPORT**

**DEPARTMENT OF HEALTH CARE SERVICES (DHCS)  
1915(B) WAIVER REPORT TO CENTERS FOR MEDICARE  
& MEDICAID SERVICES (CMS) FOR  
CALENDAR YEAR (CY) 2025**

April 2026



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## Introduction:

On December 29, 2021, CMS approved California's request to renew its 1915(b) waiver, CMS (Centers for Medicare & Medicaid Services) control CA 17.R10, entitled California Advancing and Innovating Medi-Cal (CalAIM). This approval allowed California to transition Medi-Cal managed care delivery system programs, previously authorized under California's Medi-Cal 2020 section 1115 demonstration, into its section 1915(b) waiver.

CalAIM advances key state priorities by leveraging Medicaid to address complex challenges faced by California's most vulnerable residents. These challenges include homelessness, behavioral health care access, complex medical conditions among children, the increasing number of justice-involved populations with significant clinical needs, and the growing aging population. Through the 1915(b) CalAIM waiver renewal, CMS and California have partnered to further integrate the Medi-Cal managed care system. This integration aims to meet the physical, behavioral, developmental, long-term care, oral health, and health-related social needs of all Medicaid beneficiaries through a person-centered approach.

In addition, CMS approved California's request for a section 1115(a) demonstration five-year extension titled, "California Advancing and Innovating Medi-Cal (CalAIM)" (Project Number 11-W-00193/9) in accordance with section 1115(a) of the Social Security Act. The approval of this 1115 demonstration is part of the broader CalAIM initiative, which includes transitioning Medi-Cal managed care programs from the 1115 demonstration into 1915(b) waiver authority. The demonstration builds upon previous person-centered approaches, initially authorized as Whole Person Care (WPC) pilots under the Medi-Cal 2020 demonstration, to support beneficiaries' physical, behavioral, developmental, and long-term care needs while addressing social determinants of health.

Four years into CalAIM implementation, significant investments in technical assistance, infrastructure development, provider network expansion, and member engagement have established a strong foundation for integrating Community Supports into the Medi-Cal delivery system. Program maturation continued in 2025 with policy refinements the introduction of Closed-Loop Referral requirements, and enhanced JavaScript Object Notation (JSON) reporting. Community Supports in general experienced steady growth and stabilization of use across most services.

Medi-Cal managed care plans (MCPs), through their contracts with the Department of Health Care Services (DHCS), continue to operationalize a comprehensive menu of fifteen (15) Community Supports – twelve (12) state-approved In Lieu of Services (ILOS)

under the 1915(b) CalAIM Waiver, two (2) authorized under the Section 1115 demonstration, and one (1) authorized under the BH-CONNECT waiver authority – to enhance access to cost-effective, community-based alternatives to traditional medical services. Per [42 CFR § 438.3\(e\)\(2\)](#), an *in lieu of service or setting* (ILOS) is a service or setting that is provided to an enrollee as a substitute for a covered service or setting under the State Plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting under the State Plan.

This report is submitted in accordance with the Special Terms and Conditions (STCs) of the 1915(b) waiver (STC B20), which require annual reporting on various aspects of Community Supports implementation, including programmatic and operational changes, oversight and monitoring, utilization data, and grievances and appeals. While this reporting requirement applies to the 1915(b) waiver, both the 1915(b) and 1115 demonstration terms allow California to consistently implement and report on all 14 Community Supports services. As such, this report provides information on all approved Community Supports services.

The 14 Community Supports services, which were preapproved by the State and phased in starting January 1, 2022, include:

- » **Housing Transition Navigation Services** - Assistance and support for individuals in transitioning from homelessness to stable housing.
- » **Housing Deposits** - Financial assistance for housing deposits to help individuals secure stable housing.
- » **Housing Tenancy & Sustaining Services** - Services aimed at helping individuals maintain their housing stability, such as ongoing support for rent and tenancy-related needs.
- » **Short-Term Post-Hospitalization Housing\*** - Provision of temporary housing for individuals who require it after hospitalization.
- » **Recuperative Care (Medical Respite)\*** - Care services for individuals who need a safe and stable place to recover after a medical procedure or illness.
- » **Caregiver Respite (formerly Respite Services)** - Temporary relief and support for caregivers of individuals with disabilities or special needs.
- » **Day Habilitation Programs** - Programs that provide structured activities and support for individuals with disabilities during the day.

- » **Assisted Living Facility Transitions (formerly Nursing Facility Transition/Diversion to Assisted Living Facilities or Residential Care Facilities for the Elderly)** - Support for transitioning individuals from nursing facilities to assisted living facilities like Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF).
- » **Community or Home Transition Services (formerly Community Transition Services/Nursing Facility Transition to a Home)** - Assistance for individuals transitioning from nursing facilities to community-based living arrangements.
- » **Personal Care and Homemaker Services** - Assistance with personal care and homemaking tasks for individuals who need support to remain independent in their homes.
- » **Environmental Accessibility Adaptations** - Modifications to homes to make them accessible and safe for individuals with disabilities.
- » **Medically Tailored Meals/Medically Supportive Food** - Provision of specialized meals or food for individuals with specific medical conditions.
- » **Sobering Centers** - Facilities that provide a safe environment for individuals under the influence of alcohol or substances to sober up and receive support.
- » **Asthma Remediation** - Services and support aimed at addressing environmental factors that contribute to asthma.

In addition, Transitional Rent, authorized under the BH-CONNECT waiver, will be implemented as the 15<sup>th</sup> Community Support beginning January 1, 2026:

- » **Transitional Rent\*\*** - Temporary rental assistance to support housing stability for members experiencing or at risk of homelessness.

\* Services authorized under California’s Section 1115 CalAIM Demonstration.

\*\* Service authorized under California’s BH-CONNECT Demonstration.

Community Supports continue to play a critical role in addressing the health and non-medical health-related needs of Medi-Cal members through cost-effective interventions. These services are intended for individuals with complex health needs and unmet social drivers of health who are at risk of avoidable emergency department use, hospitalizations, institutionalization, and other high-cost interventions.

DHCS continues to monitor and evaluate Community Supports in accordance with STC B19, with a focus on network adequacy, service utilization, and overall program effectiveness. Monitoring efforts help identify gap areas for additional capacity-building

and ensure that Community Supports are accessible and sustainable across diverse geographic regions.

The independent evaluation of Community Supports, required under STC B21, will assess the impact of these services on member health outcomes, including reductions in emergency department visits, inpatient hospital stays, and long-term care utilization. The evaluation will also validate whether Community Supports services are effective, medically appropriate, and cost-effective alternatives to existing Medicaid-covered services or settings.

To ensure a comprehensive understanding of program impact, data collection and analysis efforts are stratified by key subpopulations of interest. This approach enhances the ability to identify existing gaps in access and health outcomes and informs efforts to expand services where needed.

## **Contents of This Year Four ILOS Annual Report (STC B20a):**

In a letter to CMS dated October 6, 2022, DHCS noted that during the planning of the initial Year 1 report, data completeness and availability constrained the ability to accurately report on several required components of the Annual Report under STC B20. Specifically, DHCS anticipated a 9- to 12-month lag in obtaining fully validated claims and encounter data necessary for comprehensive analysis.

Reflecting these timing considerations and consistent with previous communications with CMS, this Year Four ILOS Report includes all program data that has been validated to date by DHCS. Consistent with prior years, the report focuses on STC B20a's descriptive requirements and provides structured narrative updates on 2025 program execution by DHCS and Medi-Cal managed care plans (MCPs).

This report outlines our successes and accomplishments to date, highlights key program milestones, details implementation timeframes, and describes efforts related to capacity building, provider growth, and technical assistance, while also acknowledging outstanding challenges. In keeping with the approach used in Year Three, these narratives are anchored in DHCS's documented oversight processes and MCP-level implementation activities.

All utilization data presented in this report are preliminary and subject to revision as ongoing data validation efforts improve overall data quality. For Calendar Year (CY) 2025, DHCS has included validated data for quarters Q4 2024 through Q3 2025.

Validated Q4 2025 submissions are in process and will be reflected in future updates and in the Managed Care Program Annual Report (MCPAR) submission as validation completes.

In addition, this report summarizes DHCS's planned approach to program monitoring in the following areas, as required by STC B20:

- a. The state's annual oversight and monitoring activities;
- b. Utilization data for ILOS and any other data related to the cost-effectiveness of ILOS;
- c. Grievances and appeals data for ILOS;
- d. Data, stratified, when possible, related to the state's monitoring of health outcomes and quality metrics;
- e. Data reflecting the timeliness and accuracy of managed care plans' encounter data, as well as data reflecting the state's submission of timely, accurate, and validated data Transformed Medicaid Statistical Information System (T-MSIS); and
- f. Routine data and analyses of the cost effectiveness of each ILOS as determined appropriate and necessary by CMS. Examples may include, but not be limited to, supplemental data requirements on cost and utilization data.
- g. Any other documentation or data requested by CMS.

As DHCS continues to enhance its data collection and validation processes, the Department remains committed to refining its analyses and strengthening the evidence base for the impact of Community Supports and ensuring program integrity. This continuous improvement effort will inform both the current performance assessment and future program development.

During CY 2025, DHCS emphasized use of Quarterly Implementation Monitoring Report (QIMR)-based analyses to mitigate data lags (including claims data), coordinated with internal data teams to finalize unduplicated utilization counts and ensure MCPAR integration, and continued structured MCP engagement through Model of Care submissions and iterative reviews to align with state and federal requirements.

## **Successes and Accomplishments:**

Building on the strong foundation established during CY 2022 and expanded in CY 2023, DHCS made significant progress in advancing the Community Supports initiative in CY 2024. DHCS sustained this momentum through 2025, focusing on targeted implementation support and data-readiness activities that prepared additional services to go live and strengthened statewide consistency. Over the past year, the Department continued to invest in the necessary infrastructure, technology, provider capability, coordination, and workforce capacity to support Community Supports and related initiatives. Engagement efforts were broadened through an enhanced series of public webinars and in-person regional forums, which provided updated policy guidance, shared refined best practices, and incorporated additional lessons learned from community providers. DHCS also embarked on a statewide listening tour in 2023 and 2024 to gather feedback from providers, MCPs, and the broader community. The Listening Tour further captured emerging needs and feedback from a wide range of stakeholders, including providers, plans, county health agencies, members, and community-based organizations.

Investments in care management capabilities and Community Supports infrastructure have been pivotal to the successful implementation of Community Supports, which, as of the end of Q3 2025, encompasses over 798K services utilized by 357.4K Medi-Cal members in the last 12 months of the reporting period. DHCS intensified its focus on improving information technology (IT) systems and data-exchange platforms to support real-time reporting and more robust analytics. The IPP was refined to further support Community Supports and drive sustainable capacity building at both the MCP and provider levels, including efforts to bridge silos across physical and behavioral health services. Through the Providing Access and Transforming Health (PATH) program, authorized under the CalAIM 1115 demonstration, the State invested \$1.85 billion over five years to build capacity and infrastructure for CalAIM including for Enhanced Care Management (ECM) and Community Supports. Taken together, these investments supported MCPs and the delivery system in increasing Community Supports service election, improving utilization, applying consistent statewide operations practices and ensuring program integrity and oversight.

The Department has strengthened its oversight through a robust semi-annual review process for Model of Care (MOC) submissions from MCPs. As described in the "Oversight and Monitoring Activities" section below, the comprehensive MOC process enables DHCS to conduct monitoring of MCPs' performance against their submissions. For example, DHCS can identify trends and gaps in service delivery; provide technical

assistance, conduct targeted surveys and follow-up directly with MCP to verify that submitted policies align with Department guidance and Community Supports service definition. DHCS continued these MOC cycles and targeted technical assistance through 2025, culminating in approvals that supported additional Community Supports elections scheduled to go live on January 1, 2026.

DHCS also made significant strides in improving data reporting and reconciliation. This work supports DHCS's efforts to ensure program integrity. By leveraging existing encounter data reporting mechanisms alongside the QIMR process, the Department addressed data gaps through updated Billing and Invoicing Guidance, and revised Community Supports Coding Guidance. The new Community Supports Data Sharing Guidance, introduced in April 2023, continues to support compliant data exchange among MCPs and providers, including identifying compliant practices. In 2025, DHCS continued emphasizing the use of QIMR-based (and JSON-based) reporting to mitigate claims-data lags; Q4 2025 QIMR submissions were received in February 2026 and entered validation, with MCPAR integration updates proceeding as validation completes. Meanwhile, JSON submissions, which include additional ECM and Community Supports member-level referral, authorization, and service receipt date information (to support DHCS's Closed Loop Referral reporting requirements) began full production in July 2025, with monthly submissions required on the 10<sup>th</sup> of each month following the reporting month. The Department continued offering enhanced technical assistance to plans around the newer JSON-based reporting mechanism in preparation for the planned, full QIMR-to-JSON transition scheduled to occur in the latter half of 2026.

From July 2025 through June 2026, DHCS is maintaining a dual-reporting bridge in which MCPs submit monthly JSON files alongside the established quarterly QMIR submissions, allowing the Department to validate JSON outputs against QMIR measures and claims/encounter data before switching workflows. JSON entered full production for the July 2025 reporting month (first submission due August 10), while Q2 2026 constitutes the final QIMR cycle. During this period, DHCS and internal data teams conduct side-by-side quality checks, reconcile member/service counts, and provide targeted technical assistance to MCPs with missing or misaligned files to ensure robustness prior to retiring the QIMR.

Complementing these reporting and oversight activities, ongoing capacity building and accountability measures have been central to DHCS's efforts. The Department's continued evaluation of MCPs' progress through their IPP and QIMR/JSON submissions has driven the expansion of service delivery infrastructure and provider capacity, aligning with state priorities. Throughout 2025, DHCS oversight and technical assistance

reinforced provider readiness and network development, enabling MCPs to broaden service portfolios while maintaining continuity of care across counties.

DHCS continues to develop and disseminate Community Supports guidance to its contracted MCPs and Community Supports Providers, providing all stakeholders with up-to-date policy and implementation resources. Updated guidance and technical artifacts were disseminated throughout 2025 to help sustain consistent operations and support new service elections.

As reflected in Table 1 below, MCPs' phased implementation of Community Supports continued to expand in 2025, with MCPs adding new services in the counties they operate in at the January 1 and July 1 start windows and preparing additional elections for go-live on January 1, 2026. The rollout has been robust, and the statewide portfolio continues to broaden, with MCPs in several counties maintaining full implementation while others continued expanding their service offerings and availability over the course of 2025. Notably, MCPs in every county of the state now offer a broad range of Community Supports, with at least nine (9) Community Supports available in each county (up from eight a year ago), and MCPs in several more counties have achieved full implementation. Twenty-eight (28) counties now have all 14 Community Supports available, and even smaller, rural counties have demonstrated their ability to maintain a strong portfolio of services.

The table also shows some adjustments – particularly for the January 1, 2024, implementation phase – which represent the impact of the 2024 MCP Transition. This transition involved several MCPs moving between counties, resulting in some reductions in the counts for specific start dates as MCPs realigned their service areas. Despite these adjustments, the overall trend remained positive in 2024 and persisted in 2025, with continued investments in delivery infrastructure and the expansion of service networks.

MCPs remain committed to launching new Community Supports in six-month increments. This steady, phased approach continues to drive the expansion of service offerings and strengthen the statewide network over time.

**Table 1: Number of Pre-Approved Community Supports Services Live as of January 2026 by County and Implementation Date**

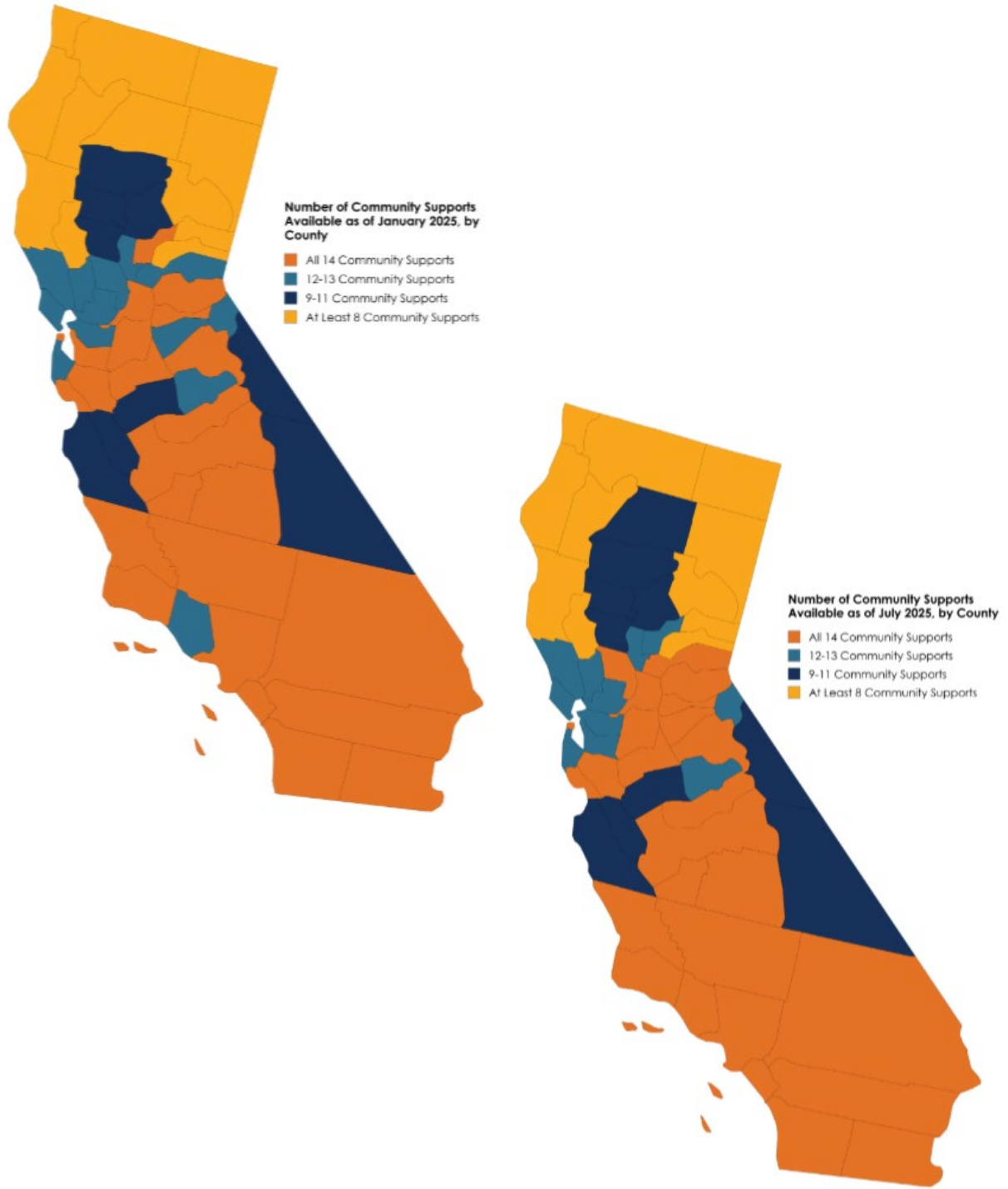
County	Start Date 1/1/2022 - 7/1/2023	Start Date 1/1/2024	Start Date 7/1/2024	Start Date 1/1/2025	Start Date 7/1/2025	Start Date 1/1/2026	Total Services Live (out of 14)
Alameda	11	1	1	-	-	1	14
Alpine	12	1	-	-	-	-	13
Amador	13	1	-	-	-	-	14
Butte	10	-2	1	1	-	1	11
Calaveras	11	1	1	0	1	-	14
Colusa	11	-3	1	0	-	1	10
Contra Costa	13	0	0	0	-	-	13
Del Norte	8	0	0	0	-	1	9
El Dorado	11	3	-	-	-	-	14
Fresno	12	2	-	-	-	-	14
Glenn	11	-3	1	0	-	1	10
Humboldt	8	0	0	0	-	1	9
Imperial	14	-	-	-	-	-	14
Inyo	12	-2	0	0	-	2	12
Kern	14	-	-	-	-	-	14
Kings	14	-	-	-	-	-	14
Lake	8	0	0	0	-	1	9
Lassen	8	0	0	0	-	1	9
Los Angeles	14	-	-	-	-	-	14
Madera	13	1	-	-	-	-	14
Marin	8	3	2	0	-	-	13
Mariposa	10	1	2	0	-	-	13
Mendocino	8	0	0	0	-	1	9
Merced	8	0	1	-	1	-	10
Modoc	8	0	0	0	-	1	9
Mono	10	1	1	-2	-	2	12
Monterey	10	0	0	1	-	-	11
Napa	8	3	2	0	-	-	13
Nevada	12	-4	0	0	-	1	9
Orange	14	-	-	-	-	-	14
Placer	13	-1	2	-	-	-	14

County	Start Date 1/1/2022 - 7/1/2023	Start Date 1/1/2024	Start Date 7/1/2024	Start Date 1/1/2025	Start Date 7/1/2025	Start Date 1/1/2026	Total Services Live (out of 14)
Plumas	10	-2	0	0	-	1	9
Riverside	14	-	-	-	-	-	14
Sacramento	14	-	-	-	-	-	14
San Benito	10	-1	-	1	-	-	10
San Bernardino	14	-	-	-	-	-	14
San Diego	14	-	-	-	-	-	14
San Francisco	13	1	-	-	-	-	14
San Joaquin	14	-	-	-	-	-	14
San Luis Obispo	6	4	4	-	-	-	14
San Mateo	9	0	3	1	-	-	13
Santa Barbara	6	4	4	-	-	-	14
Santa Clara	13	1	-	-	-	-	14
Santa Cruz	9	2	3	-	-	-	14
Shasta	8	0	0	0	1	1	10
Sierra	10	-2	0	0	-	1	9
Siskiyou	8	0	0	0	-	1	9
Solano	8	3	2	0	-	-	13
Sonoma	8	3	2	0	-	-	13
Stanislaus	14	-	-	-	-	-	14
Sutter	12	-1	2	0	-	-	13
Tehama	10	-2	1	0	-	1	10
Trinity	8	0	0	0	-	1	9
Tulare	14	-	-	-	-	-	14
Tuolumne	11	3	-	-	-	-	14
Ventura	12	0	2	-	-	-	14
Yolo	8	4	2	0	-	-	14
Yuba	12	2	-	-	-	-	14

*Due to the 2024 MCP Transition (effective January 1, 2024), there were a few changes to Community Supports elections in several rural counties where the new MCP entering the county did not offer the same Community Supports the exiting MCP provided. DHCS*

required continuity of the Community Supports services and worked with the entering MCPs to retain delivery infrastructure and restore access to these services.

**Figure 1: Community Supports Elections State Map**



With the continued growth in the Community Supports initiative, MCPs expanded their elected service offerings throughout CY 2025, resulting in a cumulative net increase in the number of services available across counties in California. Short-Term Post-Hospitalization Housing, Recuperative Care, Sobering Centers, and Asthma Remediation showed the strongest momentum, with many MCPs electing to add these offerings in counties where no similar option previously existed. Other services including Day Habilitation Programs and Assisted Living Facility Transitions, continued to show progress, contributing to a broader portfolio of options for Medi-Cal members residing throughout California. Overall, the trend in 2025 was one of steady expansion, with new service elections strengthening the availability of Community Supports statewide.

The effects of the 2024 MCP Transition, important to still note, continued to be felt, albeit less so over time. It involved strategic realignments of MCP service areas and resulted in some adjustments to service availability; however, these adjustments did not diminish the overall trend of expansion. On the contrary, the transition opened new opportunities in areas that previously had fewer offerings.

Notably, Community Health Plan of Imperial Valley completed electing its remaining three services to reach full implementation in Imperial County effective January 1, 2025, while Blue Cross Partnership (Anthem), and Health Net continued to lead in the number of newly elected services statewide. Partnership Health Plan (PHC) advanced minor service expansions in July 2025 through there were some reductions in Sierra and Nevada counties, two rural counties.

In summary, Medi-Cal members in 56 of California's 58 counties saw notable increases in available Community Supports service offerings over the course of 2025 and members have access to a significantly enhanced array of Community Supports, further advancing the initiative's goals of addressing the complex health and social needs of California's most vulnerable populations.

To sustain pace and ensure readiness, DHCS conducted a 2025 Monitoring Meeting series with each MCP, reviewing primary and secondary performance indicators for Community Supports – including the number of active providers by county and service, as well as service utilization rates – and issuing technical assistance and follow-ups where needed. This engagement complemented DHCS's ongoing stakeholder support (e.g., MCP Technical Assistance (TA) webinars and guidance production/dissemination), helping plans better calibrate their implementation timelines and provider onboarding strategies.

Policy guidance advanced in parallel. DHCS refined the Community Supports Policy Guide, bifurcating it into two separate volumes (Volume 1 focused on Health-Related Social Needs (HRSN)-focused services and Volume 2 with a housing focus and introduction of the new “Transitional Rent” service authorized under BH-CONNECT) and updating several service definitions to better clarify operational expectations and billing conventions. Of note, Medically Tailored Meals/Medically Supportive Foods (MTM/MSF) service subcomponents were significantly clarified and distinguished, including through newly-introduced and updated Healthcare Common Procedure Coding System (HCPCS) codes.

DHCS continued updating its [Elections Chart](#) semi-annually on its ECM and Community Supports webpage, detailing which Community Supports services are available in each county, by plan, including expected implementation dates for each service.<sup>1</sup> This cadence – paired with MCP TA touchpoints and technical guidance – supports steady, measured expansion while preserving transparency for MCPs, providers, members, and the public at large.

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<sup>1</sup> Available at: <https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf>

## **Program Implementation Highlights:**

DHCS concentrated on day-to-day execution in 2025: sustaining stakeholder touchpoints, reinforcing plan readiness, and tightening the data pipelines that underpin monitoring and reporting. The emphasis was on keeping operations steady while broadening access to Community Supports across counties.

Over the course of 2025, the Department maintained its frequent, structured engagement with plans and partners. Monthly MCP Technical Assistance webinars, described more fully below, provided timely guidance and clarifications, while smaller workgroup sessions carried implementation details forward in a practical, “how-to” format. These meetings also served as the main vehicle for sharing updated guidance and reminding MCPs of reporting and MOC submission timelines. The CalAIM Implementation Advisory Group (IAG) continued as a forum where MCPs, counties, and DHCS reviewed rollouts, surfaced operational issues, and discussed provider contracting progress, allowing DHCS to make targeted course corrections in real-time.

Semi-annual MOC cycles remained a core lever for program stability. Plans submitted updated MOCs semi-annually, documenting their referral/authorization workflows, utilization management strategies, provider vetting protocols, and implementation schedules. DHCS reviewed all submissions and iterated with MCPs to ensure alignment with state and federal expectations. The process continued to help standardize practice patterns across plans and counties and supported measured expansion without sacrificing consistency.

In parallel with the MOC cycles, DHCS conducted a 2025 Monitoring Meetings series with each MCP, focusing on primary and secondary indicators that matter for access and oversight – active providers by county and service, service utilization rates, referral patterns, and operational issues requiring follow-up. Where gaps were identified, DHCS issued targeted technical assistance and tracked remediation, using the meetings to keep momentum and promote accountability.

To secure the foundation for future monitoring and ongoing program integrity, DHCS established a planned dual-reporting bridge: monthly JSON submissions alongside the established quarterly QIMR, enabling side-by-side validation against QIMR measures and claims/encounter data before fully switching workflows. JSON moved to production beginning with the July 2025 reporting month, while Q2 2026 constitutes the final QIMR cycle. Over this period, DHCS and internal data teams established a testing period for each JSON phase of implementation, reconciled counts, addressed missing months, and

provided ample technical assistance to its MCP partners to ensure the JSON cadence and submissions are robust by the time QIMR-based reporting sunsets.

DHCS continued building system visibility so MCPs can identify members and resolve issues faster. In September 2025, the Medi-Cal Connect portal launched, which gave MCPs access to dashboards and longitudinal member information. This improved cross-program transparency and supported earlier identification of members who may benefit from ECM and/or Community Supports – an operational win as provider networks scale. Medi-Cal Connect functionality will continue to advance and progress over the next several years as new features are built out and introduced and as additional data systems are connected to it.

DHCS refined the Community Supports Policy Guide and associated technical materials to keep operations clear and measurable. Notably, several definitions were significantly updated and clarified, and new/updated HCPCS coding helped further delineate discrete service subcomponents – such as the “non-recurring set-up expenses” under Community or Home Transition Services and the various “medically tailored” and “medically supportive” nutrition interventions under MTM/MSF – so that MCPs can track costs accurately against lifetime maximums and distinguish the newly articulated MTM/MSF interventions for reporting. These adjustments help plans better manage and administer the Community Supports services they offer and give DHCS cleaner indicators for monitoring.

DHCS’s semi-annual Elections Chart updates kept county- and plan-level availability visible to stakeholders as timelines advanced. The combination of steady TA, predictable review cycles, and clearer data infrastructure supported expansion while preserving operational reliability. In general, MCPs paced their service elections to align with provider readiness and local market conditions.

DHCS continues to provide timely responses to questions and feedback submitted by a diverse range of stakeholders. Stakeholder engagement remains a cornerstone of the initiative, as DHCS is committed to maintaining open lines of communication and offering comprehensive guidance on this unique and innovative set of services.

Throughout the year, DHCS has hosted numerous webinars and meetings to facilitate dialogue, share updates, and address emerging issues. Key activities included:

- » **Bi-monthly CalAIM Implementation Advisory Group**

This advisory group is composed of select MCPs, counties, and other stakeholders engaged in ECM and Community Supports. It plays a pivotal role

in ensuring DHCS maintains real-time visibility into the rollout of newly launched benefits. The group provides:

- Critical input to address implementation challenges and inform DHCS decision-making;
- Detailed review of policy decisions, draft documents, and communications prior to broader dissemination;
- Recommendations for the development of infrastructure investments supported by performance incentives and PATH funding opportunities; and
- Guidance on technical assistance needs in the marketplace to support providers and MCPs.

Topics of discussion include:

- Implementation Experience: Feedback from MCPs and providers on the rollout of ECM and Community Supports, highlighting successes and areas for improvement.
  - Member Experience: Insights into how members are accessing and benefiting from ECM and Community Supports services.
  - Provider Contracting: Updates on the progress of contracting between MCPs and providers to expand service delivery networks.
  - Referrals and Authorizations: Challenges and opportunities in facilitating timely and appropriate referrals and authorizations for members eligible for Community Supports.
- » **Monthly MCP Technical Assistance (TA) and Guidance Webinars:** These webinars are designed specifically for health plan executives and personnel responsible for implementing Community Supports. They provide a vital forum for addressing operational challenges, delivering policy updates, and reinforcing best practices. Key highlights of these sessions include:
- Detailed guidance and clarifications on DHCS policies to ensure MCPs have a clear understanding of their responsibilities, as well as the standards for implementing Community Supports.
  - Presentations from subject matter experts on practical implementation strategies, addressing topics such as referral

workflows, data reporting requirements, and member engagement, providing DHCS with valuable operational insights.

- Spotlights on MCPs and providers who share their experiences, challenges, and successes, enabling attendees to learn from one another and adopt proven effective practices.
- An open forum where MCP representatives can ask questions directly to DHCS staff, which helps foster transparency and real-time problem-solving.

These webinars have proven instrumental in equipping MCPs with the tools and knowledge needed to navigate the complexities of Community Supports implementation while aligning with DHCS program objectives.

» **Weekly meetings with the Local Health Plans of California (LHPC) and the California Association of Health Plans (CAHP):**

Weekly meetings with LHPC and CAHP serve as essential touchpoints for ongoing technical assistance and updates regarding the implementation of ECM and Community Supports. These sessions help ensure consistent communication and collaboration between DHCS and the associations representing MCPs statewide. Key aspects of these meetings include:

- Regular reporting on the progress of ECM and Community Supports implementation, including status updates on contracting, member engagement, and provider onboarding.
- A platform for LHPC and CAHP to relay feedback from their member plans, helping DHCS identify and address systemic issues promptly.
- Collaborative discussions on emerging policy needs and considerations, ensuring that updates and refinements reflect real-world implementation challenges.
- Opportunities to align efforts across health plans, DHCS, and community providers, which help foster a unified approach to delivering these innovative services.

These opportunities have been crucial in enabling DHCS to maintain a collaborative relationship with LHPC and CAHP. This allows DHCS to remain agile in addressing implementation challenges while advancing the broader goals of the CalAIM initiative.

DHCS has leveraged the above forums to identify best practices, address stakeholder concerns, reinforce alignment with overarching program goals, and ensure program integrity. This iterative approach enables continuous improvement, ensuring that the initiative evolves in response to stakeholder feedback and the realities of on-the-ground implementation. In addition, this collective engagement informed the ECM and Community Supports Action Plan, which is a set of tactics the Department committed to taking to smooth implementation challenges, such as developing guidance to streamline the authorization and referral process and improving data exchange.

For example, DHCS continually engages with MCPs to address and reconcile discrepancies identified in their authorization policies for newly implemented Community Supports services. These discussions help reduce policy variations across plans and counties and enable DHCS to ensure greater consistency in service delivery and access for members.

Other key activities and events over the course of CY 2025 (DY 21) include the following:

On January 7 and 8, 2025, DHCS implemented multiple emergency actions in response to the developing wildfire situation in Southern California. DHCS coordinated closely with local and federal partners to support health care facilities, conduct evacuations, and maintain access to essential services for affected Medi-Cal members. During this period, DHCS issued guidance on emergency access to medical care, prescription refills, equipment replacement, transportation, and services for individuals in assisted living or Home and Community-Based Alternatives programs.

On January 8, 2025, DHCS hosted its first monthly Managed Care Plan Call of the year. The purpose of this meeting was to collaborate with our Medi-Cal Managed Care health plans to discuss upcoming projects and program transitions, including updates on Community Supports implementation.

On January 10, 2025, U.S. Department of Health and Human Services Secretary Xavier Becerra declared a Public Health Emergency (PHE) for California granting CMS additional flexibility to address the health needs of individuals impacted by the Southern California wildfires, which caused significant displacement and hardship for Medi-Cal members. MCPs played a critical role in effectively deploying ECM and Community Supports services as medically appropriate to their impacted members. These efforts were made possible through extensive preparedness planning and proactive emergency response protocols, ensuring uninterrupted care and services during this emergency.

On January 11, 2025, DHCS hosted its bi-monthly CalAIM IAG meeting. For this meeting, DHCS was interested in learning about the top CalAIM-related policy or implementation

issues that concern IAG members, to inform the identification of areas where additional policy refinement, guidance, or implementation support may be needed in the market for 2024.

On January 13, 2025, DHCS reiterated its commitment to working with local and federal partners and highlighted its emergency resources, including dedicated Q&A materials for Medi-Cal members, access to emergency supplies, and multi-agency preparedness and recovery guidance. These updates were issued department-wide.

On January 15, 2025, additional support was documented in the CalHHS Wildfire Memo, which described statewide cross-agency response efforts for vulnerable populations.

On January 17, 2025, DHCS leadership participated in the L.A. Strong Essentials Distribution event, providing direct relief and resources to fire-impacted communities.

On January 22, 2025, DHCS expanded administrative flexibilities, including streamlined enrollment and waived prescription requirements, and requested federal accommodations to ensure uninterrupted health care access. While Community Supports did not issue any wildfire-specific implementation policies in 2025, these department-wide emergency actions align with broader Medi-Cal system efforts to safeguard members during disasters.

On January 23, 2025, DHCS hosted its January CalAIM Monthly MCP Technical Assistance meeting covering a wide span of updates including the CalAIM Academy for Hospitals and Health Systems, Closed-Loop Referral guidance, ECM Streamlined Authorization, and the ECM/Community Supports/CCM JSON Exchange phases, during which DHCS detailed the transition to Phase 3 and previewed Phase 4. The meeting also provided updates on Community Supports Quarterly Monitoring and service definition refinements to four Community Supports services effective July 2025. Additional highlights included federal approval of the BH-CONNECT demonstration and the introduction of Transitional Rent as a new Community Supports benefit, with eligibility criteria and implementation timelines, as well as updates to Housing Community Supports resulting from CMS changes to the HRSN Framework. The meeting concluded with findings from the 2024 Local Health Jurisdiction (LHJ) Survey focused on collaboration with MCPs on CHA/CHIP alignment.

On January 24, 2025, DHCS hosted its bi-monthly CalAIM IAG meeting. This meeting featured updates on the following topics: Transitional Rent, ECM Monitoring, an overview of Medi-Cal Connect, Community Supports Quarterly Monitoring, and ECM and Community Supports Release of the Q1-Q2 2024 Quarterly Implementation Report.

On February 11, 2025, DHCS hosted an All-Comer Webinar on Flexible Housing Subsidy Pools (or Flex Pools). This webinar highlighted the same-day release of the Flex Pools Technical Assistance Resource, which defined Flex Pools and described their key functions, benefits, and components. The webinar also promoted Flex Pools as an effective model for counties and MCPs to consider for administering newly available funding for rent assistance. It additionally introduced the upcoming technical assistance to support entities in regions that had expressed interest in Flex Pools, but not yet operationalized them.

On February 14, 2025, DHCS confirmed receipt of all final QIMR submissions for the Q4 2024 reporting period (October 1 – December 31, 2024).

On February 27, 2025, DHCS hosted its February CalAIM Monthly MCP Technical Assistance meeting. The meeting provided updates on Closed-Loop Referral (CLR) requirements going live July 1, 2025, including new data, tracking, supporting, and monitoring expectations for ECM and Community Supports. A significant portion of the session focused on refined Community Supports service definitions, including updates to Nursing Facility Transition/Diversion to ALFs, Community Transitions Services/Nursing Facility Transition to Home, Asthma Remediation, and Medically Tailored Meals/Medically Supportive Food. DHCS also highlighted the extensive MCP and stakeholder engagement that informed these refinements, along with upcoming implementation timelines and technical assistance opportunities. Additionally, MCPs received updates on ECM/Community Supports/CCM JSON Phase 4 new dates.

On March 20, 2025, DHCS hosted its bi-monthly CalAIM IAG meeting. This meeting featured updates on the following topics of Tulare/Kings Knowledge Management Page, Community Supports: Select Service Definition Refinements, Transitional Rent: Policy Design Updates & Feedback Session.

On March 27, 2025, DHCS hosted its March CalAIM Monthly MCP Technical Assistance meeting, beginning with updates on the Tulare and Kings Knowledge Management Website and the Connected Communities of Care pilot, including its purpose, design principles, long-term vision, early results, and key Knowledge Management Pages. DHCS then presented "Addressing the Knowledge Gap of Primary Care Providers," emphasizing the MCP role in educating network PCPs about ECM and Community Supports, referral pathways, and communication channels. The meeting continued with an ECM/Community Supports/CCM JSON Exchange update outlining Phase 4 testing and production timelines and upcoming technical documentation. DHCS next reviewed new time limits applicable to Community Supports services with room and board components, including updated STCs, Nomenclature, revised duration limits, global

HRSN housing caps, and implementation expectations effective January 1, 2025. DHCS also provided updates on Community Supports service definitions, including February 2025 changes to Asthma Remediation and the transition of assessments and asthma self-management education to the Asthma Preventative Services (APS) Benefit, followed by a Best Practices Spotlight featuring Regional Asthma Management and Prevention (RAMP). The meeting concluded with a review of upcoming MCP milestones for Q2–Q3 2025.

On April 30, 2025, DHCS released the updated Community Supports Policy Guide, now bifurcated into two separate volumes, to the public. In this version of the Policy Guide, DHCS updated service definitions for seven (7) Community Supports services, including Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Assisted Living Facility Transitions, Community or Home Transition Services, Medically Tailored Meals/Medically-Supportive Food, and Asthma Remediation. All updates were based on input and questions raised by Managed Care Plans, providers, and other stakeholders over the previous two years. The updated Policy Guide includes targeted clarifications to a select subset of definitions with the aim of improving standardization and increasing the utilization of these Community Supports. DHCS allowed for public comments for the Policy Guide while it was in draft form; along with that, DHCS furnished a memo that provided the background, overview, and rationale of the refinements.

On May 14, 2025, DHCS hosted an All-Comer Webinar to introduce Volume 2 of the Community Supports Policy Guide. This session focused on Community Supports for members experiencing or at risk of homelessness, provided key updates to existing service definitions, and described enhanced coordination requirements between Managed Care Plans and County Behavioral Health Agencies regarding housing initiatives.

On May 15, 2025, DHCS confirmed receipt of all final QIMR submissions for the Q1 2025 reporting period (January 1 – March 31, 2025).

On May 16, 2025, DHCS held another All-Comer Webinar to present implementation updates for Volume 1 of the Policy Guide. The webinar highlighted changes made in April 2025, emphasized improvements to closed loop referrals, and discussed specific updates to service definitions. Covered services included:

- » Medically Tailored Meals / Medically Supportive Food
- » Asthma Remediation, Assisted Living Facility Transitions
- » Community or Home Transitions

» Personal Care & Homemaker Services

All updated in February 2025. These refinements represent some of the most significant milestones in the 2025 Community Supports implementation.

On May 22, 2025, DHCS hosted its May CalAIM Monthly MCP Technical Assistance meeting, beginning with updates on the ECM/Community Supports/CCM JSON Exchange, including Phase 4 testing and production timelines and distribution of the technical documentation set. DHCS then presented ECM/Community Supports Monitoring, outlining the purpose of Monitoring Implementation Review Meetings, key measures included in MCP Progress Reports, and Joint Monitoring Questions focused on service integration, network capacity, provider relations, and member growth and experience. The meeting continued with a Medi-Cal Connect update, providing an overview of the platform's vision, key features such as Longitudinal Member Record and RSST, advisor engagement activities, onboarding expectations, and upcoming All-Plan engagements ahead of the July 2025 Release 3 launch. DHCS concluded with an overview of the updated Community Supports Policy Guide organized into two volumes and summarized the effective dates for service definition updates across multiple Community Supports. The meeting concluded with upcoming MCP milestones for Q3 2025.

On June 5, 2025, DHCS hosted Public Consulting Group (PCG), the Third-Party Administrator for the PATH initiative, and the Collaborative Planning and Implementation (CPI) Facilitators in Sacramento for an in-person meeting. The CPI initiative provides funding to support regional collaborative planning efforts among MCPs, providers, community-based organizations, county agencies, public hospitals, tribes, and others to support implementation of ECM and Community Supports. Stakeholders in a region form collaborative planning groups that work together to identify, discuss, and resolve implementation issues, as well as determine how PATH and other CalAIM funding initiatives can be utilized to address gaps identified in MCP Needs Assessments and Gap Filling Plans. One objective of the meeting was to promote bi-directional communication and input across the facilitators and DHCS by sharing insights from "the field" in alignment with the ECM and Community Supports Action Plan 2.0, including identification of challenges and potential solutions regarding CalAIM implementation. A second objective was for facilitators, PCG, and DHCS to discuss and come to a consensus on goal-setting opportunities for the CPI initiative.

On June 5, 2025, DHCS published two Data Sharing Authorization Guidance (DSAG) Toolkits. These toolkits complement the previously released [DHCS DSAG 2.0 Guidance](#) focusing on real world scenarios that will help on the ground providers and

organizations navigate data privacy and data sharing laws and regulations related to the delivery of Medi-Cal Housing services and the Re-entry Initiative. The toolkits aim to clarify when, why, and under what circumstances consent may be needed to share sensitive health and social service information under the relevant data sharing laws. The Toolkits are listed as DSAG Medi-Cal Housing Support Services Toolkit and DSAG Re-Entry Initiative Toolkit.

On June 11, 2025, DHCS sent out final approvals for all MCP's July 2025 Model of Care Submissions as well as updating the Final Elections for the July 2025 Implementation phase. On June 25, 2025, DHCS met with Alameda Alliance for Health, for an Implementation Monitoring Meeting to gain insights into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On June 26, 2025, DHCS hosted its June CalAIM Monthly MCP Technical Assistance meeting. DHCS began with updates on ECM/Community Supports/CCM JSON Exchange activities, confirming distribution of Technical Documentation version 4.1 and providing reminders about upcoming Phase 4 testing and production dates. The meeting continued with an overview of CPI best practices and sustainability activities, including updates on the Best Practices Roadmap, CPI workgroups, sustainability framework development, and CPI measurement efforts. DHCS then reviewed Community Supports updates, including correct use of Place of Service Code 99 for Community Supports, the forthcoming HCPCS coding update for Community or Home Transition Services, the MTM and MTG two-thirds nutrient threshold requirement, and clarifications related to Housing Deposits. DHCS concluded the meeting with Medi-Cal Connect, providing detailed updates on Release 3 vision and capabilities, onboarding preparation, MCP training expectations, the Longitudinal Member Record, the Quality Measures Dashboard, and the Risk Stratification, Segmentation, and Tiering (RSST) risk tiering model.

On July 1, 2025, DHCS received the final updated Models of Care and final January 2026 Elections from MCPs implementing Community Supports in all 58 California counties, including proposed networks and estimated capacities for services.

On July 1, 2025, DHCS met with CalOptima Health for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community

Supports programs. Community Supports focused on a few key aspects, which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Supports services.

On July 2, 2025, DHCS met with Blue Cross Partnership (formerly known as Anthem Blue Cross) for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On July 10, 2025, DHCS held another Implementation Monitoring Meeting and met with Blue Shield of California Promise Health Plan to gain insight into the effectiveness of the Plan's ECM and Community Supports programs. Community Supports focused on a few key aspects, which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Supports services. On July 17, 2025, DHCS hosted its bi-monthly CalAIM IAG meeting. This meeting featured updates on the following topics of Community Supports: Medically Tailored Meals | Medically Supportive Foods Community or Home Transition Services Updates & Feedback - Please note this will include a discussion around MTM/MSF services and HCPCS coding, Round Robin: Community Supports Impact, CPI Best Practice Roadmap and Sustainability Planning Update.

On July 17, 2025, DHCS met with Kern Family Health Care for an Implementation Monitoring Meeting to gain insights into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated

these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On July 23, 2025, DHCS sent out the Community Supports Impact Questionnaire to MCP's and select Community Supports Providers. Through this questionnaire, DHCS seeks to better understand voluntary efforts that MCPs and Community Supports Providers have undertaken themselves to measure the impact of these services on the Members they serve. DHCS plans to combine information gathered through this questionnaire with statewide findings to strengthen material available for CMS reporting and to enhance information shared with MCPs, providers, stakeholders, and the public. On July 24, 2025, DHCS hosted its July CalAIM Monthly MCP Technical Assistance meeting. DHCS began with updates on the ECM/Community Supports/CCM JSON Exchange, confirming distribution of Technical Documentation version 4.2 and reviewing upcoming Phase 4 testing and production requirements. DHCS next provided information on Medically Tailored Meals and Medically Supportive Foods HCPCS coding updates, including discussion of the proposed HCPCS codes and modifiers for Nutrition Education and Nutrition Assessment as well as proposed separate HCPCS codes and modifiers to differentiate Medically Tailored Groceries, Medically Supportive Groceries, Healthy Food Vouchers, Produce Prescriptions, and Food Pharmacy services. The meeting then moved to Medi-Cal Connect, where DHCS presented a timeline update and highlighted Release three capabilities, future capabilities, and opportunities for MCPs to provide feedback supporting policy implementation. DHCS also reviewed new data sharing features, the introduction of APIs and flat files, the RSST risk tiering model, and plans for additional Longitudinal Member Record and Quality Dashboard functionality in mid-September. DHCS concluded by outlining opportunities for MCP participation in the Policy into Action document.

On July 24, 2025, DHCS met with Gold Coast Health Plan for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On July 29, 2025, DHCS hosted an All-Comer Webinar to announce the release of the Authorization to Share Confidential Member Information (ASDMI) Form and two Data Sharing Authorization Guidance (DSAG) Toolkits focused on Medi-Cal Housing Support

Services and the Medi-Cal Justice-Involved Reentry Initiative. The ASCMI Form is a release of information form that Medi-Cal Partners – including counties, agencies, providers, health plans, community-based organizations, and others - may use to obtain their clients' consent to exchange their sensitive health and social services information. DHCS piloted the ASCMI Form in 2023 and is excited to publish a revised version for Medi-Cal Partners' use when seeking to exchange their Members' sensitive information to coordinate their care. DSAG Toolkits illustrate real-world scenarios that will help Medi-Cal Partners navigate complex data sharing and privacy laws and understand when consent is or is not needed to share information to support care coordination across sectors.

On July 30, 2025, DHCS met with Health Net Community Solutions to go over the large-scale transition at Soul Housing's Recuperative Care program that would require close coordination with their team over the next two months. DHCS met with them to clarify Transition Plan, Provider Reassignment, Continuity of Care, and Ongoing Status Updates.

On July 31, 2025, DHCS met with Contra Costa Health Plan for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Supports programs. Community Supports focused on a few key aspects, which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Supports services.

On August 7, 2025, DHCS met with San Francisco Health Plan, for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On August 8, 2025, DHCS met with Health Net Community Solutions to follow up with the Termination of Soul's Recuperative Care Program. It was requested to meet with their team every three weeks to receive updates and ensure that all members are successfully transitioning and receiving the necessary care and services. This discussion included speaking on the topics of Discharge into Housing Settings, Coordination with

County BH Partners, Member Categorization and Care Coordination, Leadership and Task Force, Engagement with Housing Authorities, Disposition Planning, Communication and Member Engagement, and DHCS Involvement.

On August 13, 2025, DHCS resumed monitoring and met with Inland Empire Health Plan for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a look at their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On August 14, 2025, DHCS met with Health Plan of San Mateo for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On August 15, 2025, DHCS confirmed receipt of all final QIMR submissions for the Q2 2025 reporting period (April 1 – June 30, 2025).

On August 20, 2025, DHCS met with L.A. Care Health Plan for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On August 27, 2025, DHCS met with both Health Net Community Solutions and CalViva Health for an Implementation Monitoring Meeting to gain insight into the effectiveness of both Plans' ECM and Community Supports programs. Community Supports focused on a few key aspects, which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and

Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Supports services.

On August 28, 2025, DHCS hosted its August CalAIM Monthly MCP Technical Assistance meeting. DHCS opened with a summary of the 2024 Population Health Management (PHM) Strategy Deliverables, highlighting key takeaways related to MCP engagement in Community Health Assessments (CHA) and Community Health Improvement Plan (CHIP) processes, California Pay Data Reporting (CRD/CAC), resource contributions, data sharing readiness, technical assistance needs, and alignment with LHJ survey responses. DHCS then presented Population Health Management Policy Guide Updates on Monitoring and Technical Specifications, including the streamlined PHM Monitoring approach, updated quality measures, revised PHM Key Performance Indicators (KPIs), technical specification changes, reporting schedule, and next steps for PHM Monitoring. DHCS continued with an update on ECM, Community Supports, and ECM/Community Supports/CCM JSON Exchange, sharing timeliness expectations, submission workarounds, and upcoming updates to the JSON Data Dictionary for Transitional Rent Provider Types. The meeting then reviewed guidance on Coordinating Transitional Rent and BHSa Housing Interventions, including expectations for MCP and county behavioral health coordination, contracting with county BH agencies as Transitional Rent Providers, and requirements for the Transitional Rent Model of Care. DHCS also provided a Medi-Cal Connect update, which included PHM context, the Medi-Cal Connect vision and goals, the release timeline, and a deep dive on RSST covering algorithm design, underutilization, equity evaluation, tiering thresholds, and MCP readiness steps. DHCS concluded with upcoming MCP milestones for Q3 and Q4 2025.

On August 28, 2025, DHCS met with AIDS Healthcare Foundation for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On September 11, 2025, DHCS met with Partnership Health Plan of California for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community

Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On September 18, 2025, DHCS met with CenCal Health for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Supports programs. Community Supports focused on a few key aspects, which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Supports services.

On September 23, 2025, DHCS met with SCAN Health Plan for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's Community Supports program. Community Supports focused on a few key aspects, which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Supports services. On September 25, 2025, DHCS hosted its September CalAIM Monthly MCP Technical Assistance meeting. DHCS presented updates to the PHM Monitoring Policy Guide Technical Specifications, including the PHM Monitoring timeline, the updated list of six PHM KPIs, revised reporting schedule, updated measurement periods, and changes to age, race, language, and exclusion criteria. The meeting then transitioned to Medi-Cal Connect, covering the Medi-Cal Connect Overview, R3.0 Launch Update, Secure File Transfer Protocol (SFTP) access updates, 3.1 capabilities, RSST requirements, RSST implementation steps, and additional resources. DHCS next discussed Local Administrator Onboarding, including roles, responsibilities, and key functionalities for user access management. DHCS concluded with feedback opportunities for MCPs.

On September 25, 2025, DHCS met with Santa Clara Family Health Plan for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects including a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated

these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On October 2, 2025, DHCS met with Mountain Valley Health Plan (Health Plan of San Joaquin), for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects including a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On October 3, 2025, DHCS released the finalized Transitional Rent Payment Methodology. This document includes the maximum reimbursable amount ("reimbursable ceilings") and administrative fees associated with Transitional Rent—the newest Community Support designed to provide up to six months of rental assistance for Medi-Cal Members who are experiencing or at risk of homelessness and meet additional eligibility criteria.

On October 9, 2025, DHCS met with Community Health Group Partnership Health Plan for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects including a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On October 16, 2025, DHCS met with Community Health Plan of Imperial Valley for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects including a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On October 23, 2025, DHCS hosted its October CalAIM Monthly MCP Technical Assistance meeting. DHCS provided updates on JSON Transitional Rent, including the

release of Technical Documentation v4.3, Data Dictionary v4.3, Schema v4.3, and the addition of three new data elements to support implementation of Transitional Rent, followed by ECM/ Community Supports/CCM JSON Exchange updates and upcoming Testing and Production dates. DHCS then presented a Medi-Cal Connect Status Update covering the 3.1 Launch Update, current capabilities such as Risk Tiering, Longitudinal Member Records, the Quality Measure Dashboard, Program Flags, and the Learning Management System, along with training opportunities and SFTP access updates. DHCS previewed new R4.0 features, including upcoming dashboards, enhanced ECM and Community Supports flags, and the Policy Into Action resource designed to help MCPs use Medi-Cal Connect to support policy.

On October 30, 2025, DHCS hosted a webinar, "The Fierce Urgency for Community Partnerships." This webinar set the stage for a conversation about how California is advancing health equity and improving outcomes by partnering across sectors and centering community voices. DHCS and the California Department of Public Health (CDPH) provided an overview of California's health care delivery transformation journey, shared updates on initiatives that improve accountability, community engagement, and transparency, and discussed recent efforts to strengthen and align community planning and community investments across public health, managed care, and behavioral health. Considering recent federal developments, the webinar also highlighted how the state is well-positioned to continue working with communities and partners to build a more coordinated, person-centered health system.

On October 30, 2025, DHCS met with Kaiser Permanente for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services.

On October 31, 2025, DHCS hosted a webinar on Transitional Rent Payment Methodology. This webinar discussed Transitional Rent Overview, Overview of Transitional Rent Payment Structure, Payment for Cost of Rent or Temporary Housing, and Administrative Fee. On November 6, 2025, DHCS met with Central California Alliance for Health for an Implementation Monitoring Meeting to gain insight into the effectiveness of the Plan's ECM and Community Support programs. Community Supports focused on a few key aspects which included a review of their 12-month

referral growth for Community Supports, Active Providers (defined as those able to deliver services), and the accessibility of the Managed Care Plans Public Information for Members and Providers. DHCS evaluated these measures to assess that MCPs are performing in accordance with policies and procedures to ensure delivery of Community Support services. On November 14, 2025, DHCS confirmed receipt of all final QIMR submissions for the Q3 2025 reporting period (July 1 – September 30, 2025).

On November 20, 2025, DHCS hosted the November CalAIM Monthly MCP Technical Assistance meeting and began with an overview of the Omnibus Maternity APL, including its comprehensive policy roadmap, consolidated guidance, and feedback timeline. DHCS outlined key policy areas such as risk assessments, maternity services, prenatal and newborn screenings, access to maternal providers, behavioral health, lactation services, doula and CHW services, PHM, Community Supports, and reproductive health. The meeting continued with updates on the 2025 PHM Strategy Deliverables, including the new electronic submission process and the February 2, 2026, deadline. DHCS then presented Transitional Rent reporting requirements beginning January 2026, covering encounter submissions, supplemental payment guidance, and JSON reporting updates. DHCS also provided a Medi-Cal Connect update, reviewing platform features, RSST implementation expectations, utilization snapshots, and available resources. The meeting concluded with MCP feedback themes, upcoming milestones through mid-2026.

On November 25, 2025, DHCS scheduled follow up meetings with the lower performing plans to discuss the plan's implementation of ECM and Community Supports Services to gain a deeper understanding of the challenges identified, discuss contributing factors, explore opportunities for improvement, and highlight any promising practices or progress made. The plans included in these follow up meetings are Health Net, CalViva, Kaiser, Blue Cross Partnership, Community Health Plan of Imperial Valley, Molina Health Care, Central California Alliance for Health, and Santa Clara Family Health Plan.

On December 18, 2025, DHCS hosted its December CalAIM Monthly MCP Technical Assistance meeting, beginning with updates on the 2025 PHM Strategy Deliverable, including the template structure, required Parts 1–3, electronic submission process, and the February 2, 2026, deadline. DHCS then presented the CPI Sustainability Toolkit session, reviewing PATH CPI goals, the four-year roadmap, sustainability priorities, the developing toolkits, and planning considerations for MCPs as PATH approaches its 2026 sunset. Next, DHCS provided policy updates on Initial Health Assessments for dual-eligible members, outlining federal requirements, identified policy gaps, and proposed changes for integrated and non-integrated Medicare populations. The meeting

continued with the QIMR ECM Provider Reporting Update, HCPCS coding updates for Community Supports, and a JSON validation rule change allowing multiple open referrals for the same service type. DHCS also delivered a Medi-Cal Connect update, addressing data lags, maintenance processes, and release communication. The meeting concluded with upcoming MCP milestones for early 2026 and reminders regarding the 2026 MCP TA meeting cadence.

On December 30, 2025, DHCS released the Community Supports Pricing Resource, an addendum to the 2021 Non-Binding Community Supports Pricing Resource (formerly known as the Non-Binding ILOS Pricing Guidance). This Addendum focuses on Community Supports that have undergone substantial refinements to service definitions or billing guidance since the beginning of the Community Supports program. In particular, this update included pricing benchmarks and corresponding HCPCS codes and modifiers for newly defined and distinguished subservices, as outlined in the 2025 Community Supports Policy Guide (Volume 1).

In January 2026, DHCS released an updated version of the ECM and Community Supports HCPCS Coding Guidance, originally published in 2021. The 2026 update incorporates feedback gathered from more than 200 MCPs and ECM/Community Supports providers beginning in late 2022 and reflects clarifications and refinements made to improve statewide consistency in coding and reporting. The updated guidance continues to identify the HCPCS codes and modifiers that must be used by providers when submitting ECM and Community Supports encounters to MCPs, and by MCPs when submitting standardized encounter data to DHCS for oversight and monitoring. Revisions made in 2025-2026 focus on increasing statewide data standardization, aligning code descriptions with CMS conventions, clarifying modifier usage, and reducing administrative burden across plans and providers. DHCS will continue to review and periodically update the guidance based on ongoing stakeholder feedback.

DHCS regularly updates its [ECM and Community Supports webpage](#) with guidance materials and program documents, in response to stakeholder and consumer feedback. DHCS restructured the page in April 2024 to ensure key policy and guidance documents are highlighted while at the same time archiving some of the older, more outdated guidance. All program documentation, including historic documentation, remains and will continue to remain accessible to the general public.

Revised Community Supports [elections](#) are posted on the [DHCS website](#) once DHCS issues its final approval for all outstanding MCP MOCs. DHCS will continue to update Community Supports elections semi-annually. Technical assistance and guidance webinars are recorded and hosted on the [DHCS website](#) and are updated regularly.

DHCS also maintains a regularly updated FAQs document on its ECM and Community Supports webpage, which highlights several FAQs from MCPs, providers, and stakeholders. The FAQs document also includes answers and policy clarifications provided by DHCS.

## **Community Supports Policy Guide**

Over the course of DY 19, DY 20, and DY 21, DHCS and its stakeholders continued to identify several key areas of the Community Supports Policy Guide for which additional TA, guidance, and/or further clarification were necessary. DHCS refreshes its Community Supports Policy Guide when necessary to incorporate new language and/or developments in policy, including:

- » Prime/Subcontractor Authorization Policy
- » Homelessness Determinations
- » Eligibility for Services
- » Member Handbooks and Website Update Requirements
- » Provider Network Allowances
- » Continuum of Care Requirements
- » Other technical corrections

DHCS last updated its Community Supports Policy Guide in July 2023 to provide several key program updates. In April of DY 21 (2025), DHCS updated and bifurcated the Community Supports Policy Guide into two volumes to improve clarity and navigation: Volume 1 (HRSN-related services) and Volume 2 (housing-related supports). The housing volume introduced “Transitional Rent” for the first time as a new service authorized under BH-CONNECT, with policy, operational, and reporting parameters staged for implementation and public reporting aligned to the statewide timeline.

Service definitions have been clarified to reduce variation and strengthen operational alignment across the state. Notably, the service definition for MTM/MSF was significantly expanded with plain-language criteria, delivery modalities, and documentation expectations; and transition-focused services now include clearer descriptions of allowed activities and limits.

To support accurate billing, monitoring, and oversight, the Policy Guide now incorporates new and updated HCPCS codes that more accurately delineate service subcomponents. These include explicit coding for the “non-recurring set-up expenses” under Community or Home Transition Services, enabling MCPs to track associated costs

against lifetime maximums, and differentiated MTM/MSF codes/modifiers that reflect newly articulated nutrition interventions.

Monitoring and oversight best practices have been added to assist MCPs and their providers with consistent implementation. The Policy Guide consolidates expectations for provider vetting/readiness, referral/authorization closure, documentation standards, and member-information sharing – paired with pointers to DHCS technical documentation and MCP TA channels – so that plans can maintain compliance while scaling capacity.

DHCS publishes the bifurcated Community Supports Policy Guide Volumes and all associated technical materials on its ECM & Community Supports webpage. Policy Guide updates are provided on an as-needed basis to reflect policy changes, operational clarifications, and any necessary technical corrections.

## Oversight and Monitoring Activities (STC B20b):

Prior to all new implementations of newly elected services, MCPs are required to submit a comprehensive and updated MOC detailing their policies for implementing Community Supports in the counties in which they operate.<sup>2</sup> Prior to go-live for each election of new Community Supports, MCPs must submit updated policies for those new services. DHCS reviews and approves MOC submissions from each MCP, notifying MCPs of their approval to implement new services at least 30 days prior to each implementation period. In Year Four, DHCS paired the semi-annual MOC cycles with plan-specific monitoring touchpoints to verify provider readiness, referral/ authorization workflows, and service-level performance indicators (e.g., active providers by county/service and utilization rates), issuing targeted technical assistance where gaps were identified.

To monitor ECM and Community Supports implementation, DHCS developed the Quarterly Implementation Monitoring Report QIMR, which MCPs are required to submit across multiple domains. For Community Supports specifically, MCPs report data on service requests, approvals, and denials, as well as provider capacity and network adequacy. These data points are critical for tracking implementation progress and identifying emerging trends or gaps in service delivery. The information collected through QIMRs is integral to informing DHCS decision-making, including the design and application of MCP performance incentives and technical assistance priorities. In 2025, DHCS maintained QIMR-based reporting while instituting a dual-reporting bridge to monthly JSON submissions, validating JSON outputs against QIMR measures and encounters/claims data. QIMR-based reporting will extend through Q2 2026, after which JSON will become the authoritative reporting source.

DHCS is committed to transparency and is working to produce and publish program data at the earliest opportunity, while adhering to strict privacy and confidentiality standards. Validation timelines vary by cycle; DHCS performance quality checks, reconciles discrepancies, and confirms completeness before data move into visualization tools. Once validated, the data is visualized using Microsoft Power Business Intelligence (Power BI), which provides a dynamic and user-friendly platform for monitoring program performance. In late 2025, the BI team prepared JSON ingestion via PACES-sourced data

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<sup>2</sup> See the Model of Care [Instructions and Timelines](#) and the [Legacy Template](#) for details.

dashboards to support side-by-side views with legacy QIMR tables and reduce lag as JSON-based reporting continues to mature.

The Power BI dashboards, currently under continuous refinement, are designed to accurately display key metrics, including service utilization, provider participation, and beneficiary access trends. These dashboards help DHCS, and its stakeholders evaluate progress, identify areas for improvement, and inform both policy and operational adjustments. In September 2025, Medi-Cal Connect launched, giving MCP staff portal-based visibility to dashboards and longitudinal member information, improving identification of members likely to benefit from receiving ECM and/or Community Supports.

An example of how the data are visualized in DHCS’s Power BI Dashboard is included in Figure 2.

**Figure 2: Program History for Members Receiving Community Support Services as of September 2025: Examples of Outputs from DHCS’s Power Business Intelligence (BI) ECM-Community Supports Dashboard:**



DHCS maintains an ongoing system of monitoring that informs routine “360 Implementation Reviews” with MCPs, assessing their administration of Community Supports. As part of this oversight, DHCS evaluates MCP performances, identifies areas of concern, and follows up with targeted technical assistance or corrective action as needed. These reviews continued throughout 2025, tailored to local market conditions and provider network development. DHCS closely tracked all measures reviewed with plan staff and documented next steps/action items resulting from these touchpoints to remediate plan-specific barriers.

In addition to quarterly reporting, DHCS initiated efforts to cross-validate QIMR data with other sources, such as encounter and claims submissions through the Post Adjudicated Claims & Encounters System (PACES), to provide a more comprehensive and accurate picture of program performance and ensure alignment across reporting mechanisms. In 2025, the dual-reporting period enabled JSON-vs-QIMR/encounter comparisons at the member/service level. DHCS also coordinated internally with BI/ Master Data Management (MDM/HIMD) data teams to maintain public-report continuity during the bridge year.

Operational guidance evolved alongside oversight in 2025. DHCS refined Community Supports service definitions and clarified coding conventions, including ECM Presumptive Authorization (effective January 2025) and Closed-Loop Referral (CLR) reporting requirements (effective July 2025), to support consistent tracking and monitoring across MCPs.

DHCS continues to work toward ensuring high data quality during the initial years of Community Supports implementation, while recognizing the gaps in reporting capabilities among many new providers. Data completeness, quality, and lags result from the fact that many Community Supports providers are new to Medi-Cal and/or the managed care delivery system. MCPs (or their contracted community care hubs) need to invest time and effort to train and support providers in data submission efforts. To date, DHCS has collected and validated fifteen (15) quarters of data for Community Supports; however, MCPs continue to express caution about interpreting trends, given the variability in provider experience and capacity.

DHCS will continue to submit timely, accurate, and validated encounter data to the Transformed Medicaid Statistical Information System (T-MSIS), in accordance with STC 8.12(ii).

DHCS acknowledges that outstanding challenges with timely and accurate data collection remain, particularly as Community Supports represent a novel and

transformative addition to Medi-Cal. These challenges have improved over time but persist due to the complexity of onboarding a diverse array of community-based providers and other non-traditional provider types who may be new to Medi-Cal's reporting and administrative requirements. Many of these providers are simultaneously navigating the operational intricacies of managed care for the first time, which necessitates ongoing technical assistance, capacity building, and support from DHCS and MCPs.

Recognizing these dynamics, DHCS is committed to actively addressing barriers to implementation and fostering a robust infrastructure for Community Supports. For example, DHCS investments towards statewide initiatives, such as the Community Supports Spotlight Series conducted in CY 2022 (DY 18), which provided targeted training on critical service areas. DHCS has also worked with the California Health Care Foundation to develop Community Care Hub Toolkits, which are entities intended to reduce barriers for CBOs, community-based Providers, and other Providers that address HRSNs to contract with MCPs and participate in the Medi-Cal delivery system. These entities can provide administrative services while supporting program integrity efforts. While early initiatives like these laid a foundation for implementation, current efforts focus on refining data collection processes, streamlining provider onboarding, and strengthening MCP oversight to ensure long-term sustainability. By emphasizing practical solutions and collaborative problem-solving, DHCS continues to enhance program operations and provider engagement to support the integration of Community Supports into Medi-Cal's standard delivery system.

In addition to technical assistance, DHCS continues to refine its approach to provider engagement by developing new tools and resources tailored to the specific needs of Community Supports providers. Examples include step-by-step guides for navigating Medi-Cal systems, offering simplified templates for documentation and billing, and rapid-response channels to address common administrative hurdles. These efforts aim to reduce burdens on providers, improve data submission accuracy, and enhance overall program efficiency.

As 2025 concluded, DHCS sustained these initiatives and prepared to scale support to meet evolving program needs. The challenges of data collection and operationalization were not viewed as static issues but rather as opportunities for continuous improvement and innovation. By fostering strong partnerships with MCPs and community stakeholders, DHCS seeks to build a more resilient and effective infrastructure that maximizes the potential of Community Supports to improve health outcomes and reduce health disparities for Medi-Cal members statewide.

In CY 2025 (DY 21), DHCS offered additional targeted technical assistance to support MCPs and providers in implementing and operationalizing refinements to select Community Supports service definitions. These efforts prioritized services such as Medically Tailored Meals, Asthma Remediation, Assisted Living Facility Transitions, and Community or Home Transition Services, ensuring MCPs and providers aligned operations with updated definitions, enhanced service delivery, and improve member outcomes. Activities included focused webinars and training sessions, updated policy guidance, and individualized support to address implementation challenges. Monitoring meetings and report cards were aligned to keep oversight streamlined and integrated. DHCS also facilitated peer-to-peer learning opportunities to share strategies, highlight promising practices, and foster collaboration across stakeholders.

These initiatives are part of a broader commitment to advancing the integration of innovative, community-driven services within Medi-Cal, strengthening the program's capacity to meet the diverse health-related social needs of beneficiaries statewide.

## **JavaScript Object Notation (JSON) Transition**

During 2025, DHCS advanced the transition to monthly JSON reporting while maintaining the Excel-based QIMR to ensure continuity and quality. JSON, an open standard file format, is designed to facilitate streamlined data collection and transmission. This approach aligns with other mandatory reporting processes utilized by DHCS and is being pursued to help address existing challenges with data timeliness.

Currently, QIMR data still lags real-time implementation by approximately four to six months. The transition to JSON will significantly reduce this lag, enabling more timely monitoring and decision-making.

Phased implementation proceeded as follows (with dual-reporting maintained):

- » **Phase 1 (January 2024):** Limited data elements specific to Enhanced Care Management (ECM) and Complex Care Management (CCM) enrollment status.
- » **Phase 2 (July 2024):** ECM Populations of Focus, Eligibility, Outreach, Authorizations, and Provider Networks.
- » **Phase 3 (January 2025):** ECM Care Manager & Provider Facility Details
- » **Phase 4 (July 2025):** All remaining Community Supports elements, including member-level details, utilization, authorizations, and provider networks. Initial CLR reporting is also included for the first time, with details captured around referral and authorization decision dates, referral status, authorization status, and

date of first service receipt. ECM CLR Reporting & Presumptive Authorization details were also introduced in this phase.

DHCS produced accompanying Technical Documentation through an available Technical Assistance Companion Guide, which contains all the technical information (including data dictionaries, file layouts, JSON Schemas, and details on response files) required for MCPs to submit one data file to DHCS monthly. A Data Dictionary is also available, describing the required data values as well as the validation edits performed on specific data elements.

As stated above, MCPs are required to continue reporting as normal through the QIMR process, within 45 days of the end of each quarter, through Q2 2026, with the final QIMR submission due to DHCS by August 15, 2026.

## **Closed-Loop Referral (CLR) Reporting**

In alignment with ongoing enhancements to data collection and monitoring under the Population Health Management (PHM) framework, DHCS introduced Closed-Loop Referral (CLR) requirements to strengthen tracking, support, and oversight of referrals for priority CalAIM services. CLR is defined as a referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored, and results in a Known Closure (e.g., Member receiving services, Member declines, Provider declines, etc.).

These requirements, detailed in the [Closed-Loop Referral \(CLR\) Implementation Guidance](#)<sup>3</sup> (an addendum to the PHM Policy Guide, updated May 2025) and accompanying [CLR FAQs](#)<sup>4</sup>, became effective July 1, 2025, pursuant to the MCP Contract, PHM [APL 22-024](#)<sup>5</sup>, and related guidance. Initial implementation applies to all ECM Populations of Focus and 13 Community Supports (excluding Sobering Centers due to their real-time delivery nature), with Transitional Rent included upon its launch (January 2026).

By enhancing referral tracking and closure monitoring through integrated JSON reporting, CLR supports more timely and accurate data on service connections to ECM

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<sup>3</sup> Available at: <https://www.dhcs.ca.gov/CalAIM/Documents/CLR-Implementation-Guidance.pdf>

<sup>4</sup> Available at: <https://www.dhcs.ca.gov/CalAIM/Pages/Closed-Loop-Referral-FAQs.aspx>

<sup>5</sup> Available at: <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-024.pdf>

and Community Supports. Building on the JSON transition for ECM and Community Supports reporting – which has improved data timeliness and accuracy – DHCS updated JSON submission requirements to incorporate CLR data effective July 1, 2025. This integration leverages existing monthly JSON pathways (e.g., Return Transmission File, Authorization Status File updates) to capture key elements such as referral volume, status changes, timelines, closure reasons, and quality measures, without imposing new separate reporting systems. Future phases may incorporate additional aligned data elements to further refine monitoring.

Managed Care Plans are required to:

- » Track minimum data elements for each CLR;
- » Support referrals through timely notifications (e.g., authorization decisions and loop closures) and barrier troubleshooting;
- » Monitor trends to identify gaps, provide technical assistance, and implement systematic improvements that promote successful connections to ECM and cost-effective Community Supports.

DHCS monitors CLR implementation through updated JSON submissions, with the authority for ad hoc data requests as needed. These enhancements bolster DHCS oversight by increasing the share of Members successfully connected to needed services, addressing referral gaps, and promoting equitable access under CalAIM. Early implementation has focused on alignment with existing data-sharing protocols to minimize administrative burden while advancing member outcomes, and positions CLR to contribute to the demonstrated cost-effectiveness of priority services by facilitating greater utilization of Community Supports as medically appropriate, lower-cost alternatives to traditional Medicaid-covered services or settings, consistent with federal requirements and ongoing statewide analyses. DHCS will leverage CLR data in future phases to inform independent evaluations (STC B21) assessing the impact of improved referral processes on health outcomes, utilization trends, and cost-effectiveness.

### **Other Monitoring and Oversight Activities:**

DHCS is committed to ensuring that members and providers can easily access information about ECM and Community Supports. As such, it has established clear requirements for making information about the programs publicly available. Per the [Community Supports Policy Guide](#), MCPs' websites must include the following easily accessible member- and provider-facing information:

- » **Community Supports Services offered by MCPs:** up-to-date information about all of 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 Community Supports Policy Guide (terminology should not differ from DHCS's terminology).
- » The eligible population(s) for each service, inclusive of any DHCS-approved approach to narrow or limit the eligible populations.
- » Any such limitations must meet the requirements in the [CalAIM Waiver Special Terms and Conditions](#), must be approved (in writing) by DHCS, and must be included in member handbooks.
- » Member and provider-facing information about how to access the Community Supports offered by the MCP.
- » **Community Supports Provider Networks:** MCPs are required to list all Community Supports providers in their provider directories as follows:
  - MCPs are to list all Community Support providers in the provider directories as "Other Services Providers," and should specify if a provider is an ECM, Community Supports Provider, or both.
  - MCPs must add a disclaimer in their provider directory stating that Community Supports require prior authorization and are limited to members who meet specific eligibility criteria.
  - MCPs may use symbols denoting Community Supports providers that may be listed in other sections of their provider directories in lieu of listing providers multiple times.

DHCS conducts focused reviews of MCP websites to ensure that all required information relevant to Community Supports is available and accessible to members and providers. Reviews for all MCP websites are conducted on a semiannual basis as Community Supports elections are updated. The latest reviews, completed in October 2025, confirm:

- » Up-to-date member and provider-facing information about Community Supports and how to request access to Community Supports.
- » Up-to-date information about all 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's terminology.

- » The eligible population(s) for each service, inclusive of any DHCS-approved approach to modify or restrict the Community Supports service definitions (including eligibility).

With the end of the fourth full year of Community Supports Implementation, the number of Community Supports elected by MCPs across California's 58 counties has significantly increased. Now that MCPs have had sufficient time to ramp up their processes, DHCS's primary focus remained increased monitoring in addition to the following regular activities:

- » Data Monitoring, Aggregation, & Analysis
- » Model of Care Reviews (every six months)
- » Surveys/Interviews to Discuss IPP Investments
- » Fact Sheets and Program Report Development
- » Ad hoc Meetings with MCPs Based on Individual Plan Needs
- » Oversight of Earned IPP Funding and Provider Investments Workgroups/Office Hours with MCPs (with a focus on sharing best practices as well as providing support and technical assistance), coordinated with monitoring meetings to minimize burden and keep remediation timelines clear.

## Public Reporting

On March 27, 2025, DHCS publicly released its [Enhanced Care Management \(ECM\) and Community Supports Quarterly Implementation Report for Q3 2024](#)<sup>6</sup> along with the following message:

***DHCS Releases Latest Enhanced Care Management and Community Supports Quarterly Report***

*On March 27, 2025, Department of Health Care Services (DHCS) released the latest **Enhanced Care Management (ECM) and Community Supports [quarterly report](#)** summarizing utilization data from July **2024 through September 2024**.*

*Key highlights from the report include:*

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<sup>6</sup> Report available at:

<https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117>

**Consistent growth:** Since ECM launched in January 2022, 279,824 unique Medi-Cal members have successfully enrolled in ECM benefits. In the third quarter of 2024 alone, 143,188 unique members accessed ECM benefits, an increase of 13 percent from the second quarter of 2024.

**Youth participation:** In Q3 2024, 28,342 children and youth under age 21 accessed ECM benefits, marking a 13 percent increase from Q2 2024.

**Community Supports usage:** Approximately 296,500 unique Medi-Cal members have utilized Community Supports, with more than 754,000 total services delivered.

**Increased service access:** By Q3 2024, nearly 90 percent of Medi-Cal members had access to at least 10 of the 14 Community Supports services. More than 41 percent of members have access to the full suite of services.

**Key services utilized:** Over 61 percent of members using Community Supports accessed Medically Tailored Meals/Medically Supportive Foods, and approximately 32 percent used one or more services from the Housing Trio (Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, and Housing Deposits).

This latest ECM and Community Supports implementation report shows a sustained increase in utilization quarter-over-quarter as additional populations of focus have become eligible for ECM and additional Community Supports services are offered in counties across the state. DHCS expects to see more enrollment growth across ECM and Community Supports in the coming months and years. In 2025, DHCS will continue to support and sustain this growth through expanded ECM and Community Supports program monitoring efforts, robust stakeholder engagement, and policy design refinements.

On July 3, 2025, DHCS publicly released its ECM and Community Supports Quarterly Implementation Report for Q4 2024<sup>7</sup> along with the following message and press release:

**MEDI-CAL REPORTS STRONG GROWTH IN ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORTS**

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<sup>7</sup> Report available at:

<https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117>

## **Children and Youth Enrollment in Enhanced Care Management Nearly Tripled; Close to 1 Million Community Supports Services Delivered to Members Since Launch**

**SACRAMENTO** — The Department of Health Care Services (DHCS) today shared [new data](#) showing how [Enhanced Care Management](#) (ECM) and [Community Supports](#) are increasing and helping more people as part of the state's Medi-Cal transformation under California Advancing and Innovating Medi-Cal (CalAIM).

"The trends reflected in the data demonstrate the real and growing impact of CalAIM in supporting the health and well-being of Medi-Cal members," said **DHCS Director Michelle Baass**. "We're seeing especially strong progress in reaching children and youth, expanding access to critical supports like housing and food, and growing the provider networks needed to deliver these services. Together, these efforts are helping more Californians live healthier, more stable lives."

**WHAT THE NUMBERS SHOW:** Since ECM launched in January 2022, more than 326,000 unique Medi-Cal members have enrolled in this benefit that provides comprehensive, person-centered care coordination for members with complex needs. In the last three months of 2024 alone, more than 149,400 members received ECM services, including more than 31,000 children and youth under 21, nearly four times more than when ECM launched for these groups in July 2023.

Community Supports are also reaching more Medi-Cal members. By the end of 2024, approximately 368,400 members had used these services, with more than 920,000 total services delivered. These supports offer cost-effective, community-based alternatives to traditional medical care, addressing social factors that impact health. Of those who accessed Community Supports in Q4 2024:

- » Nearly 60 percent accessed Medically Tailored Meals/Medically Supportive Food.
- » About 40 percent used one or more of the Housing Trio services (Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, and Housing Deposits).

**WHY THIS MATTERS:** More Medi-Cal members with complex medical and social needs are accessing ECM and Community Supports. Key drivers of growth include:

- » Significant expansion in services for children and youth, whose ECM enrollment increased by nearly 160 percent over 2024.
- » Steady provider growth for justice-involved members, with contracted ECM providers growing by 14 percent per quarter for adults and 32 percent per quarter for youth between late 2023 and late 2024.

- » *Increased access and scale of Community Supports, now available in 40 counties, with 91 percent of Medi-Cal members having access to at least 10 services.*

**PROVIDER NETWORKS ARE GROWING:** *The number of providers delivering ECM and Community Supports has grown significantly. Managed care plans now hold approximately 2,600 provider contracts for Community Supports alone, up from about 750 in early 2022. This reflects a strong commitment from community-based organizations, housing providers, and local health systems to support CalAIM's goals.*

**COMMUNITY SUPPORTS ARE COST-EFFECTIVE:** *DHCS's June 2025 [cost-effectiveness report](#) shows that Community Supports help reduce overall health care costs by preventing avoidable hospitalizations, emergency room visits, and long-term institutional care, while improving health outcomes*

**WHAT'S NEXT:** *Starting January 1, 2026, Transitional Rent will become a mandatory Community Support and will be available to provide up to six months of rental assistance to members who are experiencing or at risk of homelessness, are experiencing significant behavioral health needs, and meet certain risk factors. This is another important step in making sure Medi-Cal members have the support they need to live healthy, stable lives in their communities.*

*DHCS will continue to center feedback from Medi-Cal members to ensure ECM and Community Supports are responsive, accessible, and equitable. By listening closely to people who are directly impacted, California aims to enhance the effectiveness of these programs and better support members' health and well-being.*

On October 10, 2025, DHCS publicly released its ECM and Community Supports Quarterly Implementation Report for Q1 2025<sup>8</sup> along with the following message and press release:

**ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORTS CONTINUE TO GROW**

***New Data Show Increased Enrollment, Stronger Provider Partnerships, and Improved Care Coordination for Medi-Cal Members with Complex Needs***

**SACRAMENTO** — *The Department of Health Care Services (DHCS) today released [new data](#) showing continued growth and impact from [Enhanced Care Management \(ECM\) and](#)*

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<sup>8</sup> Report available at:

<https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117>

[Community Supports](#) as part of the state's Medi-Cal transformation under California Advancing and Innovating Medi-Cal (CalAIM). These services help Medi-Cal members stay healthier and avoid other, costlier health care services, such as emergency department visits and hospital stays.

In just the first three months of this year:

- » 38,000 children and youth received ECM — a 120 percent increase from the same period last year.
- » 68,000 adults and nearly 13,000 children and youth experiencing homelessness were served — increases of 86 percent and 172 percent, respectively.
- » Providers serving youth experiencing homelessness nearly doubled.
- » More than 429,000 Medi-Cal members have accessed Community Supports, with more than 1.1 million services delivered to date.

"This is what Medi-Cal transformation looks like," said **Michelle Baass, Director of the Department of Health Care Services**. "We're not just expanding services. We're reaching more people than ever."

ECM helps people with complex health and social needs, including homelessness, serious mental illness, or frequent hospital visits, get the care they need, wherever they are. A Lead Care Manager helps coordinate all aspects of care, from doctor visits and mental health services to housing and nutrition support. Since launching in January 2022, ECM has connected more than 372,000 Medi-Cal members to high-touch, person-centered care.

Community Supports are also growing rapidly. These services offer [cost-effective](#), community-based alternatives to traditional medical care, addressing housing, nutrition, and other social drivers of health. As of early 2025:

- » Nearly all Medi-Cal members have access to at least 10 Community Supports.
- » Most have access to the full suite of 14 Community Supports.
- » About 42 percent used housing-related services, such as help finding and keeping housing or paying for housing deposits.

"Behind every number is a story: a parent who found stable housing, a teen who got mental health care, a senior who received meals tailored to their condition," said **State Medicaid Director Tyler Sadwith**. "This is how we build a healthier California."

**WHY THIS IS IMPORTANT:** The growth in ECM and Community Supports comes as California rolls out historic policies under the Behavioral Health Services Act (BHSA), aimed at reducing homelessness and expanding behavioral health care. ECM and

*Community Supports are proving to be vital tools to help people navigate housing, nutrition, and health systems with dignity and support. From ECM and Community Supports to Transitional Rent and permanent housing, California is building a continuum of care that supports people across every stage of their recovery journey.*

*To support this expansion, DHCS has awarded more than \$1.43 billion through its [Providing Access and Transforming Health](#) (PATH) initiatives, including Capacity and Infrastructure Transition, Expansion, and Development (CITED), Collaborative Planning and Implementation, and the Technical Assistance Marketplace. These funds help community-based organizations, clinics, and local agencies grow their capacity to deliver ECM and Community Supports by hiring staff, upgrading systems, and improving care coordination. The final round of CITED funding closed in May 2025, with new awardees to be announced later this year.*

**WHAT'S NEXT:** *DHCS will continue listening to Medi-Cal members who use ECM and Community Supports. Member feedback, gathered through surveys, focus groups, and other outreach, will help improve how these services are delivered, making them easier to access, more effective, and more responsive to different cultures and communities.*

## Utilization Data for Community Supports (DY 21) (STC B20c and B20g):

Since the launch of Community Supports in January of 2022, more than 528,000 unique Medi-Cal members have been authorized for and have received one or more Community Supports services through their MCPs. In the most recent 12-month period of validated data (from Q4 2024 through Q3 2025), more than 357,400 unique members utilized Community Supports, with over 798,000 individual services delivered. In Q3 2025 alone, more than 210,000 services were provided to more than 190,000 unique members – representing a 40 percent year-over-year increase in unique members served.

The program continues to demonstrate maturation and stabilization. While many services experienced steady growth throughout the reporting period, utilization patterns have begun to stabilize in Q2 and Q3 2025 for most services, reflecting increased program maturity, broader provider networks, and more consistent service delivery across the state.

Assisted Living Facility Transitions (formerly Nursing Facility Transition/Diversion) recorded the largest quarterly increase of 74 percent and the highest percentage growth over the course of the year, rising from approximately 1,000 unique members in Q4 2024 to over 4,000 by Q3 2025. Asthma Remediation also experienced notable growth during the period and began to stabilize in the most recent quarter. Most other Community Supports services showed steady utilization increases across the annual reporting period before leveling off in mid-to-late 2025.

Medically Tailored Meals continued to be the highest utilized service, with utilization increasing to over 156,000 unique members. Housing-related Community Supports—including Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services—remained among the most widely offered and utilized services statewide, underscoring their importance in providing stable housing solutions. Recuperative Care, Day Habilitation Programs, Short-Term Post-Hospitalization Housing, and Caregiver Respite (formerly Respite Services) continued to fill critical gaps during transitional periods and support caregivers, while lower-volume services (e.g., Sobering Centers, Environmental Accessibility Adaptations) address targeted needs and contribute meaningfully to member outcomes.

Current available data indicate the following number of unique individuals served across this reporting period (Q4 2024 – Q3 2025) for each of DHCS’s available Community Supports are shown in Table 2.

A few key highlights:

- » Assisted Living Facility Transitions showed the strongest growth, with utilization increasing by nearly 300 percent from Q4 2024 to Q3 2025 – rising from about 1,000 unique members to over 4,000.
- » Short-Term Post-Hospitalization Housing also experienced robust growth, increasing by nearly 68 percent over the reporting period, reflecting steady expansion of post-acute recovery supports.
- » Environmental Accessibility Adaptations utilization showed strong growth in the reporting period, increasing by over 63 percent and underscoring a strong upward trajectory in member engagement.
- » Housing Transition/Navigation Services continued to be one of the most widely used Community Supports, growing 28.5 percent year-over-year and serving nearly 60,000 unique members in Q3 2025.
- » Medically Tailored Meals/Medically Supportive Food remained the highest-utilized service overall, reaching over 156,000 members in Q3 2025 and showing consistent utilization across the year.
- » Several Community Supports – including Housing Tenancy and Sustaining Services, Medically Tailored Meals/Medically Supportive Food, Recuperative Care, Day Habilitation Programs, and Personal Care and Homemaker Services – showed signs of stabilization in utilization rates over the last two quarters, reflecting increased program maturity, broader provider networks, and more consistent service delivery statewide.

**Table 2: Utilization of Community Supports by Member Counts, 2024 Q4 – 2025 Q3<sup>9</sup>:**

<b>Community Support</b>	<b>2024 Q4</b>	<b>2025 Q1</b>	<b>2025 Q2</b>	<b>2025 Q3</b>	<b>% Increase 2024 Q4 – 2025 Q3</b>	<b>Grand Total<sup>10</sup></b>
Housing Transition/ Navigation Services	46,683	53,720	57,287	59,995	28.5%	110,961
Housing Deposits	3,299	3,747	3,648	3,319	0.6%	12,553
Housing Tenancy and Sustaining Services	19,971	20,825	20,184	20,243	1.4%	35,994
Short-Term Post-Hospitalization Housing	2,550	3,351	3,777	4,279	67.8%	8,157
Recuperative Care (Medical Respite)	4,892	5,910	6,373	5,856	19.7%	14,884
Caregiver Respite (formerly Respite Services)	2,077	3,092	3,623	4,403	112.0%	7,957
Assisted Living Facility Transitions	1,007	1,565	2,304	4,015	298.7%	5,294
Community or Home Transition Services	225	391	330	401	78.2%	688
Personal Care and Homemaker Services	4,534	5,127	5,518	5,253	15.9%	11,354
Day Habilitation Programs	1,628	2,095	2,295	2,307	41.7%	4,823
Environmental Accessibility Adaptations	1,075	1,368	1,570	1,758	63.5%	2,934

<sup>9</sup> Data is subject to future revision if any MCPs resubmit reports with updated CY 2024-2025 data.

<sup>10</sup> Reflects the total number of unique members for each service in the last 12 months (reporting period).

Community Support	2024 Q4	2025 Q1	2025 Q2	2025 Q3	% Increase 2024 Q4 – 2025 Q3	Grand Total <sup>10</sup>
Medically Tailored Meals/ Medically Supportive Food	89,846	89,605	97,049	95,267	6.0%	200,070
Sobering Centers	906	1,359	1,242	1,332	47.0%	3,633
Asthma Remediation	765	993	1,247	854	11.6%	3,493
<b>Grand Total of Unique Members<sup>11</sup></b>						<b>356,373</b>

**Table 3: Total Number of Members who Utilized Community Supports in the Past 12 Months (2024 Q4 – 2025 Q3) by Primary Spoken Language, Compared with Overall MCP Population:**

Population	Last Date In Reporting Period	English	Spanish	Vietnamese	Other
Percent of Members Who Utilized Community Supports In the Past 12 Months by Language	9/30/2025	73%	22%	1%	4%
Percentage of Overall MCP Population In the Most Recent Month of the Reporting Period by Language	9/30/2025	64%	29%	1%	6%

<sup>11</sup> Total unique members are the overall unique count of members across all Community Support services. Each member is counted once if multiple services are used.

**Table 4: Total Number of Members who Utilized Community Supports in the Past 12 Months (2024 Q4 – 2025 Q3) by Age, Compared with Overall MCP Population:**

Population	Last Date In Reporting Period	Ages 0-5	Ages 6-11	Ages 12-20	Ages 21-64	Ages 65+
Percentage of MCP Members Who Utilized Community Supports In the Past 12 Months by Age	9/30/2025	1%	2%	4%	70%	23%
Percentage of Overall MCP Population In the Most Recent Month of the Reporting Period by Age	9/30/2025	9%	11%	17%	51%	12%

**Table 5: Total Number of Members Who Utilized Community Supports in the Past 12 Months (2024 Q4 – 2025 Q3) by Sex, Compared with Overall MCP Population:**

Population	Last Date In Reporting Period	Male	Female
Percentage of MCP Members Who Utilized Community Supports In the Past 12 Months by Sex	9/30/2025	41%	59%
Percentage of Overall MCP Population In the Most Recent Month of the Reporting Period by Sex	9/30/2025	47%	53%

**Table 6: Utilization Rates for Community Supports in the Last 12 Months of the Reporting Period (2024 Q4 – 2025 Q3), by County:**

County	Last Date In the Reporting Period	Average MCP Members in the Last 12 Months of the Reporting Period	County HHP/WPC Status	Number of Community Supports Available in County	Number of Community Supports Utilized in the Last 12 Months of the Reporting Period	Rate of Utilization per 10,000 MCP Members in the Last 12 Months of the Reporting Period
Alameda	09/30/2025	479,650	Y	13	12,520	261
Alpine	09/30/2025	267	N	13	0	0
Amador	09/30/2025	8,655	N	14	311	359
Butte	09/30/2025	85,636	N	10	7,822	913
Calaveras	09/30/2025	12,824	N	14	213	166
Colusa	09/30/2025	10,210	N	9	945	926
Contra Costa	09/30/2025	322,285	Y	13	19,053	591
Del Norte	09/30/2025	12,400	N	8	415	335
El Dorado	09/30/2025	38,790	N	14	1,539	397
Fresno	09/30/2025	507,371	N	14	53,570	1056
Glenn	09/30/2025	13,688	N	9	982	717
Humboldt	09/30/2025	58,077	N	8	3,431	591
Imperial	09/30/2025	97,739	Y	14	26,034	2664
Inyo	09/30/2025	4,753	N	11	83	175
Kern	09/30/2025	469,945	Y	14	26,281	559
Kings	09/30/2025	63,673	Y	14	6,235	979
Lake	09/30/2025	34,115	N	8	3,359	985
Lassen	09/30/2025	8,716	N	8	268	307
Los Angeles	09/30/2025	3,892,671	Y	14	157,917	406
Madera	09/30/2025	79,668	N	14	8,422	1057
Marin	09/30/2025	53,670	Y	13	1,854	345
Mariposa	09/30/2025	5,699	N	13	895	1570
Mendocino	09/30/2025	40,860	Y	8	1,847	452
Merced	09/30/2025	149,631	N	11	36,767	2457
Modoc	09/30/2025	3,939	N	8	89	226
Mono	09/30/2025	2,986	N	11	33	111

<b>County</b>	<b>Last Date In the Reporting Period</b>	<b>Average MCP Members in the Last 12 Months of the Reporting Period</b>	<b>County HHP/WPC Status</b>	<b>Number of Community Supports Available in County</b>	<b>Number of Community Supports Services Utilized in in the Last 12 Months of the Reporting Period</b>	<b>Rate of Utilization per 10,000 MCP Members in the Last 12 Months of the Reporting Period</b>
Monterey	09/30/2025	189,830	Y	11	29,984	1580
Napa	09/30/2025	34,958	Y	13	1,287	368
Nevada	09/30/2025	28,632	N	8	1,881	657
Orange	09/30/2025	960,129	Y	14	57,957	604
Placer	09/30/2025	78,905	Y	14	2,936	372
Plumas	09/30/2025	5,822	N	8	188	323
Riverside	09/30/2025	960,641	Y	14	26,944	280
Sacramento	09/30/2025	614,212	Y	14	37,457	610
San Benito	09/30/2025	20,693	N	10	2,071	1001
San Bernardino	09/30/2025	926,390	Y	14	36,582	395
San Diego	09/30/2025	935,133	Y	14	45,234	484
San Francisco	09/30/2025	238,199	Y	14	18,577	780
San Joaquin	09/30/2025	299,338	Y	14	12,208	408
San Luis Obispo	09/30/2025	67,718	N	14	17,330	2559
San Mateo	09/30/2025	165,732	Y	13	4,833	292
Santa Barbara	09/30/2025	174,758	N	14	42,017	2404
Santa Clara	09/30/2025	441,628	Y	14	8,065	183
Santa Cruz	09/30/2025	78,976	Y	13	10,897	1380
Shasta	09/30/2025	65,807	Y	9	9,008	1369
Sierra	09/30/2025	862	N	8	23	267
Siskiyou	09/30/2025	17,902	N	8	506	283
Solano	09/30/2025	140,635	Y	13	4,862	346
Sonoma	09/30/2025	137,454	Y	13	6,078	442
Stanislaus	09/30/2025	242,459	N	14	6,047	249
Sutter	09/30/2025	43,764	N	13	1,913	437
Tehama	09/30/2025	30,151	N	9	2,084	691

County	Last Date In the Reporting Period	Average MCP Members in the Last 12 Months of the Reporting Period	County HHP/WPC Status	Number of Community Supports Available in County	Number of Community Supports Services Utilized in the Last 12 Months of the Reporting Period	Rate of Utilization per 10,000 MCP Members in the Last 12 Months of the Reporting Period
Trinity	09/30/2025	5,307	N	8	330	622
Tulare	09/30/2025	284,168	Y	14	9,839	346
Tuolumne	09/30/2025	14,293	N	14	844	591
Ventura	09/30/2025	252,403	Y	14	24,378	966
Yolo	09/30/2025	59,282	N	14	2,061	348
Yuba	09/30/2025	37,607	N	13	2,775	738

**Table 7: Utilization Rates for Community Supports in the Last 12 Months of the Reporting Period (2024 Q4 – 2025 Q3), by MCP:**

Managed Care Plan:	Last Date In the Reporting Period	Average MCP Members in the Last 12 Months of the Reporting Period	Number of Community Support Services Offered by MCP	Number of Community Supports Services Utilized in the Last 12 Months of the Reporting Period	Rate of Community Supports Services Utilization per 10,000 MCP Members in the Last 12 Months of the Reporting Period
Positive Healthcare (AIDS Healthcare Foundation)	09/30/2025	930	9	381	4099
Alameda Alliance for Health	09/30/2025	406,371	11	8,923	220
Blue Cross	09/30/2025	833,891	14	34,241	411

<b>Managed Care Plan:</b>	<b>Last Date In the Reporting Period</b>	<b>Average MCP Members in the Last 12 Months of the Reporting Period</b>	<b>Number of Community Support Services Offered by MCP</b>	<b>Number of Community Supports Services Utilized in the Last 12 Months of the Reporting Period</b>	<b>Rate of Community Supports Services Utilization per 10,000 MCP Members in the Last 12 Months of the Reporting Period</b>
Partnership					
Blue Shield of CA Promise Health Plan	09/30/2025	191,399	14	7,593	397
CalOptima	09/30/2025	888,124	14	56,623	638
CalViva Health	09/30/2025	434,705	14	60,810	1399
CenCal Health	09/30/2025	242,477	14	59,347	2448
Central California Alliance for Health	09/30/2025	443,777	12	80,581	1816
Community Health Group Partnership Plan	09/30/2025	385,175	14	17,068	443
Community Health Plan Imperial Valley	09/30/2025	97,711	14	26,032	2664
Contra Costa Health Plan	09/30/2025	264,223	13	15,891	601
Gold Coast Health Plan	09/30/2025	243,549	12	24,283	997
Health Net Community Solutions	09/30/2025	1,594,483	14	76,428	479
Health Plan of San Joaquin	09/30/2025	404,520	14	11,603	287
Health Plan of San Mateo	09/30/2025	148,753	10	4,202	282
Inland Empire	09/30/2025	1,494,252	14	56,866	381

<b>Managed Care Plan:</b>	<b>Last Date In the Reporting Period</b>	<b>Average MCP Members in the Last 12 Months of the Reporting Period</b>	<b>Number of Community Support Services Offered by MCP</b>	<b>Number of Community Supports Services Utilized in the Last 12 Months of the Reporting Period</b>	<b>Rate of Community Supports Services Utilization per 10,000 MCP Members in the Last 12 Months of the Reporting Period</b>
Health Plan					
Kaiser Permanente	09/30/2025	1,189,556	14	35,084	295
Kern Family Health Care	09/30/2025	405,471	14	24,824	612
L.A. Care Health Plan	09/30/2025	2,372,019	14	95,315	402
Molina Healthcare of California	09/30/2025	560,604	14	26,663	476
Mountain Valley Health Plan	09/30/2025	8,460	13	189	223
Partnership Health Plan of California	09/30/2025	905,451	10	53,896	595
SCAN Health Plan	09/30/2025	19,951	5	296	148
San Francisco Health Plan	09/30/2025	179,729	10	16,942	943
Santa Clara Family Health Plan	09/30/2025	296,144	14	4,000	135

## Community Supports Providers

Community Supports are delivered by a network of providers contracted by MCPs across the state. The number of provider contracts is determined based on provider network data submitted by MCPs as part of the QIMR process. MCPs are required to list the county, National Provider Identifier (NPI), provider type, and services provided for each Community Supports provider in their network.

In the following tables, each unique combination of NPI, provider type, MCP, and county represents a Community Supports provider contract. For example, a community-based organization (CBO) that contracted with three MCPs in a given county to provide Community Supports is counted three times for this measure.

**Table 8: Total Number of Community Supports Provider Contracts Since Community Supports Launched:**

Reporting Quarter	Cumulative Number of Community Supports Provider Contracts Since Launch
CY 2022 Q1	722
CY 2022 Q2	845
CY 2022 Q3	1,287
CY 2022 Q4	1,452
CY 2023 Q1	1,852
CY 2023 Q2	1,979
CY 2023 Q3	2,201
CY 2023 Q4	2,349
CY 2024 Q1	3,393
CY 2024 Q2	3,884
CY 2024 Q3	4,347
CY 2024 Q4	4,598
CY 2025 Q1	5,018
CY 2025 Q2	5,359
CY 2025 Q3	6,313

**Table 9: Total Number of Community Supports Provider Contracts by Service in the Past 12 Months (2024 Q4 – 2025 Q3):**

<b>Community Supports Offered by Provider:</b>	<b>Total Number of Community Supports Provider Contracts</b>
Housing Transition Navigation Services	2,389
Housing Tenancy and Sustaining Services	1,509
Housing Deposits	1,390
Medically Tailored Meals/Medically Supportive Food	1,011
Caregiver Respite (Respite Services)	983
Personal Care and Homemaker Services	909
Recuperative Care (Medical Respite)	561
Short-Term Post-Hospitalization Housing	516
Assisted Living Facility Transitions	342
Day Habilitation Programs	314
Environmental Accessibility Adaptations (Home Modifications)	308
Asthma Remediation	227
Community or Home Transition Services	210
Sobering Centers	125

# Grievances and Appeals Data for Community Supports (STC B20d):

MCPs have established grievance and appeals processes in place to address concerns. DHCS's [All Plan Letter 21-011 \(APL\)](#) provides MCPs with clarification and guidance regarding the application of federal and state legal requirements for processing grievances and appeals from members served. As defined in the APL:

- » Grievances are any expression of dissatisfaction about any matter other than an adverse benefit determination. As specifically stated in the APL, "a complaint is the same as a grievance." A member does not need to use the term 'grievance' for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by an MCP.
- » Appeals are federally defined as a review by an MCP of an adverse benefit determination.
- » Adverse benefit determinations are defined to mean any of the following actions taken by an MCP:
  - The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
  - The reduction, suspension, or termination of a previously authorized service.
  - The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 CFR section 447.45(b) is not an adverse benefit determination.
  - The failure to provide services in a timely manner.
  - The failure to act within the required time frames for standard resolution of grievances and appeals.
  - For a resident of a rural area with only one MCP, the denial of the member's request to obtain services outside the network.
  - The denial of a member's request to dispute financial liability.

For both grievances and appeals, MCPs have five (5) calendar days to acknowledge the grievance or appeal and 30 days to render a standard resolution. In instances where an expedited resolution is required, MCPs must render a resolution within 72 hours.

The primary source of information on plan grievances and appeals is the Managed Care Program Data File, which is updated monthly. At the time of this report, grievances and appeals are organized in the ECM/Community Supports dashboard as follows:

- » Appeal/Grievance Type, including case management/care coordination; quality of care; provider/staff attitude; provider availability; billing; disability discrimination; eligibility; authorization; and inappropriate care.
- » Resolution Types of “Unresolved,” “Resolved in favor of member,” and “Resolved in favor of plan.”

Issues with beneficiary protection and member experience may also come to DHCS’s attention through [State Fair Hearing](#) data and Department of Managed Health Care second-level grievances and appeals data.

[APL 21-011](#) provides guidance to MCPs regarding new and existing state regulations for members’ rights to request hearings after exhausting the MCPs’ internal appeals process. The objective of the [State Fair Hearings Division](#) (housed within the California Department of Social Services) is to resolve disputes of applicants and recipients of public services in an impartial, independent, fair, and timely manner, ensuring that due process hearings are provided in accordance with federal and state law, to render legally correct decisions.

Inherent delays impact the processing of grievances and appeals, as time is needed between the initial grievance or appeal and the subsequent decision. This decision must then be submitted to DHCS and updated in state systems according to the scheduled data refresh cycles. DHCS currently has grievance and appeal data for Community Supports through the end of March 2025, or Q1 2025, included in the table below. At this time, both grievances and appeals are generally limited to “Community Supports” , but DHCS is working towards further delineation to allow MCPs to report grievances and appeals specific to each Community Supports service.

**Table 10: Community Supports Grievances Data Q2 2024 - Q1 2025**

<b>Quarter:</b>	<b>Total:</b>	<b>County:</b>	<b>MCP:</b>	<b>Member Demographics:</b>	<b>Resolution Type:</b>
Q2 2024	349	Alameda (*) Contra Costa (*) Kern (23) Los Angeles (16) Mariposa (*) Merced (42) Monterey (26) Orange (146) Riverside (25) Sacramento (*) San Benito (*) San Bernardino (34) San Diego (*) San Francisco (*) San Joaquin (*) San Mateo (*) Santa Cruz (*) Solano (*) Ventura (*)	Alameda Alliance (*) CCAH (82) CONTRACOSTA (*) CalOptima (146) GCHP (*) HPSJ (*) HPSM (*) IEHP (59) KERN (23) LAC (16) Molina (11) PHC (*) SFHP (*)	American Indian/Alaska Native: (*) Asian/PI: (*) Black/African American: (48) Hispanic: (11)4 White: (114) Other/ Unknown: (55)	In Favor of Member: (258)  In Favor of the Plan: (*)  Unresolved: (*)
Q3 2024	543	Alameda (*) Contra Costa (*) El Dorado (*) Humboldt (*) Kern (21) Los Angeles (31) Mariposa (*) Merced (48) Monterey (18) Orange (276) Riverside (22)	Alameda Alliance (*) BSCPHP-San Diego (*) CCAH (81)  CENCALHEALTH (*)  COMMUNITYHEALTHGROUP (*)	American Indian/Alaska Native (*) Asian/Pacific Islander (*) Black/African American (89) Hispanic (154) Other/Unknown : (86) White (181)	Resolved in Favor of Member (378) Resolved in Favor of Plan (152) Unresolved (13)

Quarter:	Total:	County:	MCP:	Member Demographics:	Resolution Type:
		Sacramento (*) San Bernardino (25) San Diego (38) San Joaquin (*) San Luis Obispo (*) San Mateo (*) Santa Barbara (*) Santa Cruz (11) Solano (*) Stanislaus (*) Ventura (*) Yolo (*) Yuba (*)	CONTRACOSTA (*) CalOptima (276) GOLD COAST HEALTH PLAN (*) HEALTHNET (*) HPSJ (*) HPSM (*) IEHP (37) KERN (21) LAC (26) MOLINA (47) PHC (*)		
Q4 2024	684	Alameda (*) Butte (*) Contra Costa (13) Del Norte (*) Humboldt (*) Kern (28) Lake (*) Los Angeles (82) Merced (47) Monterey (26) Orange (274) Placer (*) Riverside (50) Sacramento (11) San Benito (*) San Bernardino (42)	Alameda Alliance (*) BSCPHP-San Diego (*) CCAH (84)  CENCALHEALTH (19)  COMMUNITYHEALTHGROUP (*)  CONTRACOSTA (13) CalOptima (274) GOLD COAST HEALTH PLAN (*)	American Indian/Alaska Native (*) Asian/Pacific Islander (*) Black/African American (124) Hispanic (179) Other/Unknown : (112) White (218)	Resolved in Favor of Member (384) Resolved in Favor of Plan (276) Unresolved (24)

Quarter:	Total:	County:	MCP:	Member Demographics:	Resolution Type:
		San Diego (53) San Joaquin (*) San Luis Obispo (*) San Mateo (*) Santa Barbara (12) Santa Cruz (*) Shasta (*) Solano (*) Stanislaus (*) Trinity (*) Ventura (*) Yuba (*)	HEALTHNET (*) HPSJ (*) HPSM (*) IEHP (86) KERN (28) LAC (64) MOLINA (64) PHC (16) ahf03 (*)		
Q1 2025	810	Alameda (23) Butte (*) Contra Costa (*) Fresno (*) Humboldt (*) Kern (42) Lake (*) Los Angeles (101) Madera (*) Mariposa (*) Mendocino (*) Merced (59) Monterey (26) Orange (267) Placer (*) Riverside (48) Sacramento (15) San Benito (*) San Bernardino (36)	Alameda Alliance (23) BSCPHP-San Diego (11) CALVIVA (*) CCAH (101)  CENCALHEALT H (19) COMMUNITYH EALTHGROUP (*)  CONTRACOSTA (*) CalOptima (267) GOLD COAST HEALTH PLAN (*) HEALTHNET (32) HPSJ (*)	American Indian/Alaska Native (*) Asian/Pacific Islander (*) Black/African American (165) Hispanic (244) Other/Unknown : (112) White (250)	Resolved in Favor of Member (405) Resolved in Favor of Plan (380) Unresolved (25)

Quarter:	Total	County:	MCP:	Member Demographics:	Resolution Type:
		San Diego (93) San Francisco (*) San Luis Obispo (*) Santa Barbara (*) Santa Cruz (11) Shasta (*) Siskiyou (*) Solano (*) Sonoma (*) Stanislaus (*) Trinity (*) Ventura (*) Yolo (*)	IEHP (76) KERN (42) LAC (69) MOLINA (99) PHC (40) SFHP (*) AHF (*)		

**Table 11: Community Supports Appeals Data Q2 2024 - Q1 2025**

Quarter:	Total:	County:	MCP:	Member Demographics:	Resolution Type:
Q2 2024	*	Los Angeles (*) Monterey (*) San Joaquin (*) San Mateo (*) Solano (*)	CCAH (*) HPSJ (*) HPSM (*) LAC (*) PHC (*)	Black/African American (*) Hispanic (*) Unknown (*) White (*)	Resolved in Favor of Member (*) Resolved in Favor of Plan (*)
Q3 2024	45	Alameda (*) Contra Costa (*) Los Angeles (*) Merced (*)	Alameda Alliance (*) CCAH (18) CONTRACOSTA (*)	Asian/Pacific Islander (*) Black/African American (*) Hispanic (11) Other/Unknown:	Resolved in Favor of Member (*) Resolved in Favor of Plan (28)

Quarter:	Total:	County:	MCP:	Member Demographics:	Resolution Type:
		Monterey (*) Orange (*) Riverside (*) San Bernardino (*) Santa Cruz (*)	CalOptima (*) IEHP (*) LAC (*)	(*) White (15)	Unresolved (*)
Q4 2024	237	Alameda (*) Contra Costa (*) Los Angeles (*) Mariposa (*) Merced (46) Monterey (31) Orange (43) Placer (*) Riverside (45) Sacramento (*) San Benito (*) San Bernardino (40) San Diego (*) San Mateo (*) Santa Cruz (11)	Alameda Alliance (*) BSCPHP-San Diego (*) CCAH (92)  CONTRACOSTA (*) CalOptima (43) HPSM (*) IEHP (85) LAC (*) MOLINA (*) PHC (*)	American Indian/Alaska Native (*) Asian/Pacific Islander (*) Black/African American (38) Hispanic (70) Other/Unknown: (27) White (85)	Resolved in Favor of Member (*) Resolved in Favor of Plan (185) Unresolved (*)
Q1 2025	364	Alameda (27) Butte (*) Contra Costa (*)	Alameda Alliance (27) CALVIVA (*) CCAH (77)	American Indian/Alaska Native (*) Asian/Pacific	Resolved in Favor of Member (85) Resolved in

Quarter:	Total:	County:	MCP:	Member Demographics:	Resolution Type:
		Del Norte (*) Fresno (*) Humboldt (*) Kings (*) Los Angeles (15) Madera (*) Mariposa (*) Mendocino (*) Merced (34) Monterey (24) Orange (80) Placer (*) Plumas (*) Riverside (71) Sacramento (*) San Benito (*) San Bernardino (57) San Diego (*) San Joaquin (*) Santa Cruz (15) Sutter (*) Tehama (*) Tulare (*) Yuba (*)	CONTRACOSTA (*) CalOptima (80) HEALTHNET (16) HPSJ (*) IEHP (126) LAC (*) MOLINA (*) PHC (12)	Islander (*) Black/African American (56) Hispanic (120) Other/Unknown: (50) White (109)	Favor of Plan (263) Unresolved (16)

## Monitoring Health Outcomes and Quality Metrics (STC B20e):

This section satisfies [STC B20\(e\)](#), which requires the state to include in its Annual Report, “data, stratified when possible, related to the State’s monitoring of health outcomes and quality metrics.”

In accordance with 42 CFR §438.3(e)(2), an ILOS can be used as an immediate or longer-term substitute for a covered service or setting under the State Plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting under the State Plan. The services (included under the umbrella of “Community Supports”) have been shown to broadly reduce or prevent the future need to utilize services such as inpatient services, emergency department services, and nursing facility services.

### Methodology

In compliance with the requirements under the STCs, DHCS is providing comparative utilization data for each of the Community Support services under the 1915(b) authority (referred to as the 12 In Lieu of Services (ILOS)). For most of the 12 ILOS, DHCS analyzed the utilization impact of a subset of ILOS by examining the time period from January 2022 to June 2025, specifically analyzing the six months before and twelve months after the members received a service between January 2023 and June 2024, in order to assess potential impacts on health care use. The utilization measures presented here are consistent with the hypothesized reduction in avoidable health care use that we would expect to see as a result of the provision of ILOS. Specifically, each ILOS could potentially substitute for the State Plan-covered services or settings listed in Table 12 or result in the provision of more appropriate State Plan-covered services in less acute settings (e.g., outpatient versus inpatient).

For “Personal Care and Homemaker Services, Respite Services, and the “diversion” component of Assisted Living Facility Transitions, DHCS compared utilization of individuals utilizing using these ILOS to utilization of Medi-Cal members receiving a minimum of 90 consecutive days of long-term care services (“LTC utilizers”).

### Findings

California’s updated utilization analysis shows that all of the ILOS are associated with reduced service utilization in a subset of the hypothesized State Plan services or

settings. The findings are summarized in Table 12 and key highlights are summarized below:

### **Housing Transition Navigation Services (HTNS)**

As hypothesized, inpatient utilization decreased by 27.4 percent during the period from six months before to twelve months after members received HTNS. Emergency department (ED) utilization decreased by 12.3 percent, and mental health outpatient (MHOP) utilization fell by 12.1 percent. Outpatient utilization increased by 7.7 percent, and long-term care (LTC) utilization rose by 24.5 percent.

Taken together, these findings suggest reduced acute care utilization accompanied by increased engagement in ambulatory services and some growth in LTC use. The increase in LTC utilization may reflect appropriate identification of members whose clinical needs require facility-level care. The decrease in MHOP utilization may be related to improved care coordination and stabilization as members transition out of homelessness.

### **Housing Deposits**

As hypothesized for members receiving housing deposits, inpatient utilization decreased by 12.1 percent and ED utilization decreased by 12.7 percent. Outpatient utilization fell by 3.4 percent, LTC utilization decreased by 31.3 percent, and MHOP utilization fell by 25.4 percent.

These findings are consistent with rapid housing stabilization and reduced reliance on high-acuity services. Declines in LTC utilization may indicate that housing is functioning as a substitute for institutional care when appropriate. The decrease in MHOP utilization may reflect improved mental-health stability associated with securing housing and the supportive services offered through the housing process.

### **Housing Tenancy & Sustaining Services**

Among 14,854 members receiving HTSS, inpatient utilization increased by 9.2 percent, which was unexpected. However, ED utilization decreased by 7.7 percent. Outpatient utilization increased by 6.1 percent. LTC utilization increased by 20.8 percent, and MHOP utilization decreased by 21.5 percent.

The increase in outpatient services likely represents re-engagement with primary and specialty care as members stabilize in housing over the longer term (i.e., since sustained services are provided over the course of several months) and unmet needs are identified and being treated. This may also explain the short-term increase in inpatient utilization as conditions are identified and the member is appropriately treated for these conditions. Growth in LTC utilization may reflect appropriate placement for members with significant medical complexity. The decline in MHOP utilization may indicate

improved mental-health functioning related to housing stability and enhanced supports. DHCS will continue to monitor HTSS trends to better understand these patterns over time.

### **Caregiver Respite (formerly Respite Services)**

Among 1,076 members receiving Caregiver Respite, inpatient utilization decreased by 59.2 percent and LTC utilization decreased by 23.1 percent.

These results indicate that providing relief to caregivers can help individuals remain safely at home, thereby reducing reliance on acute and institutional services.

### **Day Habilitation Programs**

Among 1,839 members, inpatient utilization decreased by 33.8 percent, outpatient utilization increased by 40.6 percent and ED utilization decreased by 22.8 percent. LTC utilization declined by 36.9 percent and MHOP utilization fell by 35.8 percent.

These findings suggest that Day Habilitation Programs support improved daily functioning and independence, enabling members to rely less on acute and institutional services. Increased outpatient utilization suggests appropriate engagement with routine and preventive care, while decreased MHOP utilization may indicate improvements in mental-health well-being as members, particularly those experiencing homelessness, gain skills and stability.

### **Assisted Living Facility (ALF) Transitions (formerly Nursing Facility Transition/Diversion to Assisted Living Facilities or Residential Care Facilities for the Elderly) – Transition Component**

Among 362 members, inpatient utilization declined by 30.6 percent; LTC utilization decreased by 31.2 percent; and interestingly, ED utilization increased by 58.9 percent.

These results reflect the expected effects of transitioning members out of institutional care and into assisted living settings. Declines in inpatient and LTC utilization are consistent with placement in a lower-acuity, community-based environment. Increased ED utilization may be explained as medically complex individuals residing in ALFs—where onsite clinical capabilities are limited—will use emergency care when urgent needs arise.

### **Assisted Living Facility Transitions – Diversion Component (LTC utilizers)**

Among 548 members, and compared to a broader LTC utilizer cohort, inpatient utilization was 27.6 percent lower, ED utilization was 131.5 percent higher, and LTC

utilization was 99.0 percent lower. The substantial decline in long-term care utilization is expected, as individuals in this component are, by definition, diverted from LTC and supported at an ALF level of care and also a comparison of those utilizing LTC against those who use the service to avoid LTC. Inpatient utilization is also expected to decline given the diversion away from higher-acuity settings. An increase in ED utilization is not unexpected for this population, as members residing in ALFs may be medically fragile and are appropriately sent to the ED when urgent needs arise before returning to the ALF setting. DHCS will continue to monitor trends as more data become available.

### **Community or Home Transition Services (formerly Community Transition Services/Nursing Facility Transition to a Home)**

Among 182 members, inpatient utilization decreased by 37.3 percent; ED utilization declined by 26.4 percent; and LTC utilization increased by 1.7 percent. While the universe of members receiving these services in the study period remains small, emerging patterns suggest that helping individuals transition to the most appropriate setting may contribute to decreased acute care utilization. The slight increase in LTC utilization may reflect members appropriately entering LTC based on clinical needs rather than avoidable use of higher-acuity services. DHCS will continue to monitor these trends as this Community Support continues to be offered and more members use the service.

### **Personal Care and Homemaker Services (LTC utilizer comparison)**

Among 4,415 members, and compared to a broader LTC utilizer cohort, inpatient utilization decreased by 18.9 percent and LTC utilization decreased by 99.9 percent. This is expected as this is a comparison of members utilizing LTC with members utilizing PCHS.

These results indicate that providing in-home supports helps individuals remain in their homes and avoid institutional care.

### **Environmental Accessibility Adaptations**

Among 1,185 members, as expected, inpatient utilization decreased by 40.9 percent; ED utilization decreased by 27.3 percent; and LTC utilization decreased by 14.4 percent.

Results indicate that Environmental Accessibility Adaptations – which provides modification to the home environment – appear to support improved functional ability and safety, reducing reliance on acute and institutional care.

### **Medically Tailored Meals/Medically Supportive Food**

Among 107,025 members, inpatient utilization decreased by 30.0 percent and ED

utilization decreased by 14.2 percent. At the same time, outpatient utilization increased by 1.7 percent.

These findings reflect improved management of chronic conditions, resulting in reduced acute inpatient care use and an appropriate shift toward outpatient care. DHCS will continue to monitor these trends.

### Sobering Centers

Among 3,262 members, inpatient utilization increased by 1.3 percent and ED utilization decreased by 1.0 percent.

These utilization patterns suggest that Sobering Centers engage a high-needs population that previously may not have been connected to care. DHCS will continue to monitor utilization patterns.

### Asthma Remediation

Among 3,763 members receiving Asthma Remediation, as expected, inpatient utilization decreased by 15.0 percent, ED utilization decreased by 15.8 percent, and outpatient utilization increased by 9.1 percent.

The reductions in inpatient and ED utilization suggest that remediation of environmental asthma triggers contributed to improved symptom control and reduced acute inpatient care needs. Increased outpatient utilization reflects appropriate engagement with community-based care following improvements in home environments.

**Table 12: ILOS Impact on Applicable Plan Utilization:**

ILOS	Category of Service Impact	Members Studied
<b>Housing Transition Navigation Services</b>	27.4% reduction in inpatient services utilization 7.7% increase in outpatient services utilization 12.3% reduction in emergency room services utilization 24.5% increase in long-term care services utilization 12.1% reduction in outpatient mental health services utilization	53,136

<b>ILOS</b>	<b>Category of Service Impact</b>	<b>Members Studied</b>
<b>Housing Deposits</b>	12.1% reduction in inpatient services utilization 3.4% reduction in outpatient services utilization 12.7% reduction in emergency room services utilization 31.3% reduction in long-term care services utilization 25.4% reduction in outpatient mental health services utilization	6,503
<b>Housing Tenancy and Sustaining Services</b>	9.2% increase in inpatient services utilization 6.1% increase in outpatient services utilization 7.7% reduction in emergency room services utilization 20.8% increase in long-term care services utilization 21.5% reduction in outpatient mental health services utilization	14,854
<b>Caregiver Respite (formerly Respite Services)</b>	59.2% reduction in inpatient services utilization 23.1% reduction in long-term care services utilization	1,076
<b>Day Habilitation Programs<sup>12</sup></b>	33.8% reduction in inpatient services utilization 40.6% increase in outpatient services utilization 22.8% reduction in emergency room services utilization 36.9% reduction in long-term care services utilization 35.8% reduction in outpatient mental health services utilization	1,839

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<sup>12</sup> Although Inpatient Services and Skilled Nursing Facility Services are not listed as substitutable State Plan services or settings for Day Habilitation Programs in the Community Supports Policy Guide, the cost effectiveness results identified them as such.

<b>ILOS</b>	<b>Category of Service Impact</b>	<b>Members Studied</b>
<b>“Transition” Component of Assisted Living Facility Transitions</b>	30.6% reduction in inpatient services utilization 58.9% increase in emergency room services utilization 31.2% reduction in long-term care services utilization	362
<b>“Diversion” Component of Assisted Living Facility Transitions – LTC Utilizer Comparison</b>	27.6% reduction in inpatient services utilization 131.5% increase in emergency room services utilization 99.0% reduction in long-term care services utilization	548
<b>Community or Home Transition Services</b>	37.3% reduction in inpatient services utilization 26.4% reduction in emergency room services utilization 1.7% increase in long-term care services utilization	182
<b>Personal Care and Homemaker Services – LTC Utilizer Comparison</b>	18.9% reduction in inpatient services utilization 99.9% reduction in long-term care services utilization	4,415
<b>Environmental Accessibility Adaptations (Home Modifications)</b>	40.9% reduction in inpatient services utilization 27.3% reduction in emergency room services utilization 14.4% reduction in long-term care services utilization	1,185
<b>Medically Tailored Meals/Medically Supportive Food</b>	30.0% reduction in inpatient services utilization 1.7% increase in outpatient services utilization 14.2% reduction in emergency room services utilization	107,025

<b>ILOS</b>	<b>Category of Service Impact</b>	<b>Members Studied</b>
<b>Sobering Centers</b>	1.3% increase in inpatient services utilization 1.0% reduction in emergency room services utilization	3,262
<b>Asthma Remediation</b>	15.0% reduction in inpatient services utilization 9.1% increase in outpatient services utilization 15.8% reduction in emergency room services utilization	3,763

## **Cross-Sectional Analyses - Overview**

### **Methodology and Study Limitations**

In addition to the longitudinal results presented above, DHCS also performed a cross-sectional analysis comparing members utilizing ILOS to members not utilizing ILOS on one CMS Core Set measure: asthma medication ratio (AMR).

For this measure DHCS identified members receiving Community Supports in any quarter of CY 2023. We compared the CMS Core Set measure differences among members receiving Community Supports (intervention) with those members who did not receive Community Supports (control). No other adjustments were made to create a comparative cohort.

The cross-sectional differences among intervention and control cohorts indicate difference in case-mix and other interaction effects. For example, the population receiving the Community Support is likely to have greater health care and social services needs. This intervention population, by definition, was also identified and targeted for Community Support services. Thus, differences between the cohorts are likely due to case-mix and targeting effects of higher-risk members, rather than due to program effects. Thus, any significant cross-sectional differences between the ILOS-utilizing and non-ILOS-utilizing groups should be read as complementary to the longitudinal analysis and cannot directly support or contradict the before-and-after results. In combination, the longitudinal trends and cross-sectional differences motivate future holistic risk-adjusted analyses to separate program impact from underlying population differences.

### **Findings: AMR: Asthma Medication Ratio**

The AMR measure calculated the percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or more during the measurement period. AMR rates were based on the Managed Care Accountability Set (MCAS) Patient Level Data (PLD). AMR measure of > 0.5 ratio of controller medication shows better asthma control. See Table 13 for AMR summary rates.

**Table 13: AMR: Asthma Medication Ratio, Measure Year 2024 – Summary Rates**

<b>Population</b>	<b>Quarter Flag</b>	<b>Rate</b>	<b>Non-Community Supports Rate</b>	<b>Confidence Interval (95.0%)</b>	<b>CI Overlap with Non-Community Supports Members</b>
All Members	NA	66.22	NA	NA	NA
Member, Non-Community Supports	Non-Community Supports	66.23	66.23	[65.88 - 66.57]	Reference
Member, Only Asthma Remediation	Any Asthma Remediation in CY2023	73.54	66.23	[68.49 - 78.04]	Higher than Non-Community Supports
Member, Only Asthma Remediation	Community Supports in 1 Quarter	73.82	66.23	[67.16 - 79.54]	Higher than Non-Community Supports
Member, Only Asthma Remediation	Community Supports in 2 Quarters	71.30	66.23	[62.15 - 78.98]	Overlap
Member, Only Asthma Remediation	Community Supports in 3 or 4 Quarters	80.77	66.23	[62.12 - 91.49]	Overlap
Member, Non-Asthma Remediation, Other Community Supports	Any Other Community Supports in CY2023	64.16	66.23	[61.45 - 66.79]	Overlap
Member, Non-Asthma Remediation, Other Community Supports	Other Community Supports in 1 Quarter	65.00	66.23	[60.43 - 69.31]	Overlap

Population	Quarter Flag	Rate	Non-Community Supports Rate	Confidence Interval (95.0%)	CI Overlap with Non-Community Supports Members
Member, Non-Asthma Remediation, Other Community Supports	Other Community Supports in 2 Quarters	63.27	66.23	[57.90 - 68.34]	Overlap
Member, Non-Asthma Remediation, Other Community Supports	Other Community Supports in 3 or 4 Quarters	64.00	66.23	[59.59 - 68.19]	Overlap

Notes:

*Member, Non-Community Supports: Members who did not receive any Community Support Services*

*Member, Only Asthma Remediation: Members who received only Asthma Remediation Community Support.*

*Member, Non-Asthma Remediation, Other Community Supports: Members who received a Community Support other than Asthma Remediation.*

The AMR analysis found that MCP members who received Asthma Remediation in CY 2023 had significantly higher AMR rates in 2024 compared with members who had not received Asthma Remediation. Rates for members with “Only Asthma Remediation Community Supports” had an AMR of 73.54 percent (95 percent Confidence Interval (CI): 68.49 - 78.04). In contrast, members receiving “Non-Asthma Remediation Community Supports” had an AMR of 64.16 percent (95 percent CI: 61.45 - 66.79) and members not receiving Community Supports had an AMR of 66.23 percent (95 percent CI: 65.88–66.57). Thus, the confidence interval for “Only Asthma Remediation Community Supports” did not overlap with either confidence interval for the comparison groups, and relative percent differences in the AMR values was greater than 10 percent.

These higher AMR rates reflect improved asthma control for those who received the Asthma remediation. Higher AMR rates were also seen for “Only AR Community

Supports” cohorts with two quarters or with three or four quarters of Community Supports (71.3 and 80.77 respectively), but CIs were wide and overlapping, preventing reliable interpretation, even when relative differences exceeded 10 percent. Figure 2 shows that members who received any Community Supports - asthma remediation or otherwise (“Any Community Supports”), showed no significant difference relative to non-Community Supports members (66.11 vs. 66.23; overlapping CIs). This is attributable to the majority of members receiving “Only Non-Asthma Remediation Community Supports” constituting about 79 percent of the “Any Community Supports” cohort, and their lower AMR rate (64.16; 61.45-66.79) having an outsized influence on the “Any Community Supports” rate compared to the “Only AR Community Supports” group.

## Encounter Data Timeliness and Accuracy (STC B20f):

DHCS affirms it will submit timely, accurate, and validated encounter data to the Transformed Medicaid Statistical Information System, or T-MSIS, in accordance with all STCs.

DHCS is monitoring discussions and acknowledges the following important considerations about Monitoring Information:

- » **Data Completeness:** MCPs and the Community Supports providers continue to face significant challenges in establishing timely data-sharing processes for transferring information needed to complete the QIMR. As a result, MCPs have advised that data for any given quarter may not be entirely complete for up to 365 days after the end of the quarter. Any updated data will be then sent to DHCS as a QIMR resubmission from the MCP. Although DHCS actively uses implementation data to help drive discussion in plans, this challenge is acknowledged in those discussions and includes assessment of volumes of services or members served, which are impacted by data issues. DHCS continues to instruct MCPs to resubmit updated data to mitigate gaps and improve visibility into Community Support implementation.
- » **Data Lags:** Due to the time required to collect, submit, and process implementation data, information may be outdated at the time of the review, and/or action to address issues will not be reflected until the next data submission. MCPs are required to submit QIMR data approximately 45 days after the end of the quarter, and those submissions undergo an extensive quality assurance review process.

## Data related to the cost-effectiveness of Community Supports (ILOS) (STC B20g):

In accordance with 42 CFR §438.3(e)(2), an ILOS can be used as an immediate or longer-term substitute for a covered service or setting under the State Plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting under the State Plan.

Starting in 2022, California was the first state to use ILOS authority, rather than waiver authority, to cover a robust set of services that address social drivers of health and non-medical health needs on a broad scale. The services (included under the umbrella of “Community Supports”) were expected to reduce or prevent the future need to utilize services such as inpatient services, emergency department services, and nursing facility services. Most of these services were not new to the Medicaid program; they had been provided to Medicaid members under home and community-based services programs for decades. Additionally, hospitals and MCPs across the nation tested expansions of these services to better manage quality and cost outcomes for their members. Notably, CMS also listed many of these specific services as examples of potentially covered services in [State Health Official Letter 21–001](#).

CMS released subsequent [guidance](#) codifying California’s approach for ILOS and establishing some new guardrails and reporting requirements. This guidance, the federal rule [preamble](#), and the federal regulations clarify that ILOS can be preventive in nature and do not need to be immediate substitutes to standard Medicaid benefits as long as they advance the objectives of the Medicaid program and are approvable in Medicaid and the effects of the services can be measured over multiple years. Furthermore, CMS has clarified that cost-effectiveness does not require budget neutrality, and additional ILOS spending can be partially, and not totally, offset by savings from other Medicaid services.<sup>13</sup>

The guidance and regulations require that all states implementing ILOS regularly report to CMS an ILOS Cost Percentage. The ILOS Cost Percentage, per CMS [guidance](#), is the primary indicator of the cost effectiveness of ILOS. The ILOS Cost Percentage cannot exceed 5 percent. In addition, the ILOS guidance and regulations require states with ILOS Cost Percentages over 1.5 percent to provide additional documentation on how

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<sup>13</sup> <https://www.federalregister.gov/d/2024-08085/p-2362>

they assess cost effectiveness for ILOS and to perform a retrospective evaluation after five rating periods. California's ILOS Cost Percentage has been substantially below 1.5 percent for all years of ILOS implementation. The ILOS Cost Percentage was 0.15 percent in calendar year 2023, 0.19 percent in calendar year 2024 (featured in this report), 0.80 percent in calendar year 2025, and 0.97 percent in the most recent 2026 rate certification. As such, because of these "*de minimis*" ILOS Cost Percentages, California's ILOS would not normally be subject to enhanced federal monitoring of cost-effectiveness.<sup>14</sup>

As the CalAIM Section 1915(b) waiver approval preceded the [guidance](#) and [regulations](#) that codify cost-effectiveness reporting requirements for ILOS, CMS included additional Special Terms and Conditions (STCs) under California's Section 1915(b) waiver regarding monitoring and reporting for ILOS beyond what is required of other states under the federal regulations for ILOS, including STC B20g that requires California to report on the cost-effectiveness of ILOS. Notably, the guidance and regulations do not require additional reporting on cost effectiveness that CMS outlined in the CalAIM Section 1915(b) STCs. California is being held to a higher standard on cost-effectiveness reporting relative to all other current and future states implementing similar approaches.

## Methodology

In compliance with the requirements under the CalAIM Section 1915(b) STCs, DHCS is providing a comprehensive look at the cost effectiveness of each individual ILOS and utilized three different approaches to assess the impacts of ILOS on categories of service (used for rate-setting purposes).

DHCS assessed the impact of each ILOS on expenditures for services it was intended to substitute, as outlined in the Medi-Cal Community Supports Policy Guide [Volume 1](#) and [Volume 2](#), where possible. In addition, the B&A cost-effectiveness analysis

It is important to note this analysis is being completed much earlier, and therefore on a much shorter study period, than the retrospective evaluation of ILOS using five years of data required by 42 CFR §438.3(e)(2) when the final ILOS Cost Percentage in any of the first five rating periods that each ILOS is authorized exceeds 1.5 percent. With this narrow view, the impact of these services, many of which are realized after the implementation of the ILOS, will not be fully captured within this analysis.

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<sup>14</sup> [SMD 23-001 - ILOS](#)

## **Before and After (B&A) Methodology**

DHCS evaluated select ILOS by identifying members who first received the relevant service between January 2023 and June 2024 and maintained eligibility in the 12 months before and after service use. Claims and encounters were then restricted to a six-month baseline period and a 12-month follow-up period surrounding each member's first month of service for the subject ILOS.<sup>15</sup> These claims and encounters span July 2022 through June 2025. In the prior analysis, we limited the evaluation window to the six months before and six months after a member's first use of a relevant service due to limited data availability. The current analysis expands the post-period to twelve months, allowing us to better capture longer-term cost trends and utilization patterns following receipt of the relevant ILOS. As before, the analysis accounts for medical cost inflation by trending forward unit costs of the services from the before period to the after period. The unit cost trends utilized were consistent with those used for actuarially sound and certified rate development.

## **Long-Term Care (LTC) Methodology**

For select ILOS, DHCS compared per-member-per-month (PMPM) costs of individuals utilizing these services starting between January 2023 and June 2024 and compared them to PMPM costs in the same time period of Medi-Cal members receiving a

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<sup>15</sup> DHCS utilized the B&A approach for the following ILOS: Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Respite Services, Day Habilitation Programs, the "transition" component of Assisted Living Facility Transitions, Community or Home Transition Services, Environmental Accessibility Adaptations, Medically Tailored Meals/Medically Supportive Food, Sobering Centers, and Asthma Remediation.

minimum of 90 consecutive days of long-term care services (“LTC utilizers”).<sup>16,17,18</sup> Claims and encounters were restricted to those occurring from the first month the relevant service was utilized to June 2025, or to the month prior to the next month in which the member utilized LTC services. These claims and encounters span January 2023 to June 2025.

## **Interrupted Time Series (ITS) Methodology**

For select ILOS, an ITS segmented regression analysis was performed. The ITS design uses historical data to forecast the counterfactual (i.e., what is assumed to have happened in the absence of receiving the ILOS).

For each ILOS evaluated using the ITS methodology, separate analytic samples were developed containing managed care encounters spanning January 2022 and June 2025 for members who had at least one encounter for the relevant service between January 2023 and June 2024. Given that individuals could receive the community support at different months and years, DHCS indexed the start of the post-intervention period as the first month of receipt of the relevant service; the post-intervention period included data up to 24 months after the first use of the relevant service. The pre-intervention period included data up to 24 months prior to the first use of the relevant service. The specific pre-and post-intervention period differs for each individual utilizer depending on when they first utilized the relevant service. ITS analyses included individual fixed effects to adjust for unobservable characteristics to adjust for confounding factors including adjustments for inflation via time fixed effects.

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<sup>16</sup> DHCS utilized the “LTC comparison” approach for the following ILOS: Respite Services, the “diversion” component of Assisted Living Facility Transitions, and Personal Care and Homemaker Services.

<sup>17</sup> Assisted Living Facility Transitions was approved by CMS as a single Community Support. However, for the purposes of the cost-effectiveness analysis, two different methodological approaches were used to assess cost effectiveness. The B&A approach was used to assess the “transition” component of the Community Support while the LTC approach was used to analyze the “diversion” component of the Community Support.

<sup>18</sup> Respite Services was approved by CMS as a single Community Support. However, for the purposes of the cost-effectiveness analysis, two different methodological approaches were used to assess cost effectiveness. DHCS performed both analyses to understand the impact of these caregiver supports on members.

DHCS determined that employing the B&A, LTC, and ITS methodologies provides a more comprehensive and methodologically robust assessment of ILOS cost-effectiveness. The B&A and LTC analyses offer focused evaluations that center on general cost and utilization shifts specific to applicable, avoidable State Plan services or settings, while the ITS approach offers a complementary perspective by assessing changes in cost trends within Medi-Cal managed care data specifically, capturing both immediate impacts and longer-term shifts over time. Together, they offer a more complete assessment of cost-effectiveness, aligning with DHCS's need to evaluate both detailed service-specific effects and overarching trends.

## Findings

California's cost-effectiveness analysis shows that the 12 ILOS continue to demonstrate, or are expected to reach in the remaining years of the waiver period, a cost-effective impact, reducing costs within applicable, avoidable State Plan service categories.

- » 10 out of the 12 ILOS are demonstrating cost savings: Housing Transition Navigation Services, Housing Deposits, Respite Services, Day Habilitation Programs, Assisted Living Facility Transitions, Community or Home Transition Services, Personal Care and Homemaker Services, Environmental Accessibility Adaptations, Medically Tailored Meals/Medically Supportive Food, and Asthma Remediation.
- » Sobering Centers: The B&A analysis for Sobering Centers does not reflect achievement of cost savings overall in the study period, as post-utilization costs are higher than pre-utilization costs. The ITS analysis offers a different perspective, showing significant cost reduction for members relative to what they would have cost absent the ILOS. When examining expenditures across all categories of service, the ITS results indicate a statistically significant reduction of approximately \$57.97 PMPM following receipt of Sobering Centers services. These findings indicate that the intervention is effective in reducing or reversing cost trends and suggest that while initial engagement with the health system may increase costs in the short term, longer-term cost trends may reflect reductions in overall expenditures as members stabilize and connect to appropriate care.
- » Housing Tenancy and Sustaining Services (HTSS): The B&A analysis for HTSS does not reflect achievement of cost savings overall in the study period, as post-utilization costs are higher than pre-utilization costs. HTSS does, however, demonstrate cost reductions in inpatient and emergency room expenditures. The

ITS analysis offers a different perspective, showing significant cost reduction for members relative to what they would have cost absent the ILOS. When examining expenditures across all categories of service, the ITS results indicate a statistically significant reduction of approximately \$31.57 PMPM for following receipt of HTSS. These findings indicate that the intervention is effective in reducing or reversing cost trends and suggest that increased costs in the short term as members engage with needed health and social services may be offset by longer-term cost trends reflecting reductions in overall expenditures as housing stability improves. This pattern is consistent with the service's role in supporting members with complex medical, behavioral health, and social needs, where initial engagement with care may increase utilization as previously unmet needs are identified and addressed, but stabilization over time may lead to more appropriate and lower-cost patterns of care.

Based on observed trends in the data analysis, DHCS projects that Sobering Centers and HTSS will be proven to be a cost-effective substitute for State Plan services or settings once more experience data is gathered over multiple years, consistent with federal requirements set forth in CMS regulations and guidance.

## Results

California implemented Community Supports alongside a broad range of initiatives intended to address the whole-person care needs of Medi-Cal members, including Enhanced Care Management. Through ECM, many individuals with high needs, many of whom also accessed Community Supports, were connected to medically necessary care for the first time or re-engaged with the health care system and addressed unmet care needs. As a result, the broader array of services and supports offered under the CalAIM initiative, including ECM, may influence the overall cost-effectiveness results. In addition, for those Community Supports evaluated under the B&A approach, the cost effectiveness results are expected to be influenced by the time basis of the evaluation, which results in immediate or frontloaded costs being fully captured but longer-term savings over time not being captured within the time period included in the analysis. As more data becomes available, DHCS will continue to refine its methodology and explore other potential measures for future annual reports. In addition, DHCS will complete a full independent evaluation, per the terms of its Section 1915(b) waiver STCs.

The table below highlights the impact under the B&A methodology of each ILOS on the applicable, avoidable State Plan services or settings which could be crosswalked. Many instances show an increase in outpatient services, likely due to a combination of

previously unidentified health care needs and members accessing care in less acute settings, which is consistent with the objectives of ECM, while inpatient and emergency room costs and utilization decrease, which is consistent with the objectives of ILOS. DHCS has included PMPM cost changes when observed.

**Table 14: ILOS Impact on Applicable State Plan Service and Net PMPM Costs – B&A Methodology:**

<b>ILOS</b>	<b>Category of Service Impact</b>	<b>Members Studied</b>	<b>Net Impact Across Applicable Category of Service Costs<sup>19</sup></b>
<b>Housing Transition Navigation Services</b>	28.5% reduction in inpatient services costs 18.6% increase in outpatient services costs 12.8% reduction in emergency room services costs 20.4% increase in LTC services costs 8.8% reduction in outpatient mental health services costs	53,136	-3.2%
<b>Housing Deposits</b>	14.2% reduction in inpatient services costs 7.6% reduction in outpatient services costs 11.6% reduction in emergency room services costs 22.4% reduction in LTC services costs 28.9% reduction in outpatient mental health services costs	6,503	-15.2%

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<sup>19</sup> "Net impact" represents the change in the sum of costs for the relevant ILOS and applicable, avoidable State Plan services listed in the "Category of Service Impact" column.

ILOS	Category of Service Impact	Members Studied	Net Impact Across Applicable Category of Service Costs <sup>19</sup>
<b>Housing Tenancy and Sustaining Services</b>	4.3% reduction in inpatient services costs 47.2% increase in outpatient services costs 5.8% reduction in emergency room services costs 27.2% increase in LTC services costs 18.0% reduction in outpatient mental health services costs	14,854	+26.4%
<b>Respite Services<sup>20</sup></b>	66.7% reduction in inpatient services costs 27.4% reduction in LTC services costs	1,076	-19.9%
<b>Day Habilitation Programs<sup>21</sup></b>	18.6% reduction in inpatient services costs 52.5% increase in outpatient services costs 14.7% reduction in emergency room services costs 32.9% reduction in LTC services costs 27.1% reduction in outpatient mental health services costs	1,839	-9.1%

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<sup>20</sup> Although inpatient services are not listed as a substitutable State Plan service or setting for Respite Care in the Community Supports Policy Guide, the cost effectiveness results identified it as such.

<sup>21</sup> Although inpatient services and long-term care services are not listed as substitutable State Plan services or settings for Day Habilitation Programs in the Community Supports Policy Guide, the cost effectiveness results identified them as such.

ILOS	Category of Service Impact	Members Studied	Net Impact Across Applicable Category of Service Costs <sup>19</sup>
<b>“Transition” Component of Assisted Living Facility Transitions</b>	35.2% reduction in inpatient services costs 93.2% increase in emergency room services costs 29.4% reduction in LTC services costs	362	-9.7%
<b>Community or Home Transition Services</b>	57.4% reduction in inpatient services costs 23.0% reduction in emergency room services costs 1.2% reduction in LTC services costs	182	-9.1%
<b>Environmental Accessibility Adaptations (Home Modifications)</b>	60.2% reduction in inpatient services costs 19.6% reduction in emergency room services costs 23.5% reduction in LTC services costs	1,185	-51.4%
<b>Medically Tailored Meals/Medically Supportive Food</b>	37.4% reduction in inpatient services costs 9.7% increase in outpatient services costs 14.0% reduction in PMPM emergency room costs	107,025	-10.5% <sup>22</sup>

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<sup>22</sup> DHCS updated the service definition in the [Community Supports Policy Guide](#) effective July 1, 2025, to strengthen expectations for MTM/MSF service quality and MCP oversight, and to address patterns of over-utilization.

ILOS	Category of Service Impact	Members Studied	Net Impact Across Applicable Category of Service Costs <sup>19</sup>
<b>Sobering Centers</b>	0.0% increase in inpatient services costs 1.3% increase in emergency room services costs	3,262	+4.9%
<b>Asthma Remediation</b>	18.8% reduction in inpatient services costs 25.1% increase in outpatient services costs 14.9% reduction in emergency room services costs	3,763	-1.2% <sup>23</sup>

For a subset of ILOS, DHCS assumed that the ILOS prevented or delayed the need for care in an LTC facility. For the purposes of this analysis, DHCS compared PMPM costs for members receiving each service to PMPM costs for individuals utilizing LTC services. The table below highlights the impact under the LTC methodology of each ILOS on the applicable, avoidable State Plan services or settings which could be crosswalked.

**Table 15: ILOS Impact on Applicable State Plan Service and Net PMPM Costs – LTC Methodology:**

ILOS	Category of Service Impact	Members Studied	Net Impact Across Applicable Category of Service Costs <sup>24</sup>
<b>Respite Services</b>	21.5% lower inpatient services costs	1,247	-89.1%

<sup>23</sup> The B&A analysis for Asthma Remediation was refined to concentrate on asthma-related inpatient and emergency room encounters.

<sup>24</sup> Reductions shown are in comparison to individuals utilizing long-term care.

ILOS	Category of Service Impact	Members Studied	Net Impact Across Applicable Category of Service Costs <sup>24</sup>
	Approximately \$9,600 lower PMPM LTC services costs		
<b>“Diversion” Component of Assisted Living Facility Transitions</b>	1.4% higher inpatient services costs 235.1% higher emergency room services costs Approximately \$9,500 lower PMPM LTC services costs	548	-62.4%
<b>Personal Care and Homemaker Services</b>	46.8% higher inpatient services costs Approximately \$9,600 lower PMPM LTC services costs	4,415	-79.9%

For a subset of ILOS, DHCS conducted an ITS analysis to assess changes in costs over time before and after receipt of the relevant ILOS. This approach uses historical utilization and expenditure data to estimate the counterfactual and evaluate whether costs changed following receipt of the service. The cost savings identified in the table represent the difference in expenditure trends observed before receipt of the ILOS compared to the expenditure trends following receipt of the ILOS.

**Table 16: ILOS Impact on Aggregate PMPM Costs Across All Categories of Service – ITS Methodology:**

ILOS/Community Supports	Members Studied	Cost Savings Per Member Per Month Across All Categories of Service <sup>25</sup>
<b>Housing Transition Navigation Services</b>	137,391	\$90.83

<sup>25</sup> ITS results are presented at the aggregate “all categories of service” level. The ITS model estimates changes in total expenditures over time following receipt of the ILOS.

<b>ILOS/Community Supports</b>	<b>Members Studied</b>	<b>Cost Savings Per Member Per Month Across All Categories of Service25</b>
<b>Housing Deposits</b>	19,889	\$88.57
<b>Housing Tenancy and Sustaining Services</b>	44,513	\$31.57
<b>Medically Tailored Meals/Medically Supportive Food</b>	250,264	\$60.28
<b>Sobering Centers</b>	7,813	\$57.97
<b>Asthma Remediation</b>	7,668	\$30.99

**Analysis Considerations**

An important consideration when interpreting these analyses is the limited availability of data within the timeframe of this report, which may constrain the ability to observe longer-term trends or fully assess cost and utilization impacts. With a narrow view, the impact of these services, many of which are realized after the implementation of the ILOS, will not be seen within this analysis. ITS analyses often indicated an initial increase in costs upon receiving an ILOS, likely driven by greater engagement with needed health and social services. However, subsequent trends showed a downward trend in the cost curve, suggesting that the services contribute to reducing overall costs over time. Despite these limitations, DHCS believes it is reasonable to conclude in this analysis that the ILOS are having an important impact on members and are cost-effective substitutes for State Plan services or settings. DHCS plans to contextualize this impact further in subsequent evaluation reporting.

## ILOS Cost Percentage

DHCS calculated the ILOS cost percentage by dividing the portion of the total capitation payments that are attributable to all ILOS, excluding a short term stay in an IMD, for each managed care plan by the actual total capitation payments for each managed care plan; including all State directed payments (defined as paid directed payments and projected payments for the applicable time period not yet paid) and pass-through payments in CY 2024. The calculation reflects observed enrollment for the period of January 1, 2024, through December 31, 2024, with runout through December 2025.

**Table 17: ILOS Cost Percentage:**

Reporting Period	Cost Percentage
1/1/2024 - 12/31/2024	<b>0.19%</b>

## Policy/Administrative Issues and Challenges:

### Community Supports Policy Guide

Over the course of CY 2023, CY 2024, and CY 2025, DHCS and its stakeholders identified several key areas of the Policy Guide requiring additional technical assistance and clarification. DHCS continues to refresh the Community Supports Policy Guide as needed to incorporate new language, policy developments, and stakeholder feedback on topics including:

- » Prime/Subcontractor Authorization Policy
- » Homelessness Determinations
- » Eligibility for Services
- » Member Handbooks and Website Update Requirements
- » Provider Network Allowances
- » Continuum of Care Requirements
- » Other technical corrections

In April 2025, DHCS bifurcated the Community Supports Policy Guide into two separate volumes to improve clarity and support implementation of new and evolving services:

- » Volume 1 (HRSN-Focused Services) addresses eight Community Supports targeting health-related social needs.

- » Volume 2 (Housing-Focused Services) addresses seven Community Supports for members experiencing or at risk of homelessness, including the addition of Transitional Rent.

To facilitate phased implementation across both volumes, DHCS released an “Effective Dates” document in July 2025 that provides a clear table of effective dates for service definition updates, room/board caps, and other refinements. This bifurcation and supporting documentation built directly on the Spring 2025 clarifications to service definitions (e.g., Assisted Living Facility Transitions, Community or Home Transition Services, Medically Tailored Meals/Medically Supportive Food, and Asthma Remediation) and aligned Recuperative Care and Short-Term Post-Hospitalization Housing definitions with CMS guidance on HRSN coverage time limits.

## Development of Additional Guidance

DHCS remains committed to continuous improvement based on data, stakeholder input, and implementation experience. In CY 2025, the Department advanced multiple policy, data, and operational refinements, including:

- » **Closed-Loop Referral (CLR) Implementation Guidance** (effective July 1, 2025, for ECM and 13 Community Supports, with carve-out for Sobering Centers);
- » **Closed-Loop Referral (CLR) FAQs** (updated May 2025, providing operational details on implementation, tracking, closure reasons, noticing requirements, and scope decisions for MCPs and providers);
- » **JSON Monthly Reporting technical documentation** (Companion Guide, Schemas, and Data Dictionary);
- » Updates to the **Quarterly Implementation Monitoring Report (QIMR)** to accommodate new provider types and bridge dual-reporting needs;
- » **Transitional Rent Payment Methodology** (released October 2025, establishing non-risk payment structure separate from capitation for the new housing-focused service);
- » Updated **CalAIM Data Sharing Authorization Guidance 2.1** (strengthening standards for information exchange between MCPs and providers, with explicit incorporation of CLR data elements);
- » **Cost Effectiveness of California Medi-Cal Community Supports Fact Sheet** (published June 2025, summarizing statewide aggregate savings from ILOS as lower-cost alternatives to traditional services);
- » Semi-annual updates to the **Community Supports Elections Chart** (in June and December, reflecting current county- and MCP-level elections for Community Supports across all 58 counties);
- » Updated **Community Supports Pricing Resource (Non-Binding)**(released December 2025, offering regional pricing guidance to support consistent contracting negotiations and rate setting);
- » Finalized **HCPCS Coding Options for ECM & Community Supports** (developed 2025 and published January 2026, providing standardized codes and modifiers to drive billing consistency across MCPs and providers);

DHCS continues to deliver technical assistance through the TA Marketplace, which funds hands-on support and on-demand resources via CA PATH for MCPs, providers, and justice-involved initiatives at all levels of readiness.

## **Priority Areas and Action Plan Close-Out:**

DHCS identified five priority areas designed to increase the total number of Members served and improve uptake of ECM and Community Supports:

- » Standardizing Eligibility
- » Streamlining and Standardizing Referral/Authorization Processes
- » Expanding Provider Networks and Streamlining Payment
- » Strengthening Market Awareness
- » Improving Data Exchange

With the ECM and Community Supports Action Plan sunseting at the end of CY 2025, the associated activities have been successfully completed or transitioned to ongoing monitoring and oversight. Progress in each area is summarized below, with sustained focus shifting toward data quality, equity, access, and cost-effectiveness.

### **Standardizing Eligibility**

DHCS required full alignment with Community Supports service definitions by January 1, 2024, eliminating previously approved restrictions or limitations. The 2025 Policy Guide bifurcation and Effective Dates document further standardized eligibility criteria, with corresponding updates to member handbooks and websites. DHCS continues to perform statewide aggregate cost-effectiveness analyses (detailed in the June 2025 Fact Sheet), while MCPs retain flexibility for permissible utilization management under federal rules and regulations.

### **Streamlining and Standardizing Referral/Authorization Processes**

To reduce administrative burden and promote parity, DHCS encouraged streamlined authorization policies, including presumptive and retrospective options for time-sensitive services. The July 2025 CLR requirements operationalize standardized tracking, closure expectations, and data exchange, with defined scope and carve-outs to balance real-time service needs. DHCS also began iterative development of statewide referral standards for Community Supports in 2025, which will incorporate minimum data elements while supporting both community-based outreach and internal identification.

This work will continue in 2026 and culminate with the release of additional statewide Community Supports referral standards by year's end.

## **Expanding Provider Networks and Streamlining Payment**

Through MOC reviews and QIMR analysis, DHCS emphasized contracting with culturally responsive, locally based CBOs and specialized providers. A new MOC cycle for Transitional Rent, combined with finalized HCPCS coding options and invoicing templates, have driven greater consistency in billing and service definitions. DHCS continues to enforce timely provider payment requirements (APL 23-020<sup>26</sup>) to support provider stability, particularly for new CBO entrants.

## **Strengthening Market Awareness**

DHCS reinforced MCP obligations to train staff, update public materials, and promote referral pathways. Ongoing equity and access monitoring – including penetration rates, provider sufficiency assessments, and plan-specific action plans – has been enhanced through public reporting continuity and JSON integration into BI/PACES data marts. MCPs are encouraged to transition appropriate non-Community Supports HRSN services into the program to leverage allocated funding and expand awareness.

## **Improving Data Exchange**

DHCS updated the Community Supports Member Information Sharing Guidance (now version 2.1) to incorporate CLR requirements and strengthen standards between MCPs and providers. To bridge dual-reporting (QIMR quarterly and monthly JSON) and improve timeliness, DHCS implemented validation protocols and lag-reduction strategies via the new JSON technical documentation and QIMR accommodations. All MCPs have attested to compliance, supporting more accurate and timely data for oversight, evaluation, and cost-effectiveness analyses.

DHCS continues robust stakeholder engagement through a regular cadence of LHPC/CAHP weekly meetings, learning collaboratives, and TA webinars to sustain implementation momentum and address emerging needs. Staff remain available to assist MCPs, providers, and other partners in navigating these updates.

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<sup>26</sup> Available at:

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-020.pdf>

## Progress on the Evaluation and Findings (STC B21):

On September 11, 2024, DHCS executed a contract with UCLA-RAND to evaluate all 14 Community Supports, including the 12 services authorized under the 1915(b) waiver and the two Community Supports authorized under the 1115 Waiver (short-term post-hospitalization services and recuperative care). In 2025, the UCLA-RAND Community Supports evaluation team advanced implementation of the approved Evaluation Design (covering all 14 Community Supports and meeting the Community Supports evaluation requirements of both the CalAIM 1115 and CalAIM 1915(b) waivers), which was submitted to CMS on August 4, 2025, and approved by CMS on November 7, 2025. Building from earlier work under the Providing Access and Transforming Health (PATH) evaluation and the broader CalAIM evaluation framework, the team focused on refining data collection tools, integrating available administrative and program level data, and preparing for the interim evaluation report.

Throughout the year, the evaluation team analyzed available QIMR data, refined the provider level database, and synthesized preliminary findings for the interim evaluation report. The team completed interviews with ECM and Community Supports providers and Collaborative Planning and Implementation (CPI) facilitators, cleaned and coded transcripts, and finalized the provider survey instrument, which launched on June 3, 2025. Work also progressed on drafting Managed Care Plan (MCP) interview materials and preparing for the next round of MCP outreach. Regular coordination with DHCS continued throughout this period.

Consistent coordination with DHCS ensured alignment on evaluation questions, data specifications, and business rules across CalAIM initiatives. Delays in the receipt of complete eligibility and claims data, consistent with challenges observed across several 1115 evaluation components, impacted the timing of certain analyses. Although all necessary data has now been provided to the evaluation team, cost related analyses and comparisons of the eligible population were not included in the CalAIM Section 1115 Interim Evaluation Report, which DHCS submitted to CMS on December 29, 2025. These analyses will be addressed comprehensively in the Final CalAIM 1115 Evaluation Report, which will include all 14 Community Supports and is due to CMS on December 31, 2028.

