PROPOSED UPDATES TO THE COMMUNITY SUPPORTS POLICY GUIDE VOLUME 1

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Section 2: Community Supports Overview Updates

Utilization Management, Provider Screening, Enrollment, Credentialing, Revalidation & Recredentialing, and Program Integrity

Overview

This section clarifies that covered Community Support services are subject to applicable requirements under the Medi-Cal Managed Care Plan (MCP) Contract in the same manner under which other covered benefits requirements are subject. Specifically, the Community Supports Policy Guide updates includes sections pertaining to utilization management; provider screening, enrollment, credentialing, revalidation, recredentialing of Community Supports providers; as well as responsibilities to ensure program integrity. These updates are intended to further enable MCPs to strengthen oversight, standardize procedures, and ensure compliance with federal and state regulations

1. Utilization Management Controls

Policy Clarifications:

- MCPs must apply utilization management techniques to covered Community Supports services, as they are required to do for other covered Medi-Cal benefits.
- Utilization management includes authorization timelines, reassessment schedules, and service duration standards.

Purpose:

- Ensure consistent, cost-effective, and medically appropriate delivery of Community Supports.

2. Provider Screening, Enrollment, Credentialing, Revalidation & Recredentialing

Policy Clarifications:

- MCPs must ensure that only providers who are enrolled, credentialed, revalidated, and recredentialed, in accordance with APL 22-013 are paid for Community Supports services.
- In general, providers with a state-level Medi-Cal enrollment pathway must enroll through that pathway and comply with all federal and state screening requirements (APL 22-013, MCP contract, federal law). For providers without a state-level enrollment pathway, MCPs must screen, enroll, credential, revalidate, and recredential, that mirrors the DHCS-enrollment processes. Currently, however, no state-level enrollment pathway exists for Community Support providers, except for Assisted Living Facility Transition Providers in certain counties in which the Assisted Living Waiver is available.
- MCPs must conduct credentialing and recredentialing consistent with federal managed care requirements (42 CFR 438.214).
- MCPs are required to verify exclusion and enrollment status monthly, using federal and State exclusion lists.

Purpose:

- Prevent fraud, waste, and abuse, and ensure only qualified providers deliver Community Supports.
- Align with federal and state requirements for provider oversight and maintain program integrity.
- Clarify and standardize the distinction between screening, credentialing, revalidation, and recredentialing, as outlined in APL 22-013.

3. Program Integrity

Policy Clarifications:

- MCPs must monitor and ensure the quality and integrity of providers and services, both during initial screening and on a regular basis.
- Screening includes checks for fraud, waste, abuse, criminal history, liability claims, and business licensing issues.

- MCPs must submit policies and procedures for DHCS approval detailing how they will conduct screening, enrollment, credentialing, revalidation, and recredentialing for providers without a state-level enrollment process.
- MCPs must adhere to MCP Contract requirements pertaining to the fraud waste and abuse prevention program and those that outline actions to be taken where there are credible allegations of fraud.

Purpose:

- To strengthen program integrity and ensure ongoing compliance with all federal, state, and DHCS requirements.
- To provide clear guidance for MCPs on maintaining high standards for program integrity.

4. Alignment Across Policy Guides

- Language and requirements have been harmonized across Community Supports Policy Guide Volumes 1 and 2, ensuring consistency in screening, enrollment, credentialing, revalidation, and recredentialing for all Community Supports Providers.

Purpose:

- Reduce confusion and administrative burden by standardizing terminology and requirements across all policy documents.
- Clarify that credentialing and revalidation are distinct processes, each serving compliance purposes under APL 22-013.

Section 3: Select Service Definition Updates

Caregiver Respite

Overview

This section details updates to the Caregiver Respite Community Support, focusing on eligibility, allowable settings, provider requirements, and program integrity. The changes aim to clarify service scope, ensure alignment with other state programs, and reinforce oversight. Notably, the service name was changed from "Respite Services" to "Caregiver Respite" to more accurately reflect the intent of the benefit: providing relief specifically to caregivers of eligible Members.

1. Eligibility and Allowable Settings

Policy Clarifications:

- Clarified that Caregiver Respite may be provided to Members in child welfare foster care placements who otherwise meet eligibility criteria, specifically when support is needed beyond what is funded by Foster Family Agencies (FFA) via the California Department of Social Services.
- Emphasized that Caregiver Respite is intended to supplement, not duplicate, other state-funded services, and may be used to fill coverage gaps.
- Clarified that Caregiver Respite is only available when it helps prevent placements for which Medi-Cal would be financially responsible, not just those specific to a Managed Care Plan

Purpose:

- Ensure that Caregiver Respite is used to prevent unnecessary institutional placements for which Medi-Cal is responsible, and to supplement (i.e. not supplant or duplicate) other state-funded services by filling coverage gaps when additional support is needed.

2. Provider Requirements

Policy Clarifications:

- Removed "Short-term Residential Therapeutic Program (STRTP) providers or other care providers who are serving youth with complex needs" from the list of allowable providers.
- Reiterated that providers must have experience and expertise with these unique services and that MCPs remain responsible for conducting provider screening, enrollment, credentialing, revalidation, and recredentialing.

Purpose:

- Ensure that only qualified providers deliver Caregiver Respite, maintaining high standards for service delivery.
- Align provider requirements with updated program integrity and oversight expectations

3. Service Limits and Restrictions

Policy Clarifications:

- Clarified that Caregiver Respite is limited to up to 336 hours per calendar year, including both in-home and facility services, with exceptions for caregiver medical emergencies.
- Reaffirm that Caregiver Respite cannot be provided virtually or via telehealth.
- Specified that the service is only allowable to avoid placements for which Medi-Cal is the payer.

Purpose:

- Reinforce the intent of Caregiver Respite as a short-term, coverage gap-filling support, not a substitute for ongoing care.
- Ensure compliance with Medi-Cal policy and prevent inappropriate use of the benefit

4. Program Integrity and Oversight

Policy Clarifications:

- Reiterate MCP responsibility for ongoing provider screening, credentialing, and monitoring.
- Clarify that MCPs must ensure providers meet all requirements and that services are not duplicative or outside the intended scope.

Purpose:

- Strengthen oversight and ensure that Caregiver Respite is delivered appropriately and only by qualified providers.
- Align with broader program integrity updates across Community Supports.

Assisted Living Facility (ALF) Transitions

Overview

This section provides policy clarifications for the Assisted Living Facility (ALF) Transitions Community Support. The clarifications address eligibility, service components, overlap with other programs, allowable settings, provider requirements, and program integrity. The intent is to ensure consistent application of the benefit, prevent duplication of services, and support smooth transitions for Members

Policy Clarifications

- **Eligibility Criteria:**
  Clarified that Members residing in a private residence or public subsidized housing are eligible for ALF Transitions if they meet the criteria for needing a nursing facility level of care and are transitioning to an ALF. Members already residing in an ALF who are at risk of institutionalization may also receive ongoing assisted living services through this Community Support.

- **Service Components:**
  Confirmed that ALF Transitions includes two distinct components:

  1. **Time-limited transition services and expenses** (e.g., moving costs, application assistance) to help a Member establish residency in an ALF.
  2. **Ongoing assisted living services** provided after the Member transitions into the ALF, with no time limit for these services.

MCPs must offer both components as appropriate for the Member's needs.

- **Overlap with Other Programs:**
  Clarified that Members may be eligible for both ALF Transitions and waiver programs such as the Assisted Living Waiver (ALW) or California Community Transitions (CCT) but cannot receive duplicative services at the same time. MCPs are encouraged to assist with enrollment in waiver programs when appropriate and must ensure no duplication of payment or services.

- **Allowable Settings:**

  ALF Transitions supports placements into licensed Residential Care Facilities for the Elderly (RCFEs) and Adult Residential Facilities (ARFs). In ALW counties, MCPs may contract with and place members in ALW-enrolled facilities.

  DHCS encourages MCPs to consider contracting with qualified non-ALW RCFEs/ARFs that meet DHCS standards to ensure timely Member access.

- **Provider Requirements**
  MCPs must contract with providers who have experience and expertise in delivering ALF Transitions services. MCPs are responsible for screening, enrolling, credentialing, revalidating, and recredentialing providers in accordance with DHCS policy and APL 22-013.

  In ALW Counties, given that there is a DHCS enrollment pathway for RCFEs/ARFs to participate in the Assisted Living Waiver, MCPs may leverage that enrollment pathway for ALF Transition Community Support Providers.

- **Program Integrity:**
  MCPs must ensure that ALF Transitions services are not duplicative, are delivered by qualified providers, and are consistent with all federal and state requirements. MCPs must monitor service quality and maintain documentation to support compliance.

Purpose

These clarifications are intended to:

- Ensure ALF Transitions is used appropriately to support Members transitioning from institutional settings to community-based assisted living, or to prevent unnecessary institutionalization.
- Prevent duplication of services and payments across programs.
- Support Member choice and access to appropriate settings and services.
- Maintain high standards for provider qualifications and program integrity.

Community or Home Transition Services

Overview

This section provides policy clarifications for the Community or Home Transition Services Community Support. The clarifications address eligibility, service components, overlap with other programs, provider requirements, and program integrity. The intent is to ensure consistent application, prevent duplication of services, and support successful transitions for Members leaving institutional care

Policy Clarifications

- **Eligibility Criteria:**
  Clarified that Members currently residing in a nursing facility or Recuperative Care setting for 60+ days, who are interested in moving to a private residence or public subsidized housing and can do so safely with appropriate supports, are eligible for Community or Home Transition Services. Members must meet the nursing facility level of care criteria

- **Service Components:**
  Confirmed that Community or Home Transition Services includes two components:

  1. **Time-limited transition services and expenses** to help a Member move from a licensed facility to a private residence or public subsidized housing (e.g., housing search, application assistance, moving expenses, utility setup, pest eradication, accessibility modifications).
  2. **Non-recurring set-up expenses** necessary to establish a basic household, with a lifetime maximum of $7,500 for these expenses (excluding coordination costs).
     MCPs must offer both components as appropriate for the Member's needs

- **Overlap with Other Programs:**
  Clarified that Members may be eligible for both Community or Home Transition Services and waiver/demonstration programs such as California Community Transitions (CCT) or the Home & Community Based Alternatives (HCBA) Waiver,

but cannot receive duplicative services at the same time. MCPs are encouraged to assist with enrollment in waiver programs when appropriate and must ensure no duplication of payment or services

- **Allowable Services and Limits:**
  Specified that Community or Home Transition Services does not cover ongoing monthly rent, mortgage, food, or regular utility charges, and is limited to non-recurring expenses necessary for transition. The $7,500 lifetime maximum applies only to set-up expenses, not to coordination services. Exceptions to the maximum are allowed if a Member is compelled to move due to circumstances beyond their control
- **Provider Requirements:**
  MCPs must contract with providers who have experience and expertise in delivering transition services. MCPs are responsible for screening, enrolling, credentialing, revalidating, and recredentialing providers in accordance with DHCS policy and APL 22-013
- **Program Integrity:**
  MCPs must ensure that Community or Home Transition Services are not duplicative, are delivered by qualified providers, and are consistent with all federal and state requirements. MCPs must monitor service quality and maintain documentation to support compliance

Purpose

These clarifications are intended to:

- Ensure Community or Home Transition Services are used appropriately to support Members transitioning from institutional settings to community-based living.
- Prevent duplication of services and payments across programs.
- Support Member choice and access to appropriate settings and services.
- Maintain high standards for provider qualifications and program integrity.

Personal Care and Homemaker Services

Overview

This section provides policy clarifications for Personal Care and Homemaker Services (PCHS) as a Community Support. The clarifications address eligibility, service scope, interface with other programs, provider requirements, and program integrity. The intent is to ensure consistent application, prevent duplication of services, and support Members in remaining safely in their homes

Policy Clarifications

- **Eligibility Criteria:**
  Clarified that PCHS is available to individuals at risk for hospitalization or institutionalization in a nursing facility, those with functional deficits and no other adequate support system, or those approved for In-Home Supportive Services (IHSS). Eligibility criteria are aligned with those used for IHSS
- **Service Scope and Limits:**
  Confirmed that PCHS can be used:
  - During the IHSS application process, including waiting periods.
  - In addition to approved county IHSS hours when more support is needed and a request for increased hours is pending, or when IHSS benefits are exhausted.
  - For Members ineligible for IHSS, to prevent a short-term stay in a skilled nursing facility (not to exceed 60 days).
  - PCHS is limited to specific circumstances and cannot be used in lieu of applying for IHSS when eligible
- **Interface with IHSS and Waivers:**
  Clarified that IHSS must be the primary source of support for eligible Members. PCHS may supplement IHSS when an application is pending, additional support is needed, or IHSS allocations are insufficient.

- Members must demonstrate cooperation and timely progress with IHSS applications or requests for additional hours.
- Waiver Personal Care Services (WPCS) provided through the HCBA Waiver must be coordinated separately to avoid duplication.
- Individuals enrolled in the HCBA Waiver and eligible for or receiving WPCS are not eligible for PCHS, but those on the waitlist may receive PCHS while awaiting approval

» **Provider Requirements:**
MCPs must contract with providers who have experience and expertise in delivering personal care and homemaker services. MCPs are responsible for screening, enrolling, credentialing, revalidating, and recredentialing providers in accordance with DHCS policy and APL 22-013.

» **Program Integrity:**
MCPs must ensure that PCHS is not duplicative, is delivered by qualified providers, and is consistent with all federal and state requirements. MCPs must monitor service quality and maintain documentation to support compliance

Purpose

These clarifications are intended to:

» Ensure PCHS is used appropriately to support Members in remaining safely at home and to prevent unnecessary institutionalization.

» Prevent duplication of services and payments across programs.

» Maintain high standards for provider qualifications and program integrity.

Environmental Accessibility Adaptions (Home Modifications)

Overview

The updates introduce several clarifications that refine documentation requirements, evaluation expectations, allowable scope, provider qualifications, and lifetime limits for EAAs. The intent is to standardize application of the benefit, ensure compliance with federal and state requirements, and strengthen medical necessity verification.

Policy Clarifications

Documentation Requirements

- A physician or other health professional order specifying the equipment or service.
- Documentation from the equipment/service provider describing how it meets the Member's medical need.
- Physical or occupational therapy evaluations and reports (unless waived).
- A description of similar equipment used previously and why it is inadequate.

Independent Therapy Evaluation Requirement

- PT/OT evaluations should come from an entity with no connection to the vendor supplying the equipment or modification.

Required Home Visit

- A home visit must occur to determine whether the modification is suitable for the environment.

90-Day Assessment and Authorization Timeline

90-day timeframe for assessment and authorization, while acknowledging exceptions only for:

- Delays in homeowner consent
- Member-requested extensions

Lifetime Maximum

The policy reinforces the $7,500 lifetime limit, and clarifies exceptions:

- When a Member changes residence
- When a Member experiences a significant change in condition

What Is *Not* Allowed

EAAs may not include:

- Modifications that are purely aesthetic
- Changes adding square footage, unless required for accessibility
- Improvements of general utility to the household

- **Requirements for Written Notice to Property Owners**

  MCPs must provide written notice:

  - When modifications are permanent
  - As a disclaimer, affirming that the State is not responsible for maintenance, repair, or removal if the Member leaves

- **Provider Requirements**

  - All physical adaptations must be performed by a California-licensed contractor
  - PERS installations may follow manufacturer-specific requirements

- **Reinforced Use of State Plan Services First**

  - MCPs must use State Plan services first, such as DME, when those services would meet the Member's needs (e.g., portable ramps, shower chairs).

- **HCPCS Coding Language**

  - EAAs must be billed using S5165 + U6
  - These codes remain in place until permanent codes are established

Purpose:

Clarify expectations for MCPs to ensure uniform, compliant, and defensible determinations

- Strengthen medical necessity validation and provider accountability
- Ensure modifications are safe, appropriate, and cost-effective
- Prevent duplication with State Plan benefits
- Support Members' ability to safely remain at home and avoid institutional care

Medically Tailored Meals/Medically Supportive Food

Overview

This section provides policy clarifications for Medically Tailored Meals/Medically Supportive Food (MTM/MSF) as a Community Support. These updates to the MTM/MSF service definition refine several key elements of the benefit to improve consistency, clinical targeting, and program oversight. The changes build on implementation experience and stakeholder feedback since the service was first introduced and are intended to ensure MTM/MSF is used appropriately for Members with nutrition-sensitive conditions while strengthening accountability and reducing the risk of misuse.

Policy Clarifications

- **Eligibility Criteria:**
  Streamlined to focus on Members with documented nutrition-sensitive chronic or serious health conditions. The updates remove broader complicating factors that previously led to inconsistent interpretation across plans and providers. For mental and behavioral health conditions, eligibility emphasizes chronic or disabling disorders with moderate to severe functional impacts where tailored nutrition can improve outcomes. Eligibility no longer treats "extensive care coordination needs" as a standalone qualifying factor.

- **Service Scope and Limits:**
  Sharpen the distinction between Medically Tailored Meals/Groceries (intended to constitute a substantial portion of the Member's diet) and Medically Supportive Food interventions (intended to supplement the diet). New sub-service categories have been introduced with corresponding HCPCS coding guidance, including Produce Prescriptions (retail and box-based), Healthy Food Vouchers, and Food Pharmacy models. Authorization periods are generally limited to up to 12 weeks initially, with reauthorization tied to documented ongoing clinical engagement and evidence of benefit.

- **Interface with Other Services/Benefits:**
  Clarify that MTM/MSF must supplement, rather than replace or duplicate, other available nutrition supports. New language emphasizes graduation pathways and

warm handoffs to longer-term resources (such as CalFresh/SNAP or other community nutrition programs) once a Member no longer requires the intensive, time-limited intervention. The service is explicitly not intended to address food insecurity in the absence of a documented nutrition-sensitive health condition.

- **Referral Pathways(s):**
  Referrals for MTM/MSF must originate from the Member's established healthcare team and include clinical documentation of the nutrition-sensitive condition. Member self-referrals, family-initiated requests, and direct referrals from MTM/MSF providers must go through the Member's healthcare team to ensure appropriate clinical oversight. This requirement reinforces that the service is a clinical intervention rather than a general food assistance benefit.
- **Program Integrity:**
  Introduce stronger utilization management guardrails, including clearer reauthorization criteria and expectations for documented clinical benefit. Additional controls have been added for retail-based delivery models (such as non-transferable benefits, identity verification, and monitoring for anomalies or low redemption rates). These changes are designed to support appropriate use, improve data quality, and reduce the risk of fraud, waste, and abuse.

Purpose

These refinements are intended to bring greater consistency and clinical rigor to the MTM/MSF benefit while preserving flexibility for Managed Care Plans and providers. By sharpening eligibility, strengthening the connection to the healthcare team, clarifying service distinctions, and enhancing oversight and utilization management, the updates aim to ensure that MTM/MSF is directed to Members for whom tailored nutrition can meaningfully improve health outcomes.

The changes also support enhanced program integrity, more reliable data for monitoring and evaluation, and sustainable implementation over time.

Sobering Centers

Policy Clarifications

- **Provider Screening, Enrollment, Credentialing, Revalidation, and Recredentialing Requirements**
  - Sobering Center providers must meet the full set of MCP responsibilities for: Screening, Enrollment, Credentialing, Revalidation, Recredentialing.

Asthma Remediation

Overview

Recent updates refine the scope of Asthma Remediation by removing components that now belong under the Asthma Preventive Services (APS) benefit and clarifying what documentation, supplies, and processes must be used moving forward. The revisions also standardize how MCPs authorize services, what is considered medically appropriate, and how modifications are delivered.

Policy Clarifications

- APS Becomes the Required Pathway for Assessment and Education

  Asthma self-management education and in-home environmental trigger assessments are no longer included in Asthma Remediation. These must be provided under the APS State Plan benefit effective January 1, 2026.

- APS Assessment Required to Approve Remediation

  A completed APS in-home environmental trigger assessment within the last 12 months now serves as the sole medical appropriateness documentation for Asthma Remediation. No additional clinician documentation is required.

- Updates to Allowable Remediation Items

  The list of covered items is clarified, including:

  - Only mechanical air filters/cleaners are allowable—electronic air cleaners are not permitted.
  - Integrated Pest Management (IPM) is confirmed as an eligible remediation service.

- Timing of Services

  Modifications and supplies do not need to be provided all at once. They may be delivered over time as long as the total remains within the lifetime maximum.

» Clarification on Permanent vs. Non-Permanent Items

Written notice to property owners is required only for permanent physical adaptations. Non-permanent items (e.g., HEPA vacuums, dehumidifiers, portable air filters, cleaning supplies) do not require this notice.

» Provider Requirements

Contractors performing physical modifications must hold a California Contractor's License.

MCPs must ensure Providers delivering the APS benefit meet provider screening, enrollment, validation, credentialing, revalidation and recredentialing. Since there is a state-enrollment enrollment pathway for APS providers, MCPs must use that pathway.

» Referral Pathway Clarification
    - All referrals—whether initiated by the Member, community sources, or the MCP—must be routed through APS, and authorization must rely on the APS assessment.

Purpose

- Ensure non-duplication between Community Supports and the APS State Plan benefit.
- Streamline and simplify the medical appropriateness determination through reliance on the APS assessment.
- Improve clarity on allowable services, required documentation, provider qualifications, and delivery processes.
- Strengthen alignment with safety standards by excluding electronic air cleaners and reinforcing licensing requirements.
- Maintain flexibility in service delivery while safeguarding program integrity and appropriate use of the benefit.

Section IV-VIII Updates:

IV. Engaging Members in Community Supports

The updates clarify that MCPs may "graduate" or discontinue Community Supports when Members no longer qualify, when there is sustained lack of engagement, or when safety concerns arise. This aligns Continuity-of-Care expectations with DHCS policy and clarifies when Notices of Action are required.

V. Provider Contracting, Enrollment, Credentialing, and Screening Requirements

Updates clarify that when a state-level Medi-Cal enrollment pathway exists, providers must enroll through DHCS unless the MCP has an approved equivalent pathway. Where no state pathway exists, MCPs must fully mirror DHCS' enrollment and revalidation requirements and maintain separate processes for screening, credentialing, revalidation, and recredentialing. Additional updates reinforce MCP responsibility for verifying qualifications, ensuring network capacity, and monitoring service quality.

VI. Data Systems and Data Sharing

The updates emphasize that MCPs may not require Community Supports providers to document all services inside MCP portals and must balance data-sharing needs with administrative burden. MCPs must maintain IT systems that support assignment, tracking, data exchange, and encounter submission for Community Supports and adhere to updated Member Information Sharing Guidance.

VII. Coding, Billing, and Provider Payments

Changes include updated HCPCS codes and modifiers for several Community Supports, clarification that these codes remain in use until permanent codes are established, and confirmation that modifier use is defined specifically for Community Supports. Guidance reiterates that MCPs must use DHCS-established coding and cannot require alternative codes. Updates also clarify payment expectations, clean-claim requirements, and the availability of non-binding pricing resources.

VIII. Monitoring, Reporting, and Enforcement

The section was updated to reflect the sunset of the Quarterly Implementation Monitoring Report (QIMR) as of July 1, 2026. Beginning Q3 2026, monthly JSON submissions become the primary and authoritative data source. Additional updates clarify DHCS' monitoring measures, MCP accountability expectations, and enforcement processes for contract non-compliance.