Tri Counties CalAIM PATH Collaborative

June 25, 2025

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Please introduce yourself in the chat!

BluePath HEALTH

Today's Agenda

Time	Agenda Topic
11:00-11:05	Welcome and Introductions
11:05-11:20	Local Housing Spotlights: *Ventura County Continuum of Care (CoC)* *Many Mansions*
11:20-11:30	DHCS Updates to Housing-Related Community Supports
11:30-11:50	Transitional Rent Overview: *David Tovar, Gold Coast Health Plan* *Gillian Stucki, Kaiser Permanente*
11:50-12:00	Resources, Announcements, and Closing
12:00-12:30	Office Hours

Resources for Supporting Immigrant Communities

Health Care Providers and Immigration Enforcement: Know Your Rights, Know Your Patients' Rights

805 Immigrant Rapid Response Network Resources (English and Spanish) and Upcoming Trainings

Migrant Family Safety Plan Toolkit (English and Spanish)

2025 Collaborative Aim Statement

By December 2025, the Collaborative will strengthen local implementation of CalAIM by creating a sustainable network of providers. We will accomplish this through hosting quarterly peer learning sessions and at least 2 workforce development trainings.

- Strengthen the capacity of providers to sustainably deliver CalAIM services
- Build education and awareness of CalAIM among members, providers, and community partners to drive referrals
- Increase ECM & Community Supports referrals and care coordination among providers

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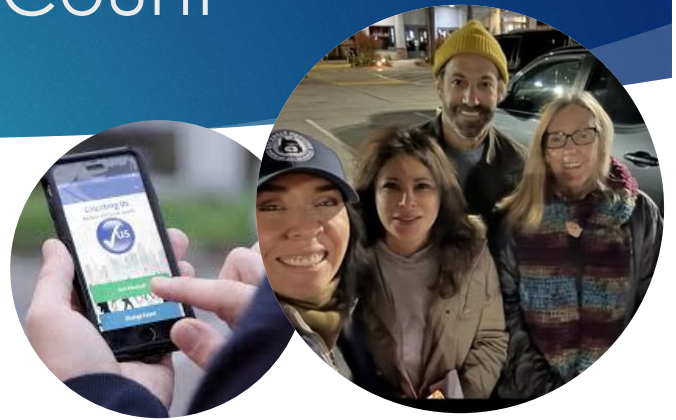
Local Housing Spotlights: Ventura County Continuum of Care

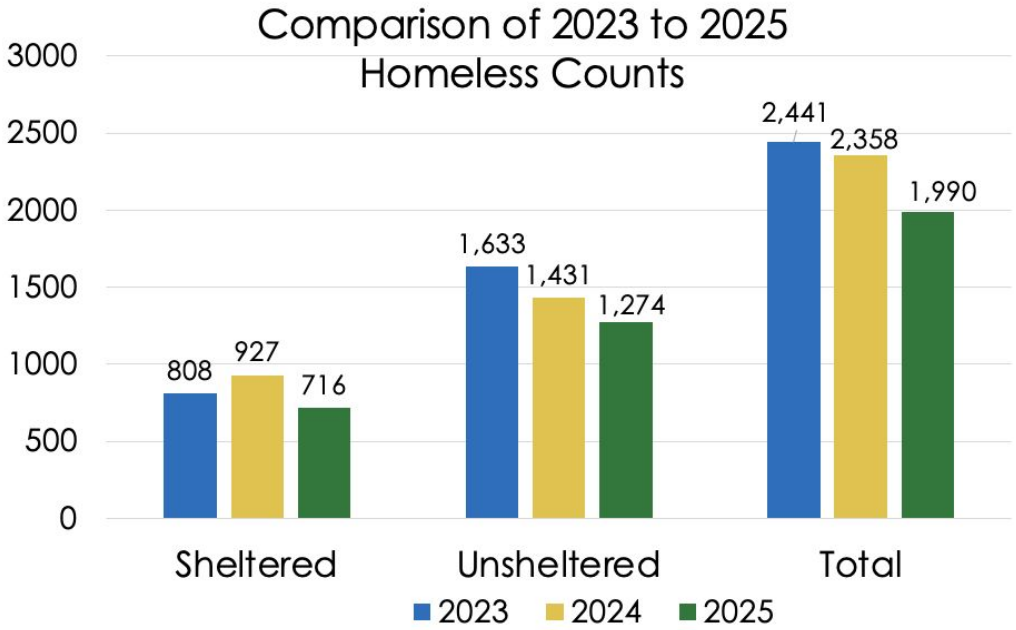
COUNTY of VENTURA

VENTURA COUNTY
CONTINUUM OF CARE ALLIANCE

Addressing Homelessness in Ventura County

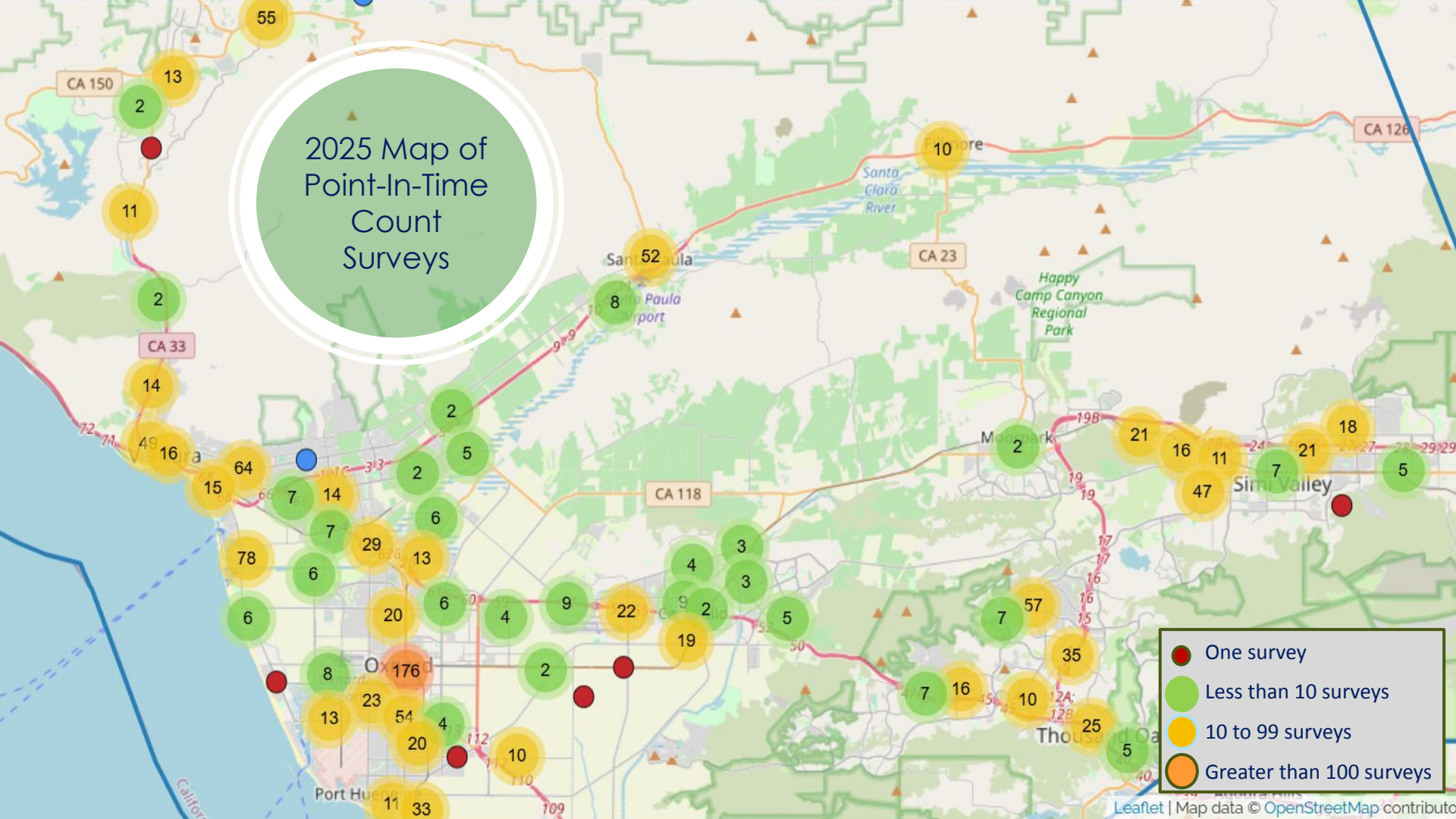
2025 Homeless Point in Time Count



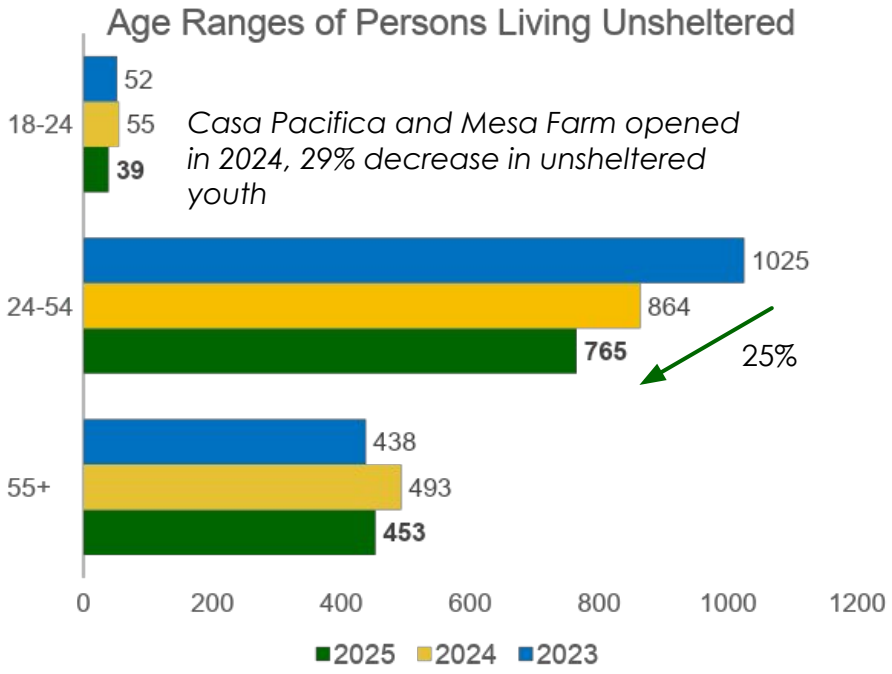


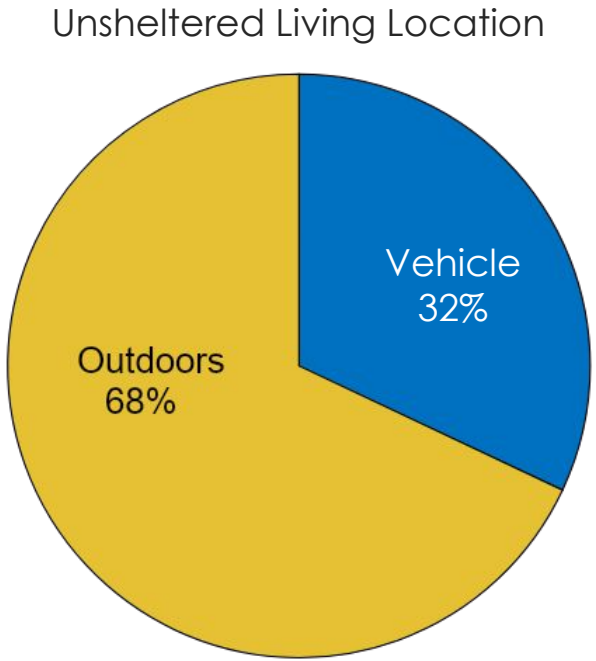
- **Overall decrease of 18.5% since 2023.**
- **Sheltered count decreased by 211 persons or 22.8% since 2024.**
- **Unsheltered count decreased by 157 persons or 11% since 2024.**

2025 Map of Point-In-Time Count Surveys



2025 Unsheltered Homeless Count Details

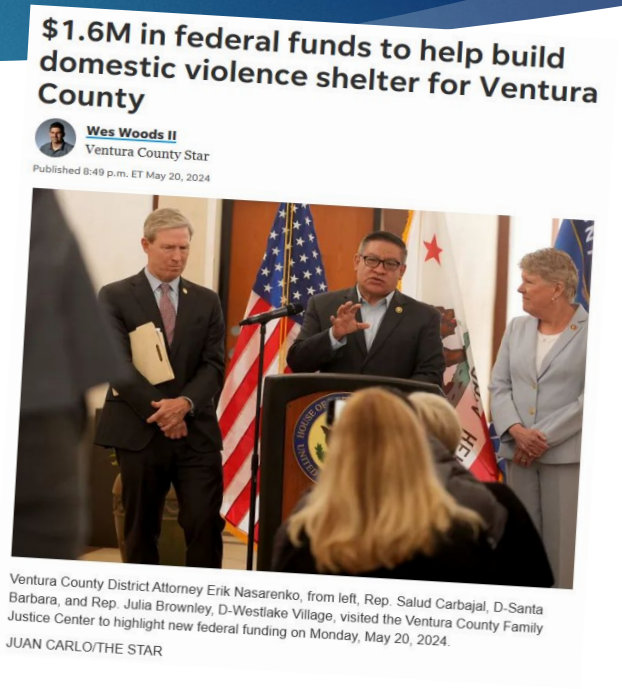




2 Year Homeless Count Observations

2023 to 2025 Comparison

- 34% decrease in unsheltered persons experiencing chronic homelessness (unhoused for over one year with a permanent disabling condition)
- 53% decrease in the number unhoused Veterans when comparing 2023 to 2025 Point in Time Count results
- Increase in the number of persons with history of domestic violence living unsheltered
- Ramp down of Project Roomkey and transition of interim beds to permanent housing units resulted in sheltered persons now being permanently housed reducing the sheltered count.



$1.6M in federal funds to help build domestic violence shelter for Ventura County

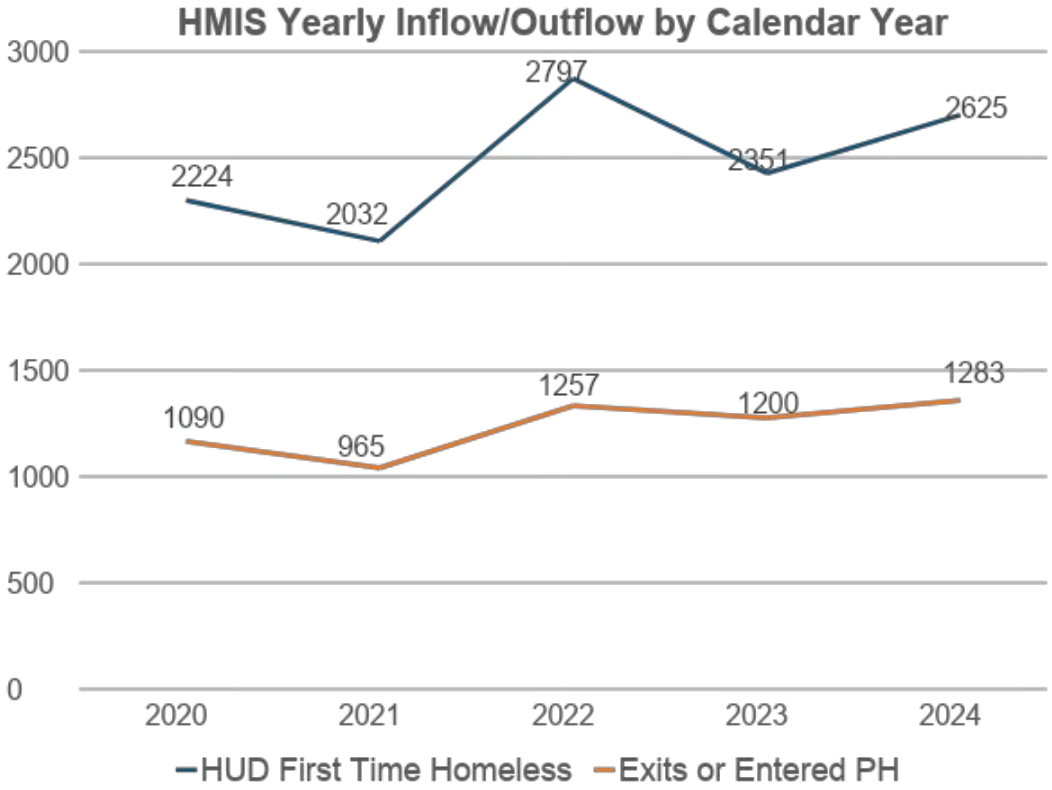
Wes Woods II
Ventura County Star

Published 8:49 p.m. ET May 20, 2024

Ventura County District Attorney Erik Nasarenko, from left, Rep. Salud Carbajal, D-Santa Barbara, and Rep. Julia Brownley, D-Westlake Village, visited the Ventura County Family Justice Center to highlight new federal funding on Monday, May 20, 2024.

JUAN CARLO/THE STAR

Homeless Management Information System (HMIS) Data Tracking



Ventura County Homelessness Plan

Action Area 1: Housing Prioritization & Funding

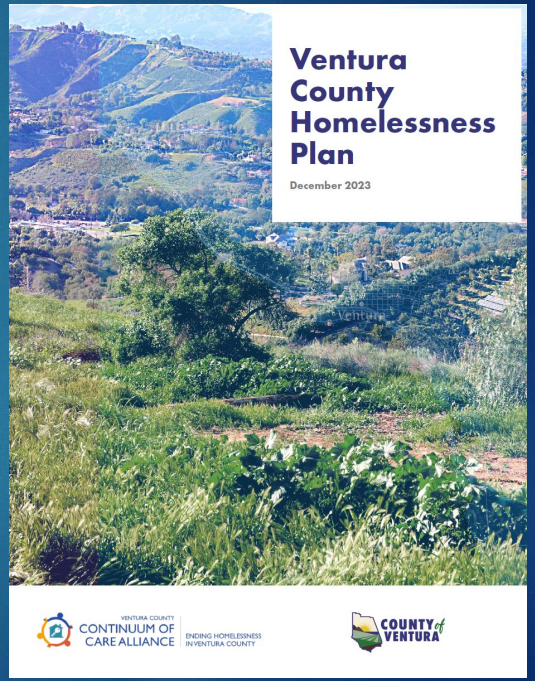
Action Area 2: Regional Coordination & Leadership

Action Area 3: Outreach & Service Delivery

Action Area 4: Data-Driven Decision Making

Action Area 5: Representation & Inclusivity

Adopted by the Board of Supervisors on February 27, 2024



Prioritizing Housing and Prevention

Key progress

- 15.6% reduction in the number of individuals experiencing homelessness as reported by the 2025 Point-in-Time Count compared to 2024 and an 18.5% reduction since 2023.
- $2.5 million in CA grant funding for homelessness prevention contracted to Human Services Agency and United Way of Ventura County.
- Revised shelter costs share agreements including performance metrics tied to funding
- Investments in housing resources - 117 permanent housing units added in 2024.

Projects Under Construction and Predevelopment that Include County Funding

Total affordable housing units: 664 (includes 201 permanent supportive housing units dedicated to homelessness)

Camino de Salud, 48 units, CEDC

Santa Clara Apts, 40 units, HACSB

College Community Courts, 56 units, PSHH

Valentine Rd Apts, Phase II, 94 units, HACSB

Dolores Huerta Gardens, 57 units, CEDC

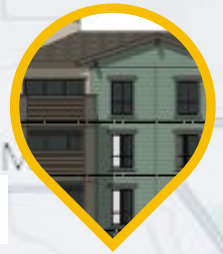
Casa de Carmen, 55 units, CDP

Cypress Place (II), 59 units, PSHH

Rancho Sierra Senior Apts, 49 units, MM

Stepping Stones, Phase II, 9 units, CP

Fillmore Terrace, 49 units, PSHH



Arroyo Spring Apts, 148 units, ASD

Developers:

- A Community of Friends (ACOF)
- Alliant Strategic Development (ASD)
- Community Development Partners (CDP)
- Cabrillo Economic Development Corporation (CEDC)
- Casa Pacifica (CP)
- Housing Authority of City of San Buenaventura (HACSB)
- Many Mansions (MM)
- [illegible]'s Self Help Housing Corporation (PSHH)

Under construction, completion 2025

In predevelopment

Outreach and Service Delivery

- Health Care Agency Ambulatory Care has expanded the number of days per week and added a physician to engage unsheltered individuals resulting in an increase of 6% (190) in the number of persons served.
- Behavioral Health has implemented the Behavioral Health Bridge Housing program adding 144 beds/units to the continuum of care.
- Ventura County Sheriff's Homeless Liaison Unit is fully staffed including a Captain position.
- Implemented a regional supportive services plan to ensure housing retention and leveraged resources, including CalAIM and behavioral health services.

Questions?

COUNTY of VENTURA

VENTURA COUNTY CONTINUUM OF CARE ALLIANCE | ENDING HOMELESSNESS IN VENTURA COUNTY

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Local Housing Spotlights: Many Mansions

Many Mansions

Many Mansions' mission is to develop and maintain quality **affordable housing** and to provide **services** that enrich the lives of our residents, uplifting the community.

We envision a vibrant, inclusive community where everyone has access to affordable housing and the support needed to thrive.

Many Mansions -- Snapshot

- 23 affordable housing apartment communities
- > 2,000 residents in 900 apartments
- All below 60% AMI, majority below 50% AMI
- 234 Households in Permanent Supportive Housing
- Some complexes designated for veterans, TAY, (coming soon – seniors)

Resident Youth in Villa Garcia

We build and then maintain sustainable, quality, well-designed new housing for those who need it most.

With affordable housing and the sense of security it provides, residents have the stability they need to bring other opportunities into focus.

***Summit View**, 48 units for homeless veterans*

Programs & High-Level Goals

Supportive Services	Community Services	Youth Programs
• Housing Retention • Self Determination & Self Sufficiency • Community Integration	• Economic Resiliency • Improved Wellbeing	• Closing Educational Achievement Gaps

Supportive Services

For residents who have experienced chronic homelessness and often struggle with persistent & severe mental illness

- **Intensive Case Management:** on-site support, crisis intervention, referrals to community resources, etc.
- **Life Skills Workshops** to promote independence and support wellbeing (healthy living, household budgeting, accessing mainstream benefits)
- **Activities & Events** to reduce isolation and promote community integration

Community Services

For residents who *do not* have a history of homelessness but require a similar level of care; and program enhancement for supportive residents.

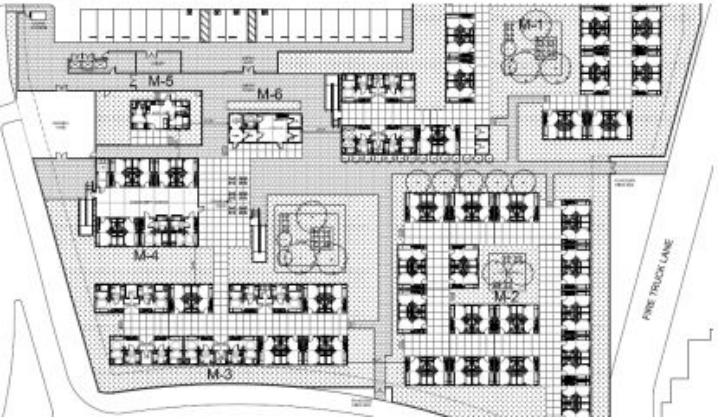
- **Workshops, Resource Referrals, and Individualized Support**
- **Resource Fairs**
- **Social Events, Resident Councils**
- **Food Assistance & Wellness Resources**

Youth Programs

For Many Mansions youth aged 5-22

- **Youth Club**—after-school program (8 sites)
- **Camp Many Mansions**—6-week summer camp
- **Teen Leadership Program**
- **College & Career Program**—promotes continuing education, including financial aid
- **Resources & Access:** internet/computers, school supplies, food assistance, holiday gifts, etc.

Community Partnerships



Coming Right Up

Interim & Permanent Housing

Senior Housing

+ 93 new PSH units by 2026

+ > 100 new PSH units by 2027

+ Additional > 140 general affordable units by 2027

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Housing-Related Community Supports

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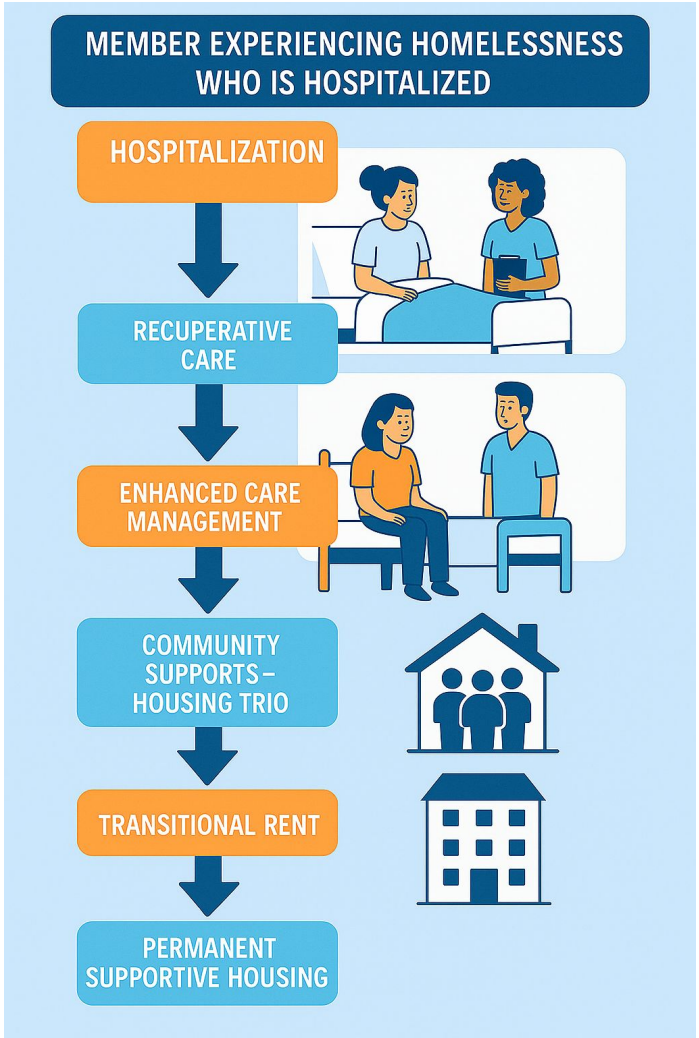


Volume 2 Community Supports Revisions

- In April 2025, DHCS released updated Community Supports definitions for the following services:
  - Housing Transition Navigation Services (HTNS)
  - Housing Deposits
  - Housing Tenancy and Sustaining Services (HTSS)
  - Day Habilitation Programs
  - Recuperative Care (Medical Respite)
  - Short-Term Post-Hospitalization Housing
  - Transitional Rent **(NEW)**

Key Themes for Updated Community Supports Guidance Volume 2

- **Global Cap on Room and Board Services**, 6-month limit per 12 rolling month period for room and board services:
  - Recuperative Care
  - Short-Term Post-Hospitalization Housing
  - Transitional Rent
- Coordination with County Behavioral Health
- **NEW** Community Support: Transitional Rent
- All Members who receive Housing Community Supports must also be offered ECM

Community Supports Revisions: Housing Transition Navigation Services

- **Eligibility Criteria**:
  - Experiencing or at risk of homelessness and meeting certain clinical risk factors; OR
  - Determined eligible for Transitional Rent; OR
  - Prioritized for permanent supportive housing or rental subsidies.
- Adds helping members find and apply for housing in addition to maintaining it
- Expands housing assessment to include Member preferences and strengths
- Updated service duration to as long as necessary

Community Supports Revisions: Housing Deposits

- **Eligibility Criteria**:
  - Experiencing or at risk of homelessness and meeting certain clinical risk factors; OR
  - Determined eligible for Transitional Rent; OR
  - Prioritized for permanent supportive housing or rental subsidies.
- **Removed coverage of first and last month's rent**
- Added coverage of application fees
- Minor updates to service activities to improve clarity
- Available **once per CalAIM demonstration** period
- Members **no longer required to receive HTNS** as condition of eligibility

Community Supports Revisions: Housing Tenancy and Sustaining Services (HTSS)

- **Eligibility Criteria**:
  - Experiencing or at risk of homelessness and meeting certain clinical risk factors; OR
  - Determined eligible for Transitional Rent; OR
  - Prioritized for permanent supportive housing or rental subsidies.
- Minor updates to service activities to improve clarity, marked with footnotes for explanation
- Updated service duration to **as long as necessary**
- Members **cannot receive HTSS and HTNS** at the same time.

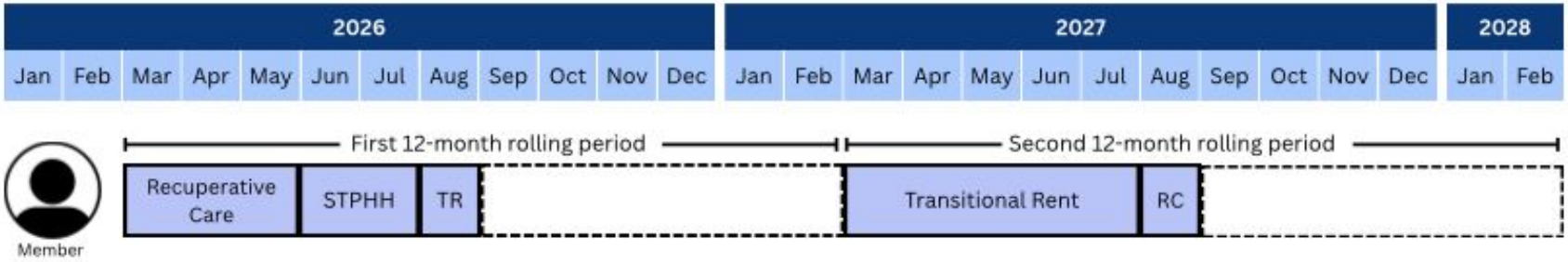
Housing Trio Updates: Effective Dates

Housing Transition Navigation Services	**Volume 2** (pp. 25-30)	1/1/2026
Housing Deposits	**Volume 2** (pp. 31-36)	1/1/2026
Housing Tenancy and Sustaining Services	**Volume 2** (pp. 37-42)	1/1/2026
NEW **Transitional Rent**	**Volume 2** (pp. 57-80)	**7/1/2025** for MCPs that elect to launch at this time **1/1/26** for all MCPs for the Behavioral Health Populations of Focus (POF) (and any other populations the MCP has elected to cover)

Global Cap on Room & Board Services

Members may access **up to 6 months of Recuperative Care, Short-Term Post-Hospitalization Housing, and Transitional Rent within any 12-month period**. However, Transitional Rent is limited to a total of 6 months over the entire 5-year demonstration period.

Example Member Journey:



Community Supports Revisions: Recuperative Care (Medical Respite)

- Updated **Eligibility Requirements** (must meet both requirements):
  - Required to be in recovery from an injury or illness
  - Experiencing or at risk of homelessness

- Added **Peer Respite setting** as a licensing/allowable provider for recuperative care

- Restriction/Limitation: **global cap** to receive services for durations of 6 months on a 12 month rolling basis

- Added provision to require **MCPs to offer ECM services** if Member meets eligibility of Recuperative Care and should be offered HTNS/transitional rent if applicable

Source: DHCS - Community Supports Policy Guide Volume 2

Community Supports Revisions: Short-Term Post-Hospitalization Housing

- Updated **Eligibility Requirements** (must meet **ALL** requirements):
  - Exiting an institution;
  - Experiencing or at risk of homelessness;
  - Receiving ECM; have a serious chronic condition; have a serious mental illness; or are at risk of institutionalization or requiring residential SUD services;
  - Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care.
- Added **Peer Respite setting** as a licensing/allowable provider for recuperative care
- Restriction/Limitation: **global cap** to receive services for durations of 6 months on a 12 month rolling basis
- Added provision to require **MCPs to offer ECM services** if Member meets eligibility of STPPH

Community Supports Revisions: Day Habilitation Programs

- Updated that services can include **assistance with providing a referral to a non-CS housing resource** in the case that the Member does not meet eligibility for HTNS, Housing Deposits, HTSS, or Transitional Rent.
- Requires **MCPs to offer ECM services** if Member meets eligibility of Day Habilitation
- Members needing assistance with housing-related support should be **referred to the Housing Trio**
- Added a **list of providers a MCP may choose to contract** with for these services (e.g. county agencies, mental health or substance use disorder treatment providers, others)

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Transitional Rent

Transitional Rent Overview

David Tovar (GCHP) and Gillian Stucki (KP)

Gold Coast Health Plan℠
A Public Entity

KAISER PERMANENTE®

Transitional Rent Program Overview

What is it?

Six months of rent for Medi-Cal members experiencing or at risk of homelessness and meet certain additional eligibility criteria (e.g. Behavioral Health services)

Who is this for?

Transitional Rent is designed to provide a time limited opportunity to help those who:

Behavioral Health Integration:

- In each county the MCP operates, it must offer a contract to the county behavioral health department, or their designated county department or agency, to serve as a Transitional Rent (TR) Provider.
- DHCS will launch the BH Population of Focus first to establish a pathway from Transitional Rent to Behavioral Health Services Act (BHSA)-funded housing, particularly for individuals with significant BH needs.

Key Takeaways:

DHCS states that "*MCPs and county behavioral health agencies* must establish stronger partnerships, coordination, and communication to serve Members with significant behavioral health needs."

- County BH agencies are required spend 30% of BHSA funds on housing interventions.
- DHCS expects members who receive TR from their MCP to **seamlessly continue to receive coverage** of rental assistance and other housing interventions.

Transitional Rent Breakdown

1 Program Overview

- New Medi-Cal Community Support launching **on January 1, 2026.**
- Provides up to **six months** of rent or temporary housing assistance to qualified individuals.
- Designed for eligible Medi-Cal members who are experiencing or at risk of homelessness.

2 Target Population

- Focuses on individuals **with clinical risk factors** that may contribute to homelessness.
- Includes those in critical life transitions, such as exiting institutional care or other support systems.
- Aims to address the needs of those at the highest risk of losing their housing.

3 Eligibility Criteria

- Eligibility is based on specific clinical risk factors, including those accessing **Specialty Mental Health Services or having chronic health conditions**.
- Targeted towards populations transitioning from multiple settings.
- Eligibility also includes individuals who are eligible for Full Service Partnership (FSP) services, ensuring comprehensive support.

4 Support Duration

- The program offers temporary rental assistance for a **maximum of six months**, allowing individuals time to stabilize their housing situation.
- This duration is intended to bridge the gap to permanent housing solutions, promoting long-term stability.
- Participants will receive ongoing support to facilitate their transition to permanent housing, enhancing their chances of success.

Eligibility Criteria for Transitional Rent

To qualify for Transitional Rent, within the initial launch, individuals must meet all three eligibility criteria, including specific clinical risk factors, homelessness status, and being part of designated transitioning populations.

POF	Clinical Risk Factor	Social Risk Factor	Specified Transitioning Criteria
POF 1 (BH POF)	• Meet the access criteria for SMHS, *or* • Meet the access criteria for DMC, *or* • Meet the access criteria for DMC-ODS services	Experiencing or at risk of homelessness	Transitioning out of an institutional or congregate residential setting
POF 2			Transitioning out of a carceral setting
POF 3			Transitioning out of an interim setting
POF 4			Transitioning out of recuperative care or short-term post-hospitalization housing[1]
POF 5	• Have one or more serious chronic physical health conditions, *or* • Pregnant to 12-months postpartum, *or* • Have physical, intellectual, *or* developmental disabilities		Transitioning out of foster care
POF 6			Experiencing unsheltered homelessness
POF 7			

Transitional Rent Populations of Focus (POFs)

Under both start dates, MCPs have the option to go live with additional POFs under Transitional Rent, beyond the required BH POF for the January 1, 2026 launch.

POF 1	**Behavioral Health POF *(mandatory starting 1/1/2026)***
POF 2	Pregnant and postpartum POF
POF 3	Transitioning out of an institutional or congregate residential setting
POF 4	Transitioning out of a carceral setting
POF 5	Transitioning out of an interim housing
POF 6	Transitioning out of recuperative care or short-term post-hospitalization housing
POF 7	Transitioning out of foster care
POF 8	Experiencing unsheltered homelessness

Individuals who qualify for the BH POF (POF 1) must meet the access criteria for SMHS, DMC, or DMC-ODS, be experiencing or at risk of homelessness and be within a specified transitioning population OR unsheltered OR FSP-eligible.

Individuals who qualify for Pregnant and Postpartum POF (POF 2) must also be experiencing or at risk of homelessness and be within a specified transitioning population OR unsheltered OR FSP-eligible.

Individuals who qualify for POFs 3 – 8 must also be experiencing or at risk of homelessness and meet one of the clinical risk factors.

Transitional Rent may be used to cover the following expenses:

1. Rental assistance in allowable settings for up to six months[1]

2. Storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment

1. Subject to the six-month global cap on Room and Board services.

Transitional Rent Providers

The Transitional Rent Provider will:

- ✓ Identify an appropriate setting/unit.
- ✓ Ensure the housing unit is habitable.
- ✓ Help the Member to review, understand, and execute the lease agreement, and ensuring the lease agreement is compliant and legal.
- ✓ Structure rent payment agreement with landlord or property owner.
- ✓ Issue timely payments to the landlord or other housing provider.
- ✓ Coordinate with the supportive services providers.

Allowable Providers

- County agencies, including county behavioral health agencies
- Flex Pools
- Affordable housing providers
- Supportive housing providers
- CoC-affiliated entities
- Social services agencies
- Public Housing Authorities
- Other providers of services for individuals experiencing homelessness

Housing Support Plan

With the addition of Transitional Rent, DHCS is further emphasizing the key role the housing support plan plays across services.

When is a housing support plan required?

- Development and maintenance of a housing support plan has always been part of the expectation for the **Housing Trio**.
- MCPs must ensure that a Member has a housing support plan in place as a condition for authorizing a Member for **Transitional Rent.**

Who can develop it?

Provided it meets the **requirements elements**, it may be developed by a Community Supports Provider, a flex pool or hub organization that coordinates supportive services, or other Housing Providers, including county behavioral health agencies, regardless of their participation in Medi-Cal or as a contracted Provider.

Required Elements?

- ✓ The permanent housing strategy and solution for the Member.
- ✓ The full range of permanent housing supports that will support the Member in sustaining tenancy.
- ✓ Be informed by Member preferences and needs and revised as a Member's circumstances change.
- ✓ Be based on a housing assessment that addresses identified barriers.
- ✓ Be developed in a way that is culturally appropriate and trauma-informed.

Global Cap on Coverage of Room and Board Services

Per the requirements in CalAIM and BH-CONNECT, DHCS has a "global cap" on coverage of Room and Board Services (i.e., Short-Term Post-Hospitalization Housing, Recuperative Care, and Transitional Rent).

Service	Service Includes	Limits per Service	Global Cap across Room and Board Services
Recuperative Care	Clinical services with Room and Board	6-month limit per rolling 12-month period (per **Member**)	• 6-month (i.e., 182 day) limit per rolling 12-month period also applies across all three Room and Board services. • 12 month rolling timeframe begins on the first day the Member **uses** any of these services. • **The Room and Board cap is counted in days.**
Short-Term Post Hospitalization Housing (STPHH)			
Transitional Rent	Room and Board only	6-months of service per 5-year demonstration (per **household**)	

Community Supports to Support Members Experiencing or At Risk of Homelessness

The services in volume 2 fall into categories.

Housing Trio Services

- Housing Transition Navigation Services (HTNS)
- Housing Deposits
- Housing Tenancy and Sustaining Services (HTSS)

Room and Board Services

- Recuperative Care (Medical Respite)
- Short-Term Post-Hospitalization Housing (STPHH)
- ***NEW*** Transitional Rent

Other

- Day Habilitation Programs

Behavioral Health Transformation

By enacting changes resulting from Proposition 1, Behavioral Health Transformation expands ongoing efforts to **support vulnerable people** living with the **most significant** mental health conditions and SUDs.

Behavioral Health Transformation at a Glance:

1. Evolves the Mental Health Services Act to the Behavioral Health Services Act
2. Includes bonds to increase infrastructure

High-level **aims of Behavioral Health Transformation** include:

Improving Accountability

Increasing Transparency

Expanding Capacity of Behavioral Health Facilities

How Transitional Rent and BHSA Housing Interventions Fit Together

MCPs and county behavioral health agencies must establish strong partnerships, coordination, and communication to serve members with significant behavioral health needs.

A central reform of the BHSA is the **requirement that county behavioral health agencies spend 30% of their BHSA funds on Housing Interventions** for individuals with significant behavioral health needs who are experiencing or at risk of homelessness.

Importantly, BHSA "funds shall not be used for housing interventions covered by a Medi-Cal managed care plan".[1] This means that **Members will not be permitted to receive rental assistance under the BHSA so long as Transitional Rent is available to the Member**.

Ultimately, DHCS expects Members who receive Transitional Rent from their MCP will **seamlessly continue to receive coverage** of rental assistance and other housing interventions (as applicable) **through BHSA, following the conclusion of Transitional Rent**.

1. California Welfare & Institutions (W&I) Code section 5830(c)(2)

Key Benefits for Ventura County

Transitional Rent will significantly enhance the health and stability of individuals in our community by providing essential housing support. This initiative not only aims to improve health outcomes and reduce healthcare costs but also creates a sustainable pathway towards permanent housing solutions.

Improved Health Outcomes

Stable housing leads to better physical and behavioral health.

Individuals with secure housing are less likely to experience health disparities and can access preventive care more effectively.

Research shows that stable housing reduces the risk of chronic diseases and mental health issues among vulnerable populations.

Reduced Healthcare Costs

Decreases utilization of acute and emergency services.

By providing stable housing, we can lower the financial burden on the healthcare system, as fewer individuals will require emergency interventions.

Investing in housing support can lead to significant savings in healthcare expenditures over time, benefiting both individuals and the community.

Pathway to Stability

Bridges the gap to permanent housing solutions.

Transitional Rent serves as a crucial step for individuals, allowing them to transition from temporary support to long-term housing stability.

This program helps individuals build a foundation for a more stable life, reducing the likelihood of returning to homelessness.

Whole-Person Care

Integrates housing with other essential medical and social services.

This holistic approach ensures that individuals receive the comprehensive support they need to thrive, addressing both health and housing simultaneously.

Collaboration with healthcare providers ensures that all aspects of an individual's well-being are considered in their care plan.

Community Empowerment

Strengthens community ties and promotes collaboration among stakeholders.

By working together, we can ensure that individuals are not left behind and have access to the necessary resources for a successful transition.

Community involvement in the Transitional Rent initiative fosters a sense of ownership and responsibility towards vulnerable populations.

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Questions?

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Upcoming Events and Resources

Medi-Cal Voices and Vision Council Application

The Voices and Vision Council offers a dedicated space for Medi-Cal members, MCPs, providers, community-based organizations, and state partners that work with Medi-Cal members to provide direct input to the DHCS executive leadership team regarding Medi-Cal program policies, programs, and implementation.

Access the Application here:

DHCS Community Supports Cost Report

9 out of 12 Community Supports are already *demonstrating cost effectiveness within the study period.*

- Members who used at least one of the **Housing Trio Community Supports (which includes Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services)** had reduced inpatient (24.3%) and emergency department use (13.2%) in the six months that followed receipt of the service(s).

The recently published DHCS Community Annual Report highlights the cost-effectiveness of Community Supports and their impact on reducing ED visits, hospitalizations, and long-term care

DHCS Community Supports Report

Respite Services:
61.3% Cost Reduction

Personal Care and Homemaker Services:
58.4% Cost Reduction

Housing Deposits:
31.6% Cost Reduction

We are halfway through 2025!

2025 CalAIM PATH Tri-Counties Meeting Schedule All Wednesdays, 11:00am
July 16: FULL COLLABORATIVE
August 20: San Luis Obispo & Santa Barbara August 27: Ventura
September 17: Potential DHCS Speaker
October: *IN-PERSON MEETINGS* October 15: San Luis Obispo & Santa Barbara Meeting October 16: Ventura Meeting
November 19: FULL COLLABORATIVE
December 17: FULL COLLABORATIVE

See you in July!

Tri Counties CalAIM PATH Collaborative Meeting

July 16 | 11:00am - 12:30pm

Spotlight: Justice Involved Initiative

On Zoom

Register for the Collaborative:

BluePath HEALTH

Share your feedback!

Poll

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Thanks for joining!

Questions? pathinfo@bluepathhealth.com

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Appendix

Volume 1 Community Supports Revisions

- DHCS released updated Community Supports definitions for the following services in February 2025, with minimal changes released in April:
  - Assisted Living Facility (ALF) Transitions
  - Asthma Remediation
  - Community or Home Transition Services
  - Medically Tailored Meals/Medically Supportive Food
  - Personal Care and Homemaker Services (PCHS)
- These new definitions are effective **July 1, 2025**
- Added **HCPCS Codes** for all Community Supports definitions

Community Supports With No Significant Updates (Volume 1)

- The following services do not have major definition updates:
  - Environmental Accessibility Adaptations (Home Modifications)
  - Respite Services
  - Sobering Centers

Community Supports Revisions: Medically Tailored Meals Definitions

Medically Tailored Meals (MTM): Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

Medically Tailored Groceries (MTG): Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

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Community Supports Revisions: Medically Supportive Food

Medically Supportive Groceries: Preselected foods that follow the DGA* and meet recommendations for the recipients' nutrition-sensitive health conditions.

Produce Prescriptions: Fruits and vegetables, typically procured in retail settings, such as grocery stores or farmers' markets, obtained via a financial mechanism such as a physical or electronic voucher or card.

Healthy Food Vouchers: Vouchers used to procure pre-selected foods that follow the DGA* and meet recommendations for the recipients' nutrition-sensitive health conditions, via retail settings such as grocery stores or farmers' markets.

Food Pharmacy: Often housed in a health care setting, providing patients with coordinated clinical, food, and nutrition education services targeted at specific nutrition-sensitive health conditions. The healthy food "prescription" includes access to a selection of specific whole foods appropriate for the specific health condition(s) that follow the DGA* and meet recommendations for the targeted health condition(s).

*DGA = Dietary Guidelines for Americans

Community Supports Revisions: Eligibility Criteria

Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to):

Cancer(s) Cardiovascular disorders Chronic kidney disease Chronic lung disorders or other pulmonary conditions such as asthma/COPD Heart failure Diabetes or other metabolic conditions Elevated lead levels End-stage renal disease, High cholesterol Human immunodeficiency virus Hypertension	Liver disease Dyslipidemia Fatty liver Malnutrition Obesity Stroke Gastrointestinal disorders Gestational diabetes High risk perinatal conditions chronic or disabling mental/behavioral health disorders

Community Supports Revisions: Asthma Remediation

- Asthma Self-Management Education and In-Home Environmental Trigger Assessments are now covered under the Asthma Preventive Services (APS) Benefit (transition effective January 2026)
- Streamlines eligibility and documentation requirements
- Clarifies eligible supplies
- Confirms that supplies do not need to be delivered at a single point as long as service complies with $7500 lifetime maximum

Community Supports Revisions: Nursing Facility Transition

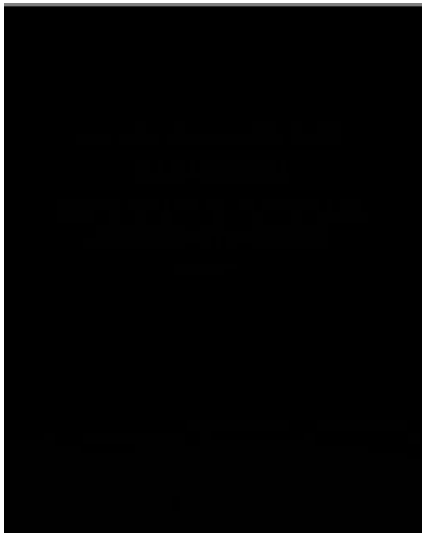
- Clarifies that members residing in private residences or public subsidized housing can be eligible for this support
- Clarifies that there are two distinct components of this Community Support:
  - Time-limited transition services and expenses
  - Ongoing assisted living services (not room and board, but support with Activities of Daily Living, meal prep, transportation, companion services, etc)

Community Supports Revisions: Community Transition Services

- Clarifies that members may receive Housing Transition Navigation, Housing Deposits, and/or Home Modifications at the same time as Community Transition Services
- Clarifies that there are two distinct components of this Community Support:
  - Transitional coordination services (securing housing, landlord communication, etc.)
  - One-time set-up expenses (security deposits, utility set-up fees, air conditioner or heater, etc.)

ECM Referral Standards and Form

DHCS developed new ECM Referral Standards and Form Template to streamline and standardize ECM Referrals made to Managed Care Plans (MCPs) from providers, community-based organizations, and other entities.



The new ECM Referral Standards define the information that MCPs are expected to collect for Medi-Cal members being referred to an MCP for ECM.

The new **ECM Referral Form Templates** are forms for use by MCPs and referring organizations that prefer a PDF or hard copy form to make a referral.

ECM Referral Standards and Form

The ECM Referral Standards and Form Templates define the following:

- Medi-Cal Member Information
- Referral Source Information
- Eligibility Criteria for Adults and Children/Youth
- Enrollment In Other Programs
- Referral Transmission Methods – including guidance encouraging batch referrals

***Note: The ECM Referral Standards will not change the existing processes for the MIF and RTF.**