Tri Counties CalAIM PATH Collaborative

August 27, 2025

BluePath HEALTH

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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
11:05-11:15	Local Spotlight: Clinicas del Camino Real
11:15-11:25	CalAIM Renewal Concept Paper
11:25-11:35	Looking Towards 2026
11:35-11:45	MCP Updates
11:45-12 pm	Announcements, DHCS Poll Questions & Closing
12:00-12:30	Office Hours

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 CalAIM Successes: Clinicas

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CalAIM Renewal Concept Paper

Background and Purpose

- In July 2025, DHCS released the “Continuing the Transformation of Medi-Cal” Concept Paper outlining its vision and goals for Medi-Cal beyond 2026
- The plan continues DHCS’ transformation efforts from CalAIM to make Medi-Cal **more coordinated, person-centered, and equitable**
- While the Medicaid waivers that created CalAIM expire at the end of 2026, California plans to apply for a renewal to enable CalAIM programs to continue

Key Goals for the Renewal Period (2027-2031)

Centering Members in the Delivery System

Ensure Medi-Cal policies and initiatives are member-centered, focusing on improving their access to care and health outcomes.

Improving Eligibility and Enrollment

Streamline and improve application and eligibility processes to ensure timely and accurate enrollment for all eligible members.

Comprehensive Purchasing Strategy

Develop a Medi-Cal purchasing strategy that incentivizes high-quality care, ensuring it's delivered at the right time and cost.

Key Goals for the Renewal Period (2027-2031)

Increasing Data Sharing

Improve data sharing and coordination among Medi-Cal plans, providers, and community partners to enhance care coordination and member outcomes.

Strengthening Accountability

Improve accountability across managed care, fee-for-service, and behavioral health services to enhance access and quality of care.

Preparing for the Future

Ensure the Medi-Cal system is prepared to meet the health needs of California's aging population and continue to evolve through 2030

CalAIM Waiver Renewal

- Federal waiver authority is **not** required to continue ECM or 12 Community Supports categorized as In Lieu of Services (ILOS).
  - Concept paper: *"No Section 1115 or 1915(b) authority is needed for California to operate ECM."*
  - Concept paper: *"Community Supports covered as ILOS are not dependent on DHCS' current CalAIM Section 1115 or 1915(b) waiver approvals."*
- DHCS proposes to continue and strengthen several services in the next waiver, including the Justice-Involved Reentry Initiative, Community-Based Adult Services, Traditional Healers, and more.

CalAIM 2027-2031 Waiver Renewal Plan

☑ Will be renewed under waiver authority:

- Section 1115: Recuperative Care, Short-Term Post-Hospitalization Housing, Contingency Management, Aligned Enrollment for Dually Eligible Members, Limiting Managed Care Plan Choice, IMD Waiver for SUD Services, Chiropractic from IHS/Tribal Facilities, Out-of-State Former Foster Care Youth, Global Payment Program, Asset Test Modification (Deemed SSI)
- Section 1915(b): Medi-Cal Managed Care (statewide), Dental Managed Care (Sacramento), Specialty Mental Health Services, DMC-ODS program.

⇆ Will transition to other CMS-approved authority (not renewed in waiver):

- Enhanced Care Management (ECM) – operates under managed care authority.
- 12 Community Supports (ILOS) – operate under managed care authority.

⃠ Will not be renewed in waiver:

- PATH Initiative, DSHP (to support PATH), Extended Postpartum Benefits for Low-Income Pregnant Women.

DHCS Waiver Renewal Estimated Timeline

July 2025
Release of Concept Paper

Oct./Nov. 2025
Post Draft 1115 Waiver Application

January 2026
Submit Application to Federal Government (CMS)

July 2026
Target Approval Date

January 2027
New Waiver Launch

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Looking Towards 2026

2026 Dates and Milestones

January 2026

- Technical Assistance Marketplace Closes for new applications
- Transitional Rent Go-Live Date
- DHCS CalAIM Renewal submission to federal government
- Medi-Medi Plans (D-SNP) Expansion Statewide

January 31, 2026: Data Exchange Framework (DxF) Milestone

- Voluntary Signatories to the DxF, including community-based organizations, county agencies, and social services organizations, begin exchanging data

December 31, 2026

- PATH Initiative sunsets

Behavioral Health Connect (BH-Connect) Overview

BH-CONNECT (Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment) is a five-year demonstration intended to expand access to community-based behavioral health care for Medi-Cal members and aims to reduce reliance on inpatient and institutional care.

Core Components and Initiatives

Evidence-Based Practices (EBPs)

- All counties must provide fidelity-based EBPs for children and youth under 21, including High Fidelity Wraparound (HFW), multisystemic therapy (MST), and more, consistent with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and medical necessity
- Counties may opt in to cover select EBPs for adults including Assertive Community Treatment (ACT) and more

Children and Youth Initiatives

Community Transition In-Reach Services*

Populations of Focus

- Children & youth in child welfare
- Individuals experiencing or at risk of homelessness
- Justice-involved individuals

**Counties may opt in to cover, though not required*

Behavioral Health Connect (BH-Connect) Implementation Timeline

Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Q1 2026			**Q2 2026**			**Q3 2026**			**Q4 2026**		

Q1 2026

- Counties submit a draft of their Integrated Plans to DHCS.
- Counties must cover Transitional Rent as a mandatory benefit for Behavioral Health Population of Focus. Coverage for other eligible populations remain optional.

Q2 2026

Counties submit final FY 2026-2029 draft of their Integrated Plans to DHCS.

Q3 2026

July 1, 2026 – County Integrated Plans for behavioral services under BH-CONNECT become effective statewide.

- Behavioral Health Services Act goes into effect.
- DHCS, in collaboration with stakeholders, will also publish biennial lists of approved evidence-based and community-defined practices.
- Required elements and timelines for County Behavioral Health Outcomes, Accountability, and Transparency Reports are established by DHCS.

Q4 2026

DHCS will launch the service to track the availability of inpatient and crisis stabilization beds statewide as part of enhanced transparency and system reform.

Go-Live Date

High Fidelity Wraparound (HFW) Concept Paper: Public Comment

Open for public comment through

5 pm P.T. on August 28, 2025.

Comments should be submitted to **BH-CONNECT@dhcs.ca.gov** with the subject line:

Comments on Proposed Medi-Cal HFW Service Requirements Aligned with National Practice Standards

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MCP Updates

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Tri-Counties PATH CPI
Ventura County

Gillian Stucki, Medi-Cal Local Engagement

August 2025

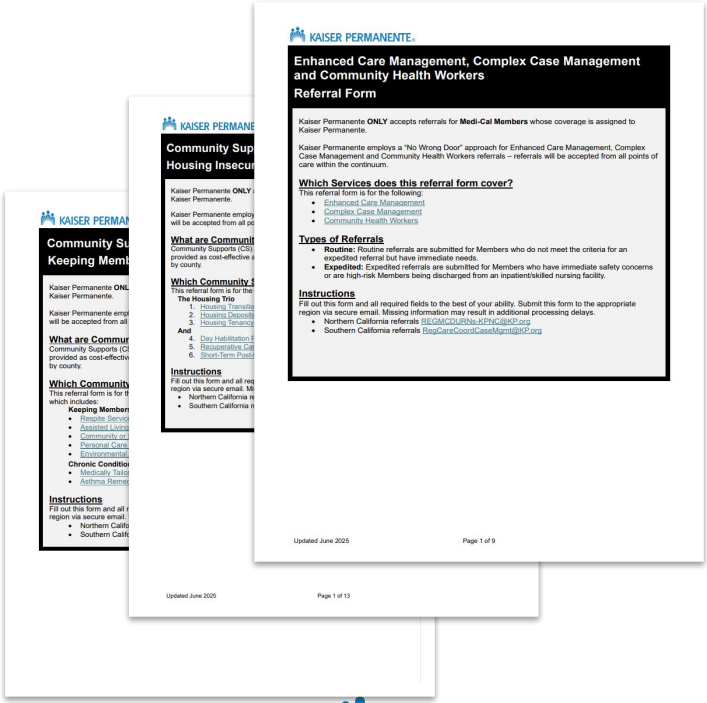
NEW Kaiser Permanente Referral Forms

Kaiser Permanente has released new CalAIM referral forms as of July 2025. New referral forms aim to improve successful linkages and enhance information collected, thereby reducing authorization delays.

1. Enhanced Care Management, Complex Care Management (CCM), and Community Health Workers Referral Form

2. Community Supports – Referral Form Housing Insecurities

3. Community Supports – Referral Form Keeping Members at the Home and Chronic Conditions



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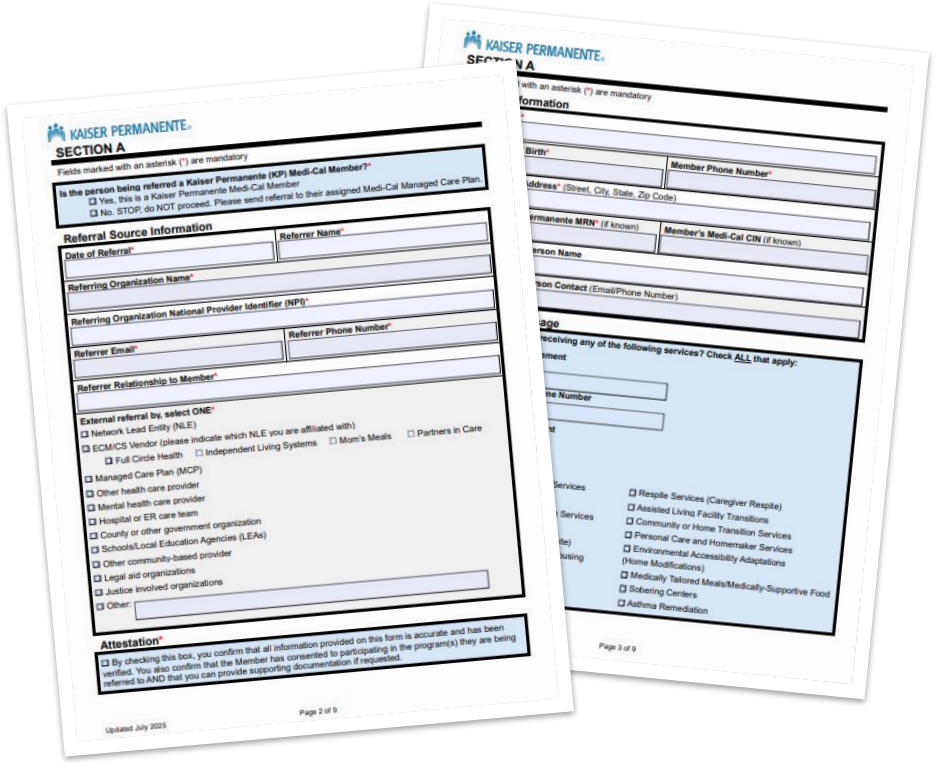
Enhanced Care Management (ECM), Complex Care Management (CCM), and Community Health Worker (CHW) Referral Form

Which services does this referral form cover?

This referral form is for the following:

- Enhanced Care Management (ECM)
- Complex Case Management (CCM)
- Community Health Workers (CHW)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SECTION A

Fields marked with an asterisk (*) are mandatory

Is the person being referred a Kaiser Permanente (KP) Medi-Cal Member?*
☐ Yes, this is a Kaiser Permanente Medi-Cal Member
☐ No, STOP, do NOT proceed. Please send referral to their assigned Medi-Cal Managed Care Plan

Referral Source Information

Date of Referral* | Referrer Name*

Referring Organization Name*

Referring Organization National Provider Identifier (NPI)*

Referrer Email* | Referrer Phone Number*

Referrer Relationship to Member*

External referral by, select ONE*
☐ Network Lead Entity (NLE)
☐ ECM/CS Vendor (please indicate which NLE you are affiliated with)
☐ Full Circle Health ☐ Independent Living Systems ☐ Mom's Meals ☐ Partners in Care
☐ Managed Care Plan (MCP)
☐ Other health care provider
☐ Mental health care provider
☐ Hospital or ER care team
☐ County or other government organization
☐ Schools/Local Education Agencies (LEAs)
☐ Other community-based provider
☐ Legal aid organizations
☐ Justice involved organizations
☐ Other:

Attestation*
☐ By checking this box, you confirm that all information provided on this form is accurate and has been verified. You also confirm that the Member has consented to participating in the program(s) they are being referred to AND that you can provide supporting documentation if requested.

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SECTION A

with an asterisk (*) are mandatory

formation

Birth* | Member Phone Number*

ddress* (Street, City, State, Zip Code)

rmanente MRN* (if known) | Member's Medi-Cal CIN (if known)

rson Name

son Contact (Email/Phone Number)

age

receiving any of the following services? Check ALL that apply:

ment

ne Number

t

Services

Services

ile)

using

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

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Community Supports Referral Form: Housing Insecurities

Which Community Supports does this referral form cover?

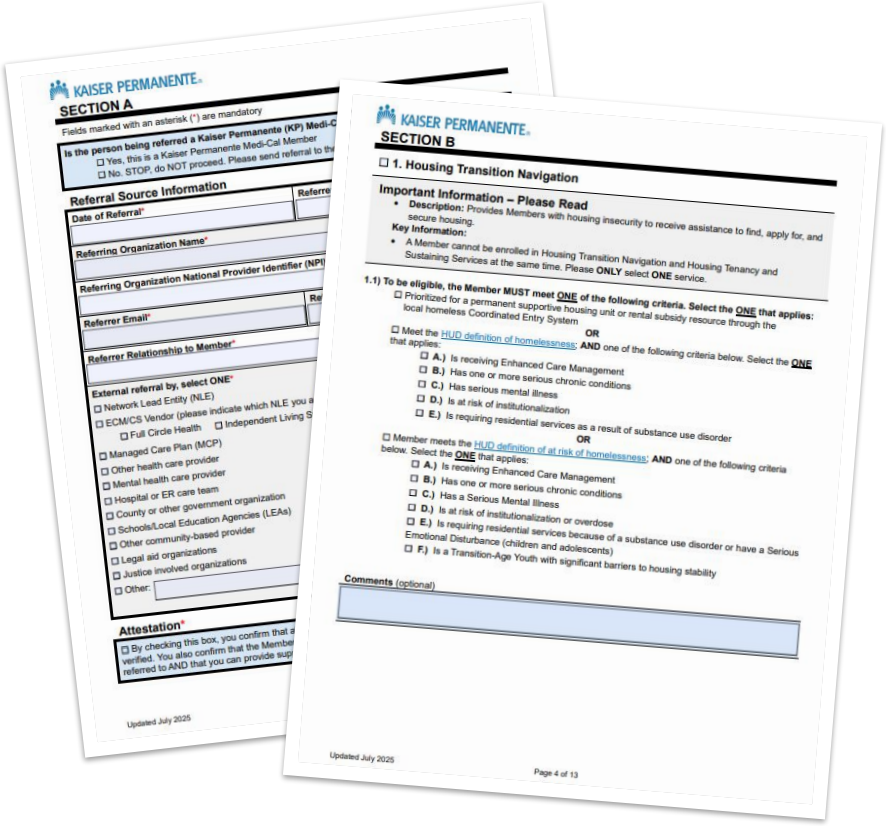
This referral form is for the CS services aimed to support Housing Insecurity, which includes:

The Housing Trio

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services

And

4. Day Habilitation Programs
5. Recuperative Care (Medical Respite)
6. Short-Term Post-Hospitalization Housing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Date of Referral*

Referring Organization Name*

Referring Organization National Provider Identifier (NPI)

Referrer Email*

Referrer Relationship to Member*

External referral by, select ONE*
☐ Network Lead Entity (NLE)
☐ ECM/CS Vendor (please indicate which NLE you a
☐ Full Circle Health ☐ Independent Living S
☐ Managed Care Plan (MCP)
☐ Other health care provider
☐ Mental health care provider
☐ Hospital or ER care team
☐ County or other government organization
☐ Schools/Local Education Agencies (LEAs)
☐ Other community-based provider
☐ Legal aid organizations
☐ Justice involved organizations
☐ Other:

Attestation*
☐ By checking this box, you confirm that a
verified. You also confirm that the Member
referred to AND that you can provide supp

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SECTION B

☐ 1. Housing Transition Navigation

Important Information – Please Read
- **Description:** Provides Members with housing insecurity to receive assistance to find, apply for, and secure housing.

Key Information:
- A Member cannot be enrolled in Housing Transition Navigation and Housing Tenancy and Sustaining Services at the same time. Please **ONLY** select **ONE** service.

1.1) To be eligible, the Member MUST meet ONE of the following criteria. Select the ONE that applies:
☐ Prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System

OR

☐ Meet the HUD definition of homelessness; **AND** one of the following criteria below. Select the **ONE** that applies:
- ☐ **A.)** Is receiving Enhanced Care Management
- ☐ **B.)** Has one or more serious chronic conditions
- ☐ **C.)** Has serious mental illness
- ☐ **D.)** Is at risk of institutionalization
- ☐ **E.)** Is requiring residential services as a result of substance use disorder

OR

☐ Member meets the HUD definition of at risk of homelessness; **AND** one of the following criteria below. Select the **ONE** that applies:
- ☐ **A.)** Is receiving Enhanced Care Management
- ☐ **B.)** Has one or more serious chronic conditions
- ☐ **C.)** Has a Serious Mental Illness
- ☐ **D.)** Is at risk of institutionalization or overdose
- ☐ **E.)** Is requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents)
- ☐ **F.)** Is a Transition-Age Youth with significant barriers to housing stability

Comments (optional)

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Community Supports Referral Form: Keeping Members at the Home and Chronic Conditions

Which Community Supports does this referral form cover?

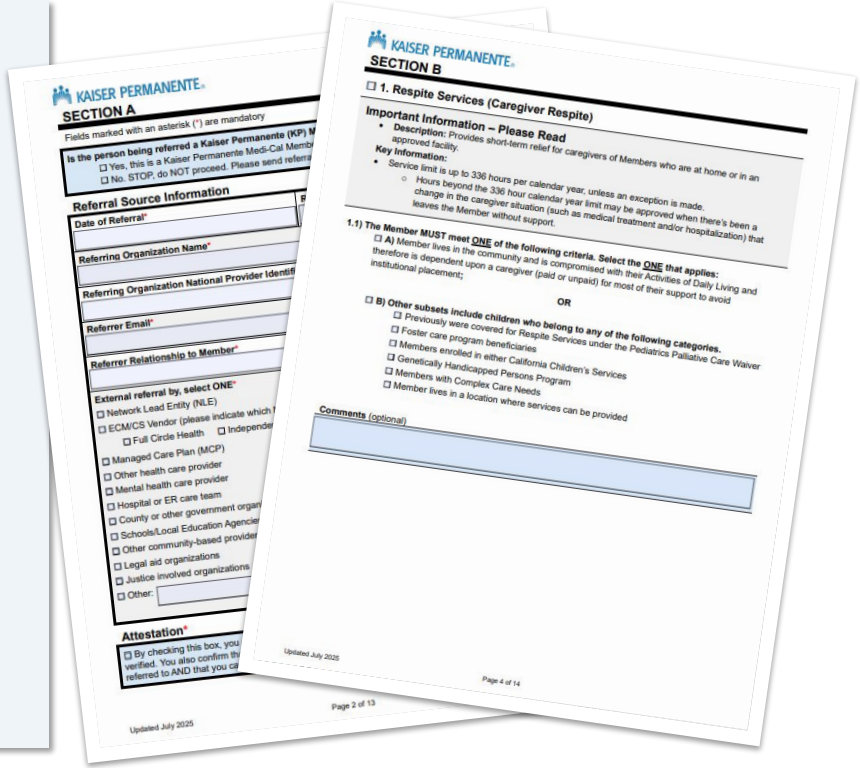
This referral form is for the CS services aimed to Keep the Member and Home and for Chronic Conditions, which includes:

Keeping Members at Home

1. Respite Services (Caregiver Respite)
2. Assisted Living Facility Transitions
3. Community or Home Transition Services
4. Personal Care and Homemaker Services
5. Environmental Accessibility Adaptations (Home Modifications)

Chronic Conditions

6. Medically Tailored Meals/Medically-Supportive Food
7. Asthma Remediation



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Submitting Referrals | ECM, CS, and CHW

Kaiser Permanente (KP) has a no-wrong-door approach to referrals.

- Referrals are accepted from any source (members, providers, family, community organizations, etc.)
- Referrals may be placed via email, via phone, or through KP Health Connect.

AREA	NORTHERN CALIFORNIA COUNTIES	SOUTHERN CALIFORNIA COUNTIES
PHONE (Member)	1-833-721-6012 (TTY 711) Monday-Friday (closed major holidays) 8:30 a.m. to 5:00 p.m.	1-866-551-9619 (TTY 711) Monday-Friday (closed major holidays) 8:30 a.m. to 5:00 p.m.
EMAIL (Counties/CBOs)	Send completed referral form to REGMCDURNs-KPNC@kp.org Subject line: “ECM Referral” or “CS Referral” or “CHW services request”	Send completed referral form to RegCareCoordCaseMgmt@kp.org Subject line: “ECM Referral” or “CS Referral” or “CHW services request”

NEW: For KP contracted providers/organizations submitting referrals to your own ECM/CS/CHW organization, please send the referral form directly to your contracted Network Lead Entity.

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Collaborative Updates, Announcements, and Resources

BHSA - Opportunity to Get Involved

Courtney Lubell, Ventura County Behavioral Health

Ventura County Behavioral Health is hosting Behavioral Health Services Act (BHSA) **Community Program Planning (CPP) meetings** to share final-year updates of the Mental Health Services Act (MHSA) and to gather public feedback on upcoming Proposition 1 changes to behavioral health.

The Community Planning meetings will include two virtual CPP meetings and three in-person meetings. Locations, dates, and times can be accessed here: **www.WellnessEveryDay.org/bhsa**.

Sharing Best Practices: Interface Children & Family Services

Interface Children & Family Services and BluePath Health

CalAIM TA Success Story

August 21, 2025

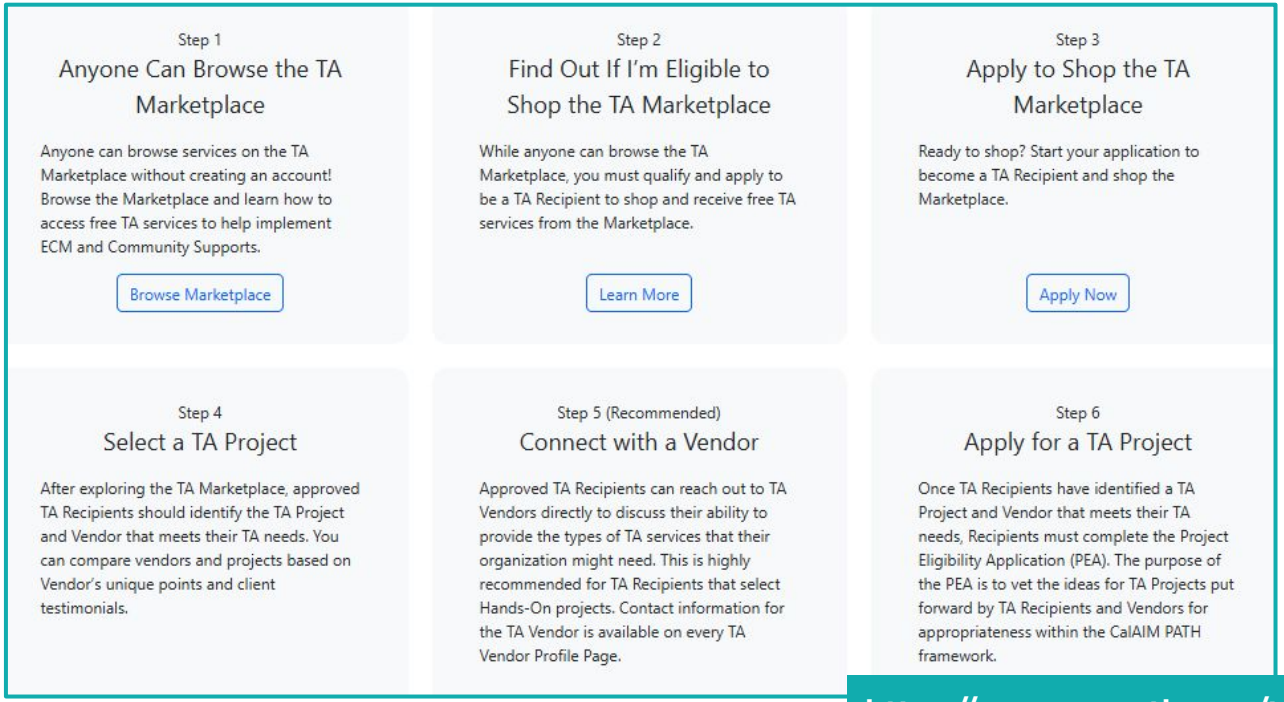
Session Recording to be provided in newsletter

Kelly Brown

Community Information Officer

Interface Children & Family Services

Reminder: TA Marketplace Applications due December ‘25



https://www.ca-path.com/technical-assistance

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Please Share Your Input

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DHCS requests your feedback

This statewide PATH Collaborative survey measures:

- The impact of participation in the collaborative
- The value of partnerships across organizations
- The sustainability of our progress

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:

Looking Ahead

Sept. 17 11am-12:30pm **on Zoom**	**All Tri Counties Collaborative Meeting**
Oct. 16 12-1:30pm **in person**	**Ventura Collaborative Meeting** ***Ventura County Community Foundation Building, Camarillo***
Nov. 19 11am-12:30pm **on Zoom**	**All Tri Counties Collaborative Meeting**
Dec. 17 11am-12:30pm **on Zoom**	**All Tri Counties Collaborative Meeting**

Save the Date!

In-Person Meeting **at the Ventura County Community Foundation Building** on **Thursday, October 16**

More details to follow!

See you in September!

Tri Counties CalAIM PATH Collaborative Meeting

September 17 | 11:00am - 12:30pm

On Zoom

Register for the Collaborative:

BluePath HEALTH

Thanks for joining!

Questions? pathinfo@bluepathhealth.com

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Office Hours

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Questions?

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Appendix

Closed-Loop Referral (CLR) Overview

Definition

Closed-Loop Referral (CLR): A referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a *known closure*. A **known closure** occurs when a Member's initial referral loop is completed with a known outcome.

Background

- CLR requirements effective on July 1, 2025 solely apply for two services:
  - ❑ Enhanced Care Management – all Population of Focus (PoF)
  - ❑ Community Supports – all services upon go-live, except Sobering Centers
- The goal is to increase the share of Medi-Cal Members successfully connected to the services they need by identifying and addressing gaps in referral practices and service availability.
- DHCS intends to expand similar CLR requirements to other applicable services (i.e. CHW) over time. An official timeline has not been shared other than for BH services beginning in some time in 2026.

Requirement Components

Tracking Referral: Track a minimum set of data elements for each referral

Supporting Referral & Closure: Provide assistance with referral and processing, notifying members and referring entities and work with providers to troubleshoot challenges

Monitoring Referrals: Monitor data to resolve challenges across referral partners, internal operations, and providers

*DHCS has shared that they are giving Plans a 1-year grace period to implement systems and processes for CLR for ECM/CS after the CLR policy is effective on July 1, 2025.

Sources: CLR Implementation Guidance May 2025, Closed-Loop-Referral-FAQs May 2025

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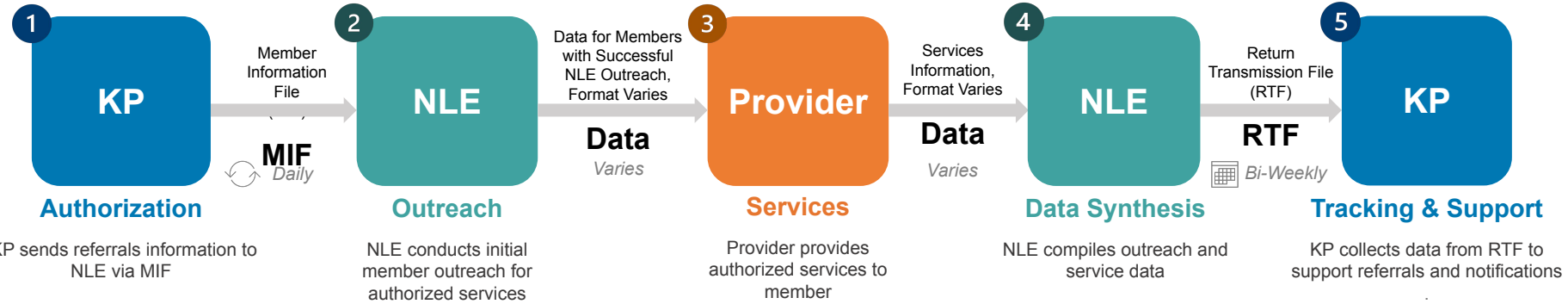
ECM & CS Provider Reporting Changes Due to CLR Guidance

- Data elements will be updated on the MIF and RTF to meet Closed Loop Referral (CLR) data requirements, *including but not limited to*:
  - Contact Information for Referring Organization / Person
  - Referral Status: Pending, Accepted, Declined, Outreach Initiated, Referral Loop Closed
  - Reason for Referral Loop Closure: Services Received, Service Provider Declined, Unable to Reach Member, Member No Longer Eligible for Services, Member No Longer Needs Services or Declines, Other, Authorization Denied *(determined only by KP)*
- For more information on how **CLR** and **MIF/RTF** updates may impact your organization, please contact your contracted **Network Lead Entity** (Full Circle Health Network, Independent Living Systems, Partners in Care).

Referral Information Workflow



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Last updated: July 2025

Additional NLE Provider Support | NLE Contact Information, SCAL

Kaiser Permanente is working with Network Lead Entities (NLEs) to develop a network of community-based ECM, CS, and CHW providers.

INDEPENDENT Living Systems

Contracted Providers
Second/Fourth Thursdays
1:00 – 2:00 pm
Join Meeting Now

Prospective Providers
First Thursdays of the Month
1:00 - 2:00 pm
Join Meeting Now

Questions?
ILSCAProviderRelations@ilshealth.com
Phone number: 844-269-3447

Full Circle Health Network

Contracted Providers
Tuesdays
3:00 - 4:00 pm
Register and Join Here

Prospective Providers
Second/Fourth Thursdays of the Month
12:00 - 1:00 pm
Register and Join Here

Questions?
network@fullcirclehn.org
Phone number: 888-749-8877

Partners in Care FOUNDATION *

Questions?
Email: Hubinfo@picf.org
Phone: 818-837-3775

* Partners In Care only serves the Southern California region

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Kaiser Permanente Appendix Items

Included in this meeting's appendix will be….

CalAIM (ECM/CS/CHW) Referral Information

Network Lead Entity Office Hours Information

- Current Providers
- Prospective Providers

Contact Information for Independent Living Systems (ILS), one of Kaiser Permanente's Network Lead Entities

Streamlined Authorization Recommendations for Enhanced Care Management

Have additional questions?

Contact your county's Medi-Cal Engagement Representative!

Gillian Stucki (she/her)

Ventura County

Gillian.H.Stucki@kp.org

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NLE: Independent Living System (ILS)| Contact Information

General Questions?
ILSCAProviderRelations@ilshealth.com
844-269-3447

Northern CA
Lorena Ahumada
Lahumada@ilshealth.com
510-960-0980
Counties: Alameda, Amador, Contra Costa, Marin, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Yolo, Yuba

Central CA
Kenya Buford-Shelley
Kshelley@ilshealth.com
559-894-0585
Counties: El Dorado, Fresno, Kern, Kings, Madera, Mariposa, Monterey, Tulare

Southern CA
Patty Martinez-Luna
Nmartinezluna@ilshealth.com
442- 414-2285
Counties: Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Ventura

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Streamlined Authorization for Enhanced Care Management (ECM)

Below summarizes Kaiser Permanente's streamlined ECM authorization process.

Details

- Streamlined Authorization is ***only*** for ECM providers who are currently contracted with Network Lead Entities (NLEs).
- Streamlined Authorization applies ***only*** to ECM, not CS or CHW.
- Providers can begin working with members right away, but they must submit an ECM referral through their NLE no later than 5 working days before the end of the streamlined authorization period.
- Total Streamlined Authorization period is 30 days or up to the date KP makes and communicates the authorization, whichever comes first.
- Providers will be paid for the 30-day ECM authorization period.
- Streamlined Authorizations route back to the original provider and ECM Lead Care Manager through the NLE.

Do's & Don'ts

- **DO** submit an ECM referral through contracted NLEs.
- **DO** indicate "Streamlined Authorization" on the referral form
- **DO** add the first date of start of services to completed referral.
- **DO** submit an ECM referral no later than 5 business days before the Streamlined Authorization period ends.
- **DON'T** submit a Streamlined Authorization for CS or CHW; the Streamlined Authorization is for ECM only.

How To Submit

- Email the ECM referral directly to the contracted NLE.
  - Full Circle Health Network: referral@fullcirclehn.org
  - Independent Living Systems: kpreferrals@ilshealth.com
  - Partners in Care Foundation: ECM@picf.org
- Send any questions directly to the contracted NLE.
- To resolve issues, email the NLE and cc: medi-cal-externalengagement@kp.org

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Submitting Referrals | ECM, CS, and CHW

Kaiser Permanente (KP) has a no-wrong-door approach to referrals.

- Referrals are accepted from any source (members, providers, family, community organizations, etc.)
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NEW: For KP contracted providers/organizations submitting referrals to your own ECM/CS/CHW organization, please send the referral form directly to your contracted Network Lead Entity.

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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)

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.

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

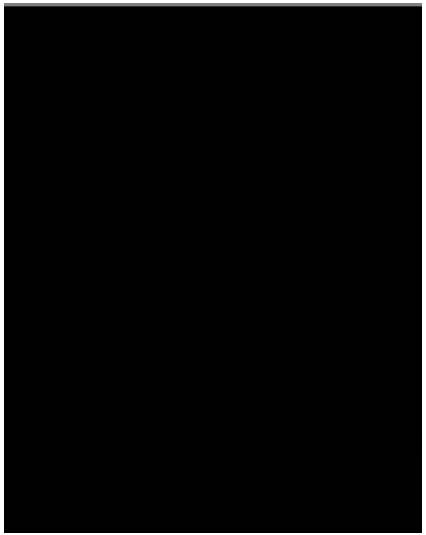
- Clarifies that members residing in private residences or public subsidized housing can be eligible for this support
- Clarifies that there are two distinct components of this Community Support:
  - Time-limited transition services and expenses
  - Ongoing assisted living services (not room and board, 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.**