Santa Barbara + San Luis Obispo CalAIM PATH Collaborative

October 15, 2025

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Today's Agenda

Time	Agenda Item	Presenter
10:00 am	Welcome and Introductions	BluePath Health
10:10-10:25 am	Celebrating Progress: Local CalAIM Success Stories	Pathway Family Services, Community Action Partnership of San Luis Obispo and New Beginnings
10:25-10:45 am	Closed Loop Referrals (CLRs) Updates	CenCal Health Plan
10:45-11:30 am	Group Activity & Networking	

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Housekeeping & Announcements

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WiFi Network: Santa Maria Inn
Passcode: 1917

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Community Agreements

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Community Agreements

Acknowledge different perspectives and expertise.

Assume positive intent, acknowledge impact, and clarify to avoid assumptions.

We all have a role in the solution.

Adapted from Decolonizing Design Community of Practice // Guiding Principles & Community Agreements

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: New Beginnings

NEW BEGINNINGS COUNSELING CENTER

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Local CalAIM Successes: Pathway Family Services

PATHWAY FAMILY SERVICES

PATHWAY FAMILY SERVICES

FOSTER CARE

EMERGENCY SHELTER HOMES/ISFC PROGRAM

ADOPTION

ENHANCED FAMILY SERVICES (CAL AIM)

PATHWAY
FAMILY SERVICES

SUCCESS STORY

Nick, age 17, was assigned to ECM services after brain surgery for seizure control. Diagnosed with Autism and Lennox-Gastaut Syndrome, he experienced frequent seizures, aggression, and loss of mobility, requiring full assistance from his mother.

LCM secured respite and homemaker services, obtained DME to improve mobility, and coordinated referrals for physical therapy—leading to Nick regaining strength and walking independently.

LCM also connected the family with ALPHA Resources to help support mother in collaborated with Tri-Counties Regional Center to ensure continued special education service through extended learning Program.

Today, Nick has made remarkable progress in mobility and independence, and his caregiver has essential support in place. Transition planning is underway to connect him with independent living resources as he enters adulthood.

SUCCESS STORY

Carlos and Juan (4 yr & 2 yr old brothers) live with their single mom. Both are receiving ECM services. Both siblings have been diagnosed with autism and are nonverbal. At the time of referral, the family was living in a shared home with multiple families. The mother reported concerns regarding domestic violence occurring within the household.

The LCM assisted by referring the family to HTNS and supporting the caregiver in completing her housing application through the Housing Authority in San Luis Obispo. The LCM also helped the caregiver gather all necessary documentation for an open apartment in San Luis Obispo and secure deposit assistance. As a result, the caregiver and both children successfully obtained stable housing through HASLO.

Following the move, the LCM assisted the caregiver with enrolling both children in school and initiating the IEP process for each child. Referrals were also placed to Tri-Counties Regional Center to ensure both members received ongoing services for autism, speech therapy, and developmental support.

Through coordinated efforts and comprehensive support, the family successfully transitioned into stable housing and connected to vital educational and developmental services — a significant milestone toward long-term stability and improved well-being.

PATHWAY
FAMILY SERVICES

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Local CalAIM Successes: Community Action Partnership of San Luis Obispo

CAPSLO
Celebrating 60 Years
Community Action Partnership of San Luis Obispo County, Inc.

CAPSLO: Client Story of Success

- In June 2022, CAPSLO first met "John," who was living outside in downtown San Luis Obispo. After several attempts at engagement, staff recognized that he was living with dementia and needed multidisciplinary support.
- John received Street Outreach Services through CAPSLO in partnership with 5CHC, Public Health, the City of SLO's MCU and CAT teams, THMA, and APS.
- In 2023, while staying at the shelter, John was connected to CalFresh, CenCal, IHSS, HTNS, and ECM services.
- With support from his ECM case manager, John met with a primary care physician and specialists to address his complex health needs.
- His Housing Navigator helped him apply for the Housing and Disability Advocacy Program (HDAP) through THMA, leading to approval for Social Security benefits in early 2024.
- When traditional housing options could not meet his needs, John's Housing Navigator collaborated with APS and used his Medicaid benefits to secure placement in an Assisted Living Facility specializing in dementia care.

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CenCal Health Plan: Closed-Loop Referrals

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CenCal Health | CalAIM & Closed-Loop Referrals

Ariel Land, Community Supports Program Manager
Heather Te, Enhanced Care Management Manger and Justice Involved Liaison

Agenda

- CalAIM Overview
- Closed Loop Referrals
- CCH Plan Updates
- Looking Ahead

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What is CalAIM?

1

Launched January 1, 2022 to transform Medi-Cal through delivery, payment, and data reforms.

2

Core programs: **Enhanced Care Management (ECM)** and **Community Supports (CS)**.

3

Focus: Address *social drivers of health* through services such as housing, food, and in-home supports.

4

Goal: Improve quality of life and reduce avoidable hospitalizations and ED visits.

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Community Supports and Enhanced Care Management

Community Supports

Cost-effective alternatives to traditional Medi-Cal services.

Optional for plans (*except Transitional Rent, required 1/1/26*).

15 approved services such as housing, meals, respite, and in-home care.

Builds on the Whole Person Care and Health Homes programs.

Goals: Address social needs that impact health, reduce hospitalizations, and improve overall well-being.

Who qualifies: Members who could benefit from supports like housing assistance, meal delivery, or help managing daily living needs.

Enhanced Care Management

Provides **intensive, whole-person care coordination** for high-need members.

Each member works with a **lead care manager** who coordinates:
- Medical and behavioral health care
- Social services and community resources.

Goals: Improve health, reduce hospital visits, and connect members to needed supports.

Who qualifies: Members with complex medical or social needs such as homelessness or serious mental illness. There are 9 Populations of Focus.

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How ECM and Community Supports Work Together

- **ECM** identifies members with high medical utilization or social needs and creates an individualized care plan.
- When social or housing barriers are identified, **Community Supports (CS)** provide the service solution (e.g., housing navigation, meals, respite).
- **Two-way collaboration:** CS providers can also identify unmet needs and submit referrals back to ECM for care management, or to other CS programs when members could benefit from multiple supports.
- This coordination ensures members receive **both care management and direct social supports**, reducing fragmentation and improving outcomes.

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Closed Loop Referrals (CLR):Connecting Care Across CalAIM

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What Are Closed-Loop Referrals (CLR)?

- A **Closed-Loop Referral** tracks every step of a member's referral — from creation to completion — with a *known outcome*.
- Goal: Ensure members are connected to services and no referral "falls through the cracks."
- Required for **Enhanced Care Management (ECM)** and **Community Supports (CS)** starting **July 1, 2025.**

Track	Support	Monitor
Track referrals and data elements	Support the member and referring entity	Monitor outcomes for closure.

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Why CLR Matters

BUILDS ACCOUNTABILITY BETWEEN MCPS, PROVIDERS, AND COMMUNITY ORGANIZATIONS.

REDUCES DELAYS, LOST REFERRALS, AND DUPLICATED WORK.

IMPROVES CARE COORDINATION AND SUPPORTS DHCS' POPULATION HEALTH MANAGEMENT (PHM) GOALS.

ENABLES DATA-DRIVEN INSIGHTS TO IDENTIFY SERVICE GAPS AND STRENGTHEN PROVIDER NETWORKS.

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The CLR Process at CenCal Health- ECM

Referral Intake

- Confirm completeness within **2 business days**.
- Save and log referral in CenCal Health Electronic Health Record.
- Send **email confirmation** to referring entity.

Referral Assignment

- Match to appropriate ECM provider based on capacity and ability to accept external referrals.
- Provide ECM Referral to ECM Provider.
- Notify referring entity once we assign the ECM Provider.

Ongoing Monitoring

- Monthly follow-ups until authorization or closure.
- Document every status update or provider inquiry to ensure compliance with DHCS timelines.

Closure

- Update EHR and notify referring entity via secure email when referral is:
  - **Approved** (service received)
  - **Closed** (rescinded, no needs, ineligible, or unable to contact)

The CLR Process at CenCal Health- CS

Referral Intake

- Confirm completeness within **2 business days**.
- Save and log referral in CenCal Health Electronic Health Record.
- Send **email confirmation** to referring entity.

Referral Assignment

- Match to appropriate CS provider based on capacity and ability to accept external referrals.
- Change status to Approved
- Notify referring entity once we assign the CS Provider.

Ongoing Monitoring

- Monthly follow-ups until authorization or closure.
- Document every status update.

Closure

- Update EHR and notify referring entity via secure email when referral is:
  - **Approved** (service received)
  - **Closed** (rescinded, no needs, ineligible, or unable to contact)

Notification Timeframes

Notification Type	When to Notify	Who to Notify	Method
Referral Received	Within 2 business days	Referring Entity	Secure Email/ Fax
Incomplete Referral	Within 5 business days	Referring Entity	Email & phone follow-up
Referral Follow-Up	Within 1 business day	Referring Entity	Secure Email
Referral Closed (Approved/Ineligible/No Contact)	Within 1 business day	Referring Entity	Secure Email
PRFT Report	Within 7 business days	Referring Entity	Secure Email

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If You Are a Referring Entity

PCPs, CBOs, Hospitals, County Partners

Submit complete referrals using the CenCal Health form.

Include all required details: member info, program, and contact.

Watch for updates — confirmation and closure emails will be sent securely.

Respond quickly to any requests for missing information.

Follow up if you don't receive an update within expected timeframes.

Share any member changes (like relocation or withdrawal).

Goal: Support a seamless handoff to the provider and ensure the member connects to care quickly and effectively.

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If You Are a CS Provider Receiving a Referral

Your Role in the Closed-Loop Referral Process

- **Acknowledge receipt** of the referral within **2 business days**.
- **Confirm capacity** and member eligibility; notify CenCal Health if unable to accept.
- **Outreach to the member** promptly to begin engagement and document all contact attempts.
- **Update referral status within 14 days** in your communications (e.g., outreach started, scheduled, unable to reach).
  - **Submit monthly progress updates** until the referral is resolved or closed.
  - Respond to CenCal Health within 1 business day of status inquiry of referral.
- **Report closure outcomes** (e.g., member declined, unable to contact) within 1 business day of determination.
- If submitting an **authorization**, no additional communication is required that submission serves as your referral update.

Goal: Provide timely feedback so CenCal Health can complete the loop and report accurate data to DHCS.

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If You Are a ECM Provider Receiving a Referral

Your Role in the Closed-Loop Referral Process

- **Acknowledge receipt** of the referral within **2 business days**.
- **Confirm capacity** and member eligibility; notify CenCal Health if unable to accept.
- **Respond to CenCal Health** within 1 business day of status inquiry of referral.
- **Outreach to the member** promptly to begin engagement and document all contact attempts.
- **Update the referral status** on the Provider Return Transmission File due the 20th of each month (e.g., outreach pending, initiated, unable to reach).
  - **Submit monthly progress updates** until the referral is resolved or closed.
- If submitting an **authorization**, provide closure reason status on the Provider Return Transmission File.

Goal: Provide timely feedback so CenCal Health can complete the loop and report accurate data to DHCS.

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CenCal Health Plan Updates

- **Housing Services Policy Update:**
  DHCS housing policy changes take effect January 1, 2026, with the launch of **Transitional Rent (TR)** to align housing supports and service standards.
- **Closed-Loop Referrals (CLR):**
  Launched in 2025 to improve tracking of CalAIM referrals, including those not authorized, through the **Provider Referral Tracking File (PRTF)**.
- **Provider Collaboration:**
  Ongoing training and workflow alignment to support readiness for TR and **CLR** implementation.
- **Program Updates:**
  - **Assisted Living Facility (ALF) Transitions** ending **December 31, 2025**.
  - **Housing Deposit** rental assistance ending **October 31, 2025**.

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Looking Ahead –Transitional Rent (TR)Launching January 1, 2026

What is Transitional Rent (TR)?

- A **temporary rental assistance** Community Support to help members bridge from homelessness or temporary housing into permanent housing.
- Covers **up to six months of rent per household** within a five-year period.
- Part of the statewide **Room and Board services cap** that also includes Recuperative Care and Short-Term Post-Hospitalization Housing (max 6 months combined per 12 months).

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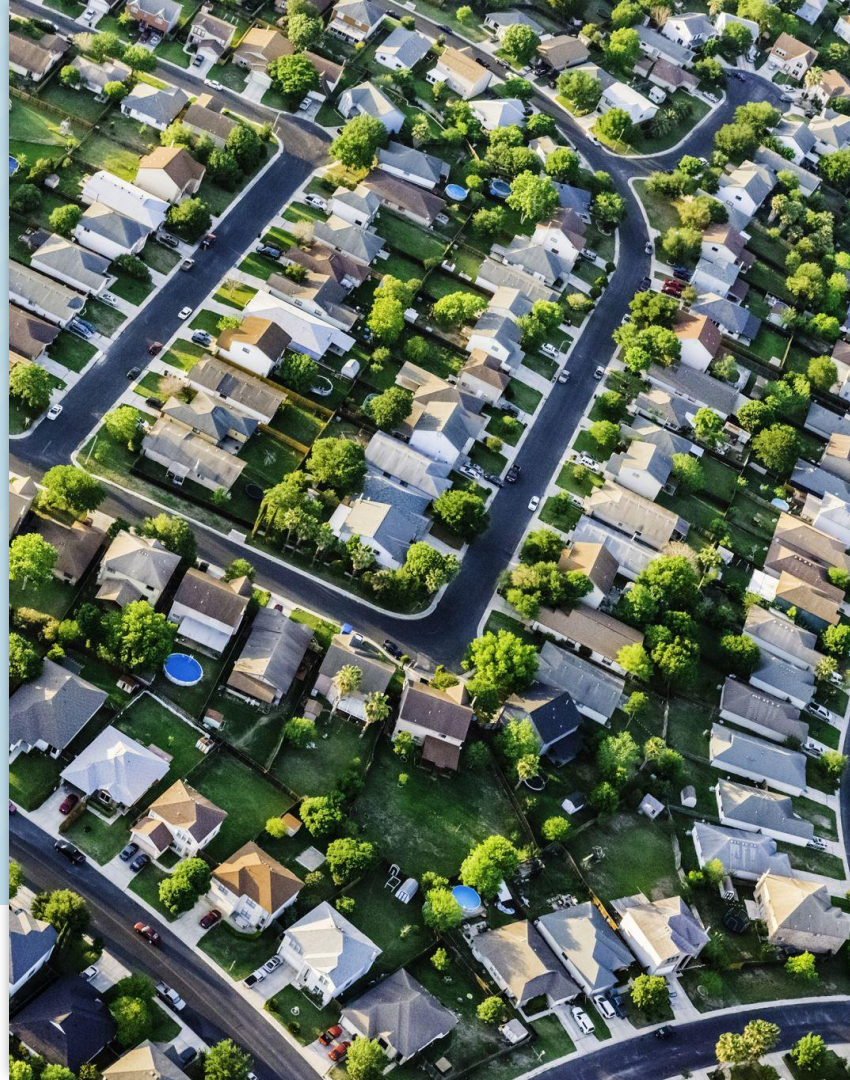

Who Will Be Eligible (Mandatory Population of Focus)

- Must have a **housing support plan** identifying a pathway to long-term housing stability (e.g., transition to BHSA Housing Interventions, permanent supportive housing, or other sustainable subsidy).
- Transitional Rent is intended to **bridge the gap** from homelessness or temporary housing to permanent housing.

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Key Takeaways

- **Work Together:** Every referral is a chance to change a life.
- **Stay Ready:** Transitional Rent and justice involved are coming — be part of the movement.
- **Stay Connected:** Communication keeps members from falling through the cracks.
- **Lead the Way:** Your partnership brings CalAIM to life in our communities.

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Closed Loop Referrals Q&A

- What are best practices for CalAIM providers completing the RTF file?
- Where do you see the greatest opportunities for providers to work together to address referral tracking and communication challenges?
- How can CalAIM providers and MCPs partner more effectively on closed loop referrals?

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Provider Networking

Provider Networking Table Topics

- Supporting Immigrant Communities
- Behavioral Health
- Justice-Involved Initiative
- Housing Resources
- Program Administration
- Motivational Interviewing

What is your biggest challenge or concern in [topic area] — and how might our Collaborative help address it or elevate solutions?

Looking Ahead

Wed. Nov. 19 11am-12:30pm **on Zoom**	**All Tri Counties Collaborative Meeting**
Wed. Dec. 17 11am-12:30pm **on Zoom**	**All Tri Counties Collaborative Meeting**

Register for the Collaborative:

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Thanks for joining!

Questions? pathinfo@bluepathhealth.com

Appendix

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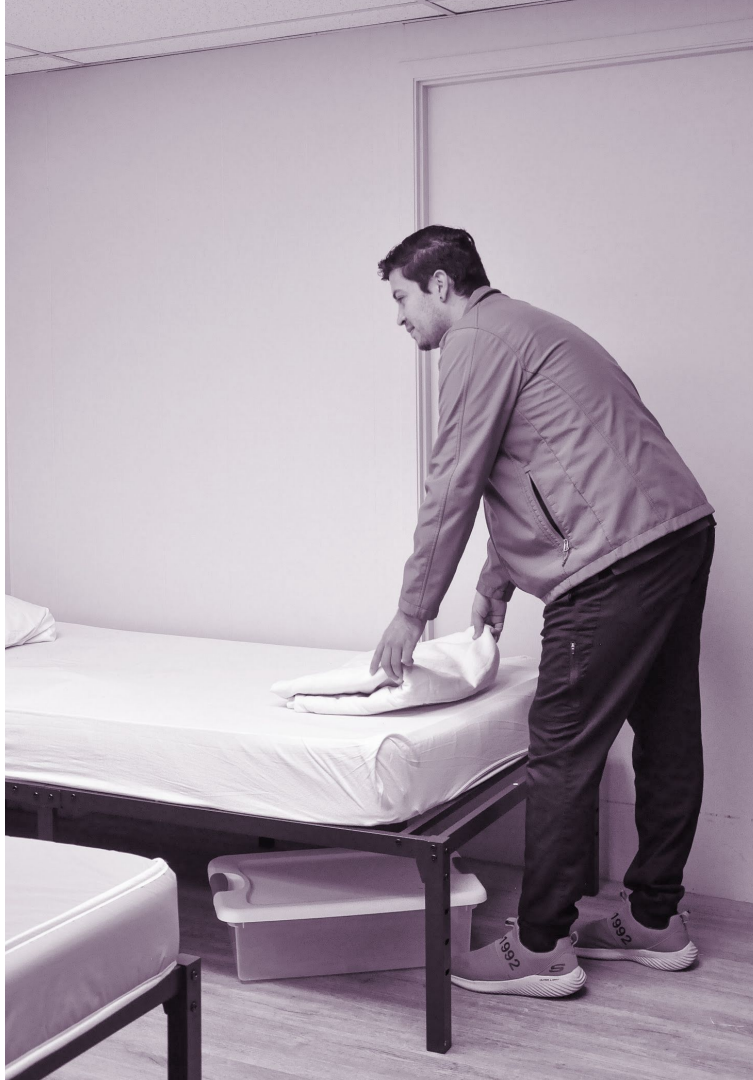
Local CalAIM Successes: Good Samaritan Shelter

GSS CalAIM Services

PATH Meeting – August 20, 2025

CalAIM at GSS: Overview

- ECM services launched 7/1/2023
- SM Sobering Center launched 10/1/2023
- HTNS/HD/HTSS launched 10/1/2023
- STPH launched 1/1/2024
- Day Hab launched 7/1/2024
- SB/SLO Sobering Centers launched 8/1/2024
- Recuperative Care launched 7/1/2022 in SM, 8/1/24 in Lompoc, 8/7/25 in SB



Total Unduplicated Clients Served under CalAIM

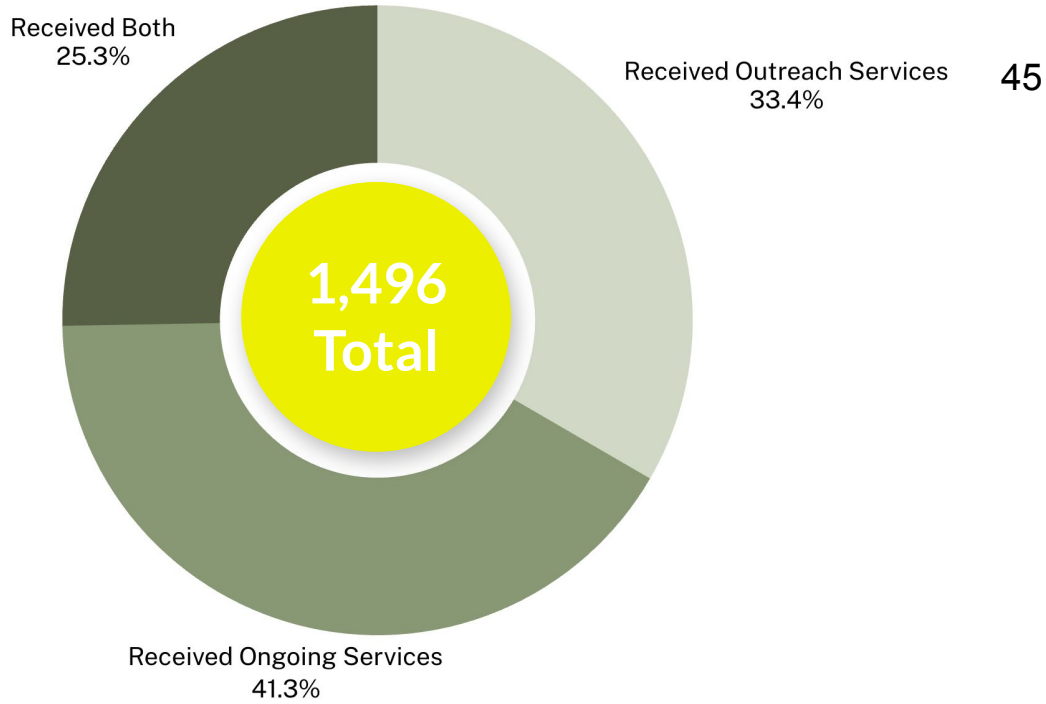
(July 1, 2023 – 6/30/2025)

Enhanced Care Management

1,010 Received Outreach Services

1,251 Received Ongoing Services

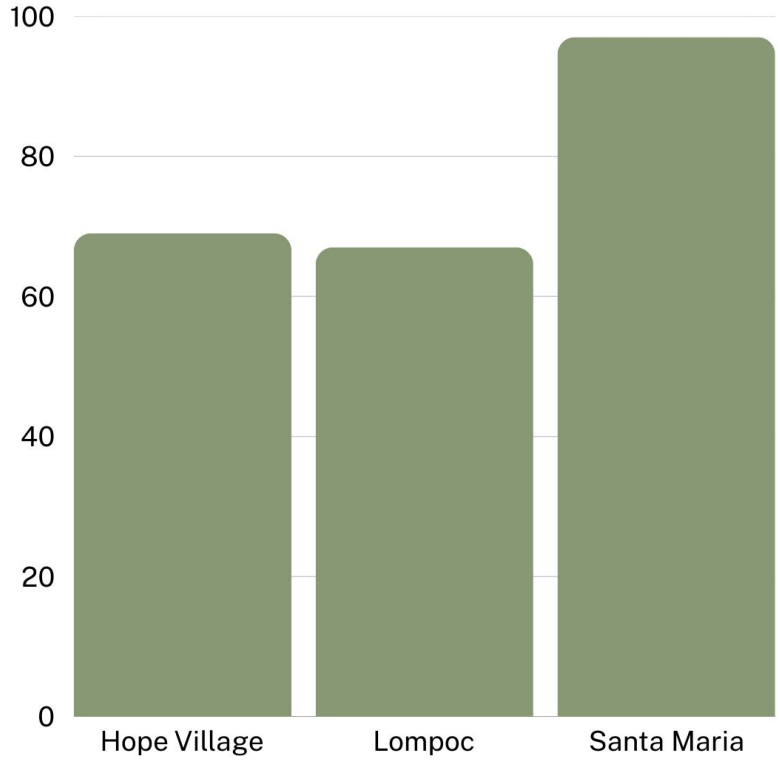
765 Received services from both Outreach and Ongoing



Recuperative Care

211 total unduplicated clients served by RCP

- 69 clients received services from Hope Village Recuperative Care
- 67 clients received from Lompoc Recuperative Care
- 97 clients received services from Santa Maria Recuperative Care

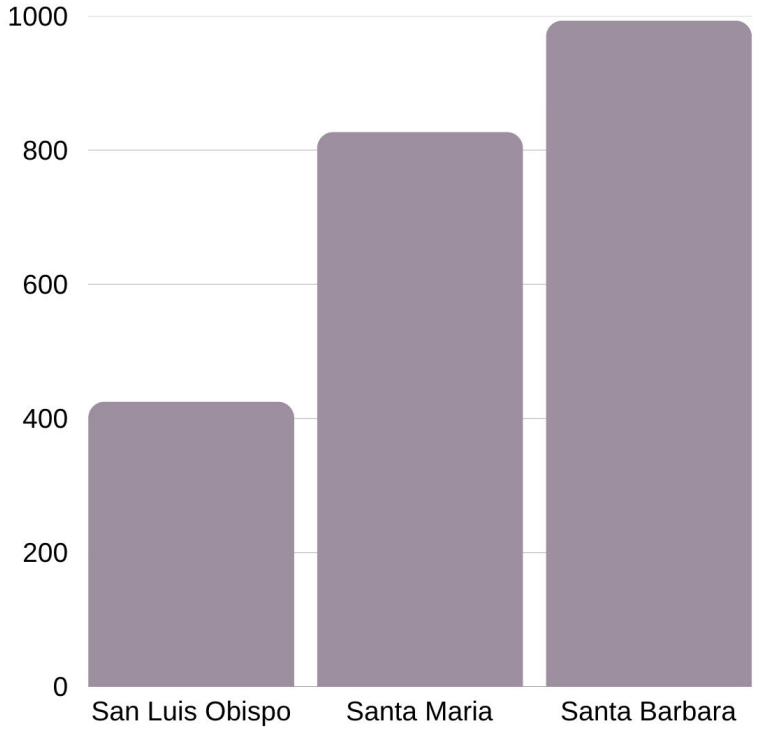


Sobering Centers

425 Clients served at SLO Sobering Center

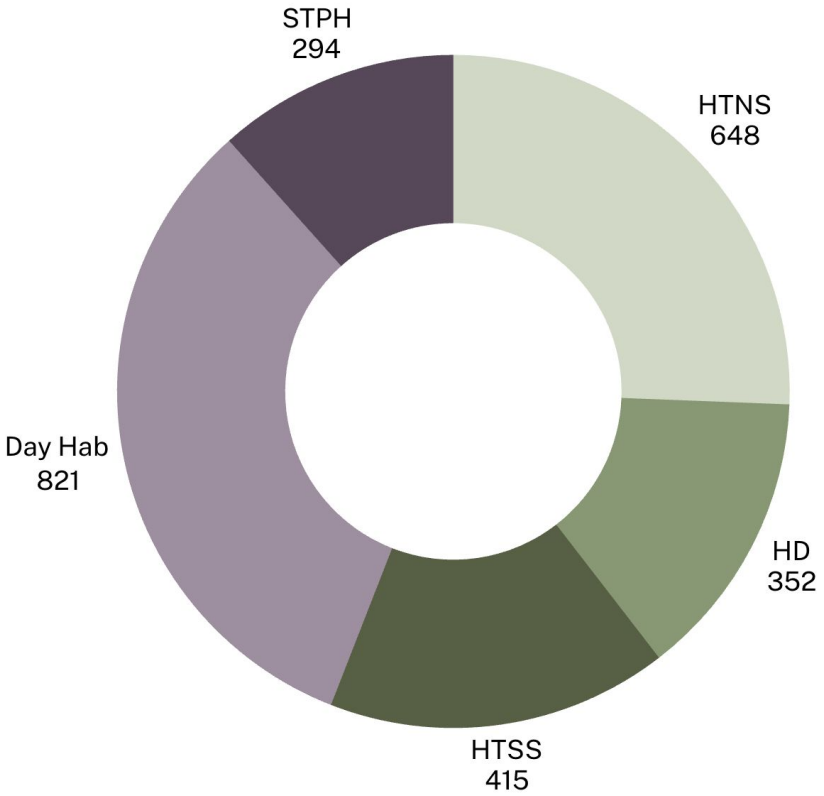
827 Clients served at SM Stabilization Center

993 Clients served at Santa Barbara Sobering Center



Other Community Supports Services

- 648 clients received services from Housing Transition & Navigation Services
- 352 clients received services from Housing Deposits
- 415 clients received services from Housing Tenancy and Sustaining Services
- 821 clients received services from Day Habilitation
- 294 clients received Short Term Post Hospitalization services



- Services rendered primarily face to face
- Best practices:
  - ECM - contact at minimum once per week
  - Housing Navigation/Sustaining - contact at minimum twice per month
- STPH services implemented at 11 shelter programs county wide
- Day Hab services implemented at 11 shelter programs countywide + permanent supportive housing programs
- ECM and Housing Trio services implemented throughout all shelter, residential treatment, outreach and housing programs
- Wraparound services implemented as much as possible
  - Example: ECM + Day Hab + RCP + HTNS + HD = client success!

ECM/HTNS

The Housing Navigation Team has been actively supporting this individual through HTNS services, in collaboration with shelter staff providing Enhanced Care Management (ECM). This client presents as a complex case, living with a serious mental illness that has significantly impacted his life since early adulthood. His most recent episode of homelessness began after the sale of his home, which was triggered by a divorce and unresolved back taxes.Through the ongoing, coordinated efforts of Housing Navigators and ECM Case Managers, the client received consistent and compassionate support. Utilizing motivational interviewing techniques and the principles of radical acceptance, the team was able to help the client shift his perspective—ultimately leading to his decision to accept the proceeds from the sale of his home.With these funds, he was able to purchase a new home and is now receiving housing retention services through Good Samaritan Shelter. This client has been enrolled in the Housing Navigation Team (HNT) program for over 18 months.

HTNS/HTSS/ECM

The Housing Navigation Team has been providing ongoing support to this client through HTNS services. Her episode of homelessness was triggered by domestic violence and the recent loss of her mother. Despite these challenges, she was rapidly housed with the assistance of housing deposit funds and is now focused on achieving long-term self-sufficiency. Previously a Registered Nurse, she allowed her license to lapse due to personal hardships and a single criminal conviction. Now safely housed and engaged in Housing Retention Services, she is working closely with the Department of Rehabilitation to pursue a Bachelor of Science in Nursing. Her goal is to further her education and reinstate her RN license. She is also actively enrolled in Enhanced Care Management (ECM) services, receiving additional support as she continues her journey toward stability and independence.

Client Stories

SOBERING CENTER

We had a married couple show up together, but came in separately. They were both unhoused, and heavy alcohol and meth users. We connected the wife with outreach, and then she went to Dignity Moves shelter, got a job at UPS, and recently graduated from the culinary program at Good Sam. We helped her husband get into the Santa Barbara Rescue MIssion residential treatment program and he just graduated from their 1 year program in July. They are both still clean and sober.

STPH/HTNS

Client has resided at Safe House in an STPH since 12/2024 and was connected to HTNS services. She is on disability and has had many medical issues arise during her time here and has been receiving STPH services. Despite all her medical concerns she keeps her head up and continues to look for housing. She just received exciting news that she was selected to get permanent housing in an apartment in Santa Maria. We are all very excited to see her grown and transition to her new life out of the shelter.

Permanent Supportive Housing - the power of HTSS

"Joe," was struggling with a high-paced work environment and new housing responsibilities as a young adult at Buena Tierra when we first met him. Joe had barely engaged in services with Good Samaritan after experiencing homelessness, and was hesitant to reach out for support. He was struggling with budgeting, often missing rent due to overspending, and was in jeopardy of losing his housing.

Upon gaining trust with case management supports over the first few months, we suggested he may benefit by enrolling in HTSS to identify personal goals, and receive support in achieving them, one step at a time. Joe agreed to enroll in HTSS, and discussed current goals and obstacles. He shared he was struggling with his mental health. With support from the Good Samaritan team, we offered to connect Joe in receiving mental health support from the Crisis Stabilization Unit.

From there, Joe identified he was unable to manage the fast-paced work environment he was at, and wanted to take time to reset and look for new employment. Joe started attending regular therapy appointments, and worked with us to find a more fitting job. He started meeting weekly to discuss current goals, one of them being new employment, after stabilizing his mental health. Joe discussed coping skills that worked for him and got a new job at a retail store that was much more fitting.

From there, Joe started working on budgeting with and came up with a payment plan to pay his overdue rent and save money monthly. Joe then transitioned into going to SBCC part-time, while continuing to work part-time.

Joe is now in good standing at Buena Tierra, and reports being very happy with his recent accomplishments being enrolled in HTSS and receiving regular support. Joe is currently saving money to potentially move into his own housing or buy a car, and reports being proud of what he's accomplished so far!

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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

CalAIM Renewal Concept Paper: Public Comment

It is open for public comment

through August 22, 2025.

Comments should be submitted to

1115Waiver@dhcs.ca.gov.

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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

It is 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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Q&A

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MCP Updates

Recent TA Marketplace Updates (as of June)

- DHCS is applying four new limitation criteria for current and new Project Eligibility Applications (PEAs), and Scopes of Work (SOWs), and Budgets in the review queue and any projects moving forward:
  1. Projects will be approved only for ***new*** TA Recipients, unless applying for Transitional Rent Support or as determined by DHCS
     - Note that organizations that participate in a TA project with a HUB or HUB-like entity are allowed to have their own independent project so long as they adhere to the other criteria.
  2. Limitation of one TA Project per TA Recipient
     - If a TA Recipient submits a batch of projects, they will be required to work with the TA Vendor to select the one project they wish to pursue that meets their immediate TA needs.
  3. Limit TAM Projects to Non-Contracted TA Recipients Needing Contracting Support
     - TA Recipients that are not yet contracted with a managed care plan for ECM and/or Community Supports will be required to provide a rationale for how their proposed TA project will support their contracting efforts. For example, a Recipient may have a project in Domain 1 to support their workflows to prepare for billing to an MCP for ECM services. The Recipient and Vendor should note that this is a requirement to become contracted with the MCP.
  4. TA Projects may not exceed $150K and must be within one year
     - TA Vendors and Recipients should work together to create a TA project application that meets a Recipient's most immediate needs within these requirements.
- Projects that do not meet the criteria above will either be sent for rework or not be accepted.
- Please note that projects must also meet the policies outlined in the TA Vendor Policy Guide and TA Recipient Policy Guide.

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)

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

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Questions?

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

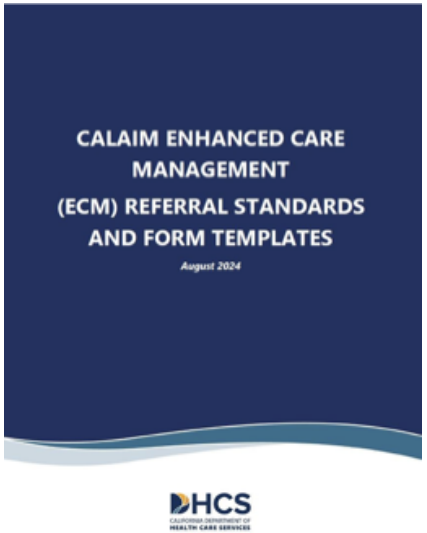
- Clarifies that members residing in private residences or public subsidized housing can be eligible for this support
- Clarifies that there are two distinct components of this Community Support:
  - Time-limited transition services and expenses
  - Ongoing assisted living services (not room and board,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