



# **An Advocate's Guide to Medi-Cal Services**

Updated December 2025

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## **Chapter XIII: Community Supports**

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## Outline of Medi-Cal Community Supports

- A. Health and Home and Community-Based Community Supports
  - 1. Respite Services
  - 2. Assisted Living Facility Community Support
  - 3. Community or Home Transition Services
  - 4. Personal Care and Homemaker Services (PCHS)
  - 5. Environmental Accessibility Adaptations (Home Modifications)
  - 6. Medically Tailored Meals/Medically Supportive Food
  - 7. Sobering Centers
  - 8. Asthma Remediation
- B. Housing-Specific Community Supports
  - 1. Housing Transition Navigation Services (HTNS)
  - 2. Housing Deposits
  - 3. Housing Tenancy and Sustaining Services (HTSS)
  - 4. Day Habilitation Programs
  - 5. Recuperative Care (Medical Respite)
  - 6. Short-Term Post-Hospitalization Housing
  - 7. Transitional Rent

This chapter describes Community Supports, Medi-Cal services offered by Medi-Cal Managed Care plans. Through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, California added Community Supports, or in-lieu of services (ILOS) as a benefit offered by MCPs.<sup>1</sup> Community Supports are community-based services or settings that MCPs may offer as alternatives to those covered under the California Medicaid State Plan.<sup>2</sup> Community Supports are designed to reduce health disparities and address unmet health-related social needs (HRSNs), such as housing and nutrition insecurity.<sup>3</sup> Beginning January 1, 2022, MCPs in all counties were encouraged to offer 14 pre-approved Community Supports.<sup>4</sup> As of July 1, 2025, a 15th benefit, Transitional Rent, is available.<sup>5</sup> With the exception of Transitional Rent, which becomes mandatory in January 2026, Community Supports are optional for MCPs to offer and for beneficiaries to use.<sup>6</sup> MCPs cannot require their enrollees to use a Community Support instead of a State-plan covered service.<sup>7</sup>

## A. Health and Home and Community-Based Community Supports

### 1. Respite Services

Respite services provide short-term relief for caregivers of Medi-Cal beneficiaries. This service is for individuals living in the community who need assistance with activities of daily living (ADLs) and rely upon a caregiver who provides most of their support. The service is distinct from medical respite (discussed further below) because it is designed to relieve the caregiver rather than as a service for the beneficiary. Respite includes services provided by the hour on an episodic basis; services provided by the day or overnight on a short-term basis because of the absence of or need for relief for the caregiver; or services that address a beneficiary's basic self-help needs and ADLs including interaction, socialization, and continuation of usual daily routines. Respite is available in an individual's home or in a facility.<sup>8</sup>

Respite services may not exceed 24 hours per day and are limited to 336 hours in a calendar year. The MCP can authorize an exception if the caregiver is unavailable because they are experiencing "an episode, including medical treatment and hospitalization that leaves a [beneficiary] without their caregiver."<sup>9</sup> Respite provided during these episodes can be excluded from the 336-hour limit. Respite is only available to avoid placements for which the MCP would be responsible. Respite may be provided by home health or respite agencies in the home, and a variety of facility types.<sup>10</sup>

### 2. Assisted Living Facility Community Support

The Assisted Living Facility Community Supports benefit (formerly known as Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly and Adult Residential Facilities) provides an alternative to nursing facility placement and is available to beneficiaries who are at risk of imminent placement in a nursing facility. Assisted Living Facilities are defined as either a Residential Care Facility for the Elderly (RCFE), or an Adult Residential Care Facility (ARF).<sup>11</sup> There are two components of the Assisted Living Facility benefit. First, time-limited transition services to assist a beneficiary in establishing residency in an Assisted Living Facility, including, assessing the individual's need for housing and services; coordinating the application process; paying for moving expenses and personal items; communicating with the facility and coordinating the move; and establishing procedures and contacts so that the individual remains in the Assisted Living Facility.

The second component is ongoing assisted living services for the duration of the time the individual is living at the facility. These ongoing services include assistance with ADLs and Instrumental Activities of Daily Living (IADLs), meal preparation, transportation, medication management, and more.<sup>12</sup> MCPs must

offer both components to the extent that they are appropriate for the beneficiary, although an individual may only require one component. To receive the Assisted Living Community Support, an individual in a facility must:

- Have resided 60+ days in a nursing facility and
- Be willing to live in an assisted living setting as an alternative to a nursing facility; and
- Be able to reside safely in an Assisted Living Facility.

To receive the Assisted Living Community Support, an individual in the community must:

- Be interested in remaining in the community; and
- Be willing and able to reside safely in an Assisted Living Facility; and
- Meet the nursing facility level of care.

### 3. Community or Home Transition Services

Community or Home Transition Services (formerly known as Community Transition Services/Nursing Facility Transition to a Home) are available for individuals who are transitioning from a licensed nursing facility to living in the community, either in their own home or in publicly funded housing. This service is available to individuals who:

- Are currently receiving medically necessary nursing facility Level of Care (LOC) services, and have lived in a nursing facility or recuperative care setting for more than 60 days;
- Wish to transition to the community with appropriate services; and
- Can reside safely in the community with appropriate services and supports.

Community Transition Services include:

- *Time limited services* to facilitate returning to the community from a facility, including: assessing the individual's housing needs and presenting options; assisting in searching for and securing housing, including the completion of housing applications and securing required documentation; communicating with the landlord as needed and coordinating the move; establishing procedures and contacts to retain housing; identifying, coordinating, securing, or funding non-emergency, nonmedical transportation as needed; identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.
- *One time set-up expenses* including: security deposits required for a lease; set-up fees for utilities or service access and up to six months' payment of back utility bills; services necessary for the individual's health and safety, like one-time cleaning prior to occupancy, and necessary repairs where those costs are not the responsibility of the landlord; air conditioner or heater; adaptive aids like hospital beds, Hoyer lifts, bedside commode, shower chair etc., that are necessary to ensure access

and safety for the individual upon move-in to the home, when they are not otherwise available.

Both time limited services and one-time set-up expenses must be available as needed.

#### **4. Personal Care and Homemaker Services (PCHS)**

Personal Care and Homemaker Services (PCHS) are available for beneficiaries who need assistance with ADLs or Instrumental Activities of Daily Living (IADLs). PCHS includes services that are provided through In-Home Supportive Services (IHSS), including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with cognitive disabilities.

MCPs can offer PCHS during the IHSS application process, and PCHS can be authorized before and up until IHSS is actually in place or if IHSS benefits are exhausted. In addition, if an individual meets IHSS eligibility criteria, they must be referred to IHSS. If a beneficiary is not eligible for IHSS, PCHS is still available to prevent a short-term stay in a skilled nursing facility (up to 60 days).<sup>14</sup>

Individuals are eligible for PCHS if:

- They are at risk for hospitalization, or institutionalization in a nursing facility; or
- They have functional deficits and no other adequate support system; or
- They are approved for In-Home Supportive Services.

#### **5. Environmental Accessibility Adaptations (Home Modifications)**

Environmental Accessibility Adaptations (Home Modifications) are available to individuals at risk of

#### **ADVOCACY TIP:**

- ✓ While individuals can be eligible for Community Supports and the California Community Transitions (CCT) program, Home & Community Based Alternatives (HCBA) Waiver, and/or the Multipurpose Senior Services Program (MSSP), they can only receive services from one program at a time.<sup>13</sup>

#### **ADVOCACY TIP:**

- ✓ Although individuals who are enrolled in the HCBA Waiver and are eligible for or receiving Waiver Personal Care Services (WPCS) are not eligible for PCHS, they can receive PCHS while waiting for HCBA Waiver approval.<sup>15</sup> In addition, while home health agencies and personal care agencies are some of the provider types, family members can be paid to provide PCHS to beneficiaries.

institutionalization who need physical modifications to their home in order to remain there safely.<sup>16</sup> Examples of Home Modifications include:

- Ramps and grab bars;
- Door widening to accommodate a wheelchair;
- Stair lifts;
- Accessible bathroom and shower;
- Specialized electric or plumbing systems for medical equipment and supplies; and
- Personal Emergency Response System

Home Modifications can be made to the home owned or rented by the beneficiary, provided there is written consent from the owner for physical changes to the home. In order to receive a Home Modification, an individual's treating medical professional must submit a written order to the MCP documenting the type of modification and how the modification meets the medical needs of the individual. In addition, a physical or occupational therapy evaluation justifying the medical necessity of the modification is required, unless the MCP determines such an evaluation is not necessary.

### **ADVOCACY TIP:**

- ✓ If a physical or occupational therapy evaluation is required, the evaluation must describe why the current home or equipment does not meet the individual's needs, including how other attempts to modify/other equipment are inadequate; why the modification is necessary and how the modification reduces the risk of institutionalization; and how the individual and/or their primary caregiver have the ability to appropriately manage or use the modification. Specific examples of failed attempts at other modifications should be included.

The assessment and authorization for Home Modifications must be completed within 90 days, beginning with the request, unless more time is needed to obtain homeowner consent, or if the individual requests a longer timeframe. Home modifications are limited to a \$7,500 lifetime maximum unless the individual moves to a new home, or their condition changes so significantly that additional modifications are necessary to ensure their health and safety and to avoid institutionalization.

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

Medically Tailored Meals (MTMs) and Medically Tailored Groceries (MTGs) are intended to address conditions that are impacted by what an individual eats, also known as nutrition sensitive conditions.<sup>17</sup> This benefit is available for Individuals who have chronic or other serious health conditions that are nutrition sensitive.<sup>18</sup> Medically Tailored Meals are defined as “meals that adhere

to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.” Medically Tailored Groceries are defined as “preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.”

Before an individual can receive MTM or MTGs, they must have an individual assessment from a Registered Dietitian Nutritionist (RDN) who must develop a nutritional plan and connection to the MTM or MTG. MTM and MTG either singularly or through a combination of meals and groceries must meet at least two-thirds of the daily nutrient and energy needs of an average individual as estimated by the RDN.

Medically Supportive Food (MSF) is a package of food that follows national nutrition guidelines to prevent, manage, or reverse nutrition sensitive conditions. MSFs are intended to supplement an individual’s diet. Like MTMs and MTGs, an RDN must oversee the selection of food in an MSF package. In addition, MCP and providers of MTM/MSF must take individual’s cultural preferences/needs (e.g., halal or kosher meals) and food preparation and storage capabilities (e.g., ability to store frozen meals) into account.

### **ADVOCACY TIP:**

- ✓ Supplemental Nutrition Assistance Program (SNAP) and Women, Infants and Children (WIC) benefits are not duplicative of MTM/MSF Community Supports because SNAP and WIC are designed to mitigate a household’s food insecurity, while MTM/MSF are part of a clinical care plan to address specific chronic or serious health conditions.<sup>19</sup>

## **7. Sobering Centers**

This community support is for individuals who are intoxicated due to alcohol or other drugs in public and would otherwise be taken to an emergency department or to jail. Services at Sobering Centers include medical triage; lab testing; a temporary bed; rehydration and food service; treatment for nausea; wound and dressing changes; shower and laundry facilities; substance use education and counseling; navigation and warm hand-offs for additional substance use services or other necessary health care services; and, for those experiencing homelessness, care support services.<sup>20</sup>

When MCPs offer Sobering Centers they must engage in direct coordination with county behavioral health agencies, and are required to partner with law enforcement, emergency services, and outreach teams to facilitate placement. Sobering Centers also include screening and linkage to ongoing supportive services. This service is covered for a period of less than 24 hours and is targeted at individuals who are 18 and older who are intoxicated but conscious, and do not need immediate medical treatment.

## 8. Asthma Remediation

Asthma Remediation consists of supplies and/or physical modifications to a home environment to enable a beneficiary to live at home with a reduced likelihood of experiencing acute asthma episodes. Asthma Remediation should supplement the Asthma Preventive Services (APS) Medi-Cal State Plan service which includes clinic-based asthma self-management education, homebased asthma self-management education, and in-home environmental trigger assessments. As of January 1, 2026, APS services must be covered as a state plan benefit, and will no longer be part of Asthma Remediation Community Supports.<sup>21</sup> Asthma Remediation is available to beneficiaries who have a completed in-home environmental trigger assessment within the last 12 months through APS that has identified medically appropriate Asthma Remediations and specified how the interventions meet the individual's needs. There is a lifetime limit of \$7,500 for Asthma Remediation services.<sup>22</sup>

## B. Housing-Specific Community Supports

There are 7 Community Supports to support individuals who are unhoused, or are at risk of being unhoused.<sup>23</sup> For most of these housing specific community supports, an individual must have a housing support plan.<sup>24</sup> This plan must:

- Identify the permanent housing strategy for the individual, including sources of payment that will support them in maintaining housing after the housing Community Supports are exhausted (e.g., the individual's income, BHSA Housing Interventions, or other long-term subsidies).
- Identify the full range of permanent housing supports that will support the individual in maintaining housing (e.g., tenancy sustaining service, utilities).
- Be informed by the individual's preferences and needs, and reviewed and revised as needed.
- Be based on a housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the individual's approach to meeting the goal, and identifies when other providers or services may be required to meet the goal.
- Be developed in a way that is culturally appropriate and trauma-informed.

Housing Support plans can be developed by a Community Supports Provider, a flex pool or organization that coordinates supportive services,<sup>25</sup> or other housing providers, including county behavioral health agencies. It is not necessary that the developer be a Medi-Cal provider.

### 1. Housing Transition Navigation Services (HTNS)

Housing Transition Navigation Services (HTNS) assist individuals with finding, applying for, and securing housing.<sup>26</sup> HTNS are available to people who are experiencing or at risk of being unhoused and meet one or more of the

following: the access criteria for Medi-Cal Specialty Mental Health Services (SMHS); the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS); have one or more serious chronic physical health conditions; have one or more physical, intellectual, or developmental disabilities; or are pregnant or through 12 months postpartum. HTNS are also automatically available to individuals who are eligible for Transitional Rent, discussed further below and for individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System (CES) or similar system.<sup>27</sup>

HTNS include:

- Conducting a housing assessment that identifies the individual's preferences and barriers related to successful tenancy.
- Developing a housing support plan based upon the housing assessment.
- Assisting in searching for housing and presenting options.
- Assisting in securing housing, including the completion of housing applications and securing required documentation
- Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI).
- Identifying and securing available resources to assist with attaining housing.
- Identifying and securing resources including but not limited to Housing Deposits, to cover expenses such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
- Providing education to the individual about Fair Housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary.
- Landlord education and engagement.
- Ensuring that the living environment is safe and ready for move-in.
- Communicating and advocating on behalf of the individual with landlords.
- Assisting in, arranging for, and supporting the details of the move.
- Establishing procedures and contacts to retain housing, including developing a housing support crisis plan.
- Ensuring availability of non-emergency, non-medical transportation as needed.

#### **ADVOCACY TIP:**

- ✓ Managed Care plans must ensure that individuals who are receiving HTNS are offered Enhanced Care Management (ECM), discussed in Chapter XII of this Guide. If an individual chooses to receive HTNS and ECM, the MCP must ensure that ECM coordinates service delivery to minimize confusion and duplication of services.

- Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility.

## 2. Housing Deposits

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household.<sup>28</sup> Housing Deposits are available to people who meet the same definition of eligibility as HTNS, and who have a Housing Support Plan.

Housing Deposits include:

- Security deposits required to obtain a lease on an apartment or home.
- Set-up fees/deposits for utilities or service access and payment in utility arrears.
- First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
- Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, along with necessary minor repairs to meet HUD Housing Choice Voucher program quality.
- Application fees to cover the cost of the lease application.
- Medically necessary adaptive aids and services, designed to preserve an individual's health and safety in the home, including items like an air conditioner or heater, unless otherwise available through Medi-Cal.

Housing Deposits do not cover room and board or payment of rent. Housing Deposits are available once, with the possibility of an additional time if there is documentation of why a second attempt to use Housing Deposits to secure housing will be effective.

## 3. Housing Tenancy and Sustaining Services (HTSS)

Housing Tenancy and Sustaining Services (HTSS) help individuals maintain housing once it is established.<sup>29</sup> The same eligibility criteria for HTNS and Housing Deposits apply to HTSS.<sup>30</sup> HTSS must be identified in the individual's housing support plan. HTSS can include:

- Providing early identification and intervention to minimize jeopardizing housing;
- Providing education and training for individuals on the rights and responsibilities, of tenants and landlords;
- Providing education for individuals about fair housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary.
- Coaching on developing and maintaining key relationships to foster successful tenancy.
- Coordinating with the landlord and care/case management provider, to address issues that could impact housing stability.

- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the individual owes back rent or payment for damage to the unit.
- Advocacy and linkage with community resources to prevent eviction.
- Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process.
- Assistance with the annual housing recertification process.
- Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis.
- Continuing assistance with lease compliance.
- Health and safety visits, including to ensure the unit remains safe and habitable.
- Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized.
- Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

#### **4. Day Habilitation Programs**

Day Habilitation Programs are intended to assist individuals with life skills necessary to live successfully.<sup>31</sup> Individuals are eligible if they are experiencing homelessness, or they exited homelessness and entered housing in the last 24 months, or they are at risk of homelessness or institutionalization and their housing stability could be improved through participation in a Day Habilitation Program. The service can be provided in an individual's home or an out-of-home, non-facility setting. The services are often considered peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. To the extent possible ECM and any other Community Supports should be provided by the same entity that is providing Day Habilitation.

Day Habilitation Program services include, but are not limited to, training on:

- The use of public transportation.
- Personal skills development in conflict resolution.
- Community participation.
- Developing and maintaining interpersonal relationships.
- Daily living skills (cooking, cleaning, shopping, money management).
- Community resource awareness such as police, fire, or local services to support independence in the community.<sup>32</sup>

Day Habilitation services are available for as long as an individual needs them, and can be provided continuously or intermittently, in both individual and group settings.

## 5. Recuperative Care (Medical Respite)

Recuperative Care, also known as medical respite care, is for individuals who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness (including a behavioral health condition).<sup>33</sup> Unlike other Community Supports, this service is covered under the CalAIM 1115 waiver.<sup>34</sup> Individuals are eligible for Recuperative Care if they require recovery in order to heal from an injury or illness and are experiencing or are at risk of homelessness.

Recuperative care helps individuals recover from injury and illness and at the same time have primary care, behavioral health, case management, and other supportive social services, such as transportation, food, and housing. Recuperative Care is designed to serve individuals who have medical needs significant enough to result in emergency department visits, hospital admissions, or other institutional care. Individuals do not need to be discharging from an institution, but must have an assessment that they have medical needs significant enough to result in ED visits, hospital admissions, or other institutional care. Recuperative care must include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition. Based on individual needs, the service may also include:

- Limited or short-term assistance with IADLs and/or ADLs to the extent permitted by licensure.
- Coordination of transportation to post-discharge appointments.
- Connection to any other ongoing services an individual may require, including mental health and substance use disorder services.
- Support in accessing benefits and housing.
- Gaining stability with case management relationships and programs.

Recuperative Care cannot last more than six months per rolling 12-month period, which starts from the first date of utilization. It is also subject to a six-month global cap on Room and Board services.<sup>35</sup>

### **ADVOCACY TIP:**

- ✓ Individuals receiving Recuperative Care in facilities that are not licensed as Community Care Facilities cannot receive ADL or IADL assistance from staff in those facilities. MCPs can coordinate the delivery of Personal Care and Homemaker Services, discussed above, or contract with a licensed third-party provider.

## 6. Short-Term Post-Hospitalization Housing

Short-Term Post-Hospitalization Housing is available for individuals who are leaving an institution and are at risk of homelessness, and continue to need supports to recuperate from an illness or to support their recovery.<sup>36</sup> Unlike other Community Supports, this service is covered under the CalAIM 1115 waiver.<sup>37</sup> To receive Short-Term Post-Hospitalization Housing, individuals must meet all of the following criteria:

- Individuals who are exiting an institution, which includes recuperative care facilities (including facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), inpatient hospitals (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder or mental health treatment facility, correctional facility, or nursing facility; AND
- Are experiencing or at risk of homelessness; AND
- Meet one of the following criteria:
  - Are receiving ECM;
  - Have one or more serious chronic conditions;
  - Have serious mental illness; or
  - Are at risk of institutionalization or requiring residential services as a result of a substance use disorder; AND
- Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post-Hospitalization Housing.

Locations where Short-Term Post-Hospitalization Housing can be provided include recuperative care, inpatient hospitals, residential substance use disorder or mental health treatment facilities, correctional facilities, or nursing facilities. Short-Term Post-Hospitalization Housing must provide individuals with ongoing supports necessary for recuperation and recovery, such as gaining (or regaining) the ability to perform ADLs, receiving necessary care, receiving case management, and beginning to access other housing supports. Short-Term Post-Hospitalization Housing settings may include a private or shared interim housing setting. Like Recuperative Care and Transitional Rent (discussed below), there is a six-month cap on receiving Short-Term Post-Hospitalization Housing on a 12-month rolling basis<sup>38</sup>

## 7. Transitional Rent

While as noted above, Community Supports are optional for MCPs, Transitional Rent is a *mandatory* service as of January 1, 2026, and MCPs may begin offering Transitional Rent as early as July 1, 2025.<sup>39</sup> Transitional Rent can provide up to six months of rental assistance in both temporary and permanent settings.<sup>40</sup> Transitional Rent must follow Housing First principles. This means that Transitional Rent cannot be conditioned on sobriety or engagement or completion of certain services, or on “housing readiness.”<sup>41</sup>

The eligibility criteria for Transitional Rent are lengthy.<sup>42</sup> Individuals are eligible if they meet all of the following criteria:

- Clinical Risk Factor Requirement: Must have one of more of the following qualifying clinical risk factors:
  - a) Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
  - b) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
  - c) One or more serious chronic physical health conditions;
  - d) One or more physical, intellectual, or developmental disabilities; or
  - e) Individuals who are pregnant up through 12-months postpartum.

**AND**

- Social Risk Factor Requirement: Experiencing or at risk of homelessness.

**AND**

- Individuals must meet one of the following requirements:
  - a) Transitioning Population Requirement: Must be included within one of the following transitioning populations:
    - (i) Transitioning out of an institutional or congregate residential setting;
    - (ii) Transitioning out of a carceral setting;
    - (iii) Transitioning out of interim housing;
    - (iv) Transitioning out of recuperative care or short-term post-hospitalization housing;<sup>43</sup>
    - (v) Transitioning out of foster care: Individuals having aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state.<sup>44</sup>

**OR**

- b) Experiencing unsheltered homelessness;<sup>45</sup>

**OR**

- c) Eligible for Full-Service Partnership<sup>46</sup> (FSP).<sup>47</sup>

Transitional Rent can be used to cover:

- Rental assistance in allowable settings
  - These include a permanent or interim setting, or a combination of both. If the setting is interim, the MCP must confirm that an individual has a housing support plan in place and is Behavioral Health Services Act (BHSA)-eligible and will be able to transition to BHSA Housing Interventions at the expiration of Transitional Rent, if the individual is otherwise not able to secure a HUD Housing Choice Voucher, permanent supportive housing subsidy, or other long-term rental subsidy.<sup>48</sup>
  - Storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment.

Transitional Rent can provide up to six months of rental assistance and rent and housing fees subject to the six-month global cap on Room and Board services within a rolling 12-month period. The six months of Transitional Rent are not required to be continuous. DHCS has issued separate guidance on payments to MCPs for Transitional Rent.<sup>49</sup> Transitional Rent has two components: 1) cost of rent or temporary housing; and 2) an administrative fee. MCPs can be reimbursed for the actual cost of rent or temporary housing, which may include the costs of storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment up to applicable reimbursable ceilings.<sup>50</sup> In addition, MCPs will receive reasonable costs for administrative fees. While the cost of rent for different types of housing is fixed, administrative fees are not specified, and MCPs and Transitional Rent Providers are expected to negotiate rates.<sup>51</sup> The Transitional Rent payment is designed to cover the cost of rent or temporary housing for the enrollee for the entire time the individual receives the support, up to six months. Individuals cannot be required to cover a share of the rent. In addition, placements must be to settings where the landlord or property owner accepts the amount of Transitional Rent provided.

### **ADVOCACY TIP:**

- ✓ Advocates should keep in mind that the Housing Deposits Community Support can be used to cover additional costs that Transitional Rent does not fund. In addition, it is important to note that currently Transitional Rent may not be used to cover eviction prevention—for instance, back rent or prospective rental assistance for individuals who are housed but at risk of being unhoused.

## **Accessing Community Supports**

### ***Information and Referrals***

MCPs have a number of obligations to identify individuals who may benefit from Community Supports. MCPs are required to inform plan enrollees as well as plan networks of providers about Community Supports and how an individual can access Community Supports. MCPs must have a process for receiving and responding to referral requests from a wide range of sources, including accepting referrals from individuals and their families, guardians and caregivers, ECM Providers, Community Support Providers and Community-Based Organizations (CBOs), and other providers. MCPs must also train their call centers on how to manage referrals for Community Supports.<sup>52</sup>

In addition, MCPs must comply with Closed-Loop Referral (CLR) requirements, which took effect on July 1, 2025 and apply to community referrals and referrals generated by MCPs.<sup>53</sup> DHCS defines a Closed-Loop Referral (CLR) as a referral

initiated on behalf of a Medi-Cal Managed Care enrollee that is tracked, supported, monitored and results in a “Known Closure.”<sup>54</sup> Under CLR requirements, MCPs must track referrals with the goal of having a majority of Community Supports referrals originate from community-based sources, rather than from the MCP itself.

In terms of publicizing the availability of Community Supports, MCPs must ensure that their websites include up-to-date information about Community Supports and ECM, and how to refer for and request those services; a short description of each available service that comports with DHCS’ terminology; and a definition of all individuals eligible for Transitional Rent from the MCP.<sup>55</sup>

### ***Authorization Processes***

MCPs must have nondiscriminatory authorization procedures that comply with the definitions of Community Supports. MCPs must outline the documentation requirements, including why the Community Support is likely to reduce or prevent the need for acute care or other Medi-Cal services, including, but not limited to, inpatient hospitalizations, skilled nursing facility stays, or emergency department visits.<sup>56</sup>

MCPs must have Policies and Procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate. DHCS has determined that Recuperative Care, Short-Term Post-Hospitalization Housing, and Sobering Centers are inherently time sensitive, and that MCPs that offer these Community Supports must provide expedited authorization if needed.<sup>57</sup>

### ***Continuity of Care***

If an individual changes plans and is receiving a Community Support, the new MCP must provide the Community Support if the new MCP offers that support. Where the new MCP offers the same support, the new MCP must:

- Automatically authorize the support in the same amount and duration, consistent with the new MCP’s parameters;
- Have a process for engaging the previous MCP, individual, and/or Community Supports Provider to mitigate gaps in care;
- Have a process for reviewing historical utilization data using a 90-day look-back period to identify individuals receiving Community Supports

For Community Supports with a lifetime maximum or the six-month maximum during a 12-month rolling period, MCPs must track and apply Continuity of Care if individuals have not reached their applicable maximums.<sup>58</sup>

### ***Grievances and Appeals***

A Notice of Adverse Benefit Determination (NOABD) is required when an MCP plan approves, modifies, or denies a request and individuals have the right to file appeals and/or grievances if they request one or more Community Support

offered by the MCP but are denied. Individuals can also file for a fair hearing to dispute a denial.<sup>59</sup>

Individuals are entitled to a notice of when the Community Support service is ending or discontinuing. However, DHCS states that a NOABD is not needed if an individual was informed at the beginning of the service (e.g., when a Medically Tailored Meal service is authorized for three months, and the individual is informed at the beginning of the authorized period of service that it is time-limited). DHCS also states notice is not necessary if the individual has opted out of the Community Support service.

### **ADVOCACY TIP:**

- ✓ Advocates should be aware that MCPs are not always issuing a notice when a request for Community Supports is denied. Advocates should request a written notice, and be prepared to file a grievance/appeal and potentially a State Fair Hearing in the event a Community Support is denied without notice. In addition, Advocates should advise individuals who are receiving a time-limited service that if they continue to need the service past the authorization date, a new request should be made before the end of the authorized period.

# Endnotes

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- <sup>1</sup> For the provision of federal regulations authorizing Community Supports, see 42 C.F.R. § 438.3(e)(2). All in lieu of services must be a cost-effective substitute for a service or setting covered under the Medicaid State Plan, voluntary for an MCP to cover and for an individual to use, and the use and actual cost of ILOS must be taken into account in developing the component of the capitation rates that represent the covered state plan services. For the state statutory authority, see CAL. WELF. & INST. CODE § 14184.206.
- <sup>2</sup> In April 2025, DHCS issued two Policy Guides, Volume 1 and Volume 2, which contain detailed information about Community Supports. See Cal. Dep't Health Care Servs., *Medi-Cal Community Supports Policy Guide Volume 1* (Apr. 2025), <https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf> [hereinafter *Community Supports Policy Guide Vol.1*] and Cal. Dep't Health Care Servs., *Medi-Cal Community Supports Policy Guide Volume 2 Community Supports to Support Members Experiencing or At Risk of Homelessness* (Apr. 2025), <https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf> [hereinafter *Community Supports Policy Guide Vol.2*]. See also Cal. Dep't Health Care Servs., All Plan Letter 21-017 (Mar. 1, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-017.pdf>.
- <sup>3</sup> CMS, Dear State Medicaid Director (Jan. 4, 2023) (SMD #: 23-001) (guidance on use of in lieu of services and settings in Medicaid managed care), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>.
- <sup>4</sup> A list of what Community Supports each MCP plan offers is available at Cal. Dep't Health Care Servs., *CalAIM Community Support – Managed Care Plan Elections* (Updated July 2025), <https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf> [hereinafter *Community Supports MCP Elections*].

<sup>5</sup> Twelve of the Community Supports are authorized through the CalAIM section 1915(b) waiver. Cal. Dep't. Health Care Servs., Section 1915(b) Waiver Proposal for California Advancing and Innovating Medi-Cal (CalAIM) (2023), <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915bWaiver-CA-0017-R10-01-Application.pdf> [hereinafter CalAIM 1915(b) Waiver]. The remaining 3 Community Supports are authorized through section 1115 demonstration waivers: Short-Term Post-Hospitalization Housing and Recuperative Care are authorized under the CalAIM 1115 Waiver. See CMS, *CalAIM Demonstration Approval Technical Correction Attachment* (Jan. 2025), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dmnrstrn-appvl-thncl-crctn-atcmnt-c-aa-01172025.pdf> [hereinafter *CalAIM Technical Correction Attachment*]. Transitional Rent is authorized under the BH-CONNECT waiver. See CMS, *Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration* (Jan. 2025) <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-bh-connect-01102025.pdf> [hereinafter *BH-Connect Waiver*] In DHCS's July 2025 CalAIM Concept Paper, which discusses the future of CalAIM, DHCS notes that the 12 Community Supports approved as ILOS are authorized under 42 C.F.R. § 438.3(e)(2), "a regulatory authority distinct from authority conferred by Section 1115 and 1915(b) waivers. ILOS is a permanent option for state Medicaid programs enshrined in federal Medicaid managed care regulations and, as required by CMS, memorialized in approved MCP contracts. The 12 Community Supports covered as ILOS are not dependent on DHCS's current CalAIM Section 1115 or 1915(b) waiver approvals." Cal. Dep't Health Care Servs., *Continuing the Transformation of Medi-Cal: Concept Paper 37* (July 2025), <https://www.dhcs.ca.gov/CalAIM/Documents/Medi-Cal-Transformation-Concept-Paper.pdf>.

<sup>6</sup> *Community Supports Policy Guide Vol.1, supra note 2. See also, BH-Connect Waiver, supra note 5, at 221.* Availability of Transitional Rent is mandatory for MCP enrollees meeting the Behavioral Health Population of Focus as of January 1, 2026 and mandatory for all MCP populations who meet the eligibility criteria for Transitional Rent as of January 1, 2027. Transitional Rent is available through the term of the BH-Connect waiver, which runs from January 1, 2025 through December 31, 2029.

<sup>7</sup> *Community Supports Policy Guide Vol.1, supra note 2, at 5.*

<sup>8</sup> *Id.* at 10.

<sup>9</sup> *Id.*

<sup>10</sup> *Id.* at 11.

<sup>11</sup> *Id.* at 13.

<sup>12</sup> *Id.* at 14.

<sup>13</sup> These programs are discussed in Chapter X of this Guide on Long-Term Services and Supports.

<sup>14</sup> In order to receive short term PCHS, the authorization request should include information about the need for short term stay in a skilled nursing facility in the absence of PCHS being available. *Community Supports Policy Guide Vol.1, supra* note 2, at 26.

<sup>15</sup> *Id.* at 26.

<sup>16</sup> *Id.* at 29.

<sup>17</sup> *Id.* at 32.

<sup>18</sup> This includes but is 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, and chronic or disabling mental/behavioral health disorders. *Id.* at 35.

<sup>19</sup> The CalFresh Program, federally known as the Supplemental Nutrition Assistance Program (SNAP), issues monthly electronic benefits that can be used to buy most foods at many markets and food stores. See Cal. Dep't Soc. Servs., CalFresh Program, <https://www.cdss.ca.gov/calfresh> (last visited Dec. 11, 2025). WIC provides nutritional support to women, infants, and children. See Cal. Dept Pub. Health, WIC Program Overview, <https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/AboutWIC/ProgramOverview.aspx> (last visited Dec. 11, 2025).

<sup>20</sup> *Community Supports Policy Guide Vol.1, supra* note 2, at 39.

<sup>21</sup> *Id.* at 42. Asthma Preventive Services (APS) became a state plan benefit in July 2022, six months after Asthma Remediation Services were added as a community support. See Cal. Dep't Health Care Servs., *Allied Health Provider Manual, Asthma Preventive Services (APS)* (2022) [https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/B30BA13C-7A4F-47B9-9403-760091E44ADC/asthprev.pdf?access\\_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO](https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/B30BA13C-7A4F-47B9-9403-760091E44ADC/asthprev.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO). Because Community Supports must not supplant state plan services, asthma self-management education and in-home environmental trigger assessments must be covered as a state plan service, not through Asthma Remediation Services.

<sup>22</sup> *Community Supports Policy Guide Vol.1, supra* note 2, at 46.

<sup>23</sup> *Community Supports Policy Guide Vol.2, supra* note 2.

<sup>24</sup> *Id.* at 17-19.

- <sup>25</sup> A “Flex Pool is a vehicle to organize rental assistance that (1) coordinates and braids funding streams, facilitating compliance and required reporting; (2) acts as a single fiscal intermediary between funders and landlords; (3) identifies, secures, and supports a portfolio of units; and (4) coordinates with providers of housing supportive services.” Cal. Dep’t Health Care Servs., *Flexible Housing Subsidy Pools Technical Assistance Resource* 5 (Feb. 10, 2025), <https://www.dhcs.ca.gov/Documents/MCQMD/Flexible-Housing-Subsidy-Pools-TA-Resource.pdf>.
- <sup>26</sup> *Community Supports Policy Guide Vol.2*, *supra* note 2, at 25–30. Along with Housing Deposits and Housing Tenancy and Sustaining Services (HTSS), HTNS make up the “Housing Trio.” See Cal. Health Care Found., *CalAIM’s Trio of Housing Community Supports – Policy at a Glance* (Mar. 20, 2025), <https://www.chcf.org/resource/calaim-housing-community-supports-policy-at-a-glance/>.
- <sup>27</sup> Individuals must meet the U.S. Department of Housing and Urban Development’s (HUD’s) current definition of homeless or at risk of homelessness as codified at 24 C.F.R. part 91.5, with three modifications: 1) If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; and 2) The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days; and 3) For the at risk of homelessness definition at 24 C.F.R. § 91.5, the requirement to have an annual income below 30 percent of median family income for the area, as determined by HUD, will not apply. CES standardizes the way individuals and families at risk of homelessness or experiencing homelessness access are assessed for and referred to the housing and services that they need for housing stability. See U.S. Department of Housing and Urban Development (HUD), *Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System (Notice CPD-17-01)* (Jan. 23, 2017), <https://www.hud.gov/sites/documents/17-01cpdn.pdf>. See *Community Supports Policy Guide Vol.2*, *supra* note 2, at 27.
- <sup>28</sup> *Id.* at 31–36.
- <sup>29</sup> *Id.* at 37–42.
- <sup>30</sup> Note that individuals cannot receive HTNS and HTSS at the same time; HTSS is designed to serve individuals who are maintaining, not obtaining housing. See *Community Supports Policy Guide Vol.2*, *supra* note 2, at Appendix B: Summary of Interaction Between Community Supports and ECM 110.
- <sup>31</sup> *Id.* at 43–47.
- <sup>32</sup> For a description of Additional Day Habilitation Program services, see *Community Supports Policy Guide Vol.2*, *supra* note 2, at 42.

- <sup>33</sup> *Community Supports Policy Guide Vol.2, supra* note 2, at 47–51. Note that Under the CalAIM waiver, CMS refers to this service as Short-Term Recuperative Care.
- <sup>34</sup> *See CalAIM Demonstration Approval Technical Correction Attachment, supra* note 5. Note that the term of the 1115 Waiver is through December 31, 2026, so this service may end if the waiver is not renewed, or the benefit is not otherwise offered.
- <sup>35</sup> The two Section 1115 waivers authorizing Short-Term Post Hospitalization Housing, Recuperative Care, and Transitional Rent, all three of which are referred to in the waivers as “Room and Board” services, establish a “global cap” on coverage of these three Community Supports. Under the cap, coverage is limited to six months of Room and Board services per enrollee within a rolling 12-month period. This means that an individual may not receive more than a combined six months of Short-Term Post-Hospitalization Housing, Recuperative Care, and Transitional Rent during any rolling 12-month period. This limitation applies even if an individual changes Medi-Cal Managed Care Plans. *See CalAIM Demonstration Approval Technical Correction Attachment, supra* note 5, at 67 and *BH-Connect Waiver, supra* note 5, at 44.
- <sup>36</sup> *Community Supports Policy Guide Vol.2, supra* note 2, at 52–56.
- <sup>37</sup> *See CalAIM Demonstration Approval Technical Correction Attachment, supra* note 5. Note that the term of the Section 1115 Waiver is through December 31, 2026, so this service may end if the waiver is not renewed, or the benefit is not otherwise offered.
- <sup>38</sup> *Community Supports Policy Guide Vol.2, supra* note 2, at 13.
- <sup>39</sup> Transitional Rent is mandatory for MCP enrollees meeting the Behavioral Health Population of Focus as of January 1, 2026 and mandatory for all populations who meet the eligibility criteria for Transitional Rent as of January 1, 2027. *See BH-Connect Waiver, supra* note 5, at 221.

<sup>40</sup> Individuals must meet the U.S. Department of Housing and Urban Development's (HUD's) current definition of homeless or at risk of homelessness as codified at 24 C.F.R. part 91.5, with three modifications: 1) If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; and 2) The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days; and 3) For the at risk of homelessness definition at 24 C.F.R. § 91.5, the requirement to have an annual income below 30% of median family income for the area, as determined by HUD, will not apply. See *BH-Connect Waiver*, *supra* note 5, at 227. See also Cal. Dep't Health Care Servs., *Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion, and Development (CITED) Round 4: Transitional Rent* (Jan. 27, 2025), [https://tpa-reference-material-prod.s3.us-west-2.amazonaws.com/2025-01-28T10%3A14%3A31.443087685\\_2025-01-27%20CITED%20Round%204%20Transitional%20Rent%20Webinar.pdf](https://tpa-reference-material-prod.s3.us-west-2.amazonaws.com/2025-01-28T10%3A14%3A31.443087685_2025-01-27%20CITED%20Round%204%20Transitional%20Rent%20Webinar.pdf).

<sup>41</sup> CAL. WELF. & INST. CODE § 8526.

<sup>42</sup> For a full description of eligibility criteria, see *Community Supports Policy Guide Vol.2*, *supra* note 2, at 58–62.

<sup>43</sup> For individuals in 3(a)(i)–(iv), they must receive authorization for Transitional Rent within six months (i.e., within 182 days) of the transition event (e.g., date of discharge, date of release). Additionally, the individual can use the Transitional Rent Benefit without a redetermination of eligibility for six months from the date of authorization.

<sup>44</sup> Individuals transitioning out of foster care on or after their 18th birthday are eligible to receive Transitional Rent until their 26th birthday and may be authorized at any time during this window. The individual can use the Transitional Rent Benefit without a redetermination of eligibility for six months from the date of authorization.

<sup>45</sup> Individuals who are experiencing unsheltered homelessness, assuming satisfaction of the clinical risk factor eligibility requirement, may be authorized at any time. The individual can use the Transitional Rent Benefit without a redetermination of eligibility for six months from the date of authorization.

<sup>46</sup> Full Service Partnerships (FSP) are “are recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental illness often with a history of criminal justice involvement, and repeat hospitalizations.” Cal. Comm'n Behav. Health, Full Service Partnerships, <https://bhsoac.ca.gov/initiatives/full-service-partnerships/> (last visited Dec. 11, 2025); CAL. CODE REGS. Tit. 9, § 3620.

- <sup>47</sup> Individuals eligible for FSP, assuming satisfaction of the social risk factor eligibility requirement (experiencing or at risk of homelessness), may be authorized at any time. The individual can use the Transitional Rent Benefit without a redetermination of eligibility for six months from the date of authorization. *Community Supports Policy Guide Vol.2, supra* note 2, at 60.
- <sup>48</sup> SB 326, The Behavioral Health Services Act, 2023-2024, available at [https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=202320240SB326](https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB326) (last visited Dec. 11, 2025). For information on the passage of Proposition 1 and BHSA, see Dep't Health Care Servs., Behavioral Health Transformation, <https://www.dhcs.ca.gov/BHT/Pages/home.aspx> (last visited Dec. 11, 2025). Cal. Dep't Health Care Servs., *Community Supports Policy Guide Vol.2, supra* note 2, at 74.
- <sup>49</sup> Cal. Dep't Health Care Servs., *Transitional Rent Payment Methodology 2* (Oct. 3, 2025), <https://www.dhcs.ca.gov/services/Documents/DirectedPymts/Transitional-Rent-Payment-Methodology.pdf>.
- <sup>50</sup> *Id.* at 6.
- <sup>51</sup> *Id.* at 8.
- <sup>52</sup> *Community Supports Policy Guide Vol.1, supra* note 2, at 48.
- <sup>53</sup> Cal. Dep't Health Care Servs., *Addendum to the PHM Policy Guide: Closed-Loop Referral Implementation Guidance* (Updated May 2025), <https://www.dhcs.ca.gov/CalAIM/Documents/WIP-CLR-Implementation-Guidance.pdf>.
- <sup>54</sup> *Id.* at 4.
- <sup>55</sup> AB 133, Cal. Assembly 2021 Reg. Sess., [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=202120220AB133](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133) (last visited Dec. 11, 2025). See also *Community Supports MCP Elections, supra* note 4. ECM and Community Support Contacts for each MCP are available at Cal. Dep't Soc. Servs., Managed Care Plan Enhanced Care Management and Community Supports Referral Pathways, <https://www.cdss.ca.gov/inforesources/cdss-programs/enhanced-care-management-and-community-supports-referral-pathways> (last visited Dec. 11, 2025).
- <sup>56</sup> *Community Supports Policy Guide Vol.1, supra* note 2, at 50.
- <sup>57</sup> *Id.* at 51.
- <sup>58</sup> *Id.* at 52; CAL. WELF. & INST. CODE § 14197.3.

<sup>59</sup> See Cal. Dep't Health Care Servs., All Plan Letter 21-011 (Aug. 31, 2022) <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf>; see also Cal. Dep't Health Care Servs., *Community Supports, or In Lieu of Services (ILOS), Annual Report: Department of Health Care Services (DHCS) 1915(b) Waiver Report to the Centers for Medicare & Medicaid Services (CMS) for Calendar Year (CY) 2024*, at 57-58 (Apr. 2025) <https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-1915b-Annual-Report-on-ILOS-STC-B20-2025.pdf>; CMS, *California Advancing & Innovating Medi-Cal (CalAIM) Waiver Revised Special Terms and Conditions via CA-0017.R10.01 Amendment Waiver Control # CA 17.R10 January 1, 2022 through December 31, 2026*, at 9 (2023) <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-Approval-Letter-Revised-STCs.pdf>.