CONCEPT PAPER

Community Hubs for *Small* Adult Residential Facilities and Residential Care Facilities for the Elderly in California

A Review of Existing Models and a Framework for a 6-Bed or Smaller Facility

CALBHB/C | www.calbhbc.org/hubs | October 2026

AI disclaimer: This paper was drafted with the assistance of an AI language model, which helped synthesize source material, build the illustrative financial model, and draft narrative text under human direction and review. All factual claims are footnoted to their original sources; the modeling assumptions and calculations original to this brief are labeled as such throughout. Readers should independently verify figures before relying on them for financial or policy decisions.

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Executive Summary

California's small Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs) — often called “board and care” or “assisted living” — are an essential part of the state's behavioral health and housing continuum for people who need community-based, supervised, non-medical residential support. However, sustaining small, community-based facilities is a significant concern. In Los Angeles County, facilities of six beds or fewer accounted for 91% of RCFE closures and 64% of ARF closures between 2016 and 2021 — a strong signal that this is the size class most at risk of disappearing from California's board-and-care system.[1] Statewide, this is a major portion in this sector. About 85% of California’s licensed RCFEs serve six or fewer residents, and the typical licensed ARF or RCFE is defined by the same six-bed-or-fewer scale, meaning a large majority of facilities sit at the size this paper addresses.[2] By extrapolating Los Angeles County 2019 data with statewide SSI/SSP figures, we *estimate* that about 45% of licensed ARFs and RCFEs in California — roughly 5,700 facilities — serve at least one resident on SSI/SSP.[3]

We review five ARF/RCFE models that are operating in California today: a large, dedicated facility funded through braided county and state homelessness dollars; a large multi-site network combining a county per-diem subsidy with in-house Medi-Cal clinical billing; a standalone facility financed purely through a negotiated county per-diem rate; a statewide, state-administered acuity-tiered rate system for facilities serving residents with developmental disabilities; and a county-owned six-bed home in a rural county, run by a contracted operator. None of the first three has been demonstrated to work at the smallest facility size — 6 or fewer beds — that is often best suited to keeping residents in their own communities. The fourth is a sustainable model but is a statewide program limited to individuals with developmental disabilities diagnosed before the age of 18. The fifth shows that a six-bed home can work when the county buys the property and contracts with an experienced operator, but it depends on one-time county capital and a relatively high per-diem rate.

This paper proposes a new model that we call the Residential Community Care Hub (RCCH). The RCCH builds on a model currently in place to support small community-based organizations: the Community Care Hub model. An RCCH would aggregate Medi-Cal managed care contracting, billing, and care coordination across a network of community-based organizations, that include ARFs and RCFEs, unlocking Medi-Cal Enhanced Care Management (ECM) and Community Supports revenue that no single small program or facility could access on its own.

The RCCH would extend the Community Care Hub model to help small ARFs and RCFEs draw as much of a facility's revenue as possible from Medi-Cal-billed services, combined with other funding, such as a county-funded patch — drawing on Behavioral Health Services Act (BHSA) funds, 2011 Realignment dollars, federal grants, local measures, or some mix of these — for whatever gap remains once Medi-Cal revenue is maximized.

We suggest a model based on supporting 6-bed facilities, with an RCCH providing a guaranteed minimum monthly payment per bed along with RCCH responsibility to provide ongoing technical assistance, support and training to its network facilities. We size the RCCH itself: how many facilities it would need in its network to cover its own costs and generate a modest surplus under this fee structure. This model addresses the complexities of the funding streams and support needs, positioning the RCCH at the center of administration, contracting, technical assistance, support and training.

1. The Need: The Human and Fiscal Case for More ARF/RCFE Capacity

1.1 The Human and Community Cost of an Inadequate Supply

Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs) are critical components of CA's housing continuum. Lack of ARFs and RCFEs impacts families, local communities, and most of all, it impacts individuals with serious mental illness (SMI) who for health and/or physical reasons cannot live independently. The social and financial costs are high as individuals enter revolving doors between crisis facilities, psychiatric facilities, emergency rooms, homelessness and incarceration. A durable supply of community-based ARFs and RCFEs is one of the few interventions that can interrupt this cycle by giving people a stable, adequately supported place to live.

1.2 The Cost of the Alternatives

The board-and-care per-diem rates discussed throughout this brief are far below the daily cost of the institutional settings that absorb people when no board-and-care bed is available. Skilled nursing facilities cost approximately $375/day.[4] California's Department of State Hospitals bills $423 to $1,186 per day for psychiatric care, depending on the level of acuity.[5] The Legislative Analyst's Office calculates that incarcerating someone in California state prison costs about $350 per day on average.[6] And Vera Institute of Justice data show Los Angeles County spends approximately $343 per day to hold someone in county jail.[7]

Setting	Approx. cost / day
Skilled Nursing Facility	~$375
Psychiatric Hospitalization (state-hospital-level care)	$423 – $1,186
State Prison (CDCR, statewide average)	~$350
County Jail (Los Angeles County)	~$343

Figures come from different populations, acuity levels, and government systems than the board-and-care per-diem rates discussed elsewhere in this brief; they illustrate the relative order of magnitude of institutional alternatives, not a directly substitutable cost for a specific individual's care. Every day a person with SMI who cannot live independently instead cycles through a psychiatric hospital, a prison, or a jail cell for lack of an available board-and-care bed is a day billed at these institutional rates rather than at a fraction of the cost in a supervised community setting.

2. The Current Landscape: The Board and Care Financing Problem

ARFs serve adults with mental illness, physical disabilities, or developmental disabilities; RCFEs serve adults 60 and older. Both are licensed, non-medical facilities required to provide 24/7 supervision, meals, medication support, and assistance with daily living. For residents who rely on public benefits, the facility's primary income is the Supplemental Security Income/State Supplementary Payment (SSI/SSP) Non-Medical Out-of-Home Care (NMOHC) rate — a rate that has never been sufficient, on its own, to cover the true cost of care.[8]

This gap has historically been addressed by layering a second revenue source on top of SSI/SSP — a county subsidy, a Medi-Cal clinical billing stream, a regional center vendor rate, or some combination.

Two federal Medi-Cal Home and Community-Based Services mechanisms already exist specifically to help people avoid or leave institutional care. **However, access to the programs is capped, resulting in thousands of Californians on waiting lists:**

> The Home and Community-Based Alternatives (HCBA) Waiver provides long-term supports and services — delivered by a nurse-and-social-worker Care Management Team that coordinates Waiver and State Plan services such as medical care, behavioral health, and In-Home Supportive Services — to eligible Medi-Cal beneficiaries at risk of nursing home or institutional placement, in the home or community residence of their choice.[9] As of the April 2026 data dashboard provided by the California Department of Health Care Services (DHCS), there were 6,588 people on the waiting list, with roughly 11,101 individuals currently enrolled and receiving active home care services through the program.
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> The Assisted Living Waiver (ALW), in place in California since 2009, gives eligible Medi-Cal beneficiaries age 21 or older who have resided in a nursing facility for at least 60 days the choice to move to an assisted living setting — an ARF or RCFE — instead of remaining in long-term nursing facility placement; ALW is available in only 15 of California's 58 counties, is capped at 18,762 participants statewide, and carried a waitlist of 18,365 people as of December 2025. [10] ALW eligibility specifically targets dual-eligible beneficiaries — people enrolled in both Medicare and Medi-Cal — who are aged and/or disabled, frequently with a serious mental illness or substance use disorder diagnosis when they qualify on the basis of disability rather than age. The goal of both Waivers is the same: facilitate the transition of institutionalized individuals to a less-restrictive, community-based setting, and prevent individuals who are at imminent risk of institutionalization from being admitted in the first place. As with the Community Supports pathway modeled in Section 4, Medi-Cal pays only for services under HCBA and ALW, not for room and board — the SSI/SSP NMOHC rate remains the funding source for housing itself across all of these mechanisms.

3. What's Currently in Place: Five Working Models

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3.1 Los Angeles County's Enriched Residential Care Program

Los Angeles County's Department of Mental Health (DMH) operates a project-based Enriched Residential Care (ERC) site: the Crocker Care Campus, a Residential Care Facility for the Elderly (RCFE) with 24 beds dedicated entirely to DMH clients.[11] The ERC program also operates on a scattered-site basis — the same two-part subsidy applied to individual beds at existing, independently owned ARFs and RCFEs, rather than a purpose-built facility.[12]

For the Crocker Care Campus, funding is braided across four distinct sources: Behavioral Health Bridge Housing (BHBH), Community Care Expansion (CCE) Preservation Program operating subsidies, Substance Abuse and Mental Health Services Administration (SAMHSA) funds, and Behavioral Health Services Act (BHSA) Housing Interventions dollars. BHBH and CCE Preservation are both time-limited state grant programs, not ongoing funding streams — meaning two of this model's four funding sources are temporary and will eventually need to be backfilled or replaced.[13]

Residents receive the Non-Medical Out-of-Home Care (NMOHC) rate (California's SSI/SSP-based room-and-board rate) plus a tiered enhanced-services operating subsidy set by a four-tier acuity system; the program is administered on the county's behalf by a third-party administrator, Brilliant Corners, through a Flexible Housing Subsidy Pool.[14]

What this model requires: a government partner willing to dedicate most or all of a facility's beds to one program — typically the full facility, though some LA County programs instead lease only a portion of a facility's beds —, project-based capital or lease financing, and a braided funding stack spanning at least four grant programs — two of which (BHBH, CCE Preservation) carry sunset dates and must eventually be absorbed into ongoing BHSA funding.

3.2 The Multi-Site Clinical Billing Model: Psynergy Programs, Monterey County

Monterey County's FY 2022-23 agreement with Psynergy Programs, Inc. pays for beds in five facilities in various counties — Cielo Vista, Nueva Vista, Nueva Vista Sacramento, Vista de Robles, and Vista Esperanza — under a single contract, with a combined average census of approximately 27.5 residents.[15]

The county pays a tiered daily rate on top of each resident's own SSI/SSP: $159.50/day for Complexity Level I (the largest tier, 20 of the network's residents), $133.10/day for Complexity Level II, $264.00/day for Intensive Support Services, and $54.60/day for lower-need residents at the Tres Vista site.[16]

Separately, on top of this housing subsidy, the county pays Psynergy up to $1,255,322 per year for Medi-Cal-billable clinical services — case management, medication support, crisis intervention, and collateral services

— delivered by Psynergy's own in-house clinical staff, nearly matching the $1,509,428 maximum housing subsidy itself.[17]

What this model requires: enough combined census across a multi-site network to justify operating an in-house Medi-Cal-certified clinic. The clinical billing layer is what nearly doubles revenue per resident — but it is not available to a single small facility working alone. These Psynergy sites should also be distinguished from Institutions for Mental Disease (IMDs): the clinical/mental health care described in this contract is delivered at an offsite clinic (rather than on the licensed ARF premises itself).

3.3 The Standalone Per-Diem Model: Davis Guest Home, Lake County

Lake County's FY 2021-22 contract with Davis Guest Home (which operates in Stanislaus County) funds out-of-county placements at a base rate of $125 per resident, per day, with acuity-adjusted rates ranging from $150 to $800 per day for higher-need placements, negotiated case by case.[18]

The contract includes an overstay penalty of $350/day if the county fails to relocate a resident within 30 days of a discharge notice, and an annual ceiling of $133,000 in the reviewed agreement — consistent with a small number of residents placed under this specific contract.[19]

Unlike the Monterey/Psynergy model, this contract does not describe a separate Medi-Cal clinical billing layer; Davis Guest Home receives only the negotiated per-diem rate on top of residents' own SSI/SSP.

What this model requires: a county willing to negotiate and hold an individual out-of-county placement contract — a mechanism that works well for isolated placements but does not, by itself, build a repeatable financing structure for a facility's full census.

3.4 The Regional Center Vendorization Model: DDS Rate Reform

A fourth model exists for ARFs that serve residents with intellectual or developmental disabilities (I/DD): vendorization through California's regional center system, administered by the Department of Developmental Services (DDS). Since 2019, DDS has implemented a statewide “rate reform” that replaced older, individually negotiated rates with standardized, acuity-tiered rate models, fully implemented as of January 1, 2025. Vendored facilities are paid a base rate equal to 90% of the applicable rate model, plus a Quality Incentive Payment of up to 10%, for a combined “full rate.”

It is important to distinguish this model from the behavioral health mechanisms discussed elsewhere in this brief. Regional center eligibility is defined by intellectual or developmental disability under the Lanterman Developmental Disabilities Services Act, not by a psychiatric diagnosis or behavioral health need. Some regional center clients do have a co-occurring mental health or substance use condition, and regional centers coordinate certain behavioral services for these dual-diagnosis individuals, but a resident cannot access regional center vendorization or its rate schedule on the basis of a behavioral health condition alone — eligibility requires a qualifying developmental disability with onset before age 18, independent of whether behavioral health needs are also present.

Rates are set separately by each of California's 21 regional centers and vary further by facility size (four beds or fewer versus five or more) and by service level, which reflects each resident's acuity and support needs. As an illustration, San Andreas Regional Center's published schedule shows monthly per-resident rates ranging from about $1,212 at the lowest service level (essentially the SSI/SSP pass-through) up to roughly $14,300–$16,100 at the highest service levels for larger, five-or-more-bed facilities, and higher still at some service levels for four-or-fewer-bed, owner-operated homes. This is a materially higher and more clinically-

tiered rate structure than either the county behavioral health ERC model (Section 3.1) or the Medi-Cal Community Supports pathway modeled in Section 4 — though it applies only to residents who are regional-center-eligible (a qualifying developmental disability with onset before age 18), not to the SMI-only or general-elderly populations those other mechanisms serve. Current rate schedules for every regional center, including those serving Los Angeles County (Frank D. Lanterman, North Los Angeles County, and San Gabriel/Pomona Regional Centers), are published by DDS and updated on a rolling basis.[20]

For a mixed-population 6-bed facility — one that serves some residents through SSI/SSP and county or Medi-Cal mechanisms and others who qualify for regional center vendorization — this rate schedule represents a fourth, generally more favorable revenue pathway that operates entirely independently of the Community Hub model built in Section 4. It is not a substitute for the Hub or the county patch for non-regional-center-eligible residents, and a facility cannot bill both a regional center vendor rate and a Medi-Cal Community Supports rate for the same resident.

What this model requires: regional center vendorization (a separate certification and contracting process from Medi-Cal or county behavioral health enrollment), and residents who meet DDS's developmental-disability eligibility criteria — a population this brief's other models do not serve.

3.5 The County-Owned, Contracted-Operator Model: Alpine House, Trinity County

Trinity County, one of California's most rural counties, used Mental Health Services Act Capital Facilities and Technological Needs funds, together with Community Services and Supports revenue, to buy a home for a county board and care facility, Alpine House, in Weaverville. The six-bed facility, with the sixth bed originally designated for respite, was created so that Full Service Partnership clients who had been placed out of county could return home, closer to family and other support.[21]

Alpine House operates as a six-bed adult residential program run by Willow Glen Care Center, a private provider that operates several residential facilities for adults with serious mental illness across Northern California. Its stated goal is to help residents build the skills to move from 24-hour supervised care to independent living in their home county, working with county mental health staff, case managers, and the Public Guardian.[22]

The county originally paired a respite bed with intensive peer support from staff based at its wellness center and reported fewer out-of-county hospitalizations and less use of crisis services as a result. Community Care Licensing requirements, however, meant that admission to the respite bed sometimes took days, which later led the county to open a separate peer respite crisis center (Cedar Home) located next door.

Other counties can also place residents at Alpine House. Lake County's contract with Willow Glen lists a daily rate for Alpine House of $230 in FY 2022-23, $235 in FY 2023-24, and $260 in FY 2024-25. The contract amendment does not say whether these rates are in addition to residents' SSI/SSP, and Trinity County's own rate for the facility was not found in the public documents reviewed for this brief.[23]

What this model requires: one-time county capital to buy the property, an experienced operator willing to run a single six-bed site, and a per-diem rate high enough to sustain it. Alpine House shows that a six-bed facility can operate when the county takes on the property cost. The operator's larger network of facilities likely helps absorb administrative and clinical overhead that a standalone six-bed owner would carry alone — the same scale problem the Community Hub model in Section 4 is designed to address.

3.6 Comparing the Five Models

	Crocker Care Campus (LA County)	Psynergy (Monterey County)	Davis Guest Home (Lake County)	DDS Regional Center Vendorization	Alpine House (Trinity County)
Scale	24 beds, 1 dedicated site	~27.5 beds, 5 facilities across various counties	Individual out-of-county placements	Any vendored facility statewide; rate varies by facility size and regional center	6 beds, 1 county-owned site
Second revenue layer	Tiered ERC operating subsidy	Tiered per-diem + separate clinical billing	Acuity-adjusted per-diem only	Acuity-tiered monthly vendor rate (base + Quality Incentive Payment)	Per-diem rate (Lake County contract: $230–$260/day)
In-house clinical billing?	No	Yes (~$1.26M/year)	No	No — flat monthly payment, not separately billed services	Not documented for Alpine House
What government must provide	Dedicate full facility; braid 4 grant sources	Contract at network scale; accept per-diem tiers	Negotiate individual placement contract	Vendorization through a regional center; limited to I/DD-eligible residents	Buy the property; contract with an experienced operator; pay a per-diem rate

None of the first three models above has been demonstrated to work at 6 beds — the scale at which a facility can be sited in an ordinary residential neighborhood and keep residents closest to their home community. The common barrier is the same in both real contracts reviewed above: unlocking a second revenue layer beyond SSI/SSP requires either project-based dedication of an entire facility's beds (Crocker Care Campus) or enough combined census to run an in-house clinic (Psynergy) — both scale-dependent, and both out of reach for a standalone 6-bed operator working alone. The fourth model, DDS regional center vendorization (Section 3.4), is a partial exception: its rates are not scale-dependent and apply to vendored facilities of any size, including 6 beds — but only for residents with a qualifying developmental disability, which does not address the funding gap for the SMI, elderly, and other non-I/DD residents this brief's Community Hub model is built to serve. The fifth model, Alpine House (Section 3.5), does operate at 6 beds, but only because the county bought the property and contracts with an operator that runs a larger network of facilities. It depends on one-time county capital and a relatively high per-diem rate.

4. The Community Hub Model: Extending These Mechanisms to Small Facilities

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4.1 What is the Community Hub Model? (See Appendix A for more information.)

A Community Hub is a third-party administrator that contracts with Medi-Cal managed care plans (MCPs) on behalf of a network of small ARFs and RCFEs and subcontracts with those facilities to deliver services. The model builds on the role Brilliant Corners plays as administrator of LA County DMH's Enriched Residential Care (ERC) program, where it serves as the fiscal intermediary that pays participating facilities.[24] A Hub adds the Medi-Cal functions small operators cannot carry on their own: MCP contracting, billing and claims processing, credentialing, compliance, and care coordination staff who screen residents and help connect them to Enhanced Care Management (ECM) and other Community Supports. Beyond contracting and billing, a Hub should also be expected to provide ongoing technical assistance and training to its network facilities — documentation practices for Ongoing Support Services billing, credentialing and Provider Application and Validation for Enrollment (PAVE) basics (if needed), and quality and compliance support — since small operators are unlikely to develop this expertise on their own and consistent documentation quality directly affects how much Medi-Cal revenue the network can draw down.[25] DHCS encourages MCPs to use community care hubs that centralize these administrative functions between plans and community-based providers.[26]

The main Medi-Cal service a Hub can make billable for small ARFs and RCFEs is the Assisted Living Facility (ALF) Transitions Community Support (formerly "Nursing Facility Transition/Diversion to Assisted Living Facilities"). It is available to MCP members who have lived 60 or more days in a nursing facility, or who live in the community (including in an ARF or RCFE) and meet the minimum criteria for nursing facility level of care. It has two components:[27]

- Transition services (time-limited) — assessing the resident's housing and service needs, completing facility applications and securing required documents, moving expenses, and coordinating the move.
- Ongoing assisted living services (the component this paper's financial model refers to as Ongoing Support Services) — help with Activities of Daily Living and Instrumental Activities of Daily Living, meal preparation, transportation, medication administration and oversight, companion services, therapeutic social and recreational programming, 24-hour onsite direct care staff for supervision and safety, and care coordination to screen for and support enrollment in ECM and other Community Supports.

Medi-Cal does not pay for room and board, and a resident cannot receive the same services through ALF Transitions and the Assisted Living Waiver at the same time.[2829] DHCS's July 2026 draft update to the guide also encourages plans not to limit ALF Transitions networks to facilities enrolled in the Assisted Living Waiver, and to consider contracting with qualified ARFs and RCFEs that are not.[30] Other services small facilities often provide — such as individualized care plan management, life skills and employment support, and enriched services like on-site therapy, counseling, or nursing — are not part of ALF Transitions. Where they are reimbursed, it is through other payers: ECM (delivered by an ECM provider, which could be the Hub), the county behavioral health plan, or county-funded programs such as DMH's ERC program. What is actually reimbursed, and by which payer, also depends on each facility's staffing and contracting arrangements.[31]

It helps to separate two questions: what a Hub or facility can bill for, and what Medi-Cal benefits a resident can receive while living in a small ARF or RCFE. Community Supports are benefits authorized for the individual member, and they must supplement, not supplant, services the member already receives through other programs.[32] Supports that duplicate the care, supervision, meals, and personal care already funded through the facility's SSI/SSP rate are therefore unlikely to be authorized, while supports that add something new can be.

For a resident with serious mental illness who does not meet nursing facility level of care, the most relevant Medi-Cal benefits are: Enhanced Care Management, for adults who meet the serious mental health or substance use disorder population criteria, which a Hub could provide as the ECM provider;[33] Day Habilitation Programs, which are open to members who are experiencing homelessness, exited homelessness within the past 24 months, or are at risk of homelessness or institutionalization;[34] Sobering Centers, for members who meet their criteria;[35] and, when a resident is ready to step down from the ARF or RCFE into more independent housing, Transitional Rent and the housing navigation, deposit, and tenancy supports, for members who are experiencing or at risk of homelessness and meet the clinical and transition criteria.[36] Transitional Rent cannot pay for an assisted living setting itself, although county BHSA Housing Interventions funds can.[37] Residents also keep their county specialty mental health and Drug Medi-Cal services and their plan's other covered benefits (see Appendices B and C). Separately, network facilities may be able to offer facility-based Caregiver Respite (formerly Respite Services) for caregivers of members living elsewhere in the community.[3839] The full menu of 15 Community Supports is listed in Appendix A, section A7.

Additional Community Care Hub Information is in Appendix A.

4.2 Why is this needed?

A significant share of small ARF and RCFE operators lack the staff and support that ongoing contract compliance and care coordination require. An RCCH would work to close that gap.

A small ARF/RCFE operator is unlikely to become a direct Medi-Cal billing provider on its own, even though the regulatory bar for Community Supports specifically is lower than it first appears. DHCS's guidance states that CBOs providing Community Supports only are not required to enroll through the PAVE portal at all — full PAVE enrollment, which requires submitting personal information for all executive staff and board members, is required only for organizations delivering Community Health Worker, asthma prevention, or justice-involved services. For Community Supports, the requirement is simply contracting directly with the Medi-Cal managed care plans (MCPs) operating in the county. That contracting process, however, still

requires executing a HIPAA Business Associate Agreement, building a claims and revenue-cycle process, and completing each MCP's own credentialing process — which realistically takes up to six months per plan, and most counties have more than one MCP. Because MCPs incur roughly the same fixed contracting overhead whether a provider serves 6 clients or 600, a single small facility is an impractical direct-contracting partner regardless of its own administrative capability — which is precisely the gap a Community Hub is built to close by holding the MCP contracts on behalf of many small facilities at once.[40]

4.3 How does this work?

A standalone Medi-Cal Enhanced Care Management (ECM) program needs on the order of 150 enrolled cases per month to cover its own overhead; a single 6-bed facility can offer at most 6 of those cases, so aggregation across many small facilities in a Hub's network is what makes this revenue reachable at all.[41] This is the same aggregation logic behind DHCS's Medi-Cal Community Care Hub concept, and DHCS places no percentage cap on what such a Hub may retain as an administrative fee; the only constraint that applies — an 85% Medical Loss Ratio floor — binds only Hubs that assume financial risk above $30 million in Medi-Cal capitation in a single county, a scale far beyond a Hub serving small ARFs and RCFEs.[42]

Applying this model to ARFs and RCFEs is not hypothetical. A 2022 brief from the Center for Health Care Strategies, prepared for the California Health Care Foundation, examined exactly this model — a “CBO network” led by a “network lead entity” that serves as a hub for coordinating services, contracting, billing, and reporting on behalf of member community-based organizations — and named Institute on Aging directly among California's existing CBO networks positioned for this role under CalAIM.[43] The Institute on Aging supported residential facility operators using this model.

Two examples cited in that brief show what this administrative layer can look like in practice, at real scale.

As of the brief's August 2022 publication, and confirmed as still active today, United Way of San Joaquin County acts as a fiscal sponsor for member organizations — nearly 70% of local CBOs operate on budgets under $55,000 — handling HR, payroll, benefits administration, claims processing, and invoicing in exchange for a modest annual fee, freeing member CBOs to focus on service delivery rather than back-office administration. United Way of San Joaquin County's own FY2025 audited financial statements still list fiscal-sponsor cash holdings, fiscal-sponsor liabilities, and administrative fee revenue as active line items, and the California Grants Portal lists it as an active fiscal sponsor for at least one grantee as of fiscal year 2025-26.[44]

In Portland, Oregon, Project Access Now's C3 Community Assistance Program coordinates and contracts with more than 200 CBOs, providing over $3 million in goods and services annually to roughly 10,000 community members and filling more than 20,000 service requests — funded by participating health care entities that pay the network directly for services rendered, plus a tiered administrative fee based on referral volume. This is the same revenue structure modeled for the Community Hub in Section 4.6, operating at a scale that demonstrates the model's administrative-fee approach is workable, even though it is not a California ARF/RCFE example specifically.[45]

The same brief also documents a real limitation. Several CBO representatives interviewed reported that “the administrative rate available through ECM and CS contracts is relatively low, making hiring additional staff to oversee the coordination of services across organizations difficult to cover” — an independent, real-world confirmation that thin per-resident Hub revenue is a genuine concern, confirming the need for braided funding from additional sources. The model proposed in section 4.5 addresses this limitation.

4.4 Possible Lead Entities and a Broader Funding Mix

In some counties, the local behavioral health agency may be positioned to take on the braiding and contracting function itself, rather than delegating it to an external Hub — contracting directly with Medi-Cal managed care plans for Enhanced Care Management and Community Supports revenue on behalf of a network of small ARF/RCFE operators, and passing that revenue through via the county's own facility contracts. This keeps the county, rather than a third-party administrator, at the center of managed-care contracting, billing, and reporting, trading the administrative burden and financial risk a Hub would otherwise absorb for tighter county control over the process.

A county could build this capability as its own infrastructure — a county-run ARF/RCFE portal that supports multiple programs (Community Supports billing, ERC-style patches, licensing and compliance tracking) through one interface, rather than standing up a separate third-party intermediary. Building the Hub as county infrastructure would also raise a design choice: whether to open that portal to ARFs and RCFEs of any size, or limit participation to smaller facilities specifically, given that larger facilities may already have the administrative capacity to contract directly.

Although county behavioral health departments could reasonably be the primary focus for developing this kind of tool, a broader design that spans local health and housing departments jointly is worth considering, even though it is a more challenging design and coordination exercise. A jointly-administered structure would let a 6-bed facility participate in multiple programs — behavioral health, public health, and housing — through a single relationship, rather than having to separately apply to and satisfy the reporting requirements of each department's own program.

This model of support braiding resembles what the California Department of Health Care Services (DHCS) calls a Flexible Housing Subsidy Pool, or "Flex Pool." A Flex Pool is not a licensing category or a legal designation — it is a functional description of an entity that performs four core tasks: coordinating and braiding funding streams; acting as a fiscal intermediary between funders and landlords; identifying, securing, and supporting a portfolio of housing units; and coordinating with housing supportive-service providers.[46] The role of a Lead Entity can be assumed by a municipal government agency (a city), as well as county government agencies, Medi-Cal Managed Care Plans (MCPs), Continuums of Care (CoCs), and public housing authorities. DHCS has documented three recurring Flex Pool models: an "Integrated" model in which a Lead Entity (usually the county) braids funding and subcontracts landlord- and participant-facing work to an Operator; a "Housing-Only" model in which an Operator (often a CBO) braids funding and contracts directly with funders; and a smaller-scale "In-House" model in which a single county team performs both roles.[47]

Whether a Community Hub, as modeled in this brief, counts as a Flex Pool depends on how strictly the term is applied. DHCS's materials specify that Flex Pools exist to administer rental subsidies for scattered-site or set-aside housing units, paid to landlords, on behalf of people experiencing or at risk of homelessness.[48] An RCCH would instead braid and bill Medi-Cal revenue on behalf of licensed ARFs and RCFEs — congregate care facilities with their own room-and-board rate (SSI/SSP NMOHC), not independent rental units with landlords. The two structures share the same underlying administrative logic — braiding multiple funding streams behind a single point of contact, and freeing small operators and CBOs from having to negotiate every funding source separately — but a Hub built around Medi-Cal-billed board-and-care services is not, strictly speaking, a Flex Pool under DHCS's current framework. That said, nothing prevents a county from extending its existing Flex Pool infrastructure or Lead Entity relationships to also cover ARF/RCFE-based

Community Supports billing, particularly under the "Integrated" or "In-House" models, where the same Lead Entity already manages multiple braided funding streams and MCP contracts.

Whichever administrative structure a locality chooses, the county patch modeled in Section 4.5 does not have to be filled solely with BHSA or 2011 Realignment dollars. Counties can braid in other local, state, and federal sources to cover the gap that remains after Medi-Cal revenue is maximized. On the federal side, SAMHSA's Community Mental Health Services Block Grant and its Projects for Assistance in Transition from Homelessness (PATH) grant both fund community-based services, treatment, and a limited set of housing supports for adults with serious mental illness, and are distributed to California counties through DHCS.[4950] On the local side, several California counties have passed dedicated ballot measures that fund homeless and behavioral health housing; Los Angeles County's Measure A, a half-cent sales tax approved by voters in November 2024, is projected to generate roughly $1 billion annually, with the majority of proceeds directed to comprehensive homeless services.[51] None of these sources is guaranteed or unlimited, and each comes with its own eligibility rules and reporting requirements — braiding them is exactly the kind of administrative work a Hub, a Flex-Pool-style Lead Entity, or a county behavioral health agency would need to take on.

Beyond funding the patch itself, BH-CONNECT is a state mechanism worth connecting to this model because it could reward counties and Medi-Cal managed care plans for actually using ARF/RCFE capacity, rather than only helping pay for it. BH-CONNECT, California's Section 1115 Medicaid demonstration approved by CMS in December 2024 and running through December 2029, includes an Access, Reform and Outcomes Incentive Program specifically designed to incentivize county behavioral health delivery systems to improve access to services and outcomes for Medi-Cal members with significant behavioral health needs — a mechanism that could, in principle, reward counties for the kind of bed utilization and care coordination this brief's Community Hub model is built to support.[52] Counties that earn these incentive payments could decide how to use them, including allocating a portion to participating ARFs/RCFEs and Hubs.

4.5 Residential Community Care Hub (RCCH): A Very Small, 6-Bed ARF/RCFE — Combining Medi-Cal Revenue with a County Patch

This model shows how Medi-Cal-billed services and a county-funded patch work together to cover a facility's full operating cost. The order of operations below is deliberate: start from the facility's real operating cost, add SSI/SSP, add Hub-enabled Medi-Cal revenue, and only then calculate the smallest county patch that closes whatever gap remains. For simplicity, the patch below is modeled as a single number; in practice it could be braided from multiple local, state, and federal sources — BHSA, 2011 Realignment, SAMHSA grants, local measures such as Measure A, or some combination — as discussed in Section 4.4. All dollar figures below are original calculations for this brief; none are independently published by the cited sources.

Throughout this section, “preservation” means keeping existing small ARFs and RCFEs open with their current operators and in their current buildings, as opposed to expanding capacity by acquiring and rehabilitating new properties. The preservation rate therefore reflects an existing facility’s current property costs, with staffing raised to sustainable wages and a 3% margin. It does not cover one-time capital needs: Genesis LA estimates that bringing a typical six-bed facility up to standard costs about $44,120 per bed, which would need a separate source such as capital grants. It also excludes replacement reserves, and operators who bought recently or pay market rent will have higher costs, closer to Genesis LA’s Lease and Ownership Models discussed below.

Step 1: Operating cost to preserve an existing facility (6 beds or fewer)

Line item	Cost / bed / year	6-bed facility / year
Operating cost, existing facility, wage-adjusted	$60,180	$361,080

Cost per bed drawn from Genesis LA & Brilliant Corners, Preserving & Expanding Board and Care Facilities in Los Angeles County (October 2025), Table 1, "6 beds or fewer" tier ($47,220/bed/year, or $129/bed/day, based on the Licensed Adult Residential Care Association's model six-bed budget), with the staffing line raised from $23,040 to $36,000 per bed per year to reflect Genesis LA's recommended $25/hour wage plus 8% payroll taxes and 15% benefits. The result, $164.88/bed/day, is multiplied by 6 beds. This preservation scenario assumes an existing facility with no new acquisition debt; Genesis LA estimates $190/bed/day, before profit, for a newly acquired and rehabilitated facility.

Step 2: SSI/SSP income

Line item	Per bed / year	6-bed facility / year
SSI/SSP (NMOHC) income	$16,777	$100,662

SSI/SSP figure from California's 2024 Non-Medical Out-of-Home Care (NMOHC) amount payable for basic services — room and board plus care and supervision, excluding the resident's personal and incidental needs allowance (~$1,398/month). 2024 figures are used to match the 2024 cost data in Step 1.

Step 3: Gross Medi-Cal billing (ALF Transitions per diem)

For each resident who is eligible for the ALF Transitions Community Support, the Hub bills Medi-Cal for the ongoing assisted living services component on the resident's behalf, generating gross billing revenue before any administrative fee is applied. Residents who are not eligible generate no ALF Transitions revenue; their facility costs are covered by SSI/SSP and the county patch (see "Two groups of residents" below). Enhanced Care Management, which the Hub could also provide, is not included because DHCS does not publish ECM rates and ECM revenue would also have to cover the Hub's own care management staff. How gross billing is divided among the Hub, the operator, and the facility is addressed in Step 4, together with the county patch.

Rather than an assumed flat rate, this revenue is grounded in a real, published DHCS benchmark: the Assisted Living Facility (ALF) Transitions Community Support (formerly "Nursing Facility Transition/Diversion to Assisted Living Facilities"), defined specifically to cover placements in RCFEs and ARFs. DHCS does not publish binding ECM rates — it states plainly that it does not release capitation information at the benefit level — but it does publish a non-binding Community Supports pricing benchmark for this exact service category, most recently reconfirmed in December 2025.[53]

This Community Support has two separately priced components. A transition-services payment of $459 per member per month (range $422–$496) covers a care manager's work placing and settling a resident into the facility — this reads as a bridge payment tied to the transition period, not an indefinite monthly amount, so it is not built into the recurring revenue model below. A separate "Ongoing Support Services" benchmark of $33 per hour (range $29–$38) covers hands-on help with activities of daily living, medication oversight, companion services, and similar support — the kind of care a small ARF or RCFE's own staff already provide. Plans do not pay for this component by the hour, however. DHCS's billing code for ongoing assisted living services (HCPCS H2022 with modifier U5) is a per diem,[54] and DHCS does not set Community Supports provider rates; each plan negotiates its own rates with its providers.[55] The hourly benchmark is useful only

as a way to estimate a daily rate: a per diem equals the hours of care a resident receives each day multiplied by the hourly rate, so 0.5 hours a day at $33 corresponds to a per diem of $16.50, and 1.0 hour a day corresponds to $33.00.

In practice, several managed care plans appear to pay for ongoing assisted living services using the Assisted Living Waiver's (ALW)* five-tier per diem schedule instead of the DHCS hourly benchmark — Santa Clara and San Francisco counties have published documents describing this approach, and anecdotal reports from Los Angeles County ARF/RCFE operators describe the same ALW rate card[56] being used as their reimbursement model. In 2026, those ALW per diems range from $95.69 a day (Tier 1) to $270.80 a day (Tier 5).[57] Even Tier 1 is equivalent to about 2.9 hours of care a day at the $33 hourly benchmark, so where plans follow the ALW schedule, Medi-Cal revenue for an eligible resident is far higher than the benchmark-based estimates. The model therefore shows three per diem scenarios: $16.50 and $33.00 (the hourly benchmark at 0.5 and 1.0 hours a day) and $95.69 (ALW Tier 1). All three are estimates of what a plan might pay, not confirmed rates for any county.

Gross Medi-Cal billing (per bed/year)	$16.50/day (0.5 hr)	$33.00/day (1.0 hr)	$95.69/day (ALW Tier 1)
Resident eligible for ALF Transitions	$6,023	$12,045	$34,927
Resident not eligible	$0	$0	$0

Gross billing = per diem × 365 days, for each resident authorized for ALF Transitions. The per diem is the remaining estimate in this calculation: the first two columns convert DHCS's non-binding $33/hour benchmark into a daily rate, and the third uses the 2026 ALW Tier 1 rate. The separate $459/month transition-services benchmark is a one-time-per-placement revenue opportunity not included in these recurring figures.

Two groups of residents

ALF Transitions is available only to members who meet nursing facility level of care (Section 4.1), and many ARF and RCFE residents with serious mental illness will not. The model therefore treats residents as two groups. A resident who is eligible for ALF Transitions brings in Medi-Cal per diem revenue that reduces the county patch. A resident who is not eligible brings in no ALF Transitions revenue, so the patch must cover the full gap between SSI/SSP and the target rate, and the Hub's 3% fee on that patch slightly increases its cost to the county. The share of residents who will qualify is not known; it will vary by facility and population, and may be higher in RCFEs serving older adults than in ARFs serving younger adults. The tables below therefore show results for each group separately and for networks in which 100%, 50%, 25%, or none of the residents are eligible.

Step 4: A simple administrative fee — 10% of Medi-Cal billing, 3% of the patch

This model uses a flat, two-part administrative fee. The Hub retains 10% of gross Medi-Cal billing and 3% of the county patch; the ARF/RCFE operator receives the remainder of each — 90% of Medi-Cal billing and 97% of the patch. Because the fee on the patch is much smaller than the fee on Medi-Cal billing, the model

rewards maximizing Medi-Cal revenue before relying on the patch, expressed as two simple, easy-to-administer rates rather than a single blended one.

Revenue source	Hub share	Operator/facility share
Gross Medi-Cal billing	10%	90%
County patch	3%	97%

A guaranteed monthly floor per bed

Because this model is designed to bring every 6-bed facility to the same target — full operating cost plus a 3% margin — regardless of per diem level or how many of its residents are eligible for ALF Transitions, that target can be expressed as a guaranteed minimum monthly payment per bed. Combining Hub-enabled Medi-Cal revenue and the county patch, net of the Hub's fees, the guaranteed floor is $3,767/bed/month ($45,208/year); adding SSI/SSP brings the facility's total guaranteed monthly floor to $5,165/bed/month ($61,985/year). In practice, the split between the Medi-Cal and patch components of that floor would vary month to month with which residents are authorized for ALF Transitions and at what per diem, with the patch (or a Hub-held reserve funded by the patch) making up whatever gap remains in months when Medi-Cal billing falls short (for example, while an authorization is pending), and the surplus banked in months when it runs ahead.

A Hub or county could implement the pooling and smoothing side of this guarantee on its own initiative, using patch dollars as a buffer across its network. Because ongoing assisted living services are billed as a per diem, each authorized resident already generates a predictable daily payment; the remaining uncertainty is which residents are authorized, for how long, and at what negotiated rate. Making a minimum monthly payment binding on the Medi-Cal side would still likely require direct negotiation with MCPs and, potentially, state policy advocacy to authorize this kind of payment structure for small-facility Community Supports arrangements.

What the patch needs to cover

Because the patch is now part of the fee base — subject to the Hub's 3% — the gross patch a county needs to contribute is slightly larger than it would be if the patch were fee-exempt. The table below shows the gross county patch needed for an eligible resident at each per diem level, and for a resident who is not eligible, under three scenarios: the preservation scenario used throughout this section, and Genesis LA's two recommended rates for six-bed facilities that carry new property costs.

Genesis LA's two recommended rates use the same staffing assumptions as the preservation scenario but add new property costs and a 10% profit margin rather than 3%. Under its Ownership Model, a mission-driven organization buys the property with an 80% loan at 7.85% interest, with the remaining 20% and all rehabilitation costs covered by grants or equity; the break-even cost is $69,430/bed/year ($190/day), or about $209/day with the 10% margin. Under its Lease Model, a private investor acquires and rehabilitates the property and master-leases it to the operator, with insurance and replacement reserves folded into the lease; the break-even cost is slightly lower at $66,667/bed/year ($183/day), or about $201/day with the 10% margin. Genesis LA identifies the Lease Model's $201/day as the most cost-effective rate for six-bed facilities. Including SSI/SSP, these scenarios correspond to guaranteed floors of $6,111/bed/month (Lease Model) and $6,364/bed/month (Ownership Model), compared with $5,165 in the preservation scenario.

Patch needed ($/bed/day)	Eligible: $16.50/day	Eligible: $33.00/day	Eligible: $95.69/day (ALW Tier 1)	Not eligible
Preservation scenario (~$170/day target)	$112.38	$97.07	$38.91	$127.69
Genesis LA Lease Model (~$201/day target)	$144.43	$129.12	$70.95	$159.74
Genesis LA Ownership Model (~$209/day target)	$153.02	$137.71	$79.54	$168.33

Patch figures are calculated as the minimum flat county subsidy, per bed per day, needed to close the remaining gap after SSI/SSP and Hub-enabled Medi-Cal revenue, net of the Hub's fees, to reach each scenario's target: a 3% margin in the preservation scenario and Genesis LA's 10% margin in the Lease and Ownership Model scenarios. Without the Hub, the patch would be $123.86, $154.95, and $163.28/bed/day, respectively. For a resident who is not eligible, the patch is the no-Hub amount plus the Hub's 3% fee.

Across a network, the patch a county pays per bed depends on how many residents are eligible. The table below averages the two groups for the preservation scenario.

Share of residents eligible	$16.50/day	$33.00/day	$95.69/day (ALW Tier 1)
100%	$112.38	$97.07	$38.91
50%	$120.04	$112.38	$83.30
25%	$123.87	$120.04	$105.50
None	$127.69	$127.69	$127.69

Gross county patch per bed per day, preservation scenario, by share of the network's residents authorized for ALF Transitions and by per diem.

Reality check: how does this compare to LA County's current rates?

This model's total per-bed revenue target — operating cost plus a 3% margin, or $169.82/bed/day — falls between Genesis LA's two cost estimates for six-bed facilities: about $129/bed/day as currently operated and $190/bed/day, before profit, for a newly acquired facility. [58]

For an eligible resident at the benchmark-based per diems ($16.50–$33.00/day), the patch this model requires — $97.07–$112.38/bed/day — sits at the upper end of what Los Angeles County's Enriched Residential Care (ERC) program pays today. Genesis LA reports ERC enhancements of $33–$100/bed/day through DMH and $33–$116/bed/day through DHS, with a typical DMH enhancement of about $43/day ($1,311.60/month) for a client in an ARF. The patch needed to preserve a small facility while paying sustainable wages is therefore more than twice the typical DMH enhancement, though comparable to DHS's higher RCFE tiers ($100–$116/day). For a resident who is not eligible, the patch is higher still, at $127.69/bed/day. If plans pay the ALW Tier 1 per diem, however, the patch for an eligible resident falls to $38.91/bed/day, below the typical DMH enhancement. Under Genesis LA's Lease and Ownership Model scenarios, the patch ranges from $70.95–$79.54/bed/day for an eligible resident at the ALW Tier 1 per diem to $159.74–$168.33/bed/day for a resident who is not eligible.

As a lower bound, if a facility continues to operate at the as-reported cost of $129/bed/day — with staff paid at or near minimum wage and without benefits — the required patch falls to $59.37–$74.68/bed/day for an eligible resident at the benchmark-based per diems, within LA County's current ERC range, and to about $90/bed/day for a resident who is not eligible. At the ALW Tier 1 per diem, Medi-Cal revenue would cover nearly the entire gap. Because these costs are drawn from Los Angeles County data, facilities in lower-cost counties may need a smaller patch.

What the Hub contributes: how much smaller the patch becomes

Without any Medi-Cal billing or Hub involvement at all, a 6-bed facility relying on SSI/SSP alone would need a patch of about $123.86/bed/day to reach the same 3% margin. For an eligible resident, Hub-enabled Medi-Cal revenue and the Hub's flat fees lower that to $97.07–$112.38/bed/day at the benchmark-based per diems — a reduction of roughly 9% to 22% — and to $38.91/bed/day at the ALW Tier 1 per diem, a reduction of about 69%. The improvement grows with the per diem, since each additional dollar of Medi-Cal billing replaces patch funding the county would otherwise have to provide. This holds even though the Hub's fee on Medi-Cal billing (10%) is higher than its fee on the patch (3%). For a resident who is not eligible, the Hub adds its 3% fee without bringing in ALF Transitions revenue, raising the patch to $127.69/bed/day; for these residents, the Hub's value lies in ECM, care coordination, and administration rather than in a smaller patch. The first table below shows how the same preservation rate is built with and without the Hub; the second shows each source's share of the facility's revenue.

Preservation rate ($/bed/day)	Without the Hub	Eligible: $16.50/day	Eligible: $33.00/day	Eligible: $95.69/day	Not eligible
SSI/SSP (net of personal allowance)	$45.96	$45.96	$45.96	$45.96	$45.96
Medi-Cal billing, net to facility	—	$14.85	$29.70	$86.12	—

Preservation rate ($/bed/day)	Without the Hub	Eligible: $16.50/day	Eligible: $33.00/day	Eligible: $95.69/day	Not eligible
County patch, net to facility	$123.86	$109.01	$94.16	$37.74	$123.86
Total preservation rate to facility	$169.82	$169.82	$169.82	$169.82	$169.82
Gross county patch	$123.86	$112.38	$97.07	$38.91	$127.69
Hub fees (10% of Medi-Cal, 3% of patch)	—	$5.02	$6.21	$10.74	$3.83
County savings compared with no Hub	—	$11.48	$26.79	$84.95	–$3.83

The facility receives the same preservation rate in every column; the Hub changes where the money comes from. Medi-Cal billing replaces part of the county patch, and the Hub's fees are paid out of the gross Medi-Cal and patch amounts. If all six residents of a facility are eligible, the county saves about $25,100 a year at the $16.50 per diem, about $58,700 at $33.00, and about $186,000 at the ALW Tier 1 per diem. Each resident who is not eligible costs the county about $1,400 a year more than it would pay without the Hub.

Share of facility net revenue	Eligible: $16.50/day	Eligible: $33.00/day	Eligible: $95.69/day	Not eligible
SSI/SSP	27.1%	27.1%	27.1%	27.1%
Hub-enabled Medi-Cal revenue (net to facility)	8.7%	17.5%	50.7%	0.0%
County patch (net to facility)	64.2%	55.4%	22.2%	72.9%

Share of the facility's net revenue at the 3% margin target, net of the Hub's fees.

4.6 The Hub's Own Economics: How Many Facilities Does It Need?

A Community Hub is itself an organization with real operating costs — staff, systems, compliance overhead, and now technical assistance and training for its network facilities — that must be covered by the Hub's 10% share of Medi-Cal billing and 3% share of the county patch. This section estimates that cost structure and calculates the network size required for the Hub to break even and to generate a modest operating surplus.

Illustrative Hub operating cost structure

Line item	Annual cost
Executive Director (1 FTE)	$120,000
Compliance/Quality Officer (1 FTE)	$90,000
Billing/Claims Manager (1 FTE)	$80,000
Training & Technical Assistance Coordinator (1 FTE)	$75,000
Fringe benefits (25% of salaries)	$91,250

Line item	Annual cost
IT/claims systems and software	$50,000
Training program materials and delivery	$15,000
Office and administrative overhead	$40,000
Total annual operating cost	$561,250

This staffing and cost structure is an illustrative estimate constructed to represent a minimally viable Hub administrative entity that also meets the technical assistance and training responsibility described in Section 4.1; it is not drawn from any single source and should be replaced with an actual Hub's budget once one is operating at this function.

Network size needed

Because the Hub earns 10% of Medi-Cal billing but only 3% of the patch, Hub revenue per bed depends on both the per diem and the share of residents eligible for ALF Transitions. Per eligible bed, it is $1,833/year at the $16.50 per diem, $2,267/year at $33.00, and $3,919/year at the ALW Tier 1 per diem. Per bed that is not eligible, it is $1,398/year, the Hub's 3% of the patch. Higher per diems shift more revenue into the higher-rate Medi-Cal share, increasing the Hub's take per bed even as the patch — and the Hub's smaller 3% cut of it — shrinks.

Share of residents eligible	$16.50/day	$33.00/day	$95.69/day (ALW Tier 1)
100%	52 / 58	42 / 47	24 / 28
50%	58 / 66	52 / 58	36 / 40
25%	63 / 71	58 / 66	47 / 53
None	67 / 76	67 / 76	67 / 76

Each cell shows the number of 6-bed facilities the Hub needs to break even / to earn a moderate profit, preservation scenario.*

**Moderate profit is defined here as a $75,000/year operating surplus above the Hub's own costs — a modest reserve/security margin for a nonprofit intermediary of this size, not a specific benchmark drawn from any source. Facility counts assume every bed is occupied, with the stated share of residents authorized for ALF Transitions.*

At the benchmark-based per diems, a Hub under this fee structure needs 42–52 facilities to break even if every resident is eligible for ALF Transitions, rising to 58–63 if only a quarter are, and to 67 if none are. That is more scale than a single mid-sized county's ARF and RCFE inventory can typically supply on its own, which reinforces the brief's broader conclusion that regional or multi-county Hub structures are the more realistic path to viability at this facility size. If plans pay ALW-level per diems, the picture improves substantially: the Hub breaks even at 24 facilities when every resident is eligible, and at 47 when a quarter are. Under Genesis LA's Lease and Ownership Model scenarios, the larger patch raises the Hub's revenue and lowers the network needed; with every resident eligible at the benchmark-based per diems, breakeven falls to 35–43 facilities and a modest surplus to 40–49.

5. What's Required to Make This Work

- A regional or multi-county (potentially statewide) entity willing to provide the administrative, fiscal and technical support that small, independently owned facilities require. This includes taking on Medi-Cal managed care contracting and billing risk across many small, independently owned facilities — a function no single small operator can build alone.
- MCPs disclosing the per diem they pay for ALF Transitions ongoing assisted living services, and how many ARF and RCFE residents they authorize for it, since this analysis shows Hub viability is sensitive to both — breakeven ranges from 24 facilities (every resident eligible, ALW Tier 1 per diem) to 67 (no residents eligible).
- MCP agreement, and potentially state policy advocacy, to make the guaranteed monthly floor per bed (Section 4.5) binding on the Medi-Cal side. Ongoing assisted living services are billed as a per diem, but payment still depends on each resident's authorization and on rates negotiated plan by plan. ARFs and RCFEs require sustainable monthly revenue in order to operate.
- A clear expectation, written into Hub contracts or county policy, that a Hub's administrative fee funds technical assistance and training for its network facilities and not just billing and compliance functions.
- Public reporting on Hub administrative fees and cost structures, since DHCS currently caps nothing and no real Hub of this kind has yet published its own budget for independent comparison to the illustrative structure modeled here.
- Facility-level validation at 6-bed scale specifically, since most contracts reviewed in Section 3 operate at 24 beds or more, and the one six-bed example (Alpine House) has not published its operating costs — none of the numbers in Section 4 have been tested against an actual small facility's books.

Appendices

Appendix A: Community Care Hubs (DHCS): An Overview

As of September 29, 2026

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A1. What a Community Care Hub is

A Community Care Hub ("Hub") is an intermediary organization that sits between Medi-Cal managed care plans (MCPs) and the community-based organizations and providers that address members' health-related social needs (HRSNs), such as housing, food, and care coordination.

In DHCS's framing, a Hub centralizes administrative work (contracting, billing, data, and quality oversight) so that smaller community providers can take part in Medi-Cal without building all of that infrastructure themselves. Some Hubs also deliver direct services to members.

Key points from DHCS guidance:

- **Not a new benefit or license.** Hubs operate inside the existing Medi-Cal managed care contracting structure, and DHCS does not certify Hub organizations.
- **Many kinds of organizations can serve as a Hub:** CBOs, county health departments, administrative services organizations (ASOs), third-party administrators (TPAs), management services organizations (MSOs), independent physician associations (IPAs), medical groups, FQHC consortia, and nonprofit or for-profit entities.
- **Functions are negotiated.** What a given Hub does is set through discussions among the MCP, the providers, and the Hub.

Source: DHCS, Module 1: Functions of a Hub.

A2. Why DHCS encourages Hubs

DHCS encourages Hubs to the extent they make it easier for CBOs and community-based providers to contract with MCPs and join the Medi-Cal delivery system. It does not require MCPs to use them.

The need comes from CalAIM. Benefits such as Enhanced Care Management (ECM), Community Supports, Community Health Worker (CHW) services, and doula services depend on community providers that often lack the staff for Medi-Cal contracting, claims, data reporting, and compliance. A Hub can carry that load for many providers at once.

DHCS names three expected benefits:

- **Efficiency** for MCPs and providers, since one Hub contract can replace many separate ones.
- **Broader networks**, by bringing in community-based, diverse providers that could not contract alone.
- **Better coordination** in how Medi-Cal benefits are delivered to members.

Source: DHCS, The MCP-Hub Toolkit.

A3. What Hubs do

DHCS groups example Hub functions into four areas. Any given Hub may offer some or all of them.

Function area	What the Hub does
Centralized contracting and network management	Holds contracts with multiple provider organizations; onboards and readies new providers; recruits and manages the network for quality, including through participatory governance; offers training and technical assistance; builds partnerships among the MCP, providers, and CBOs.
Streamlined payment operations	Helps contracted providers submit compliant electronic claims; simplifies billing and payment.
Data infrastructure	Supplies referral-management and service-data platforms; centralizes data compliance, analysis, and reporting; supports data sharing across partners.
Performance and quality management	Sets quality metrics and monitoring systems; provides clinical support and training; runs peer learning.

Many Hubs add more, such as integrated electronic health records, member engagement, or direct services to members.

Source: DHCS, Module 1: Functions of a Hub.

A4. How Hubs fit with plans and providers

The MCP always stays accountable. A Hub takes on some plan duties by contract, but the MCP remains ultimately responsible for compliance with state and federal rules, however many layers of subcontracting sit below it.

The typical chain runs:

1. **DHCS** contracts with the Medi-Cal managed care plan.
2. **The MCP** contracts with a Hub (or with a subcontractor that contracts with a Hub).
3. **The Hub** contracts with, supports, and pays a network of CBOs and community providers.
4. **Providers** deliver ECM, Community Supports, CHW, or doula services to members.

A Hub's legal role depends on what it does:

Role	When a Hub falls here
Administrative Subcontractor	Handles administrative tasks for the MCP, such as credentialing or claims.
Partially Delegated Subcontractor	Takes on broader duties, such as obligations for a member group or set of services.
Downstream Subcontractor	Contracts with an MCP subcontractor (for example, an IPA) rather than the MCP itself.
Network Provider (in addition)	Also orders, refers, or renders covered services itself.
Third-party vendor	Supports providers administratively without taking on MCP duties; may need a Business Associate Agreement (BAA).

A Hub is never a Fully Delegated Subcontractor; that role is usually filled by another plan.

When an MCP uses a Hub as a subcontractor, it must:

- Submit the agreement template to DHCS for approval and report the relationship in Exhibit J of the MCP contract, for each Hub in each county.
- Post the delegation model on its website.
- Update its ECM or Community Supports Model of Care to describe the arrangement.
- Monitor the Hub's data, quality, nondiscrimination compliance, and, if the Hub takes financial risk, its financial viability.

The program rules still apply through the Hub: APL 23-032 (ECM), APL 21-017 (Community Supports), APL 24-006 (CHW), APL 23-024 (doulas), and APL 23-006 (delegation).

Source: DHCS, Module 2: Operationalizing MCP-Hub Partnerships.

A5. Current status and funding in California

Hubs are voluntary and already operating, but DHCS has issued guidance rather than new rules. The MCP-Hub Toolkit explicitly adds no new policy; it gathers existing contract and All Plan Letter requirements in one place.

Date	Milestone
June 2026	DHCS posts a full PDF of the MCP-Hub Toolkit.
Jan 16, 2026	DHCS and Aurrera Health Group hold an informational webinar on the toolkit.
Jan 1, 2026	Transitional Rent becomes a mandatory Community Support for specific populations, and service Hubs may help administer.
Oct 2025	DHCS publishes the toolkit modules (functions, contracting, oversight).
Oct 2024	CHCF and Aurrera release a statewide landscape study based on 40 interviews and a focus group.

Funding. There is no dedicated state Hub funding stream. Hubs have been started with a mix of PATH CITED grants, the CalAIM Incentive Payment Program (IPP), county funds, Whole Person Care legacy funds, foundation grants, and self-funding. Ongoing revenue comes through MCP payments, such as per-engaged-member-per-month or fee-for-service rates, and Hubs often keep a percentage of claims or a fixed fee from providers.

Examples. Hubs named by DHCS and CHCF include Los Angeles County (contracted with all six county MCPs for Community Supports), Sacramento County Behavioral Health Services (ECM for members with serious mental illness or substance use disorder), Alameda County Health, Aliados Health, Integrated Health Partners, San Diego Wellness Collaborative, Partners in Care, and Full Circle Health Network.

Open issues flagged by the CHCF study: some plans prefer direct contracts; Hubs can add an administrative layer and cost; low-volume rural areas may not sustain them; and multi-plan counties still face non-standard processes across plans.

Sources: DHCS MCP-Hub Toolkit; CHCF, Exploring Emerging Medi-Cal Community Care Hubs.

A6. Why it matters for behavioral health boards and commissions

Hubs shape whether members with behavioral health needs can reach ECM and Community Supports through trusted local providers. ECM's populations of focus include adults with serious mental illness or substance use disorder, and county behavioral health departments can themselves act as Hubs, as Sacramento County does.

DHCS's own pre-contracting questions for plans ask how a Hub relates to county behavioral health and other local partners, and how it brings member and community feedback into its work. Those are natural questions for a board or commission to raise locally:

- Are any Hubs operating in our county, and which plans contract with them?
- Does our county behavioral health department serve as, or partner with, a Hub?
- Which ECM populations and Community Supports (including Transitional Rent) flow through a Hub here?
- How are small, culturally specific, or peer-run organizations brought into the Hub's network?
- How does the Hub coordinate referrals and data with Specialty Mental Health Services and DMC-ODS?
- How do members and community voices shape the Hub's governance?

Sources: DHCS, Module 2; CHCF landscape study.

A7. The Full Community Supports Menu

DHCS's current menu has 15 Community Supports. Plans are encouraged to offer as many as possible, but availability varies by plan and county; Transitional Rent is the only one plans have been required to offer, beginning January 1, 2026.[59] Section 4.1 explains which are most relevant to small ARFs and RCFEs. Most of the others are designed for members living in their own homes or experiencing homelessness.[60]

- **Assisted Living Facility Transitions (formerly "Nursing Facility Transition/Diversion to Assisted Living Facilities")** — transition into, and ongoing services in, an ARF or RCFE as an alternative to a nursing facility.

- **Caregiver Respite (formerly Respite Services)** — short-term relief for a member's caregiver, provided at home or in an approved facility; ARFs and RCFEs are allowable facility settings.
- **Day Habilitation Programs** — training in self-help, social, and adaptive skills for members who are experiencing homelessness, exited homelessness within the past 24 months, or are at risk of homelessness or institutionalization.
- **Community or Home Transition Services** — support and set-up funding for members moving from a nursing facility to a private residence.
- **Personal Care and Homemaker Services** — in-home help with Activities of Daily Living and Instrumental Activities of Daily Living.
- **Environmental Accessibility Adaptations (Home Modifications)** — physical changes to a member's home, such as ramps, grab bars, and stair lifts.
- **Medically Tailored Meals/Medically Supportive Food** — meals, groceries, and nutrition support for members with nutrition-sensitive health conditions.
- **Sobering Centers** — a short-term, safe setting for publicly intoxicated members as an alternative to the emergency department or jail.
- **Asthma Remediation** — supplies and home modifications that reduce environmental asthma triggers.
- **Transitional Rent** — up to six months of rent for members experiencing or at risk of homelessness who meet additional criteria; it cannot be used for assisted living settings.
- **Housing Transition Navigation Services** — help finding, applying for, and securing housing.
- **Housing Deposits** — security deposits, utility set-up fees, and first and last month's rent.
- **Housing Tenancy and Sustaining Services** — support to keep housing once it is secured.
- **Recuperative Care (Medical Respite)** — short-term residential care for members with unstable housing who are recovering from an illness or injury.
- **Short-Term Post-Hospitalization Housing** — up to six months of housing after discharge from an institutional setting; this service sunsets December 31, 2026.

A8. Sources and further reading

- The MCP-Hub Toolkit: A Resource for MCPs and CalAIM Providers (DHCS landing page, with PDF and webinar links)
- Module 1: Functions of a Hub (DHCS)
- Module 2: Operationalizing MCP-Hub Partnerships (DHCS)
- Module 3: Oversight and Monitoring of Hubs (DHCS)
- Exploring Emerging Medi-Cal Community Care Hubs (CHCF and Aurrera Health Group, October 2024)
- Enhanced Care Management and Community Supports (DHCS)

Appendix B: Medi-Cal, Medicare, Hospice, and Veteran (VA)-Covered Services and Supplies for ARF/RCFE Residents

This appendix expands on Section 4.1's discussion of Hub-provided training and technical assistance. It is organized by payer and eligibility category, since what a resident is entitled to receive — and who pays for it — depends on whether the resident has Medicare, Medi-Cal, both ("Medi-Medi"), a hospice election, or

veteran status and VA enrollment. This is intended as reference material specific to this paper, not a substitute for an individual resident's own benefits verification.

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B.1 Durable Medical Equipment (Medicare Part B / Medi-Medi)

For residents enrolled in Medicare — including the dual-eligible, or "Medi-Medi," population — Medicare Part B covers durable medical equipment (DME), including hospital beds, manual and power wheelchairs, walkers, patient lifts, and pressure-reducing mattresses and overlays, when prescribed by a physician as medically necessary and supplied by a Medicare-enrolled DME supplier. Original Medicare covers 80% of the approved cost after the annual Part B deductible, leaving a 20% coinsurance; for dual-eligible residents, Medi-Cal typically covers that remaining coinsurance and deductible as the secondary payer, making this equipment $0 out-of-pocket in most cases. A Hub's training role should include helping facility staff recognize when a resident may already qualify for this equipment and how to help arrange the physician's order and supplier referral, rather than the facility purchasing a wheelchair or hospital bed directly.[61]

B.2 Incontinence and Medical Supplies (Medi-Cal)

For incontinence-related supplies specifically — disposable briefs and diapers, protective underwear, underpads (chux), liners and pads, reusable underwear, and incontinence-specific barrier creams and washes — Medi-Cal covers these as a distinct "medical supplies" benefit, but only with a physician, nurse practitioner, or physician assistant's prescription based on an incontinence evaluation completed within the past year, and subject to real monthly quantity limits (commonly in the range of 200–243 units per month depending on the product and size). Supplies costing more than $165 per month require a completed DHCS Incontinence Supplies Medical Necessity Certification Form (DHCS 6187) in addition to the standard authorization request. Facility staff who are unaware of this benefit, or who do not know how to prompt a resident's physician to complete the required documentation, risk having the facility pay out-of-pocket for supplies Medi-Cal would otherwise cover.[62]

B.3 What Is Not Covered

Not every personal-care item qualifies, and this distinction matters just as much for training purposes. General household and hygiene products — plain lotion, facial tissue, cotton balls, rubbing alcohol, and non-prescription shampoo, for example — are generally excluded from Medi-Cal's medical supplies benefit and remain a facility or personal expense, typically funded from the resident's own SSI/SSP personal and incidental needs allowance, even though incontinence-specific creams and washes tied to a documented incontinence diagnosis are covered. Helping staff draw this line accurately — what is billable to insurance

versus what must come from the facility's own budget or the resident's personal allowance — is itself a concrete, teachable skill a Hub's training program should cover.

B.4 Home Health Services, Including Post-Hospitalization Care (Medicare Parts A/B, Medi-Cal)

Beyond equipment and supplies, residents may also be entitled to skilled home health visits — a benefit facility staff are often unaware applies inside a licensed residential setting, not just a private home. Medicare Parts A and B cover part-time or intermittent skilled nursing visits, physical therapy, occupational therapy, speech-language pathology services, medical social services, and home health aide services when provided as part of a skilled care plan. Unlike DME, these services carry no coinsurance under Original Medicare — they are covered at $0 cost to the resident.

To qualify, a resident must (1) be under the care of a physician who certifies a plan of care, (2) be "homebound" — a standard that does not require being bedridden, only that leaving requires considerable and taxing effort — and (3) need intermittent skilled nursing or therapy services, delivered by a Medicare-certified home health agency. Home health can begin after a hospital or skilled nursing facility stay of three or more days (Medicare Part A, generally within 14 days of discharge) or without any prior hospitalization at all, if the homebound and skilled-need criteria are otherwise met (Medicare Part B). For a Medi-Medi resident, Medi-Cal covers any Medicare cost-sharing; Medi-Cal-only residents (not enrolled in Medicare) may be able to access a parallel home health benefit directly through Medi-Cal, subject to that program's own medical necessity and authorization rules.[63]

The training implication is direct: when a resident returns from a hospital stay, or shows a new or worsening condition (a wound needing regular assessment, a new medication regimen needing monitoring, a fall risk needing a physical therapy evaluation), Hub-trained facility staff should recognize this as a potential trigger for a physician-ordered home health referral — bringing a nurse or therapist to the resident where they live — rather than the facility either absorbing unaddressed clinical risk or trying to arrange and pay for this kind of follow-up care itself.

B.5 Hospice Care and Hospice-Covered Durable Goods

Hospice eligibility is based on a physician-certified terminal prognosis — a life expectancy of six months or less if the illness runs its normal course — not on age. This is an important correction to a common assumption: hospice is not limited to older adults or RCFE residents. ARF residents under 60 can and do qualify for hospice when they have a qualifying terminal diagnosis, such as late-stage AIDS, certain advanced cancers, ALS, or end-stage organ failure, among other conditions. Both Medicare and Medi-Cal cover hospice care at any age once this clinical criterion is met, and facility staff should not assume a younger resident is ineligible.

For ARF and RCFE residents who do elect hospice, the benefit covers durable medical equipment and medical supplies related to the terminal diagnosis at no out-of-pocket cost — a meaningfully better arrangement than the 80%/20% Part B split described in Section B.1. Coverage typically includes hospital beds, pressure-relief mattresses and overlays, wheelchairs, bedside commodes, walkers, patient (Hoyer) lifts, oxygen equipment, suction machines, and nebulizers, along with consumable medical supplies such as incontinence products, wound care supplies, gloves and other personal protective equipment, and oral care supplies. Critically, the hospice agency itself — not a separate DME supplier — arranges, delivers, owns, and maintains this equipment as part of its per-diem hospice payment, and removes it when hospice care ends.

Coverage is tied to the resident's terminal diagnosis and plan of care; equipment needed for an unrelated condition would still need to go through the standard Medicare Part B or Medi-Cal pathways described above.[64]

Because this benefit can meaningfully reduce a facility's own equipment, supply, and even clinical-support costs for an eligible resident of any age, a Hub's training should include helping facility staff recognize the signs that a resident — whether an ARF resident under 60 or an RCFE resident 60 and older — may qualify for hospice, and know how to prompt a physician referral, rather than the facility continuing to purchase equipment or supplies out of pocket for a resident who could receive them, along with added clinical support, through hospice instead.

B.6 Veteran-Specific Benefits (U.S. Department of Veterans Affairs)

Some ARF and RCFE residents are veterans, and the Department of Veterans Affairs (VA) offers benefits that operate independently of, and are generally not coordinated with, Medicare or Medi-Cal — a veteran typically chooses whether to obtain a given item or service through the VA system or through Medicare/Medi-Cal, rather than the two automatically working together the way Medi-Medi dual eligibility does. Facility staff and Hub trainers should treat “is this resident a veteran, and are they enrolled in VA health care” as a standard intake question, since many eligible veterans are not enrolled and are missing benefits as a result.

For veterans enrolled in VA health care, the VA's Prosthetic and Sensory Aids Service provides durable medical equipment and supplies at no cost when prescribed by a VA provider as medically necessary — a list that includes hospital beds, wheelchairs, walkers, canes, crutches, shower chairs, CPAP machines and supplies, hearing aids, and, notably, incontinence supplies, among other prosthetic and sensory aids. VA health care also covers home health and geriatric (elder) care services, and hospice care, for enrolled veterans through the same standard medical benefits package. As with the Medicare and Medi-Cal pathways described above, a Hub's training should include helping facility staff recognize when a veteran resident may be able to obtain equipment, supplies, or home health/hospice support through VA enrollment instead of the facility, Medicare, or Medi-Cal absorbing that cost.[65]

Separately, and unlike VA health care, the VA Aid and Attendance pension is a cash benefit, not a service benefit: the VA does not pay an ARF or RCFE directly, but eligible wartime veterans (and surviving spouses) who need help with activities of daily living receive a tax-free monthly payment — as of 2026, up to $2,874/month for a married veteran, $2,424/month for a single veteran, and $1,558/month for a surviving spouse — that the veteran or their representative can apply toward the facility's charges however they choose. Because this benefit is paid to the individual rather than the facility, and because the application and eligibility process (including net worth and look-back rules) is more involved than a simple prescription or referral, a Hub's training role here is different in kind from the DME and supply benefits above: it is less about clinical documentation and more about helping facility staff identify likely-eligible veteran residents early and connect them or their families to a Veterans Service Officer or accredited claims agent who can assist with the application, since approval can take months and benefits are generally paid retroactively to the application date.[66]

B.7 Transportation to Appointments (Medi-Cal NEMT/NMT)

Getting a resident to a medical, dental, mental health, or substance use disorder appointment is itself a Medi-Cal-covered benefit in two forms, and facility staff are often unaware either exists — leading facilities to arrange and pay for transportation themselves when Medi-Cal would otherwise cover it.

Non-Emergency Medical Transportation (NEMT) covers ambulance, gurney/litter van, wheelchair van, or (rarely) air transport when a physician certifies, on a Physician Certification Statement (PCS) form, that the resident cannot be safely transported by ordinary means due to a physical or medical condition. Non-Medical Transportation (NMT) covers a passenger car, taxi, rideshare, bus, or train to any Medi-Cal-covered appointment — including specialty mental health and substance use disorder appointments — for a resident who attests to having no other means of transportation; NMT does not require a physician's PCS form, generally requires only authorization through the resident's Medi-Cal managed care plan or its contracted transportation broker, and is not subject to an annual visit limit.[67]

Both benefits are arranged through the resident's Medi-Cal managed care plan (or, for fee-for-service beneficiaries, the county's transportation broker), typically with a few business days' advance notice. A Hub's training should include teaching facility staff to call the plan's transportation line before assuming the facility itself must drive a resident to an appointment or pay for a ride — including trips to pick up prescriptions, durable medical equipment, or medical supplies, which NMT also covers.

If a facility or Hub is already receiving Medi-Cal Community Supports funding for a resident, this does not automatically extend to transportation. Community Supports and NEMT/NMT are separately contracted benefit categories — a facility or Hub credentialed to bill for one (for example, Housing Tenancy and Sustaining Services) is not thereby credentialed to bill for the other. In practice, this gives a facility or Hub a genuine choice for a given resident: refer the resident to the MCP's existing transportation benefit (the default, lowest-effort path, requiring no separate contracting), or have the facility or Hub itself become a contracted transportation provider and bill the MCP directly for rides its own staff or a contracted driver provides. Non-Medical Transportation in particular can be delivered by ordinary passenger vehicle and does not require the specialized licensure NEMT does, making direct provision a realistic option for some networks.

Two practical considerations weigh against a small facility taking on transportation directly, even where it is legally possible to do so:

- Some residents need more than a ride — they need a staff member to accompany them, providing physical assistance from the vehicle into the appointment location and back, not just transportation between two points. NMT alone does not include this kind of accompaniment; if a facility wants to guarantee this level of support, it is effectively committing staff time beyond the drive itself, which changes the staffing calculation described below.
- For a small (for example, 6-bed) facility, having a staff member out for the several hours a round-trip appointment, wait time, and return can take may leave the facility short-staffed for the remaining residents during that window — a constraint that does not scale down proportionally the way it might for a larger facility with more staff to cover the gap. This is a genuine reason a small operator might prefer referring residents to the MCP's transportation benefit (which supplies its own driver) over having facility staff provide transportation and accompaniment directly, even if direct provision would otherwise be a viable revenue option through Community Supports contracting.

Transportation benefits for veterans. Veteran residents may also be able to get to VA appointments through the VA's own Veterans Transportation Program, which operates separately from Medi-Cal NEMT/NMT. Its Beneficiary Travel benefit reimburses eligible veterans for travel to VA or VA-authorized care — currently 41.5 cents per mile, less a deductible of $3 each way that is capped at $18 per month — and, when a VA clinician determines it is medically necessary and it is approved in advance, can cover special-mode transportation such as a wheelchair van or ambulance. Eligibility depends on factors such as a service-connected disability rating of 30% or more, travel for a service-connected condition, receipt of a VA pension, or income below VA limits. Beyond reimbursement, the Veterans Transportation Service offers free rides to VA and VA-authorized appointments through participating VA medical centers; the Disabled American Veterans and other Veterans Service Organizations provide free volunteer-driven rides in many areas; and in counties with fewer than seven people per square mile, Highly Rural Transportation Grants fund free rides through Veterans Service Organizations and state veterans agencies.[68]

These VA options cover travel to VA or VA-authorized care, while Medi-Cal NEMT/NMT covers travel to Medi-Cal-covered appointments, so a veteran resident who uses both systems may need different arrangements for different appointments. As with the other veteran benefits in Section B.6, a Hub's training can help facility staff check whether a veteran resident is enrolled in VA health care and connect them with the transportation coordinator at the nearest VA medical center or with a county Veterans Service Officer.

Appendix C: Mental Health and Substance Use Disorder Services Available Through County Behavioral Health

California's specialty mental health and substance use disorder (SUD) services are administered separately from a resident's physical health coverage, through one of the state's 59 local behavioral health authorities: the county behavioral health department in each of California's 58 counties (Sutter and Yuba Counties have combined), plus separate departments for the City of Berkeley and Tri-City (Pomona, Claremont and LaVerne). These are often called County Mental Health Plans (MHPs) for the mental health side, and, in counties that have opted in, the Drug Medi-Cal Organized Delivery System (DMC-ODS) for the substance use side. A resident does not need to already be diagnosed or in crisis to access these services — they are available to any Medi-Cal beneficiary who meets medical necessity criteria.[69] This appendix is intended as reference material specific to this paper.

C.1 Specialty Mental Health Services (SMHS)

Specialty Mental Health Services are reserved for beneficiaries whose condition causes significant functional impairment — a higher threshold than the "mild-to-moderate" outpatient mental health services covered directly by a Medi-Cal managed care plan. When a resident's needs cross that threshold, the county MHP, not the managed care plan, becomes responsible for arranging care. Outpatient and rehabilitative SMHS commonly include:

- Mental health services (individual and group therapy/psychotherapy)
- Medication support services
- Targeted case management
- Crisis intervention, including mobile crisis services
- Crisis stabilization services
- Day treatment intensive and day rehabilitation services
- Peer support services

Higher levels of SMHS care — adult residential treatment services, crisis residential treatment, psychiatric health facility services, and psychiatric inpatient hospital services — are also county MHP-administered, and relevant if a resident's condition escalates.[70]

C.2 Substance Use Disorder Services (Drug Medi-Cal / DMC-ODS)

Most California counties have opted into the Drug Medi-Cal Organized Delivery System (DMC-ODS), which funds a fuller continuum of SUD treatment, modeled on American Society of Addiction Medicine (ASAM) levels of care, than traditional Drug Medi-Cal alone. Where available, covered services commonly include:

- Outpatient treatment services
- Intensive outpatient treatment services
- Withdrawal management (at least one level, in every DMC-ODS county)
- Residential treatment services
- Recovery services (aftercare, recovery monitoring and coaching)

- Case management
- Medication-assisted treatment (MAT) and narcotic/opioid treatment programs
- Physician consultation

DMC-ODS is a county-by-county opt-in. Currently 40 counties have opted in.[71]

C.3 Behavioral Health Services Act (BHSA): Required Supports and Services

Beginning July 1, 2026, the Behavioral Health Services Act (BHSA), approved by voters as Proposition 1 in 2024, replaced the Mental Health Services Act and changed how counties must spend this funding stream. Counties must now allocate their BHSA funds 30% to Housing Interventions, 35% to Full Service Partnerships (FSPs), and 35% to Behavioral Health Services and Supports (BHSS), unless the state approves an exemption. BHSA services also now extend to people with moderate to severe substance use disorders, not only those with serious mental illness. BHSS funds the rest of the county system, including early intervention, outreach and engagement, workforce, and capital facilities and technology.[72]

Full Service Partnerships. County FSP programs must make available a defined set of services: mental health and supportive services; substance use disorder services, including screening and medications for addiction treatment or referral; outpatient behavioral health services, either clinic- or field-based; and ongoing engagement services such as peer support, transportation, and support to keep housing. FSPs must also deliver several evidence-based practices to fidelity: Assertive Community Treatment (ACT), Forensic ACT (FACT) for people involved with the justice system, the Individual Placement and Support (IPS) model of supported employment, and, for children and youth, High Fidelity Wraparound. Services that Medi-Cal can cover must be billed to Medi-Cal when they are provided to Medi-Cal members.[73]

Housing Interventions. Housing Interventions funds can pay for rental subsidies, operating subsidies, interim housing, and capital development, with half directed to people who are chronically homeless and up to 25% available for capital projects. Of particular relevance to this paper, licensed ARFs, RCFEs, and board and care facilities are allowable settings under BHSA Housing Interventions, even though they are not allowable under Medi-Cal's Transitional Rent benefit. When placement in one of these facilities is clinically appropriate, a county can use Housing Interventions to fund allowable room and board costs without first using up the resident's Transitional Rent coverage. Operating subsidies can also cover principal and interest on loans used to acquire or develop housing. Housing Interventions cannot pay for housing services that a resident's Medi-Cal managed care plan already covers, and they are limited to BHSA-eligible people who are experiencing or at risk of homelessness.[74]

For counties, Housing Interventions offer an ongoing funding source that could cover part of the county patch modeled in Section 4 — specifically allowable room and board and operating costs — for residents who meet BHSA eligibility, replacing time-limited sources such as Behavioral Health Bridge Housing. The FSP requirements, in turn, describe services that many ARF and RCFE residents with serious mental illness can receive from county teams while living in the facility.

Appendix D: Medication Management

This appendix covers three practical medication-management topics: the legal requirement to lock medications, a pharmacy-side option that can reduce staff time spent on medication administration, and what each payer will and will not cover for the medications themselves, including common over-the-counter (OTC) drugs like acetaminophen (Tylenol). (This appendix is intended as reference material specific to this paper.)

D.1 Requirements to Lock Medications

Locked medication storage is a licensing requirement, not a billable medical benefit — no payer reimburses a facility for the cabinet itself (see Appendix B, Section B.3). Under California Title 22 (§87465(h)), any medication a facility centrally stores on a resident's behalf must be kept in a locked cabinet or drawer, stored separately by resident, kept in its original labeled container, and, if refrigeration is required, kept in a locked container within the refrigerator. Facilities are also expected to maintain shift-to-shift reconciliation logs and report discrepancies immediately, particularly for controlled substances. The federal equivalent for Medicare/Medicaid-participating long-term care facilities, 42 C.F.R. §483.45(h), imposes the same core requirement. Because this is a facility operating and licensing cost, it is generally the responsibility of the facility's own budget — or, for a new or renovated facility, a capital project — rather than something billed to a resident's insurance.[75]

One California-specific nuance worth knowing: under the End of Life Option Act, a qualified resident who has obtained aid-in-dying medication has the right to store it themselves in a locked receptacle in their own room (a locked box, safe, or cabinet) rather than having the facility centrally store it, and a facility cannot require central storage of that specific medication if the resident chooses self-storage in a locked receptacle instead.[76]

D.2 Reducing Staff Time: Compliance, Blister, Strip, or “Bingo Card” Packaging

A pharmacy can package a resident's full medication regimen into sealed, individually labeled compartments organized by date and time of day — morning, noon, evening, bedtime — instead of dispensing separate pill bottles. This is commonly called compliance packaging, blister packaging, strip packaging, or “bingo cards,” and it is specifically marketed to ARFs, RCFEs, and other long-term care settings; vendors report time savings on medication administration as high as 40%, along with fewer administration errors, since staff can visually confirm at a glance whether a dose was given.[77]

Neither Medi-Cal nor Medicare Part D pays extra for this packaging — DHCS's own Medi-Cal pharmacy reimbursement policy states plainly that “additional product cost due to special packaging is not reimbursed.” In practice, this rarely matters: most long-term-care and compliance-packaging pharmacies provide this packaging at no additional charge as a standard business practice, since it helps them win and retain facility contracts; the medications inside are billed to Medi-Cal, Medicare, or Medi-Medi exactly as they would be from a standard retail pharmacy. The practical lever for a Hub's training, then, is not a benefit to apply for — it is which pharmacy a facility uses. A facility using an ordinary retail pharmacy typically receives loose pill bottles; the same facility using an LTC-specialized or compliance-packaging pharmacy typically receives this packaging free, simply by asking.[78]

D.3 What Each Payer Covers for Medications, Including OTC Drugs

Coverage of the medications themselves — as opposed to the DME and supplies covered in Appendix B — varies meaningfully by payer, and the OTC question (does Medi-Cal or Medicare pay for a resident's Tylenol?) has a genuinely different answer depending on which payer is asked:

Payer	Prescription drugs	Over-the-counter (OTC) drugs, e.g. Tylenol	Notes
Medi-Cal Rx	Covers nearly all FDA-approved drugs on its Contract Drugs List (CDL); $1 copay per prescription (often waived)	Covers many listed OTC drugs on the CDL; unlisted OTC drugs may need prior authorization	For dual-eligible (Medi-Medi) residents, Medi-Cal Rx is secondary to Medicare Part D and can cover drug categories Part D excludes
Medicare Part D	Covers most prescription drugs on the plan's formulary; copays vary by tier	Excluded by federal law (Social Security Act §1860D-2(e)(2)(A)) — not covered under any Part D plan	OTC exclusion is categorical, not plan-specific; some Medicare Advantage plans offer a separate OTC allowance as a supplemental benefit, which is different from Part D drug coverage
Hospice (Medicare/Medi-Cal)	Covered at up to a $5 copay per prescription when related to the terminal diagnosis or symptom control	Presumed covered when used for pain, nausea, anxiety, or constipation related to the terminal diagnosis — including common OTC drugs like acetaminophen (Tylenol)	Medications unrelated to the terminal diagnosis are not covered by hospice and route back to Part D or Medi-Cal Rx instead
VA (enrolled veterans)	Covered through the VA National Formulary; free for Priority Groups 1–6 and service-connected conditions, modest copay otherwise	Many OTC drugs on the VA National Formulary are covered when prescribed by a VA provider, subject to the same copay tiers as other non-exempt prescriptions	Copays for Groups 2–8 are capped annually; the VA does not require an OTC drug to be purchased outside the VA to avoid a copay unless the veteran chooses to buy it independently

The practical implication for a Medi-Medi resident: if their Medicare Part D plan denies an OTC medication like acetaminophen, that is expected and correct — Part D categorically excludes OTC drugs by law — and Medi-Cal Rx, not an appeal to the Part D plan, is the pathway to get it covered. For a resident on hospice, the same OTC medication is very likely already covered under the hospice benefit itself if it relates to comfort or symptom control, and should not need to be billed to Part D or Medi-Cal Rx at all while hospice is in place.[79]

Appendix E: Home & Community Based Waivers and Services in California

Senate Budget and Fiscal Review — Subcommittee No. 3

Hearing of Wednesday, August 12, 2026 — Agenda Packet Excerpt (Pages 3–10)

Consultants: Elizabeth Freeman and Scott Ogus

Federal Medicaid home- and community-based services waivers allow the Medi-Cal program to develop alternatives for individuals who would otherwise require care in a nursing facility or hospital. These waivers allow for services to be offered in either a home or community setting. California's waiver authorities are offered under Section 1915(c) of the Social Security Act, which also requires that the services offered must cost no more than the alternative institutional level of care and participants must have full-scope Medi-Cal eligibility.

Home and Community-Based Alternatives Waiver. The Home- and Community-Based Alternatives (HCBA) Waiver provides Medi-Cal members with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute or nursing facility Level of Care (LOC), with the option of returning to or remaining in a home or home-like setting in the community in lieu of institutionalization. DHCS contracts with waiver agencies for the purpose of performing waiver administration functions and directing the comprehensive care management waiver service. The waiver agencies are responsible for functions including: participant enrollment, LOC evaluations, plan of treatment and person-centered care and service plan review and approval, waiver service authorization, utilization management, provider enrollment and network development, quality assurance activities and reporting to DHCS, billing the fiscal intermediary, and provider claims adjudication.

Assisted Living Waiver. The Assisted Living Waiver provides comprehensive care, including 24 hour care and supervision, for older adults and people with disabilities residing in licensed board and care facilities or publicly subsidized housing. To be eligible to receive services in the waiver, an individual must be: 1) age 21 or older; 2) have full-scope Medi-Cal eligibility with no share of cost; 3) have a nursing facility level of care needs; 4) be willing and able to reside safely in an assisted living facility or public subsidized housing. The waiver is available in fifteen counties, including Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma. The waiver provides the following services for participants: care coordination; nursing facility transition coordination; residential rehabilitation; homemaker, chore, and laundry services; personal care and 24 hour protective supervision services; personalized behavioral plans with trained staff support; meals; 24 hour awake staff; licensed nursing staff; and transportation to medical appointments and services. The waiver does not provide support for the payment of room and board costs for participants. Those who receive Supplemental Security Income (SSI) pay a room and board rate set annually by the Department of Social Services (CDSS). Individuals that do not receive SSI must pay a room and board rate set by the provider that can be adjusted at any time, potentially leading to eviction.

Multipurpose Senior Services Program (MSSP). The MSSP Waiver provides home- and community-based services to Medi-Cal eligible individuals 60 years of age or older, or with disabilities, as an alternative to nursing facility placement. To be eligible for the program, participants must be age 60 years or older, have a nursing facility level of care, not be enrolled in another waiver program, and reside in a county with an MSSP site. MSSP services include: 1) case management, 2) personal care services, 3) respite care, environmental

accessibility adaptations, minor home repair, transportation, chore services, personal emergency response system/communication device, adult day care, protective supervision, meal services, social reassurance/therapeutic counseling, money management, and communication services (translation/interpretation).

In-Home Supportive Services (IHSS). IHSS is a Medi-Cal program administered by CDSS that allows low-income individuals who are blind, over 65, or have disabilities to receive personal care and assistance with daily living in their own home by a provider of their choice, delaying or avoiding more expensive institutional settings. Eligibility is based on Medi-Cal eligibility and assessed need for supportive services. The statewide IHSS caseload for 2026-27 is approximately 875,179 individuals.

Social workers employed by county welfare departments conduct an in-home assessment of an individual's needs in order to determine the amount and type of service hours to be provided. In most cases, the recipient is responsible for hiring and supervising a paid IHSS provider—oftentimes a family member or relative.

IHSS costs are shared between federal, state, and local governments. Approximately 98 percent of the IHSS caseload receives federal financial participation, with the majority of the caseload receiving about 50 percent federal financial participation, about four percent receiving 90 percent federal financial participation, and about two percent in the IHSS Residual program receiving only state funding.

Longstanding federal and state policy promotes home- and community-based services such as IHSS as an effective and low-cost alternative to institutional care for individuals with disabilities who can remain safely in their own homes with a tailored level of assistance. As the Department of Health Care Services (DHCS) noted in a February letter to the federal Center for Medicare and Medicaid Services (CMS):

> *"A focus on gross IHSS spending obscures the far more relevant fiscal comparison: the cost of institutional care versus home-and community-based alternatives. In California, the average annual cost of a long-term stay in a skilled nursing facility (SNF) for an individual is approximately $137,000, compared with roughly $30,000 per year to serve an individual through IHSS. Each successful diversion from institutional care to IHSS avoids approximately $107,000 annually in Medicaid spending—savings shared by California and the federal government alike. This cost differential underscores why IHSS growth represents fiscal prudence, not excess."*

Other home- and community-based services options provided through other authorities include:

California Community Transition (CCT) Program. In 2007, California was awarded federal grant funding to implement California's Money Follows the Person (MFP) Rebalancing Demonstration, known as the CCT Demonstration Project. CCT targets Medicaid beneficiaries of all ages who have a skilled nursing facility level of care need, who have continuously resided in an in-patient facility for 60 days or longer, and who want to return home or to a community-based setting. Members are enrolled in the demonstration for a maximum of 365 days post-transition, but also receive transition coordination services prior to leaving the inpatient facility. Services are provided through CCT Lead Organizations who work with participants, support networks, and providers to facilitate and monitor transitions from facilities to community settings; conduct assessments to determine levels of care; implement person-centered support services; and work to identify and coordinate services from multiple delivery systems to maintain the stability of home- and community-based placements.

Community-Based Adult Services (CBAS). CBAS provides daytime support to older adults and people with disabilities so they can remain safely in their homes. The program enables caregivers to work while still supporting their loved ones. CBAS services include: 1) individual assessment; 2) professional nursing services; 3) physical, occupational, and speech therapy; 4) mental health services; 5) therapeutic activities; 6) social services; 7) personal care; 8) a meal; 9) nutritional counseling; 10) transportation to and from the CBAS center. CBAS is a required benefit in 28 counties through Medi-Cal managed care. The other 30 counties may offer CBAS as an optional benefit if a CBAS center is available. Only Tulare County has provided CBAS as an optional benefit. In addition, closures in Marin and Sonoma counties have resulted in no CBAS services available in those two counties, despite their status as mandatory counties.

Program for All-Inclusive Care for the Elderly. Programs for All-Inclusive Care for the Elderly (PACE) provide care to California's frail population as an alternative to institutionalization by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care services. These services are provided to beneficiaries while still residing in a home- or community-based setting, rather than a skilled nursing facility or other institutional setting. Eligible PACE participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. PACE programs are the sole provider of Medicare and Medi-Cal services for participants.

End Notes & References

[1]Genesis LA & Brilliant Corners, Preserving & Expanding Board and Care Facilities in Los Angeles County, October 2025 (finding that facilities of 6 beds or fewer accounted for 91% of RCFE closures and 64% of ARF closures, 2016–2021).

[2]CalHHS Open Data Portal - CDSS data as of May 25, 2025, counting facilities with "LICENSED" status

[3] Los Angeles County Board of Supervisors, board and care data summary, 2019 (CDSS data: 1,560 of approximately 3,200 ARFs and RCFEs in Los Angeles County received SSI payments in April 2019, serving about 10,400 SSI residents, or about 6.7 per facility); U.S. Social Security Administration, SSI Recipients by State and County, 2025, Table 4: California (38,453 SSI/SSP recipients in nonmedical out-of-home care, December 2025); Legislative Analyst's Office, Overview of Community Care Licensing and Board and Care Facilities, February 2020 (7,361 RCFEs and 5,206 ARFs in 2018-19). Estimate calculated for this brief: 38,453 recipients ÷ about 6.7 SSI residents per facility ≈ 5,700 facilities, or about 45% of roughly 12,600 licensed ARFs and RCFEs. The SSA count includes some recipients living with relatives or in certified family homes, and applying Los Angeles County's 2019 ratio statewide is an assumption.

[4]CareScout, Cost of Care Survey 2025 (California data released March 2026), reporting a median California nursing home cost of approximately $400/day for a semi-private room ($12,167/month); the $375/day figure used here falls within the national median range of $315–361/day for semi-private and private rooms.

[5]California Department of State Hospitals, Bed Rates, effective January 1, 2022 (Residential Recovery Unit $423/day to Skilled Nursing Facility $1,186/day); figures reflect the range of state-hospital-level psychiatric care and will vary for acute community hospital psychiatric units.

[6]California Legislative Analyst's Office, "The Average Cost to Incarcerate a Person in State Prison Is Nearly $130,000 Per Year," Assembly Budget Subcommittee No. 7 on Accountability and Oversight handout, 2026 ($127,800/year at the 2025-26 enacted budget, or approximately $350/day).

[7]Vera Institute of Justice, What Jails Cost: Cities, "Los Angeles, CA" (New York: Vera, 2021), updated to incorporate the County of Los Angeles 2024-25 Final Budget; as cited in Vera Institute of Justice, California Proposition 36 Anniversary Fact Sheet (December 2025), reporting a per-person, per-day jail incarceration cost of $342.63 in Los Angeles County.

[8]Genesis LA & Brilliant Corners, Preserving & Expanding Board and Care Facilities in Los Angeles County, October 2025.

[9]California Department of Health Care Services, Home and Community-Based Alternatives (HCBA) Waiver overview, accessed 2026.

[10] California Senate Budget Subcommittee No. 3, August 12th, 2026 Agenda, "Home and Community-Based Waiver Reforms" Page 6.

[11]Los Angeles County Behavioral Health Services Act (BHSA) Integrated Plan, FY 2026–2029, adopted by the Board of Supervisors June 9, 2026 (submitted to DHCS June 24, 2026), Housing Interventions section, pp. 123–153.

[12]Los Angeles County BHSA Integrated Plan, FY 2026–2029, adopted June 9, 2026, Housing Interventions section, pp. 123–153.

[13]Los Angeles County BHSA Integrated Plan, FY 2026–2029, adopted June 9, 2026, Housing Interventions section, pp. 123–153 (System Gaps and Operating Subsidies subsections).

[14]Los Angeles County BHSA Integrated Plan, FY 2026–2029, adopted June 9, 2026, Housing Interventions section, pp. 123–153 (Rental and Operating Subsidies subsections).

[15]County of Monterey Mental Health Services Agreement with Psynergy Programs, Inc., Fiscal Year 2022-23.

[16]County of Monterey Mental Health Services Agreement with Psynergy Programs, Inc., Fiscal Year 2022-23, Fee Schedule/Exhibit.

[17]County of Monterey Mental Health Services Agreement with Psynergy Programs, Inc., Fiscal Year 2022-23, Fee Schedule/Exhibit.

[18]Lake County Board of Supervisors, contract with Davis Guest Home, Fiscal Year 2021-22 (per-diem rate schedule).

[19]Lake County Board of Supervisors, contract with Davis Guest Home, Fiscal Year 2021-22 (overstay penalty and annual placement ceiling provisions).

[20]California Department of Developmental Services, Rates by Regional Center, accessed 2026; San Andreas Regional Center Adult Community Care Facility Rate Schedule, used as an illustrative example; rates for Los Angeles-area regional centers (Frank D. Lanterman, North Los Angeles County, San Gabriel/Pomona) are published separately at the same DDS page and are not identical to the San Andreas figures cited here.

[21] Trinity County Behavioral Health Services, Innovation Plan: Cedar Home Peer Respite, submitted to the Mental Health Services Oversight and Accountability Commission, 2017–2018 (purchase of Alpine House with MHSA funds, respite bed, peer support outcomes, and licensing delays).

[22] Willow Glen Care Center, Alpine House program description, accessed 2026.

[23] County of Lake, Amendment No. 3 to the Agreement with Willow Glen Care Center for Adult Residential Support Services and Specialty Mental Health Services, FYs 2022-23 through 2024-25, Exhibit B, section 4.1.

[24]Los Angeles County Department of Mental Health, Enriched Residential Care Program (program webpage).

[25]Los Angeles County BHSA Integrated Plan, FY 2026–2029, adopted June 9, 2026, Housing Interventions section, pp. 123–153.

[26]California Department of Health Care Services, Community Supports Policy Guide, Volume 1 (updated April 2025): Assisted Living Facility (ALF) Transitions and Respite Services definitions; Section V.

[27]California Department of Health Care Services, Community Supports Policy Guide, Volume 1 (updated April 2025): Assisted Living Facility (ALF) Transitions and Respite Services definitions; Section V.

[28]California Department of Health Care Services, Community Supports Policy Guide, Volume 1 (updated April 2025): Assisted Living Facility (ALF) Transitions and Respite Services definitions; Section V.

[29]California Department of Health Care Services, Community Supports Policy Guide, Volume 1, July 2026 Proposed Updates for Stakeholder Feedback (draft): Caregiver Respite and Assisted Living Facility (ALF) Transitions.

[30]California Department of Health Care Services, Community Supports Policy Guide, Volume 1, July 2026 Proposed Updates for Stakeholder Feedback (draft): Caregiver Respite and Assisted Living Facility (ALF) Transitions.

[31]Landry & Ortiz, Assisted Living: An Underused Community-Based Housing Option for People with Behavioral Health Needs, April 2026 ("Reimbursable Services" section).

[32]California Department of Health Care Services, Community Supports Policy Guide, Volume 1 (updated April 2025): Assisted Living Facility (ALF) Transitions and Respite Services definitions; Section V.

[33]California Department of Health Care Services, CalAIM Enhanced Care Management Policy Guide (updated September 2026), Section IV: ECM Populations of Focus.

[34]California Department of Health Care Services, Community Supports Policy Guide, Volume 2 (April 2025): Day Habilitation Programs and Transitional Rent.

[35]California Department of Health Care Services, Community Supports Policy Guide, Volume 1 (updated April 2025): Assisted Living Facility (ALF) Transitions and Respite Services definitions; Section V.

[36]Two points about Transitional Rent eligibility remain unresolved for ARF and RCFE residents. DHCS's criteria include members "transitioning out of an institutional or congregate residential setting" and list examples such as inpatient hospitals, residential treatment facilities, and nursing facilities, but they do not name ARFs or RCFEs, so it is not settled whether moving out of an ARF or RCFE qualifies. It is also not settled whether a typical resident meets DHCS's definition of "at risk of homelessness" (Community Supports Policy Guide, Volume 2, Appendix C). Both questions should be confirmed with the member's managed care plan or with DHCS. See California Department of Health Care Services, Community Supports Policy Guide, Volume 2 (April 2025), Section VII.

[37]California Department of Health Care Services, Community Supports Policy Guide, Volume 2 (April 2025): Day Habilitation Programs and Transitional Rent.

[38]California Department of Health Care Services, Community Supports Policy Guide, Volume 1 (updated April 2025): Assisted Living Facility (ALF) Transitions and Respite Services definitions; Section V.

[39]California Department of Health Care Services, Community Supports Policy Guide, Volume 1, July 2026 Proposed Updates for Stakeholder Feedback (draft): Caregiver Respite and Assisted Living Facility (ALF) Transitions.

[40]California Department of Health Care Services, Updated Medi-Cal Enrollment Requirements and Procedures for Community-Based Organizations, Local Health Jurisdictions, and County Children and Families Commissions: Questions and Answers from the Stakeholder Hearing Held on October 8, 2024; Public Works Alliance, Justice Serving Network, and California Children's Trust, To CalAIM or Not to CalAIM? The Question Every Community-Based Organization Is Asking, August 2024 (on MCP credentialing timelines and administrative infrastructure needs).

[41]California Children's Trust, CalAIM Implementation Guide for Providers Working with Youth (used here as an order-of-magnitude reference for ECM program economics).

[42]California Department of Health Care Services, Medi-Cal Community Care Hub Toolkit, accessed 2026.

[43]Anna Spencer and Isabel Clemente, The Role of Community-Based Organization Networks in CalAIM: Seven Key Considerations, Center for Health Care Strategies, prepared for the California Health Care Foundation, August 2022.

[44]Spencer and Clemente, The Role of Community-Based Organization Networks in CalAIM, August 2022 (sidebar: United Way of San Joaquin County); United Way of San Joaquin County, Audited Financial Statements, June 30, 2025; California Grants Portal, San Joaquin County grantee listings, FY 2025-26.

[45]Spencer and Clemente, The Role of Community-Based Organization Networks in CalAIM, August 2022 (sidebar: Project Access Now, C3 Community Assistance Program).

[46]California Department of Health Care Services, Flexible Housing Subsidy Pool ("Flex Pools") Models Technical Assistance Resource: Example Models for Operationalizing a Flex Pool, June 2026, p. 3 (Flex Pool core functions).

[47]California Department of Health Care Services, Flexible Housing Subsidy Pool ("Flex Pools") Models Technical Assistance Resource, June 2026, pp. 13–20 (three example models: Integrated, Housing-Only, and In-House); California Department of Health Care Services, Flex Pool Models TA Resource recorded webinar, July 31, 2026.

[48]California Department of Health Care Services, Flex Pool Models TA Resource webinar transcript, recorded June 16, 2026, published July 31, 2026 ("A Flex Pool is not a term of licensing... it's not defined in statute," and "Landlords, of course, provide the housing").

[49]California Department of Health Care Services, Community Mental Health Services Block Grant (MHBG), accessed 2026; SAMHSA administers the MHBG and distributes funds to states, which pass them through to counties.

[50]California Department of Health Care Services, Projects for Assistance in Transition from Homelessness (PATH), accessed 2026; PATH is a SAMHSA formula grant distributed annually to participating California counties.

[51]Los Angeles County Homeless Services & Housing, Measure A overview, accessed 2026 (half-cent countywide sales tax approved by voters in November 2024, projected to generate over $1 billion annually, with 60% allocated to comprehensive homeless services).

[52]Two capital-funding programs — the Community Care Expansion (CCE) program and the Behavioral Health Continuum Infrastructure Program (BHCIP), the latter funded in part through Proposition 1's Behavioral Health Infrastructure Bond — previously offered a plausible source of capital dollars for constructing or expanding small ARF/RCFE capacity, complementing rather than substituting for the operating-cost model built in Section 4.3. Both have since been fully committed. As of this writing, neither CCE nor BHCIP should be treated as an active source of new capital for this purpose; a future capital funding round would require new legislative or budget action.

[53]California Department of Health Care Services, Community Supports Pricing Resource, December 2025, Section 8 (“Nursing Facility Transition/Diversion to Assisted Living Facilities, Such as Residential Care Facilities for Elderly and Adult Residential Facilities”); California Department of Health Care Services, ECM and Community Supports FAQ (May 2022; reissued 2025), Question 17.

[54]California Department of Health Care Services, Community Supports Policy Guide, Volume 1, July 2026 Proposed Updates for Stakeholder Feedback (draft): Caregiver Respite and Assisted Living Facility (ALF) Transitions.

[55]California Department of Health Care Services, Community Supports Policy Guide, Volume 1 (updated April 2025), Section VII: Coding, Billing, and Provider Payments.

[56] Medi-Cal's Assisted Living Waiver (ALW)* reimburses participating facilities at uniform statewide rates based on five tiers of care, which apply equally in Santa Clara and San Francisco counties. Sources: DHCS, Assisted Living Waiver; CANHR, Assisted Living Waiver (ALW); Brevy, Assisted Living in California. Maximum 2026 Payable Daily Care Rates (Medi-Cal Covered) - Medi-Cal pays the Department of Health Care Services (DHCS) approved Residential Care Facilities for the Elderly (RCFEs) or home health agencies based on the participant's assessed tier of care:

- Tier 1 (T2031 U1): $95.69 per day
- Tier 2 (T2031 U2): $114.33 per day
- Tier 3 (T2031 U3): $132.97 per day
- Tier 4 (T2031 U4): $179.58 per day
- Tier 5: Up to approximately $264.97 per day *(varies by specific tier structure*

***** Actual ALW is available in only 15 of California's 58 counties, is capped at 18,762 participants statewide, and carried a **waitlist of 18,365 people as of December 2025**, exceeding its total enrollment of 14,876 as of November 2025.

[57]California Department of Health Care Services, Assisted Living Waiver, 2026 ALW Reimbursement Rates (Tier 1–5 per diem rates, service code T2031).

[58]Genesis LA & Brilliant Corners, Preserving & Expanding Board and Care Facilities in Los Angeles County, October 2025 (operator-reported and adjusted per-bed costs by facility size; DMH and DHS Enriched Residential Care enhanced rates by program and facility type).

[59]California Department of Health Care Services, Community Supports Policy Guide, Volume 1 (updated April 2025): Assisted Living Facility (ALF) Transitions and Respite Services definitions; Section V.

[60]California Department of Health Care Services, Transformation of Medi-Cal: Community Supports (supplemental fact sheet).

[61]Centers for Medicare & Medicaid Services, Medicare Coverage of Durable Medical Equipment & Other Devices, accessed 2026 (80%/20% Part B cost-sharing for DME); dual-eligible Medi-Medi coinsurance coordination confirmed in DHCS Medi-Cal eligibility guidance on Qualified Medicare Beneficiary (QMB) crossover coverage.

[62]California Department of Health Care Services, Medi-Cal Provider Manual, Incontinence Medical Supplies, accessed 2026; National Health Law Program, An Advocate's Guide to Medi-Cal Services, January 2020 (medical supplies coverage and exclusions); quantity limits illustrated using Partnership HealthPlan of California's published incontinence guidelines, 2026.

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[64]Medicare Rights Center, Medicare Interactive: Hospice Costs and Coverage, accessed 2026; Center for Medicare Advocacy, Hospice (Quick Guide to Aid in Identifying Coverable Care), accessed 2026 (100% DME coverage under the Medicare Hospice Benefit, versus 80% under regular Medicare Part B).

[65]U.S. Department of Veterans Affairs, Prosthetic and Sensory Aids Service, as summarized in Veterans Can Get Free Durable Medical Equipment from the VA, accessed 2026; VA.gov, VA Health Care overview, accessed 2026 (home health, geriatric care, and hospice as part of the standard medical benefits package).

[66]2026 VA Aid and Attendance pension rates, as summarized in Assisted Living Benefit for Veterans & Surviving Spouses, accessed 2026. The VA does not pay assisted living, ARF, or RCFE facilities directly; Aid and Attendance is paid to the veteran or surviving spouse (or their fiduciary) as a pension supplement.

[67]Partnership HealthPlan of California, Transportation Services, accessed 2026 (NEMT/NMT benefit descriptions, PCS form requirement, and authorization process); California Department of Health Care Services, Medi-Cal transportation services overview, accessed 2026.

[68] U.S. Department of Veterans Affairs, Reimbursed VA Travel Expenses and Mileage Rate, accessed 2026; Veterans Transportation Program; and Transportation to VA Health Appointments in Highly Rural Areas.

[69]California Association of Local Behavioral Health Boards and Commissions, Region Map and Listing, accessed 2026 (confirming 58 counties plus the City of Berkeley as 59 local behavioral health authorities); County Behavioral Health Directors Association of California, Overview, accessed 2026.

[70]L.A. Care Health Plan, 2026 Medi-Cal Member Handbook, Specialty Mental Health Services, accessed 2026; National Health Law Program, An Advocate's Guide to Medi-Cal Services, Chapter IV: Mental Health Services, updated February 2026.

[71]Alameda County Behavioral Health Care Services, DMC-ODS Requirements, accessed 2026 (ASAM-based continuum of care and required service categories); California Health Care Foundation, How Medi-Cal Expanded Substance Use Treatment, 2020.

[72] California Department of Health Care Services, BHSA and BH-CONNECT Frequently Asked Questions (updated August 2025); BHSA County Policy Manual, Chapter 7: BHSA Components and Requirements.

[73] California Department of Health Care Services, BHSA and BH-CONNECT Frequently Asked Questions (updated August 2025), FSP evidence-based practice and Medi-Cal billing requirements.

[74] California Department of Health Care Services, BHSA Housing Interventions Policy and Implementation Frequently Asked Questions (updated March 2026).

[75]Medication Management Compliance in California RCFEs: What DSS Expects and Common Violations Found, accessed 2026 (Title 22 §87465(h) centrally stored medication requirements); 42 C.F.R. §483.45(h) (federal long-term care medication storage requirement).

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The California Association of Local Behavioral Health Boards & Commissions (CALBHB/C) supports the work of California's 59 local behavioral health boards and commissions. www.calbhbc.org