Date of Hearing: April 14, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2348 (Bonta) – As Amended April 7, 2026

SUBJECT: Medi-Cal: community supports.

SUMMARY: Authorizes Medi-Cal managed care plans to continue to cover Community Supports (services meant to address non-health care related barriers to health) in the Medi-Cal program, and creates associated processes and requirements to promote transparency, accountability, consistency and stability in the delivery of these services. Specifically, **this bill**:

1) Authorizes a Medi-Cal managed care plan to continue to cover Community Supports.

2) Requires the Department of Health Care Services (DHCS) to provide ongoing technical assistance to Medi-Cal managed care plans and providers to enhance their ability to effectively provide Community Supports.

3) Requires DHCS to produce a detailed model Evidence of Coverage document and related policies for each Community Support, and engage stakeholders on the development of such a document.

4) Establishes a regular process and timeline for policy updates.

5) Requires DHCS to continue to convene a currently established California Advancing and Innovating Medi-Cal (CalAIM) Implementation Advisory Group.

6) Requires DHCS to continue to publish a public report on Community Supports utilization data, but makes this quarterly (consistent with current practice).

7) Defines "community provider" as a locally available community-based nonprofit organization that has direct experience with providing services to Medi-Cal beneficiaries in the county or region where the organization operates, and requires plans and DHCS to track and report the number and percentage of providers that meet this definition, as well as information related to service utilization by community providers.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by the DHCS, and under which qualified low-income individuals receive health care services. [Welfare and Institutions Code (WIC) § 14000, *et seq.*]

2) Authorizes the DHCS Director to contract, on a bid or nonbid basis, with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care of Medi-Cal beneficiaries and establishes managed care models that DHCS contracts within each county. [WIC §§ 14087.3, 14089, 14087.98, 14087.967, and 14087.5]

3) Defines a Medi-Cal plan as any individual, organization, or entity that enters into a comprehensive risk contract with the DHCS to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries. [WIC § 14184.101]

4) Establishes the CalAIM initiative effective from January 1, 2022 until December 31, 2026. The goals of CalAIM are to identify and manage the risk and needs of Medi-Cal beneficiaries through whole-person-care approaches and addressing social determinants of health; transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility; and improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform. [WIC § 14184.100]

5) Defines "CalAIM" or "CalAIM initiative" as the respective components of the California Advancing and Innovating Medi-Cal initiative authorized in state law and approved by the federal Centers for Medicare and Medicaid Services (CMS) in the CalAIM Terms and Conditions. [WIC § 14184.101]

6) Defines "CalAIM Terms and Conditions" as those terms and conditions issued and approved by the federal CMS, including any subsequent amendments, that govern implementation of the respective components of the CalAIM initiative. [*Ibid*.]

7) Defines "CalAIM term" as the entire period during which an applicable component of the CalAIM initiative is in effect, as approved by the federal Centers for Medicare and Medicaid Services, including any applicable extension period. [*Ibid*.]

8) Defines "CalAIM year" or "Initiative Year" as the applicable effective period identified in the CalAIM Terms and Conditions that corresponds to a specific period of time in 2021-2026. Allows individual CalAIM programs or components to be operated on program years that differ from the years 2021-2026, or without regard to program years, as applicable. [*Ibid*.]

9) Requires DHCS, as appropriate and to the extent practicable, to consult with interested stakeholders with regard to implementation of applicable components of CalAIM in which they will participate, including, but not limited to, the issuance of guidance pursuant to subdivision 10) below. [WIC § 14184.102 (c)]

10) Allows DHCS to issue guidance to implement CalAIM or the CalAIM Terms and Conditions, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action. [WIC § 14184.102 (d)]

11) Requires DHCS to make use of appropriate processes to ensure that affected stakeholders are timely informed , and have access to, applicable guidance issued pursuant to authority described in 10) above, and that this guidance remains publicly available until all payments related to the applicable CalAIM component are finalized. [*Ibid*.]

12) Authorizes DHCS, during the course of the CalAIM term, to develop and implement successor payment methodologies or programs to continue to support entities participating in one or more components of CalAIM following the expiration of the CalAIM term and that further the goals set forth in CalAIM-related state law. Requires DHCS to consult with the entities participating in the payment methodologies or program components under CalAIM, affected stakeholders, and the Legislature in the development of any successor payment methodologies or program components pursuant to this authority. [WIC § 14184.102 (h)]

13) Authorizes DHCS to seek to extend the payment methodologies or programs described in CalAIM-related state law, or in the CalAIM Terms and Conditions, including modification thereto, through the CalAIM term or to subsequent time periods by way of amendment or extension of the relevant CalAIM Terms and Conditions, amendment to the Medi-Cal State Plan, or any combination thereof, consistent with the applicable federal requirements. Prohibits such extension from being implemented until DHCS consults with the entities participating in, or affected by, applicable methodologies or programs, and only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized. [WIC § 14184.102 (i)]

14) Includes in the CalAIM initiative the requirement for a statewide Enhanced Care Management (ECM) benefit, designed to address the clinical and nonclinical needs on a whole-person-care basis, available to certain target populations of Medi-Cal beneficiaries to Medi-Cal recipients enrolled in a Medi-Cal plan, in the CalAIM Terms and Conditions, as determined by DHCS. [WIC § 14184.205]

15) Defines target populations for ECM and requires DHCS to develop, in consultation with the Medi-Cal plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of ECM and to publish an annual report on ECM utilization data. [*Ibid*.]

16) Includes in the CalAIM initiative the authority for a Medi-Cal plan to elect to cover those Community Supports approved by DHCS as cost effective and medically appropriate substitutes for the applicable covered Medi-Cal benefit. [WIC § 14184.206 and 42 Code of Federal Regulations (CFR) § 438.3]

17) Requires Medi-Cal plans to include information on the Community Supports offered by that plan in its member handbook and plan website, including any limitations on Community Supports on the plan website. [WIC § 14184.206]

18) Permits DHCS to approve Community Supports, including but not limited to:

    a) Housing transition navigation services;

    b) Housing deposits;

    c) Housing tenancy and sustaining services;

    d) Short-term post-hospitalization housing;

    e) Recuperative care or medical respite;

    f) Respite;

    g) Day habilitation programs;

    h) Nursing facility transition or diversion to assisted living facilities, including, but not limited to, residential care facilities for the elderly or adult residential facilities;

    i) Nursing facility transition to a home;

j) Personal care and homemaker services;

k) Environmental accessibility adaptations or home modifications;

l) Medically supportive food and nutrition services, including medically tailored meals;

m) Sobering centers; and,

n) Asthma remediation. [*Ibid*.]

19) Requires DHCS to develop in consultation with the Medi-Cal plans and other appropriate stakeholders a monitoring plan and reporting template for the implementation of Community Supports and to publish an annual report on Community Supports utilization data. [WIC § 14184.206]

20) Requires DHCS to take into account the utilization and actual cost of Community Supports in developing capitation rates. [*Ibid*.]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, CalAIM has been a transformative journey for the Medi-Cal program, challenging entities throughout the state to collaborate, innovate and improve care so that Medi-Cal enrollees stay healthier and get the right care, from the right provider, in the right setting and at the right time. The author indicates that although CalAIM was originally proposed in the context of a five-year waiver period from 2021 to 2026, many aspects of the transformation, including Community Supports, were explicitly intended to outlast the initial 5-year period and eventually transition into Medi-Cal benefits. The author notes the current CalAIM authorizing statute, implemented in 2021, provides DHCS significant authority to flexibly implement CalAIM programs, and provides DHCS the discretion to continue these programs. The author explains that as the state, local governments, Medi-Cal managed care plans, health care providers and other stakeholders have steadily worked toward robust implementation of Community Supports, most parties have lessons learned, and there are emerging best practices as well as known pain points and uncertainties that threaten to unwind years of progress and billions of dollars of investment. This bill requires a continued commitment to timely public data reporting, promotes consistency and best practices for coverage policy by requiring DHCS to publish a model "Evidence of Coverage" document and implements other provisions designed to enhance transparency, accountability, stability, consistency, and continuous improvement in Community Supports. The author concludes that, as we move from building CalAIM to refining it, this bill will cement Community Supports for the long term and help the state truly realize the promise of CalAIM.

2) **BACKGROUND.**

   a) **CalAIM**. CalAIM is a collection of major initiatives spearheaded by the DHCS to improve Medi-Cal, including addressing social drivers of health, reducing program complexity and increasing flexibility, and modernizing payment structures to promote better outcomes. The majority of CalAIM proposals were put forward in 2021 through

two comprehensive applications to the federal government for a "Section 1115 demonstration" and "Section 1915(b) waiver"—both named for the sections of the Social Security Act that authorize state and federal flexibility with Medicaid program rules to implement specific initiatives. DHCS received approval on December 29, 2021, for both the demonstration and waiver, effective through December 31, 2026. Although CalAIM expires at the end of 2026, the administration has signaled its intention to continue Community Supports beyond 2026, and ECM is now a permanent Medi-Cal benefit.

b) **Community Supports**. One component of CalAIM that addresses social drivers of health is called Community Supports. Community Supports are services that can be provided by Medi-Cal managed care plans as cost-effective alternatives to traditional medical services or settings. DHCS has a pre-approved list of 14 Community Supports, based on experience in prior demonstration programs to address health-related social needs. These supports are designed to provide flexibility to address specific needs of complex populations. The full list of Community Supports is enumerated in 18) of Existing Law, above.

c) **Federal Guidance on "In Lieu of Services" (ILOS).** Every Medicaid program has a Medicaid State Plan that specifies the benefits and services covered by that program. ILOS are alternative services to those covered under the Medi-Cal State Plan that are delivered by a different provider or in a different setting than is described in the State Plan. ILOS can only be covered if the state determines they are medically appropriate and cost-effective substitutes or settings for a State Plan service.

   Community Supports, as defined through CalAIM, are considered ILOS. Although California received approval to cover Community Supports under the CalAIM 1115 and 1915(b) waivers, ILOS authority is now enshrined in federal regulation and 2023 CMS guidance, providing the state a more straightforward authority under which to continue covering these services. According to DHCS, ILOS authority is distinct from authority conferred by Section 1115 and 1915(b) waivers. ILOS is a permanent option for state Medicaid programs enshrined in federal Medicaid managed care regulations and, as required by CMS, memorialized in approved managed care plan contracts.

   The general idea behind ILOS is that prevention of an illness or injury, or the mitigation of a condition through lower-intensity services is both cost-saving and more beneficial to an individual's health. If higher-intensity services, like skilled nursing facility, emergency department, or inpatient services can be avoided, resources are freed up to be redirected to lower-intensity and preventive care in a virtuous cycle. For instance, home modifications and adaptations can support individuals in maintaining or improving their health and reduce emergency department visits and inpatient stays by reducing falls. Similarly, medically tailored meals can improve health through appropriate diet to avoid expensive, high-intensity health care services.

   In its 2023 guidance, CMS has issued clarifying parameters for states' use of ILOSs to ensure adequate assessment of the alternative services and settings prior to use, ongoing monitoring for appropriate utilization and enrollee protections, and financial guardrails to ensure accountability and prevent inappropriate use of Medicaid resources. CMS requires that ILOSs must advance the objectives of the Medicaid program; be cost effective; be medically appropriate; be provided in a manner that preserves enrollee rights and

protections; be subject to appropriate monitoring and oversight; and be subject to retrospective evaluation, when applicable. ILOSs cannot account for more than 5% of a state's total Medicaid spending.

d) Next Steps for Community Supports after the Five-Year "CalAIM Term." According to DHCS, after December 31, 2026, the date the defined 5-year CalAIM term expires, Community Supports will continue to be covered under ILOS authority and will not need to be approved under waiver authority. The 12 Community Supports covered as ILOS are not dependent on DHCS' current CalAIM Section 1115 or 1915(b) waiver approvals. The community supports not allowable under ILOS authority are being pursued through Section 1115 demonstration authority. These include recuperative care (short-term residential setting in which members recover from an injury or illness while obtaining access to primary care, behavioral health services, case management, and other supportive social services) and short-term post-hospitalization housing (ongoing supports necessary for recuperation and recovery after exiting an institution).

e) Cost-Effectiveness of Community Supports. According to DHCS, all 12 Community Supports that are under ILOS authority are, or will likely be proven to be, cost-effective in the remaining years of the waiver demonstration period if current trends continue. An independent evaluator is conducting a rigorous independent evaluation of all Community Supports by 2028. DHCS evaluated the cost-effectiveness of Community Supports based on data from July 2022 to June 2024. According to DHCS, this early data already shows promising results, with nine of the 12 services already demonstrating cost-effectiveness. For example, a Community Support that assists with Housing Deposits demonstrated a 36.6% reduction in inpatient services costs, 34.6% reduction in outpatient services costs, 21.2% reduction in emergency room services costs, 34.3% reduction in long-term care services costs, and a 2.3% reduction in outpatient mental health services costs. When accounting for the costs of the Community Supports plus the reduction in spending for other services noted above, DHCS reports the net impact is an overall *reduction* in spending of 31.6%.

Three of the remaining services show utilization and cost reductions in Medicaid-covered services, such as emergency department or long-term care services, and are expected to be cost effective over time. These include housing tenancy and sustaining services, medically tailored meals, and asthma remediation.

f) ECM. ECM is a statewide Medi-Cal benefit created as part of CalAIM. It is available through Medi-Cal plans to provide care management to Medi-Cal enrollees with the highest needs. ECM identifies these enrollees as "Populations of Focus." Enrollees have a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. The lead care manager role is designed to "meet enrollees where they are" to meet their needs, build a trusting relationship, and provide intensive coordination of health and health-related services. DHCS estimated that between 3% and 5% of all Medi-Cal plan members statewide are potentially eligible for ECM.

g) Utilization of Community Supports and ECM. At this time and under ILOS authority, Community Supports are only available through Medi-Cal managed care plans and are

optional for the plans to implement. Nearly 5,000 Community Supports providers and over 4,000 ECM providers are contracted by Medi-Cal MCPs to offer these services.

According to DHCS, all 58 counties in California offer at least 8 Community Supports. Twenty-four counties (representing 41% of all Medi-Cal MCP members) have access to all 14 Community Supports. In Quarter 2 of 2025, about 188,000 unique members have used one or more Community Supports services, a 51% increase from a year prior. In Quarter 2 of 2025, about 206,000 unique members received ECM, an increase of 61% from a year prior.

h) Successes and Challenges. CalAIM providers, plans, advocates, and other stakeholders have mixed and varied opinions based on their unique experience with implementation of CalAIM. Although CalAIM is in the last year of the 5-year implementation period, implementation of Community Supports and ECM has yet to reach a steady state, and DHCS continues to make policy adjustments and refinements, engage with stakeholders, and provide technical assistance to plans and providers.

In conducting stakeholder outreach in fall 2025 throughout the state on the impacts of federal Medicaid cuts, the author reports being struck by the frequency with which stakeholders in every part of the state independently brought up the importance of continuing the effective parts of CalAIM, largely related to Community Supports and ECM. Based on further stakeholder outreach to a variety of CalAIM providers and advocates for these services, the author has noted that the following issues have been identified, some of which are addressed in this bill.

i) Certainty. Stakeholders describe a lack of clarity on future of Community Supports, and note current law simply provides DHCS authority to continue CalAIM programs. Even though DHCS has stated intent to eventually transition Community Supports to benefits, it is unclear when and how this will happen. The uncertainty increases risk and hesitancy for providers, which in turn makes it difficult for them invest sufficiently to achieve scale and efficiency, particularly in an era where there is additional federal disinvestment and state cost-cutting on the horizon.

ii) Inconsistency among plans on eligibility criteria and benefits policy. Differences in eligibility criteria by plan, or differences in the conditions of coverage for Community Supports by plan, can create non-value-added administrative complexity for providers, especially for those who work statewide. Stakeholders indicate eligibility criteria that are too narrow can exclude people who would benefit, resulting in missed opportunities for more effective and cost-effective care. Some providers believe some plans are narrowing eligibility criteria for certain Community Supports so significantly that it is no longer sustainable for them to continue providing the services. They note that plans' ability to opt in or out of providing the services threatens the substantial investments made in infrastructure and capacity building for Community Supports across the state. Finally, providers and advocates note inconsistency can create inequity for Medi-Cal members in different plans, even within the same county.

iii) Unpredictable policy processes. Stakeholders note DHCS can change policy with maximum flexibility, leading to an unpredictable schedule of policy updates and insufficient public transparency. Plans can un-elect Community Supports for each

plan year. Perception of instability increases risk and hesitancy for providers, as noted above. Stakeholders note it adds administrative burden and complexity to track changes and pivot service delivery without a defined process or timeline, and that poorly defined policy processes with such large implications are inconsistent with good government principles.

iv) **Insufficient technical assistance and focus on best practices to support plans to successfully implement some Community Supports**. Some stakeholders point out that plans may be more likely to opt out of providing low-utilization Community Supports, instead of investing in implementing best practices and shoring up the ability to successfully deliver services. This was presented as a particular problem for the Community Supports that transition an individual to the community from a skilled nursing facility or other institutional care.

v) **Outcomes data**. Some stakeholders feel that specific data on the cost of services and health outcomes are not transparent or available from DHCS, which makes plans hesitant to invest in services and makes them more likely to restrict eligibility criteria. One stakeholder perceived that some plans are doing their own plan-specific analyses and calculations, some of them are not, and many of them are not sharing the information back with providers they work with, limiting the providers' ability to understand what works well and to implement best practices.

3) **SUPPORT.** This bill is supported by health and children's advocates and providers of CalAIM and Medi-Cal services. Supporters note this bill provides a clear, consistent framework for the continuation of vital services that address the social drivers of health, such as assisted living, housing transition navigation, medically supportive food, and other community-based supports that have proven to improve health outcomes and reduce avoidable utilization of higher-cost care. Supporters note this bill ensures that progress made under CalAIM is not lost. Supporters cite DHCS reports that show Community Supports have reduced avoidable emergency department visits, hospital stays, and long-term care use while showing strong early signs of cost savings. Additionally, supporters note this bill aims to enhance transparency, consistency, and stability in the implementation of these CalAIM services.

4) **PREVIOUS LEGISLATION.**

a) AB 804 (Wicks and Stefani) of 2025, would have transitioned the CalAIM housing supports (a subset of Community Supports) to permanent covered benefits in Medi-Cal. AB 804 was held on the Assembly Appropriations Committee suspense file.

b) SB 324 (Menjivar) of 2025, would have required Medi-Cal managed care plans to contract with community providers for delivery of ECM and Community Supports, and required DHCS to take other actions to support this requirement. AB 804 was held on the Assembly Appropriations Committee suspense file.

c) AB 1975 (Bonta) of 2024, would have made the medically supportive food Community Supports benefit a Medi-Cal covered service. AB 1975 was vetoed by Governor Newsom, who stated: "Increasing access to nutritious foods and encouraging healthy eating habits contributes to the prevention and treatment of chronic conditions. However, this bill would result in significant and ongoing General Fund costs for the Medi-Cal

program that are not included in the budget. I encourage the Legislature to explore this policy next year as a part of the annual budget process."

d) AB 1085 (Maienschein) of 2023, was substantively similar to AB 804. AB 1085 was vetoed by Governor Newsom, who stated: "My Administration has made significant investments to combat homelessness and provide housing supports. While I appreciate and share the author's goal to support those who are experiencing homelessness, new Medi-Cal benefits must be considered as part of the annual budget process. . . . With our state facing continuing economic risk and revenue uncertainty, it is important to remain disciplined when considering bills with significant fiscal implications, such as this measure."

e) AB 1644 (Bonta) of 2023 was similar to AB 1975 and was held on the suspense file of the Assembly Appropriations Committee.

f) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, established statutory authority for various aspects of the CalAIM initiative, including authority to provide ILOS.

REGISTERED SUPPORT / OPPOSITION:

Support

18 Reasons
Alameda County Community Food Bank
Alliance for Children's Rights
Alzheimer's Association
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
California Alliance of Child and Family Services
California Community Action Partnership Association
California Retired Teachers Association
Ceres Community Project
CPCA Advocates
Downtown Women's Center
East Bay Innovations
Emergency Food Bank of Stockton/San Joaquin County
Esperanza Community Farms
Everyone's Harvest
Food As Medicine Collaborative
Foodwise Community
Fresh Approach
Fullwell
LeadingAge California
Meals on Wheels Orange County
Open Source Wellness
Partners in Care Foundation
Reinvestment Partners
San Francisco-Marin Food Bank

Santa Barbara County Food Action Network
Second Harvest Food Bank of Santa Cruz County
Sunterra Health, INC. Dba Project Foodbox
Western Center on Law & Poverty
Wholesome Wave
One individual

Opposition

None on file

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097