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**SENATE COMMITTEE ON HEALTH**  
**Senator Akilah Weber Pierson, Chair**

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**BILL NO:** AB 2348  
**AUTHOR:** Bonta  
**VERSION:** June 11, 2026  
**HEARING DATE:** June 24, 2026  
**CONSULTANT:** Jen Flory

**SUBJECT:** Medi-Cal: enhanced care management and community supports

**SUMMARY:** Requires the Department of Health Care Services to publish model managed care coverage standards and policy for the California Advancing and Innovating Medi-Cal initiative's community supports benefits, submit information to the Legislature on the feasibility of transitioning the community supports benefits to permanent Medi-Cal benefits, and makes other technical changes to the community supports and Enhanced Care Management benefits.

**Existing law:**

- 1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), and under which qualified low-income individuals receive health care services. [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 DHCS to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries. [WIC §14184.101]
- 4) Establishes California Advancing and Innovating Medi-Cal (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) Includes in the CalAIM initiative the requirement for Medi-Cal plans to offer Enhanced Care Management (ECM) benefits designed to address the clinical and nonclinical needs on a whole-person care basis for Medi-Cal recipients who meet the criteria outlined in the CalAIM Terms and Conditions for a target population, as determined by DHCS. [WIC §14184.205]
- 6) Specifies that the ECM target populations must include children or youth with complex needs; individuals experiencing homelessness; high utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits; individuals at risk for institutionalization and eligible for long-term care services; nursing facility residents who want to transition to the community; individuals with serious mental illness, and

children with serious emotional disturbance or substance use disorder; and, individuals transitioning from incarceration requiring immediate transition of services to the community. [WIC §14184.205]

- 7) 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. [WIC §14184.205]
- 8) 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 CFR §438.3]
- 9) 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]
- 10) Permits DHCS to approve Community supports, including but not limited to housing support services, services to help individuals transition out of hospital or other institutional care, personal care services, environmental accessibility adaptations, medically supportive food and nutrition services, sobering centers, and asthma remediation. [WIC §14184.206]
- 11) 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]
- 12) Requires DHCS to take into account the utilization and actual cost of Community supports in developing capitation rates. [WIC §14184.206]

**This bill:**

- 1) Adds to the definition of ECM “community-based, high touch coordination and comprehensive care management services” and specifies that ECM services include access to a lead care manager, outreach and engagement, comprehensive assessment and care management planning, coordination of care, health promotion, comprehensive transitional care, member and family support, and coordination of and referral to community and social support services. Authorizes the exclusion of Medi-Cal recipients eligible for other high-intensity care management services, as defined by DHCS. Clarifies that DHCS may include other ECM target populations.
- 2) Requires DHCS, by July 1, 2027 and after engaging stakeholders and soliciting feedback in the development of, to produce model managed care coverage standards and policy for each community support provided for plan years beginning on January 1, 2028. Requires the standards and policy to reflect best practices and provide detailed instructions on model eligibility and coverage policies sufficient for a Medi-Cal managed care plan to adopt, in whole, as its coverage policy. Requires Medi-Cal plans to provide to DHCS a specific explanation and justification for any deviation from model managed care coverage standards and policy.

- 3) Requires DHCS to provide ongoing technical assistance to Medi-Cal plans on community supports and requires Medi-Cal plans to provide technical assistance to the community supports providers.
- 4) Requires DHCS to publicly post any updates to its community supports guidance for a minimum of one month to allow for stakeholder input and to release updates to the community supports guidance six months before the effective date and limits the effective dates to July 1 or January 1. Authorizes exceptions to these requirements should DHCS need to address urgent issues, as determined by DHCS, including changes in federal approvals or the availability of federal financial participation. Requires DHCS to notify interested stakeholders with a rationale for the irregular update should an exception be invoked.
- 5) Defines “nonprofit 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. Requires Medi-Cal plans to track and report to DHCS the number and percentage of the plan’s providers that fit the definition of “nonprofit community provider” and the number and percentage of services provided by these community providers. Requires DHCS to publish this data by plan no less than annually. Clarifies that these tracking requirements do not restrict plans from contracting with providers that are not nonprofit community providers.
- 6) Changes the requirement for DHCS to produce an annual report for ECM and community supports services from annual to quarterly.
- 7) Requires DHCS to continue to convene the CalAIM Implementation Advisory Group that is in effect on January 1, 2026, and as most recently updated. Sunsets this requirement on January 1, 2032.
- 8) Requires DHCS to provide to the appropriate policy and fiscal committees of the Legislature information necessary to inform legislative consideration of transitioning community supports to benefits that are required to be covered under the Medi-Cal program including information on cost, effectiveness, and provider availability by March 31, 2029.
- 9) Deletes obsolete references to the CalAIM waiver terms and conditions, obsolete language regarding populations to be transitioned into the ECM benefit, and obsolete commencement dates.

**FISCAL EFFECT:** According to the Assembly Appropriations Committee, one-time and ongoing costs of an unknown amount, potentially in the hundreds of thousands of dollars for DHCS to engage stakeholders and develop the Evidence of Coverage and related policies for every community support, regularly update policies, and continue convening the CalAIM Implementation Advisory Group. There are additional cost pressures of an unknown amount, potentially in the hundreds of thousands of dollars, for DHCS to maintain some of its current activities related to community supports (General Fund, federal funds).

**PRIOR VOTES:**

Assembly Floor:	78 - 0
Assembly Appropriations Committee:	15 - 0
Assembly Health Committee:	16 - 0

**COMMENTS:**

- 1) *Author's statement.* 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. Although CalAIM was originally proposed for a five-year waiver period from 2021 to 2026, many aspects of the transformation, including Community supports and ECM, were explicitly intended to outlast the initial five-year period and eventually transition into permanent Medi-Cal benefits. As the state transitions from implementing these services to sustaining them, this bill is intended to remove unnecessary variation in delivery of Community supports; establish a predictable, transparent public process when DHCS makes policy changes; codify ECM consistent with current policy; ensure continued timely data reporting; and make necessary technical updates. In addition, it ensures DHCS provides the Legislature information necessary to consider transitioning Community supports to full Medi-Cal benefits. As we move from building CalAIM to refining it, this bill makes needed adjustments to Community supports and ECM for the long term and helps the state truly realize the promise of CalAIM.
- 2) *CalAIM.* CalAIM is a collection of Medi-Cal initiatives aimed at addressing social drivers of health, reducing program complexity, increasing program flexibility, and modernizing payment structures to promote better outcomes. The CalAIM proposals were originally intended to start in 2021, but given the COVID-19 public health emergency and considerable stakeholder input, CalAIM did not start until January 1, 2022. CalAIM was authorized by AB 133 (Committee on Budget, Chapter 143, Statutes of 2021), which incorporated two policy bills introduced in 2021 and the approval of a federal Section 1115 demonstration waiver and a Section 1915(b) waiver. These waivers, named for the section of the Social Security Act authorizing each, allow DHCS to waive certain federal Medicaid and Children's Health Insurance Program requirements. Section 1115 waivers generally test innovating program improvements in a budget neutral manner, while Section 1915(b) waivers allow for the use of a managed care delivery system provided it is cost-effective. Both waivers require that changes to the state program be consistent with the objectives of the Medicaid program. DHCS received approval on December 29, 2021 for both waivers, effective through December 31, 2026. Some elements of CalAIM were also added to California's Medicaid state plan as ongoing program changes which do not need to be reauthorized when the waivers end.
- 3) *ECM.* ECM is a statewide Medi-Cal benefit 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," which includes people experiencing homelessness, people at risk of avoidable hospital care, people with serious mental health or substance use disorder needs, adults at risk for long term care institutionalization, adults in nursing homes transitioning to the community, children enrolled in California Children's Services with additional needs, children involved in child welfare, people transitioning from incarceration, and specific pregnant and postpartum individuals. As described by DHCS, enrollees are to have a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. That lead care manager is to meet enrollees where they are to meet their needs, build a trusting relationship, and provide intensive coordination of health and health-related services. In the most recently published data on utilization, in the second quarter of 2024, just under 126,000 Medi-Cal enrollees received ECM (out of 14.89 million total enrollees).

- 4) *Community supports.* Community supports are optional Medi-Cal plan services offered as cost-effective alternatives to traditional medical services or settings. DHCS has a pre-approved list of 15 Community supports, building off previous pilot programs such as Whole Person Care, Health Homes, and a medically tailored meals pilot program. These services address health-related social needs of Medi-Cal enrollees such as support to secure and maintain housing, access to medically tailored meals, and various transitional services when moving out of specific facilities. While DHCS encourages Medi-Cal plans to offer all of the Community supports services, these services are not entitlements, but are offered at the option of the plan to any eligible Medi-Cal enrollee.

In obtaining federal approval for the Community supports, DHCS was required to show that these services would allow Medi-Cal enrollees to avoid higher, costlier levels of care. For example, with regards to the Medically Tailored Meals/Medically Supportive Food benefit, DHCS presented findings that the average annualized health care expenditure was \$1,863 greater for individuals assessed as food insecure relative to those not found to be food insecure, after adjusting for age, gender, race/ethnicity, education, income, insurance, and residence area. For persons who have been recently discharged from hospitals or with chronic conditions, the report cited literature of specific patient populations showing significant reductions in emergency department visits, inpatient hospitalizations, reductions in readmissions, and improvements in health outcomes and well-being such as improved control of diabetes or fewer falls when provided meal delivery services. Data from the 2024 Community Support annual report shows that nine out of first 12 services (two were added later) were already demonstrating cost effectiveness ranging from an 11.7% net cost reduction for sobering centers to a 61.3% in net cost reduction for respite services for people experiencing homelessness who are transitioning from hospital care. The remaining three services included in the report were expected to demonstrate their cost-effectiveness over a longer timeline.

- 5) *Next steps for CalAIM.* As the current CalAIM waivers expire at the end of 2026, DHCS has submitted renewals for both the 1115 and 1915b waivers. Although done as part of the CalAIM package, the ECM benefits and most of the community supports do not require waiver authority. According to DHCS, ECM is authorized under federal Medicaid managed care regulations regarding care coordination and continuity of care responsibilities of managed care plans. Twelve of the 15 community supports were authorized under managed care authority known as In Lieu of Services, which authorizes these benefits at the option of the plans. These services can continue under the Medicaid state plan. The recuperative care and short-term post-hospitalization housing community supports will be recast into this authority as well, while a final community support on rent payments is part of another behavioral health waiver that is not up for renewal at this time.

When CalAIM was initially conceived, DHCS stated during the planning process that it intended for the community supports benefits to be permanent, statewide Medi-Cal benefits, but that plan capacity and provider availability at that time did not exist. The CalAIM waivers also contained funding to help start these benefits, funding which is not being continued in the current waiver renewal process. As such, the community supports are continuing at the Medi-Cal plans' option. Because many of the community supports likely require waiver authority to turn into full benefits, continuing them under existing In Lieu of Services authority may be the only option given the current federal administration's views on social determinants of health and Medicaid spending in general. This bill would require

DHCS to give the legislature an assessment of making these benefits permanent in 2029, along with a number of other technical changes on DHCS's obligations with regards to reporting, stakeholder inclusion, and the issuance of guidance.

- 6) *Prior legislation.* 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 increase monitoring, reporting, and technical support for these benefits. *SB 324 was held on the Assembly Appropriations suspense file.*

AB 804 (Wicks and Stefani of 2025) would have made the CalAIM housing supports community supports benefits and fully covered by Medi-Cal, rather than benefits provided at the plan option. *AB 804 was held on the Assembly Appropriations Committee suspense file.*

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."*

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."*

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

AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) establishes the CalAIM initiative and the CalAIM ECM and Community supports benefit, among other things.

- 7) *Support.* The Community-Based Organization Medi-Cal coalitions write as documented by DHCS and echoed by providers and communities across the state, the ECM and Community supports benefits are improving outcomes for Medi-Cal members while simultaneously delivering measurable cost savings to California. By addressing unmet social and nonmedical needs, Community supports reduce avoidable emergency department visits, inpatient stays, and institutional care, allowing the health care system to intervene earlier, more effectively, and more humanely. By strengthening the foundation for these benefits and charting a path toward making Community supports permanent, required Medi-Cal coverage, this bill affirms California's commitment to whole-person care, health equity, and smart public investments.
- 8) *Amendments.* The author and committee have agreed to the following amendments on aspects of the bill requiring DHCS to produce information:

The quarterly reporting requirement will be changed back to annual to avoid the resources needed to prepare a formal report, but additional language will be added to specify that quarterly data should still be publicly produced:

Section 1, 14184.205(g):

(g) The department shall develop, in consultation with Medi-Cal managed care plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of ECM pursuant to this section. Until December 31, 2031, the department shall continue to publish quarterly ECM utilization data on a public data dashboard. The department shall ~~quarterly~~ annually publish a public report on reported ECM utilization data, populations served, and demographic data, stratified by age, sex, race, ethnicity, and languages spoken, to the extent statistically reliable data are available.

Section 2, 14184.206(g)

(g) The department shall develop, in consultation with Medi-Cal managed care plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of community supports pursuant to this section. Until December 31, 2031, the department shall continue to publish quarterly community supports utilization data on a public data dashboard. The department shall ~~quarterly~~ annually publish a public report on reported community supports utilization data, populations served, and demographic data, stratified by age, sex, race, ethnicity, and languages spoken, to the extent statistically reliable data are available.

Although the author intends to give DHCS flexibility in how DHCS should give the Legislature the information it needs to determine whether to transition community supports to permanent benefits, this information should at least be in writing, even if not a formal report or other document:

Section 2, 14184.206(n)

(n) By March 31, 2029, the department shall provide to the appropriate policy and fiscal committees of the Legislature information in writing necessary to inform legislative consideration of transitioning community supports to benefits that are required to be covered under the Medi-Cal program, including information on cost, effectiveness, and provider availability.

**SUPPORT AND OPPOSITION:**

- Support:**
- 18 Reasons
  - AIDS Healthcare Foundation
  - 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 Advocates for Nursing Home Reform
  - California Alliance of Child and Family Services
  - California Assisted Living Association
  - California Association of Medical Product Suppliers

California Association of Nonprofits  
California Chapter of the American College of Emergency Physicians  
California Community Action Partnership Association  
California Housing Consortium  
California Primary Care Association Advocates  
California Retired Teachers Association  
Ceres Community Project  
Community-Based Organization Medi-Cal Coalition  
DoorDash  
Downtown Women's Center  
East Bay Asian Local Development Corporation  
East Bay Innovations  
Eden Housing  
El Sol Neighborhood Education Center  
Emergency Food Bank of Stockton/San Joaquin County  
Episcopal Community Services of San Francisco  
Esperanza Community Farms  
Everyone's Harvest  
Food As Medicine Collaborative  
Foodwise Community  
Fresh Approach  
FullWell  
Health Access California  
Homestyle Direct, LLC.  
Institute on Aging  
Jamboree Housing Corporation  
LeadingAge California  
Linc Housing  
Los Angeles LGBT Center  
Meals on Wheels Orange County  
National Core  
Open Source Wellness  
Partners in Care Foundation  
Purfoods  
Reinvestment Partners  
San Diego Wellness Collaborative  
San Francisco-Marin Food Bank  
Santa Barbara County Food Action Network  
Second Harvest Food Bank of Santa Cruz County  
Sunterra Health, Inc.  
Western Center on Law & Poverty, Inc.

**Oppose:** None received

**-- END --**