Center for Health Care Strategies

Assisted Living for Medi-Cal Enrollees: Frequently Asked Questions

Between June and September 2025, the Center for Health Care Strategies (CHCS), with support from the California Health Care Foundation (CHCF), is hosting the *Assisted Living for Medi-Cal Enrollees: Virtual Learning Series* focused on strengthening cross-sector partnerships to improve appropriate, timely, and effective use of assisted living communities for Medi-Cal enrollees, including older adults and people with disabilities, individuals with behavioral health needs, and people experiencing homelessness. For foundational information on assisted living in the Medi-Cal system, see these resources from CHCF.

Following are questions posed by participants during the webinars and answers provided by presenters and/or CHCS. Questions and answers are lightly edited for clarity and will be updated following each webinar.

Webinar 1: The Untapped Potential of Assisted Living in Addressing the Housing and Care Needs of Medi-Cal Enrollees

1. Is there insight as to whether California plans to expand Assisted Living Waiver (ALW) access to non-waiver counties in the future?

California's Department of Health Care Services (DHCS) is considering integrating the ALW into its Medi-Cal managed care system, but how is not known at this point. Information about the potential integration is available at: www.dhcs.ca.gov/services/ltc/Pages/HCBS-Integration.aspx

2. Do adult residential facility (ARF) residents transfer to residential care facilities for the elderly (RCFE) when they reach age 60?

Regulations allow people younger than age 60 to live in RCFEs and people older than age 59 to live in ARFs if their needs are compatible with the facility, so residents are not automatically transferred when they turn 60. However, as the ARF population has lived longer, they have moved into RCFEs more over time.

3. How can assisted living operators of smaller facilities, like those with six beds, expect to stay open with low reimbursement rates?

The ALW has statewide fixed, tiered reimbursement rates which can be insufficient depending upon the varying costs of living and labor across the state and differences in enrollee needs. Programs for All-Inclusive Care for the Elderly (PACE) typically negotiate with facilities to reach an agreed-upon rate based on facilities' standard rates for other payer types, and those rates may be more sustainable for smaller operators or operators serving people with complex needs. Managed care plans (MCPs) and intermediary hubs also negotiate rates locally with their contracted facilities for Community Supports, with nonbinding guidance from the state on suggested rate tiers, so there is potential to negotiate a more sustainable rate for Community Supports residents.

Operators and plans have successfully negotiated satisfactory rates in some areas by using the suggested rates as a starting point and incorporating cost of living adjustments, administrative fees, and other additional costs into their local rates. To successfully negotiate rates with PACE providers and MCPs,

operators must be able to clearly demonstrate the needs and costs for providing care to MCP enrollees in their area and for their resident populations. Strong relationships between operators, service providers, and health plan financial staff can help these negotiations be more successful.

Additionally, for any of these CalAIM programs to be a success, braiding funding at the facility level is key, meaning operators should explore and utilize all available sources of funding for various services to create a more diverse and sustainable funding pool that does not rely solely on reimbursement from one source.

4. How do MCPs link their members to open beds in appropriate assisted living facilities given that bed occupancy fluctuates often and each facility offers different services?

There is currently no centralized system for assisted living operators to communicate with MCPs and other partners about bed occupancy or to conduct appropriate placements based on what services and environment each facility provides. This is one of the largest problems across the state. CHCS has heard from operators, MCPs and other partners that they typically communicate about bed capacity with each other on an as-needed basis via text or phone call.

5. How can payers/referral partners connect with Medi-Cal assisted living facilities?

California's Department of Social Services, which licenses and oversees RCFEs and ARFs, has a facility search tool where you can search for facilities by type and name, city, zip code, or county. Senior centers, long-term care ombudsmen, and other community-based care management and referral organizations can also help make connections to assisted living facilities. County behavioral health/mental health departments may also have lists of facilities they contract with, and DHCS has a list of participating ALW facilities. There is a recognized need to standardize and/or centralize the list of participating Medi-Cal facilities so that referral and placement partners can conduct their work more efficiently.

6. How can Medi-Cal enrollees apply for assisted living services?

If Medi-Cal enrollees receive Enhanced Care Management (ECM) services, they can ask their ECM provider about assisted living options. They can also ask current healthcare or social services providers about assisted living and have those providers initiate a referral to the appropriate program. MCPs may have their own application or referral form for assisted living services, like this form for Anthem members.

7. Are operators open to working with technology vendors to help address safety, elopement, and early detection of health issues in assisted living facilities? Do operators find this cost-effective or are there barriers to adoption?

Assisted living has been criticized for being late adopters of technology, and the COVID-19 pandemic illuminated the need for assisted living providers to embrace technology. Assisted living communities in California, however, are increasingly looking into technologies for communication, fall detection, and electronic record-keeping. There is also an ongoing dialogue within assisted living, and the California Assisted Living Association in particular, on how to balance resident rights with safety.

Regulations require assisted living operators to outline how they will use technology so that licensing bodies can ensure operators are not using technology as a substitute for direct care, which can pose a barrier to adoption as it requires operators to assume risk in adopting technologies. Higher-end facilities are typically the first ones to adopt new technology, and these facilities are typically less likely to serve Medi-Cal populations, so there may be less use of technology in state-funded and budget-conscious spaces.

8. Is DHCS expected to publish a Behavioral Health Information Notice/All Plan Letter to specify that mental health plan and MCP members with complex behavioral health and medical conditions are expected to have a share of cost for assisted living care?

We are not aware of any anticipated guidance DHCS is planning related to share of cost for assisted living.

9. We are having difficulties finding placement for people released from prison who have medical conditions. We often have to find placement for them in different counties, which can force them to switch MCPs if that county is out of their plan's service area. How can plans and referral partners manage this?

Ultimately, this is an opportunity for better system level coordination, and formalizing discharge and release planning with both California Department of Corrections and rehabilitation prison staff and the MCP staff. For members that need to be placed in different counties, start the planning process as early as possible to initiate a Medi-Cal county transfer to get the member assigned to an MCP in their new county. Once the MCP in the new county has enrolled the member, release planning teams can utilize the MCP's Justice-Involved Liaison to help identify an appropriate placement depending on the member's needs and help ensure services are available when the member is released.

10. How does the Assisted Living Facility Transitions Community Support (ALF CS) address the issue of affordability in counties without an ALW?

The ALF CS covers both time-limited transition services and expenses and ongoing services and care delivered in assisted living communities, which can be received indefinitely. Both the ALW and the ALF CS require individuals to have full-scope Medi-Cal eligibility with zero share of cost, meaning residents are not responsible for financially contributing to their care.

Neither the ALW or the ALF CS cover room and board expenses, which is typically the main affordability barrier in both programs. However, funding mechanisms exist that can help residents pay for room and board expenses, including adjusted Supplemental Security Income/Supplemental Security Disability Income through State Supplementary Payments, Behavioral Health Services Act programs, county or city Housing Choice vouchers, and regional center funding, among others.

11. Does Medi-Cal cover assisted living services for everyone, or only for those with citizenship or other legal documentation status?

As of January 2024, full scope Medi-Cal coverage is available to all eligible California residents regardless of immigration status. Anyone who meets the eligibility criteria for the ALW, Community Supports, and county Mental Health Plans can receive assisted living services through Medi-Cal. However, beginning in January 2026, undocumented immigrants will be prohibited from newly enrolling in Medi-Cal; and beginning in 2027, all current undocumented Medi-Cal enrollees ages 19 through 59 will be charged a $30 monthly premium.

Webinar 2: Who Thrives in Assisted Living? Strategies for Effective Assessments Across Settings

12. Have referral partners considered working with acute rehab facilities to identify and refer more Medicare patients to assisted living facilities?

Acute rehab facilities are able and encouraged to be referral partners to assisted living facilities. However, care in assisted living settings is currently only covered by Medicaid. There may be some short-term stay coverage under Medicare, depending on a beneficiary's needs, but typically this is only a Medicaid benefit.

13. If a facility already has a contract in place with a county's behavioral health plan for providing residential and specialty outpatient mental health services, do they need to contract separately with MCPs in the county that offer the ALF CS or is there an opportunity for mutual contracting?

This varies by county and plan. For example, Health Plan of San Mateo does not currently contract with specialty behavioral health assisted living facilities under the ALF CS, but it is launching a behavioral health assisted living pilot and are still determining what the contract processes will look like for that program. There may be opportunities for mutual contracting depending on the specific county's plans and processes.

14. Are there any financial or income limits to qualify for assisted living placement?

Medi-Cal Community Supports and the ALW are limited to Medi-Cal members with zero cost sharing. Overall eligibility for full-scope Medi-Cal is determined by income and asset limits. California removed the asset limit for Medi-Cal in January 2024, which expanded access to long-term-care-like assisted living for Medi-Cal enrollees, but Proposition 35 would reinstate the limit beginning in January 2026.

15. Are MCPs limited to contracting only with ALW facilities?

No, MCPs can contract with any licensed assisted living facility, including those not enrolled in the ALW program. In fact, to address capacity issues and help move people off the ALW waitlist, it is advantageous for MCPs to contract with non-ALW facilities.

16. Regarding the ongoing personal care services delivered in assisted living communities, do MCPs contract with home health agencies or other service providers directly to deliver care in AL communities, or does the contract with the community include ongoing services?

This question will be covered in-depth during CHCS' fourth webinar in August. While it is more common for a contract between MCPs and AL communities to be inclusive of services — meaning the AL operator is responsible for procuring and providing ongoing services — there are instances where it may make sense for an MCP to contract directly with a personal caregiver or more specialty provider to deliver care to a specific resident in an AL community.

17. Does Health Plan of San Mateo (and other MCPs) work with non-licensed room and boards?

Currently, facilities must be licensed by the state to contract with Medi-Cal MCPs. However, some counties may contract with non-licensed room and boards through their mental health/behavioral health plans.

18. Are there any tools or resources available that outline best practices or models of how health care systems and other continuums of care can start to standardize assessments across the system?

Los Angeles County has done some work on this. It starts with identifying which entities in your area are currently referring people into ARFs and RCFEs, and looking at what tools they're using to do assessments. For example, Los Angeles County Department of Mental Health uses the 5x5 tool to assess clients for placement in an ARF or RCFE under its mental health plan. Operators and referral partners can identify which pieces of those assessments are most important to them, and work collaboratively on creating a more standardized tool, or learning the language of other assessment tools, to simplify the process.

Webinar 3: Navigating Assisted Living Entry: Strengthening Referral Partnerships for Successful Transitions

19. How does share of cost work with MasterCare?

Members enrolled in MCPs that use MasterCare as a hub for care coordination must have some readily available income, typically Social Security Income, and agree to contribute 90% of that monthly income to room and board costs for their assisted living facility. MasterCare pays a monthly rate for both care and room and board to each facility for each member that is negotiated based on data — such as existing rates, cost of care, and zip code — then deducts the member's room and board share of cost from the total monthly rate and submits claims to the member's MCP for the remaining amount.

20. What are the regulations regarding assisted living residents who are re-hospitalized due to a new medical issue who must stay in a hospital or skilled nursing facility in excess of 30 days?

There is no federal or state-wide mandate requiring MCPs to continue paying for assisted living services while a member is in the hospital, and no requirement stating assisted living operators must hold a resident's bed while they are hospitalized.

However, some MCPs may continue reimbursing the assisted living operator for the daily rate while the resident is in the hospital or skilled nursing facility to maintain their room and eligibility when they return. For example, MasterCare pays 100% of the daily rate for days 1-14 of hospitalization, and 50% of the daily rate for days 15-30. At day 31 and beyond, they typically complete a reassessment so that eligibility is not lost and a new care plan can be developed as appropriate. Depending on the plan's relationship with the particular assisted living operator and bed capacity, the person may be able to keep their previous room, or they may need to look for a new room or a new community to return to.

21. What is a "long-term care bed"?

A long-term care bed is a bed in a skilled nursing facility that is designated for individuals with a certain medical level of care need. In contrast, a rehabilitation bed is a bed in a skilled nursing facility that is designated for individuals who need rehabilitative therapies like physical therapy, occupational therapy, or speech therapy. Rehabilitation beds are typically short-term stays and are covered by Medicare, whereas long-term care beds are longer stays and are covered by Medi-Cal with a higher reimbursement rate.

22. Will the assisted living marketplace portal that LARCA (Licensed Adult Residential Care Association) is developing also include information on private-pay assisted living communities?

Yes, the portal will include information on all assisted living communities in LARCA's network and can be used by anyone regardless of payer type. It is expected to be implemented between Q4 2025 and Q2 2026.

23. If a Medi-Cal member is already in an assisted living community and wants to transfer to a different one, how would they approach that?

The member would first contact their Cal-AIM provider (MCP, county behavioral health/mental health department, or Assisted Living Waiver Care Coordination Agency) and request to transfer facilities. Depending on eligibility, the member may receive financial assistance for the transition through Enhanced Care Management, the Assisted Living Facility Transitions Community Support, or county programs.

24. Where can we find Care Coordination Agencies that serve our specific county?

DHCS maintains the following list of participating Care Coordination Agencies and the counties they serve: https://www.dhcs.ca.gov/services/ltc/Pages/List-of-Approved-CCAs.aspx.

25. How does someone get enrolled in CalAIM to access Community Supports?

Individuals can enroll in a Medi-Cal MCP online, by phone, by mail, or in-person. For more information, visit: https://www.healthcareoptions.dhcs.ca.gov/en/enroll.

Consult this list of MCPs that offer the Assisted Living Facility Transitions Community Support: https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf.

26. What happens to an enrollee's coverage if they change their MCP to one that does not offer the Assisted Living Facility Transitions Community Support? Residents often receive marketing calls from other MCPs and the person may switch plans without realizing the impact to Community Support coverage.

Most MCPs offer some protection around this and will re-enroll the member in their original plan if there is proof that the sales process of the new plan failed to properly explain the ramifications of changing plans. Good relationships with the original MCP and/or ongoing care management providers can help mitigate these issues. However, while the resident is enrolled in the new plan, reimbursement cannot be provided to the assisted living providers.

27. How are ARFs/RCFEs qualified to serve individuals with serious mental illness?

The next webinar in the series, on August 21, 2025, will explore this topic in detail. ARFs/RCFEs can incorporate providers qualified to serve individuals with serious mental illness into their provider infrastructure (i.e. psychiatrists, behavioral therapists) so that residents can receive mental health services in addition to assistance with ADLs/IADLs.

28. Are there differences in funding for assisted living and memory care?

Medi-Cal covers memory care as well as assisted living if the assessment process determines there is a need for memory care services.