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Better care where it's needed most

Navigating Assisted Living Entry: Strengthening Referral Partnerships for Successful Transition

Assisted Living for Medi-Cal Enrollees: Virtual Learning Series

July 22, 2025

Made possible by the California Health Care Foundation

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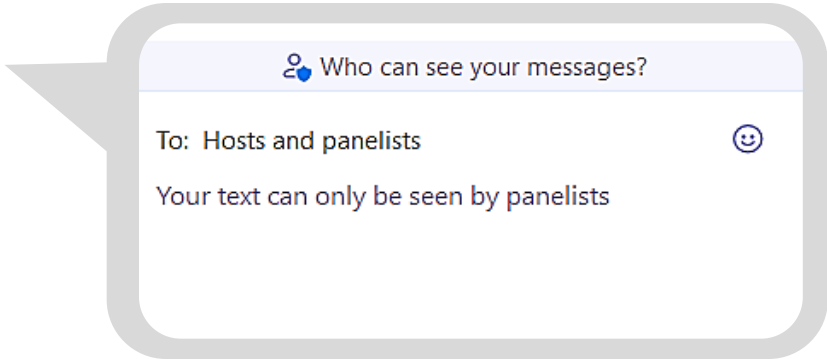

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  2. **Verbally** using the **"raise hand" feature**
     - You will be called on and taken off mute to ask your question
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     - Please limit questions to 1-2 minutes
     - Questions will be answered thematically
- Comments and other thoughts, including dialogue with other participants, can be sent **using the chat feature**.
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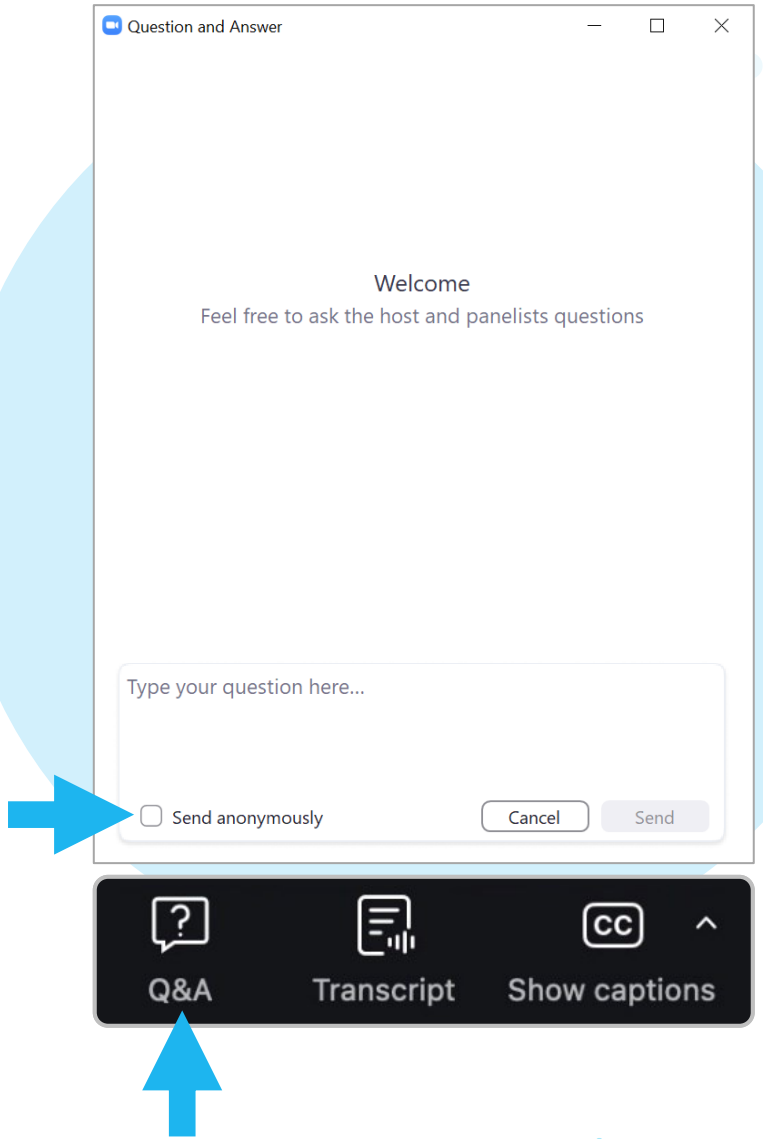

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Welcome & Introductions

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Meet the Team

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Assisted Living Virtual Learning Series Goals

- Explore opportunities to strengthen cross-sector partnerships to improve appropriate, timely, and effective use of assisted living communities for people with Medi-Cal and functional needs, including:
  - → Older adults and people with disabilities
  - → People with behavioral health needs
  - → People experiencing homelessness

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Assisted Living Journey Map

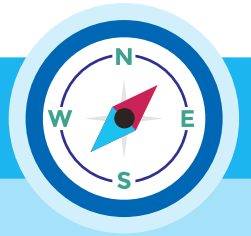
1. **Pre-Implementation: General Concerns and Solutions**

2. **Assessing Appropriateness for Assisted Living**

3. **Referral Before Accessing Services**

4. **Supports During Service Provision**

5. **Post-Assisted Living Options**



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Today's Objectives

- Identify the main referral pathways to assisted living for Medi-Cal enrollees
- Learn some of the key concerns and challenges stakeholders have in referring individuals to assisted living, particularly in non-Assisted Living Waiver counties
- Gain an understanding of the elements of one effective assisted living referral model
- Hear challenges and opportunities unique to connecting people experiencing homelessness and people with behavioral health needs to assisted living
- Engage in cross-stakeholder discussions and identify opportunities for further collaboration

Agenda

- Medi-Cal Referral and Transition Pathways
- Case Study: Los Angeles County
- Presentations
  - → Health System Referrals in a Non-ALW County: Amelia Grover, Dignity Health
  - → Facilitating Referral Partnerships in Managed Care: Debra Draves, MasterCare
  - → Navigating Assisted Living Entry: Salaneka Smith, LARCA, and Bamba Ramos, Westchester Villa
- Open Q&A

Medi-Cal Referral and Transition Pathways

Emma Rauscher, CHCS

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What Do We Mean by Referral?

- Connecting an individual with an assisted living facility
- Involves:
  - → Identifying what supports and services the person will need (often using information collected during assessment process)
  - → Finding facilities that offer those supports and services, and that work with the person's payer type for both services and room and board
  - → Coordinating tours/meetings to ensure the person and the operator both feel like the facility will be a good fit
  - → Completing applications and securing documentation for the appropriate assisted living facilities

What Do We Mean by Transition?

- Physically moving a person from their current living environment into an assisted living facility
- Involves:
  - → Communicating with the operator to coordinate move-in logistics
  - → Transporting the person and their belongings to the facility
  - → Setting up appropriate paperwork, emergency contacts, communication procedures, payment methods, and utility services, among other activities
  - → Coordinating environmental modifications or other disability accommodations for accessibility, if necessary

Typical Assisted Living Referral Sources by Population Type

	All Populations	Older Adults and People w/ Disabilities	People Experiencing Homelessness	People with Behavioral Health Needs
Institutional Settings	• Skilled nursing facilities • Intermediate care facilities • Prisons	• Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities		• Institutions for Mental Diseases
Acute Care and Crisis Services	• General hospitals • Long-term hospital stays • Jails		• Medical respite	• Psychiatric hospitals
Community Care and Service Providers	• Family caregivers • Outpatient health care providers • Social workers • Meal sites • Churches • Libraries	• Direct support professionals • Adult service providers • Senior centers • Independent living centers • Regional centers • Area Agencies on Aging	• Permanent supportive housing providers • Coordinated entry service providers • Shelters • Day habilitation programs • CalWORKS housing support	• Community behavioral health clinics
County Agencies	• Adult protective services • Human Services/Social Services departments • Diversion/re-entry offices • Public Guardian offices	• Area Agencies on Aging	• Continuums of Care	• County behavioral/ mental health departments
Payers and Care Managers	• Managed care plans • Enhanced Care Management • Community care hubs • ALW care coordination agencies			• County behavioral/mental health plans • Managed Behavioral Health Organizations

How Does Enhanced Care Management fit in?

- Enhanced Care Management (ECM) providers conduct whole-person assessments, develop personalized care plans, refer members to Community Supports if appropriate, and help coordinate the referral and transition process
- ECM Populations of Focus, Q4-2024:
  - → Adult – Living in the Community and At Risk for Long-Term Care: 18,700
  - → Adult – Nursing Facility Residents Transitioning to the Community: 1,200
- Community Supports Recipients, Q4-2024:
  - → Assisted Living Facility Transitions: 872
  - → Nursing Facility Transition to Home: 289
- Opportunity to improve identification and referral of ECM members from these populations of focus to assisted living via Community Supports

Financing Pathways for Referrals and Transitions

CalAIM Assisted Living Facility Transitions Community Support

- Covers all referral and transition expenses that are necessary for the member, meaning without these services they would be unable to move into the facility
- Covers non-recurring set-up expenses up to a total lifetime maximum of $7,500
- Members may receive other Community Supports including Environmental Accessibility Adaptations, Housing Deposits, and/or Housing Transition Navigation Services along with the ALF Community Support, as long as there is no duplication of services

Assisted Living Waiver

- Care Coordination Agencies provide referral services, including developing Individualized Service Plans for each member and identifying appropriate facilities and providers
- One-time payments to CCAs for Nursing Facility Transition Care Coordination services
- Does not explicitly cover transition services when moving from another community-based setting

MHSA and local funding for people with behavioral health needs

- e.g., HPSM Behavioral Health and Recovery Services program (see series webinar #2)
- Does not cover transition services in all counties

https://www.dhcs.ca.gov/services/ltc/Documents/ALWTransitionalCare_defined.pdf
https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

Case Study: Los Angeles County

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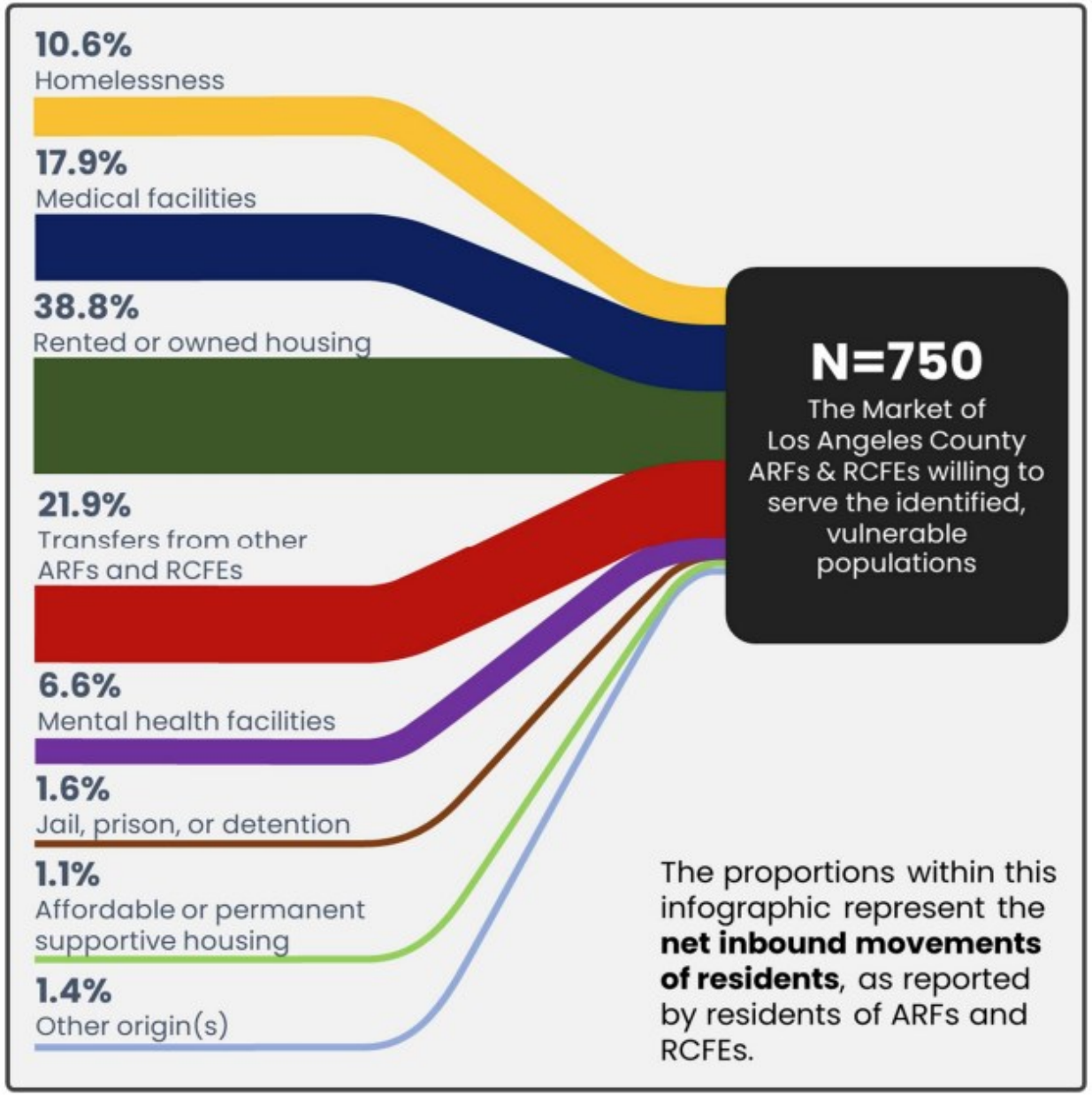
The Future Organization Research Study: Study Population

- ARFs and RCFEs in Los Angeles County that were:
  - → Willing to serve/already serving those living with mental health conditions/disabilities;
  - → Willing to serve/already serving residents 100% reliant on any form of public benefits;
  - → Willing to serve/already serving residents at risk of homelessness; and
  - → Did not exclusively provide services to privately-funded resident populations or residents with developmental disabilities
- "The Market": N = 750 *(estimation based on surveys, analysis, and incidence rate data)*
  - → ARF = 284
  - → RCFE = 466

https://brilliantc.wpenginepowered.com/wp-content/uploads/2023/08/TFO-BC-Research-Study-Serving-Our-Vulnerable-Populations-Release-Version-08.10.23.pdf (Source for slides 19-24)

The Market: Resident Inputs

- This graphic shows the breakdown of where current "market" residents resided before moving into their current ARF or RCFE, based on self-reported data.
- A majority came from their home, a different ARF or RCFE, or a medical facility



Prior locations vary by facility type…

Table 3.1: Resident Origins, by License Class	ARF	RCFE	ALL
Rented or owned accommodation	16.3%	44.8%	29.4%
Transfer from another ARF or RCFE	26.4%	16.7%	21.9%
In-patient medical, residential	16.0%	20.1%	17.9%
Unhoused / homelessness (direct)	14.2%	6.3%	10.6%
Rented or owned accommodation w/family or friends	11.3%	7.3%	9.4%
In-patient mental health, residential	10.4%	2.1%	6.6%
Jail, prison, or detention	2.4%	0.7%	1.6%
Affordable / permanent supportive housing	1.5%	0.7%	1.1%
Residential substance abuse treatment facility	0.9%	0.7%	0.8%

And by demographics.

Table 3.5: Resident Origins, by Racial Identity (MR)	WHITE	BLACK	LATINX	ASIAN	NATIVE AMERICAN	PACIFIC ISLANDER*	MIDDLE EASTERN*
Rented or owned accommodation	31.6%	21.6%	28.8%	34.3%	17.6%	33.3%	33.3%
Transfer f/ another ARF / RCFE	22.1%	26.5%	21.2%	13.4%	29.4%	33.3%	0.0%
In-patient medical, residential	19.4%	17.9%	11.5%	19.4%	11.8%	0.0%	33.3%
Unhoused / homelessness (dir.)	9.2%	13.6%	11.5%	9.0%	17.6%	33.3%	0.0%
Rented or owned accom. w/ family	9.9%	9.3%	9.6%	13.4%	11.8%	0.0%	33.3%
In-patient mental health, res.	5.1%	9.3%	11.5%	4.5%	0.0%	0.0%	0.0%
Jail, prison, or detention	0.7%	2.5%	2.9%	1.5%	5.9%	0.0%	0.0%
Afford. / perm. support. housing	1.4%	0.0%	1.0%	4.5%	0.0%	0.0%	0.0%
Res. substance abuse facility	0.3%	1.9%	1.0%	0.0%	5.9%	0.0%	0.0%

* Insufficient sample exists from these racial identity groups for valid comparison with other groups

Referral sources also vary by license type.

Table 3.11: First Mention Referral Source, by License Class	ARF	RCFE	ALL
Hospitals and Medical Facilities	33.8%	15.2%	22.4%
Referral and Placement Agencies	2.9%	33.2%	21.5%
Word of Mouth	0.7%	26.3%	16.4%
Regional Center System	25.0%	2.3%	11.0%
County Agencies	14.7%	2.3%	7.1%
Mental Health Facilities	12.5%	1.8%	5.9%
Family and Friends of Residents	1.5%	6.9%	4.8%
State Agencies	1.5%	3.7%	2.8%
Nonprofit Partners	2.2%	1.8%	2.0%
Other ARFs and RCFEs	0.7%	2.3%	1.7%

Guest Presentations

Meet Today's Speakers

Amelia Grover, LCSW, CCM
Social Work Manager
Transitional Care Center
Dignity Health

Debra Draves
CEO
MasterCare

Salaneka Smith
Director of Member Services
Licensed Adult Residential Care Association (LARCA)

Bamba Ramos
Administrator, Admissions Coordinator
Westchester Villa
LARCA member

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Assisted Living Waiver: Health System Referrals

Amelia Grover, LCSW
Social Work Manager Transitional Care Center
Dignity Health

July 22, 2025

CommonSpirit

Central Coast Community

- Non-Assisted Living Waiver (ALW) Community
- Rural community
- Limited levels of care
  - Long Term Care (LTC) in Skilled Nursing Facilities (SNF)
  - Residential Care Facilities for the Elderly (RCFE)
  - Caregiving
- Cost of services (RCFE, caregiving, etc.)

Referrals to ALW: Healthcare Challenges

- General challenges:
  - Current wait times
  - Human nature
  - Lack of navigators in outpatient healthcare systems or in community with knowledge of healthcare systems
  - Hospital and SNF prioritization are not always useful in the moment
    - Hospital length of stay vs. acuity of patient need
    - SNFs:
      - Due to wait time, likely will be placed on LTC bed→ low reimbursement for LTC beds
      - Health Status changes

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Referrals to ALW: Healthcare Challenges

- Non-ALW County Specific Challenges
  - Limited knowledge/availability of resources
  - Relocation is required
  - Referring providers lack of familiarity with the ALW "system"
    - Differences in wait times across counties
    - Changes in access
    - Acuity prioritization–how is this done?

Referrals to ALW: Healthcare Challenges

- Non-ALW County Specific Challenges: CenCal (managed care plan)
  - CenCal Community Supports (CS)
    - Have Assisted Living Facility Transition support, but…
      - No funding for room and board from Medi-Cal
      - Room and board community average $4,000–$7,000
      - Service is not sustainable because members cannot pay for board and care
      - CS providers=ALW Care Coordination Agency
    - Risk is room and boards can theoretically provide less care for a higher cost (what is the standard of care?)

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Referrals to ALW: Strategy

- Make referrals through APS/ Ombudsman's office when/where appropriate
- Use Care Coordination Agency in which the patient wants to relocate
- Evaluate for rehab potential for SNF stabilization
- Enhanced Care Management (ECM) for navigation
- Supports through CenCal:
  - Tap into Assisted Living Facility Transitions Community Support (localized support)
  - Harm reduction while they wait and/or if they refuse ALW due to access barriers:
    - Community Supports:
      - SNF Transitions to Home
      - Personal Care and Homemaker Services
      - Respite Services
      - Home Modification
    - Community-Based Adult Services (CBAS)– Wisdom Center

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What is Needed?

- Advocacy:
  - DHCS on ALW expansion
  - Other suggested methods for long term room and board payment
- Cap/Standard Market Value/Regulatory oversight to increase accessibility in RCFEs –maybe similar to rent control
- Increasing affordable housing
- Continued partnerships on Behavioral Health Services Act and Master Plan for Aging efforts (particularly around older adults experiencing homelessness)

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Questions?

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Key Concerns and Challenges with Current Assisted Living Referral and Transition Processes

Medi-Cal Enrollee, Family, and CBO

- Will the facility accept the person's payer type?
- Can the AL facility meet needs/will it be a good fit?
- Can the person afford the rent?
- Where/how do we start?

Managed Care Plans/ECM Providers/Hubs

- **No centralized way to find bed capacity information**
- Lack of communication between discharge planners, UM, CS, and ECM staff
- In-network facilities may not meet all members' needs; is ad-hoc contracting cost-effective?

Healthcare and Social Services Providers

- **No centralized way to find bed capacity information**
- Need for role clarity – contact payer or facility first?
- Lack of awareness of options outside of ALW

Assisted Living Operators

- Mismatched needs/services available
- Potential cost if not a good fit
- ALF CS: Direct referrals often bypass payers – operator may not be in that person's network
- Not enough staff to support filling all beds

Who is the lead coordinator throughout the process?


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The Challenge

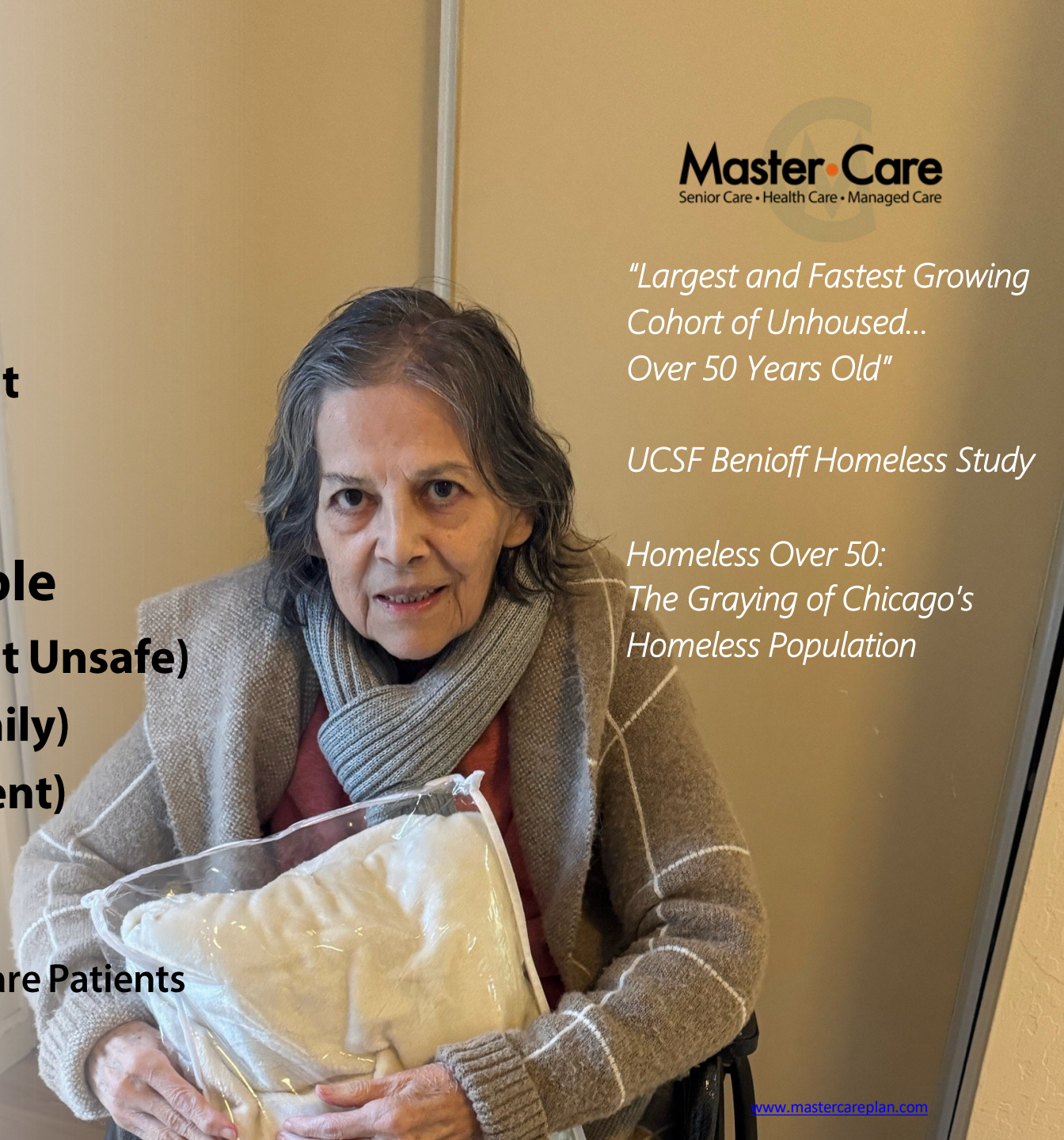
Caring for Older Adults

- **Health Care Needs**
- **Non-Medical Needs (ADLs, IADLs)**
- **Effective Ongoing Care Management**

Few Options for the Most Vulnerable

1. **Unsafe at "Home" (Living Alone, but Unsafe)**
2. **Inappropriate / Unavailable (w/Family)**
3. **Skilled Nursing (Medical Environment)**
4. **…The Street**

All images from this point forward are Master•Care Patients



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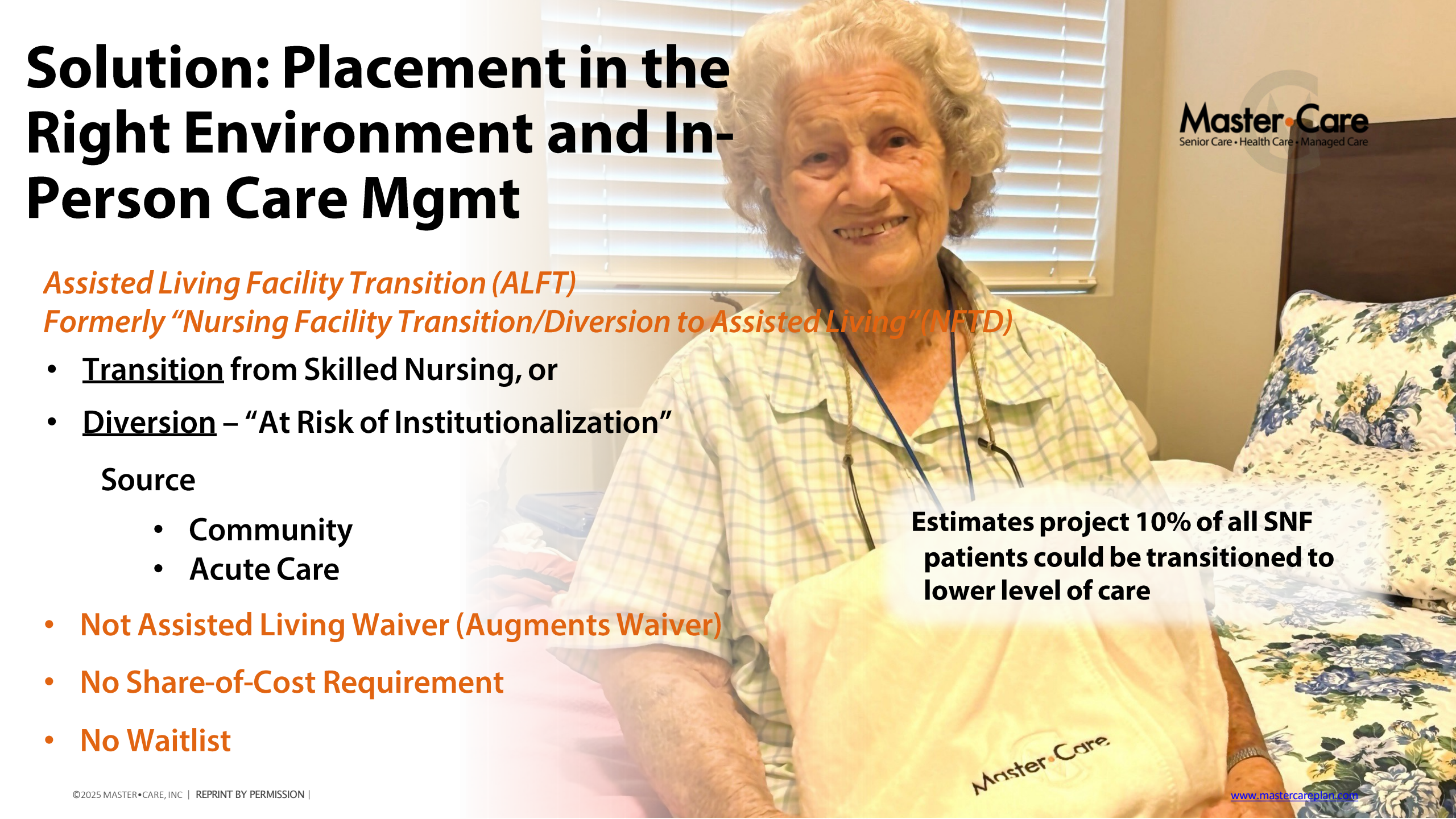
"Largest and Fastest Growing Cohort of Unhoused… Over 50 Years Old"

UCSF Benioff Homeless Study

Homeless Over 50: The Graying of Chicago's Homeless Population

Solution: Placement in the Right Environment and In-Person Care Mgmt



Assisted Living Facility Transition (ALFT)
Formerly "Nursing Facility Transition/Diversion to Assisted Living" (NFTD)

- Transition from Skilled Nursing, or
- Diversion – "At Risk of Institutionalization"

  Source
  - Community
  - Acute Care

- Not Assisted Living Waiver (Augments Waiver)
- No Share-of-Cost Requirement
- No Waitlist

Estimates project 10% of all SNF patients could be transitioned to lower level of care

What is Master•Care?

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Created Expressly to Deliver CalAIM Services:

Bridge the gap between

- SNF / Acute Care
- Medi-Cal Managed Care
- Senior Living / Home / Community
- Then follow with in-person, person-centered Care Mgmt

"Hub Model"

- Alleviates the need for A.L. Providers to become Medi-Cal Certified
- Utilizes Competitive Market Rates vs. Tiers (when supported by MCP)
- A.L. can use same Appraisal used for Private Pay
- A.L. can calculate Rates / Appropriateness same as Private Pay

Master•Care Data

- Assisted Living Transition/Diversion Services
- Ongoing, In-Person Care Management

+4,300 Enrolled Patients –
ECM & Community Supports

+1,350 Transitioned to Assisted Living*

Avg Saving over cost of Skilled Nursing per Resident: $6,700/Month

Financial Impact

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Acute Care Costs

$4100/ Day, or $123,000 / Month[1]

Skilled Nursing Costs

$390 / Day, or $11,700 / Month[1]

Assisted Living Costs

$208 / Day, or $6,250 / Month[2]

Master•Care Savings

Current Caseload

Nearly $7.5 Million/Month

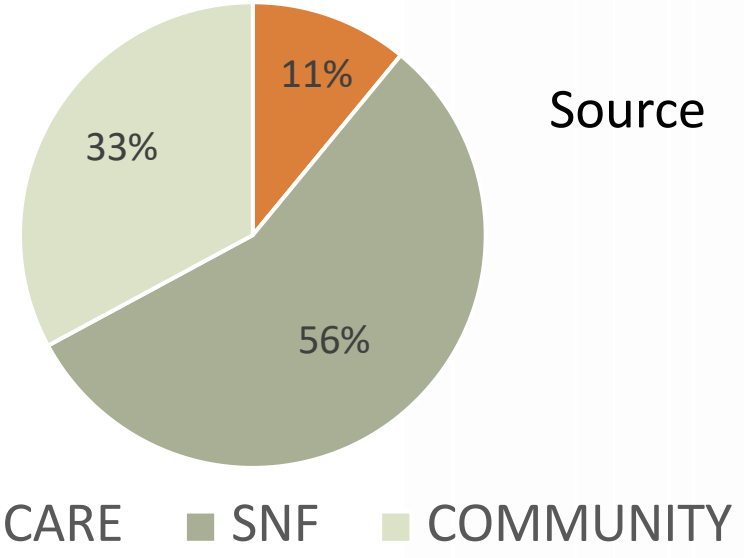
[1]CMS – Avg CA Medicaid Day Rate 2022

[2]Genworth Financial – Avg CA Assisted Living Monthly Cost 2023

[3]Cohort of 244 pts Transitioned or Diverted from 4/15/2023-12/15/2023 – Anthem Blue Cross

More Master•Care Data

AVG A.L. Day Rate Private	$208.00
Pay AVG Master•Care Rate	$161.68
vs. SNF Day Rate	$290.00
Avg Age of Member	72
% of 6-Bed Board & Care	74%



Source

Master•Care Process

Comprehensive Assessment

- In-Person / Whole-Person / Person-Centered
- Medical • Environmental • Care Needs • Social Needs • Cultural Needs

Careful Matching

- Access to Sophisticated db / Sensitive Filters
- 1000s of Quality California Assisted Living Providers
  - Thorough Vetting, Ongoing Monitoring

Post Transition

- In-Person / Person-Centered ECM to assure no avoidable E.D. Visits

Current Assisted Living Partners

- Nearly 500 Different Providers – Large Chains / Small Owner-Operated
- 74% 6-Bed Board & Care
- Accommodate Challenging Care Needs
  - Hoyer Lift, up to 3-Person Assist
  - Extreme Behaviors
    - Aggression, Elopement
  - Cultural Needs
    - i.e. Requires Korean-Speaking Caregivers
    - i.e. Strict Halal Diet
    - i.e. Transportation to Temple on Saturdays
- Resident-by-Resident Agreements – No Overarching Contract Requirement

How In-Person Care Management Fits

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In-Person Non-Medical Care Management Services paid by Medi-Cal CalAIM

Provided by Para-Professionals

- We can accompany Drs. Appts
- Assistance Identifying
  - PCP
  - Podiatrist
  - Dentist
- Help Identify UTI or Fall Risk EARLY
- ONGOING SUPPORT IN ASSISTED LIVING AND MEMORY CARE

ALFT Requirements

- Enrolled / Eligible with Participating Managed Care Plan in County
- SOME income –
  SSI (even modest amt) is fine
- Willing / Able to contribute 90% to Assisted Living "Cost of Living"
- If in SNF, must have 60 days

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Thank You

For More Information, Including Case Studies and Testimonials

D.Draves@MasterCarePlan.com

Debra Draves, CEO

Sample Referral and Transition Pathway

Referral Partner

- Identify and assess residents who could be served in the community
- Contact payer to initiate the referral
- Provide necessary documentation to assist with referral and placement process

Payer/ Care Manager

- Develop Individualized Service Plan
- Help members identify and apply for appropriate facilities
- Contact facilities to determine bed capacity
- Coordinate and reimburse* for necessary transition services

**County BH does not reimburse for this in all counties*

Transition Service Providers

- Work with payer and facility to provide transition services to members

Assisted Living Facility

- Review application, service plan, and conduct in-person assessments as needed to determine fit
- Coordinate with payer or transition services coordinator to facilitate move-in

Referral Pathway Barrier: People Experiencing Homelessness

- "56.7% of respondents indicated that their facility had no contact at all over the 12 months prior to interview with organizations serving Los Angeles County homelessness Continuum of Care (CoC), inclusive of governmental agencies such as LAHSA, Coordinated Entry Service (CES) providers, nonprofits, and homeless shelters or bridge housing providers."

https://brilliantc.wpenginepowered.com/wp-content/uploads/2023/08/TFO-BC-Research-Study-Serving-Our-Vulnerable-Populations-Release-Version-08.10.23.pdf

LARCA

LICENSED ADULT RESIDENTIAL CARE ASSOCIATION

We Care!

Navigating Assisted Living Entry: Strengthening Referral Partnerships for Successful Transitions July 22, 2025

Agenda

- Background
- Marketplace Concept
- Opportunities
- Current Activities and Experiences
- Next Steps
- Appendices (Service Model, Market Review, and Changing Landscape)

Background

- Formed in 2021 by LA BOS, DMH, and NAMI GLAC
- ***Origins***, advocating on behalf of facility owners serving SMI clients, ***now*** explore participation in all Medi-Cal systems
- Inaugural membership ~150 ARF/RCFE's, current membership is over 430 facilities and > 20,000 beds
- DHCS funded a project to explore participation with Medi-Cal Managed Care (MCP)
- Early engagement with MCP's has been positive, Health Net endorsement
- LARCA is advancing a process but will need support to implement a community-based solution (MCP engagement, County Alignment, Funding)

Marketplace Concept

Organize LARCA participation in Medi-Cal and local programs

- 6 Managed Care Plans
- 4 County departments/programs (DMH, DHS, DPSS, LAHSA)
- Other: HCBS (Assisted Living Waiver), Veterans Administration

1. **Create a marketplace tool (portal) to facilitate placements**
   - Matchmaker (people-to-properties via self-serve tool)
2. **Serve ARF/RCFE's in LARCA Network**
   - Administrative support
   - Care delivery practices/quality
3. **Expand LARCA participation in Medi-Cal and Safety Net**
   - Grow membership, increase market participation in Medi-Cal systems

Opportunities to Work Together

- Coordinate access to facilities and services across multiple systems
- Determine if there are administrative standards that can be implemented

❑ Assessments

❑ Care Coordination

❑ Reimbursement

- Learn about facility standards and compare to CDSS licensing
- Align portals (MHRLN and proposed Marketplace)
- Referral inclusion of MCP's as appropriate

Current Activities

LARCA plans for robust capabilities to serve membership

- Implement marketplace portal (Q4 2025 to Q2 2026)
- Standardize processes to support care management and administrative requirements
- Support greater coordination across multiple delivery systems (physical health, behavioral health, and social health)
- Membership growth initiatives (Better Angels and NAMI GLAC)
- Contract with Medi-Cal systems and Housing systems

LARCA has received endorsements from Health Net to develop market solution and 3 County BOS, City of Long Beach, NAMI GLAC, and CALBHBC

Next Steps

- Determine if LA County programs would like to participate in LARCA marketplace development
- Explore the potential to collaborate on MCP contracting
- Collect baseline information regarding current ARF/RCFE utilization and related practices
- Learn about County planning activities that would leverage ARF/RCFE's
- Explore portal compatibility
- Improved Assessments


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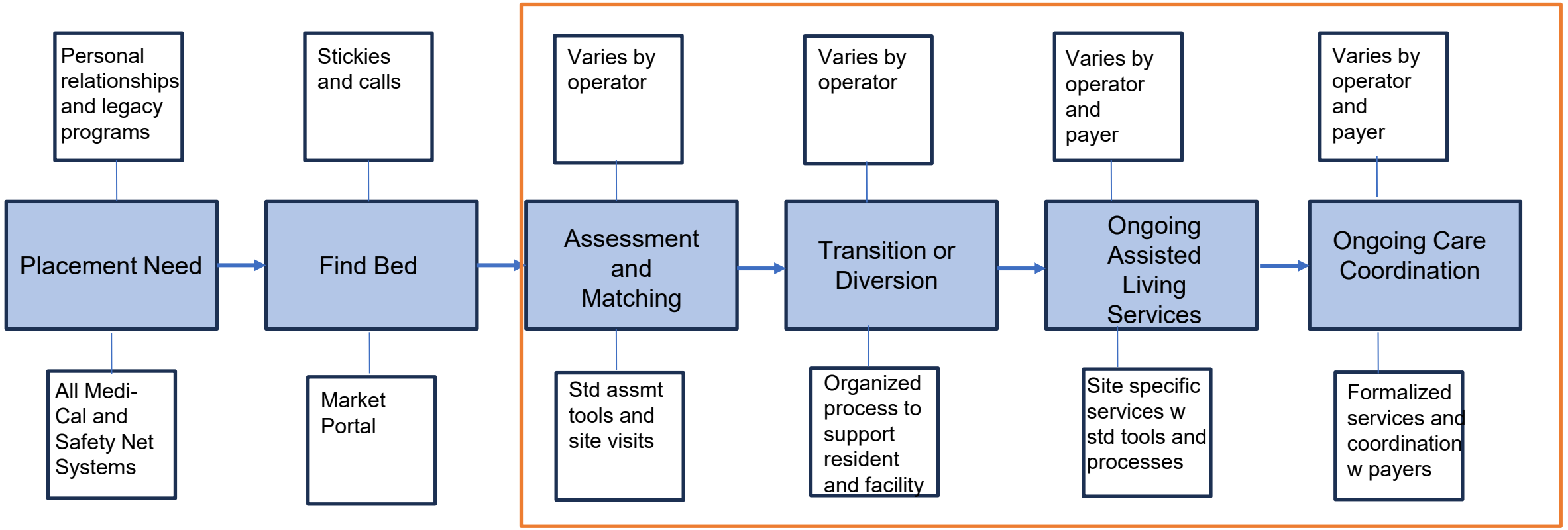
THANK YOU

Service Model

Current Model



Future Model

Medi-Cal and Safety Net Delivery Systems – ARF/RCFE's

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	Medicaid HCBS Waiver	Medi-Cal Managed Care	County Health Systems
Payer(s)	DHCS: Assisted Living Waiver	MCPs: CalAIM ECM & Community Supports	MHP Example: MHSA, FSP, Outpatient Program
Authority	DHCS/HCBS 1915c	DHCS/1915b & 1115 Waiver	DHCS/BHSA + Local and Foundation Funding
Target	Nursing Facility Eligible (Transition/Diversion) 15 Counties in-scope	Enrolled with MCP and eligible for ECM/CS per DHCS Transitions from institutional care and at-risk of institutional care for several Populations of Focus (nursing facility level of care)	Qualifies through MHP for placement with outpatient services such as FSP or other Other program-specific eligibility based on County effort to support populations such as chronic homelessness and re-entry populations
#'s Served or available beds	**15,632 Enrollment, 11,973 Waitlist (04/2024)** <u>Estimates</u> LA County 324 facilities, 17,248 beds (capacity)	Health Net – 17 authorizations/since 2022* LA Care - 320 members served/2024* **Only 906 people received the AL CS across California between September 2023 and September 2024** (CHCS May 2025 statewide) * Los Angeles PATH Collaborative 12/24	Enriched Care/unique clients: **Housing For Health 782** **Office of Diversion Re-entry 322** **Dept of Mental Health 867** Enriched Services/unique clients: **Dept of Mental Health 535** Source BOS 12/4/2024 Report on set item #1 from 6/18/24 (July – September 2024)
Services Provided	ARF/RCFE services + Care Coordination, Residential Habilitation	ARF/RCFE services + ECM, Community Supports, and other benefits	ARF/RCFE services + Additional reimbursement for base service, incremental assisted living care, and other services.
Contracting or coordinating entity	Care Coordination Agency	MCP Contracted Providers (ARF/RCFE's)	MHP and County Health System/Brilliant Corners Contracted Providers (some County departments operate separate programs)
Referrals	Managed care plans, CBO's hospitals. Nursing facilities, etc.	Enhanced Care Management CBO's, hospitals, nursing facilities, etc.	Program placement within county health systems
Reimbursement	Five Tiers/daily rate for each tier Tier 1-5 @ 30 days = $2,734 - $7,718	• Community Supports pricing guidance suggests ALW model as reference • Updated guidance include new required features (one-time and ongoing services)	LA County Examples: 1.) County $ Patches 2.) Enriched Care 3.) Enriched Services (Acuity of Individual/Capability of Facility)

Changing Landscape

Upcoming Changes and New Focus	Timing	Accountable Entity	Description	Impact to ARF/RCFE for LARCA members
BHSA	7/2026	MHP	Reduce homelessness among those with a behavioral health condition, focusing on encampments. Use of both ongoing and capital expenditure.	Increase the resources available to pay for ARF/RCFE services, likely to grow demand
Prop 1 / BH Transformation	Current	DHCS	Proposition 1 includes up to $6.4 billion in bonds to build new supportive housing and community-based treatment settings. DHCS is enacting changes resulting from Proposition 1 through the Behavioral Health Transformation project.	Grow demand for ARF/RCFE, cause higher acuity placements and greater potential for system flow
Flex Housing Pools and Lead Entity Models	Current-Emerging Practices	MCP/MHP	Flex Housing Pools and Lead Entity Models offer a quicker connection to housing by developing pools of housing and identifying candidates for housing in a more efficient manner.	Grow demand for ARF/RCFE, cause higher acuity placements and greater potential for system flow
Long-term care and D-SNP	Current	MCP	Most statewide managed care plans have increased their scope of DHCS contract to include covering the long-term care benefit. CalAIM will also cause MCP's to offer a dual Medi-Medi product that will also coordinate benefits between programs (D-SNP and Medi-Cal)	Increase demand for ARF/RCFE beds to serve transitions and avoidance from LTC while expanding focus to Medicare members in D-SNP programs.

Q&A

Center for Health Care Strategies

Wrap-Up and Next Steps

Center for Health Care Strategies

Assisted Living for Medi-Cal Enrollees: Virtual Learning Series

- **August**
  - → *Sustained Support: Continued Partnership to Ensure Resident Well-Being*
- **September**
  - → *What Comes Next?*

Resources

- Assisted Living Virtual Learning Series Page: https://www.chcs.org/resource/assisted-living-for-medi-cal-enrollees-virtual-learning-series/
- Acronym List: https://www.chcs.org/media/Assisted-Living-Virtual-Learning-Series-Acronym-List.pdf
- Virtual Learning Series FAQs: https://www.chcs.org/media/Assisted-Living-for-Medi-Cal-Enrollees-FAQs.pdf
- PATH TA marketplace provides funding and TA to stakeholders to help them design a better infrastructure for delivering ECM and CalAIM Community Supports: https://www.ca-path.com/technical-assistance
- New guidance from DHCS gives clarity to transitions for MCP members: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf
- California Assisted Living Association has a webpage with resources on ALW, CalAIM CS, SSI/SSP rate adjustments, stakeholder collaborative group directory, and others (https://caassistedliving.org/CALA/Member_Resources/Expanding_Access/CALA/Member_Resources/Expanding_Access/Expanding_Access_to_Assisted_Living_Services.aspx?hkey=d67f9828-57b1-4fe1-a72c-f779a75c7008). They also recently launched peer learning opportunities (support group for operators in the third-party payer space).

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