CONTINUING THE TRANSFORMATION OF MEDI-CAL: CONCEPT PAPER

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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SECTION 1: EXECUTIVE SUMMARY

California is deeply committed to the ongoing transformation of the Medi-Cal program and delivery system to improve health outcomes and ensure members have access to the quality care they need to lead healthier lives. The California Department of Health Care Services (DHCS) has a long history of efforts to innovate and improve the Medi-Cal program, most recently through the California Advancing and Innovating Medi-Cal (CalAIM) initiative focused on broad transformation of the health care delivery system and a complementary array of targeted behavioral health—mental health and substance use—innovations through the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative and Behavioral Health Transformation. These initiatives are part of a broad transformation of Medi-Cal to create a more coordinated, person-centered, and equitable health system that works for all Californians.

The purpose of this concept paper is to outline DHCS' vision and goals for the next five years, including plans for advancing the renewal of the CalAIM waivers and other initiatives. The concept paper was informed by a series of in-person listening sessions held in regions across the state starting in the fall of 2022 through 2025 with stakeholders—which included Medi-Cal members, community-based organizations (CBOs), managed care plans (MCPs), county behavioral health plans (BHPs), public health agencies, sheriff's departments, probation agencies, housing service providers, health care providers, and advocates—to identify Medi-Cal priorities for DHCS in 2027 and beyond. In addition, DHCS leveraged a wealth of feedback, insights, and recommendations delivered by a host of partners through a wide range of forums since the launch of CalAIM in 2022, such as bi-weekly CalAIM Implementation Advisory Group meetings, regular CalAIM Behavioral Health Workgroup meetings, monthly MCP technical assistance and guidance webinars, weekly meetings with MCP associations, quarterly Stakeholder Advisory Committee/Behavioral Health Stakeholder Advisory Committee meetings, standing meetings with MCPs, BHPs, various county associations, provider associations, advocacy groups, and more; monitored email received through dedicated mailboxes; considered comprehensive feedback provided on policy guidance; assessed grievance and appeals, monitoring, and quality data; and reviewed key findings of efficacy, outcomes, and cost effectiveness. Finally, this concept paper was additionally informed through new structures that DHCS has established to engage with and hear from Medi-Cal members directly, including the Medi-Cal Member Advisory Committee. Through this stakeholder and member engagement, DHCS heard a consistent, core

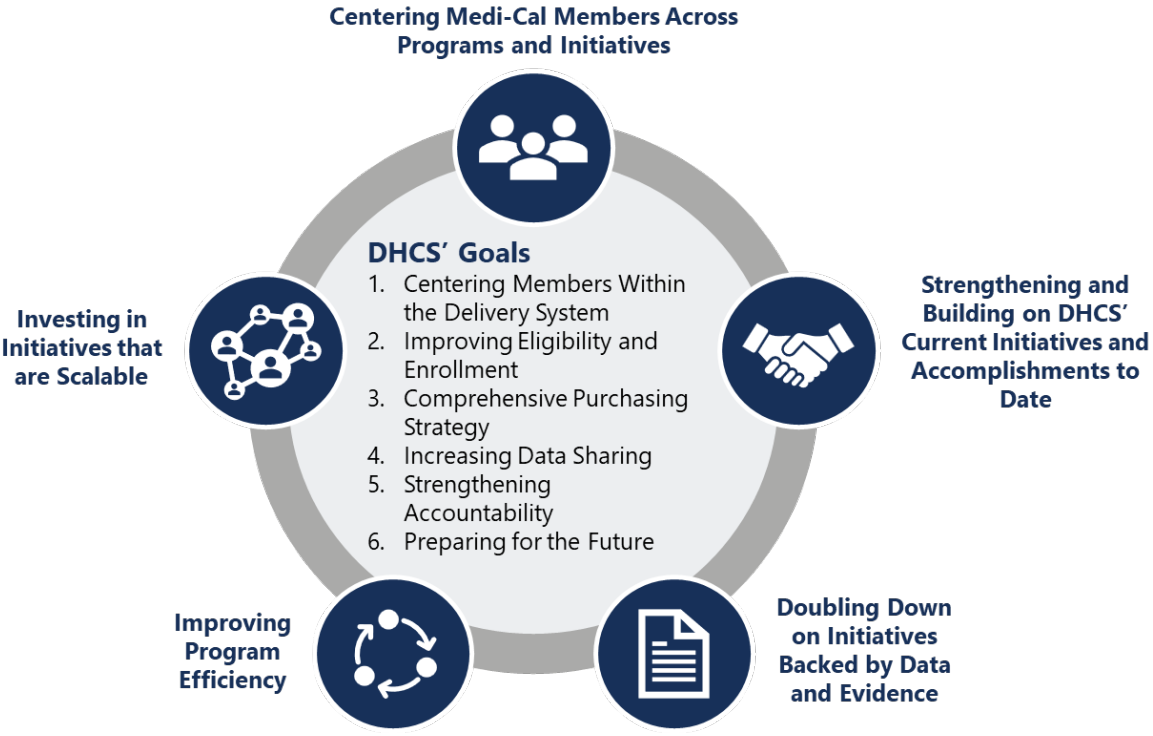
theme to guide continued Medi-Cal transformation: **centering the Medi-Cal member experience** in the design and administration of the Medi-Cal program.

DHCS is committed to fully realizing the goals of CalAIM and continuing to achieve remarkable progress in expanding implementation of its transformational programs. In partnership with MCPs, counties, providers, and CBOs, DHCS seeks to build upon the investments made and sustain the unprecedented changes ushered in by all implementation partners involved in making CalAIM a reality for Medi-Cal members. Specifically, during the next five-year period for renewing key Section 1115 and 1915(b) waivers, DHCS proposes to **continue and strengthen** key CalAIM components such as Enhanced Care Management (ECM), Community Supports, and the Justice-Involved Reentry Initiative, along with maintaining other core 1115 programs such as the Drug Medi-Cal Organized Delivery System (DMC-ODS), Contingency Management, Traditional Healers and Natural Helpers, Community Based Adult Services (CBAS), the Global Payment Program, and Integrated Care for Dually Eligible Members. DHCS is committed to productively engaging with federal partners to demonstrate the value of these programs in promoting the objectives of the Medicaid program.

As part of the waiver renewal process, DHCS seeks to **continue the Medi-Cal transformations initiated to date under CalAIM and identify potential new opportunities** to pursue building upon CalAIM's transformational foundation. As California continues the journey to transform Medi-Cal, DHCS will use **guiding principles** to provide a framework for shaping the Department's goals for Medi-Cal transformation and ensuring any new policies are fully aligned with and build upon the CalAIM transformations currently underway.

This concept paper outlines these key guiding principles and proposes new goals that are central to DHCS' efforts to continue the core commitments of CalAIM and to enhance the Medi-Cal member experience. The guiding principles and goals are below (refer to Section 4 for additional information).

Continuing Medi-Cal's Transformation: Guiding Principles and Goals



This concept paper focuses on California's Medi-Cal transformation efforts to date, highlights DHCS' goals and principles that will drive the Department's efforts to enhance and strengthen Medi-Cal, and presents the Department's proposed high-level approach for renewing key initiatives under the state's CalAIM Section 1115 and 1915(b) waivers. Recognizing that success will require communication and collaboration, DHCS will continue to engage members and stakeholders to inform the design and implementation of the proposals described in this concept paper.

SECTION 2: MEDI-CAL'S TRANSFORMATION TO DATE

The Medi-Cal Transformation Journey

California has long pioneered new ideas to improve health care quality, access, and outcomes for the millions of people enrolled in the Medi-Cal program. California was the first state to pilot risk-based Medicaid managed care in the early 1970s using a county-based delivery model. In addition, the state was also the first to pilot the On Lok demonstration, which tested a model of community-based long-term care beginning in 1972. This demonstration became the basis for the Program of All-Inclusive Care for the Elderly (PACE), which provides integrated medical, social, and long-term services to vulnerable, older adults in the community. This model is now a permanent Medicare and Medicaid program and has since been scaled nationally in 33 states and the District of Columbia.

Over time, California has advanced care delivery innovation through an expanded managed care footprint, working with county government partners to extend coverage to new populations, add services, and build provider capacity and infrastructure in the delivery system. Following the passage of the Affordable Care Act (ACA), Medi-Cal became among the first state Medicaid programs to launch new coverage expansions and reforms. Since then, DHCS has continuously pursued new opportunities to transform Medi-Cal: improving quality and outcomes, enhancing the member experience, and bolstering the long-term sustainability of the Medi-Cal program and health care delivery system.

For over two decades, California has driven Medi-Cal innovation and transformation through Section 1115 demonstrations,[1] other federal authorities,[2] and state administrative actions.

- In 2005, through California's Medi-Cal Hospital Uninsured Care demonstration, the inaugural Section 1115 demonstration, the state supported safety net hospitals with the goal of improving access to care among uninsured individuals

[1] States use Section 1115 demonstrations (also known as "waivers") to test innovations in their Medicaid programs. Section 1115 demonstration approvals are at the discretion of the Secretary of Health and Human Services (HHS), who must determine the demonstration "furthers the goals of the Medicaid program" and is budget neutral to the federal government.
[2] Includes participation in Center for Medicare and Medicaid Innovation (CMMI) models, such as Cal MediConnect, Cell and Gene Therapy Access Model, and the Transforming Maternal Health Model.

by providing funding to public hospitals for uncompensated care and creating safety net uncompensated care pools.

- In 2010, to prepare for full implementation of the ACA and continue to support safety net hospitals with the goal of improving access to and quality of care, California requested and received approval for the Bridge to Reform demonstration, a five-year renewal of the Section 1115 demonstration, to implement the ACA's historic coverage expansions, enroll new populations into the managed care delivery system, continue the safety net care uncompensated care pool, and support safety net hospitals through the Delivery System Reform Incentive Program (DSRIP).
- Through subsequent amendments to the Bridge to Reform demonstration, California integrated new populations and geographies into managed care and implemented reforms aimed at improving health outcomes. These reforms included the Coordinated Care Initiative (CCI), which helped rebalance service delivery from institutional care into the home and community. DHCS also launched the CBAS program to invest in community-based services to serve older adults and adults with disabilities and prevent institutionalization.
- Building on CCI, California further coordinated care for older adults and people with disabilities eligible for both Medicare and Medi-Cal (dual eligibles) through the Cal MediConnect Duals Demonstration as part of the Center for Medicare and Medicaid Innovation's (CMMI's) Financial Alignment Initiative to ensure dual eligibles received coordinated medical, behavioral health, and long-term services and supports (LTSS) through a single health plan.
- In 2015, California received approval for the Medi-Cal 2020 demonstration, a subsequent five-year renewal of the Section 1115 demonstration, to test new and innovative care models aimed at improving health care quality and outcomes, ensuring ongoing support for the hospital safety net in California, and strengthening Medi-Cal's long-term financial sustainability. Through Medi-Cal 2020, California launched the innovative Whole Person Care pilots to coordinate members' physical health, behavioral health, and social services, with the goal of improving patient outcomes by addressing the comprehensive needs of Medi-Cal members.
- Medi-Cal 2020 supported safety net hospital transformation by establishing the Global Payment Program, a statewide pool of funding for the remaining uninsured, that incentivized a shift from high-cost, avoidable services to high-

value, preventive services and launching the Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME) to provide incentive funding for hospitals tied to ongoing delivery system reforms.

- Other initiatives in Medi-Cal 2020 increased access for individuals with varying levels of care needs. Launch of the specialized DMC-ODS expanded the continuum of substance use disorder (SUD) services and permitted Medi-Cal reimbursement for SUD services provided to short-term residents of Institutions of Mental Diseases (IMDs).[3] DMC-ODS represented a first-in-the-nation approval for a Section 1115 SUD IMD demonstration , paving the path for over 30 states to implement a similar program.
- Concurrently, the Health Homes Program enhanced and standardized chronic disease management and coordinates the full range of physical health, behavioral health, and community-based LTSS needed by eligible beneficiaries. Together, the Whole Person Care pilots and the Health Homes Program form the bedrock for CalAIM.

The CalAIM initiative, approved in December 2021, included an additional five-year renewal of the Section 1115 demonstration and is the culmination of California's early person-centered reform efforts. These early reform efforts created the coverage foundation and delivery system infrastructure necessary to implement bold transformation initiatives of CalAIM.

[3] 42 USC § 1396d(i) defines IMDs as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

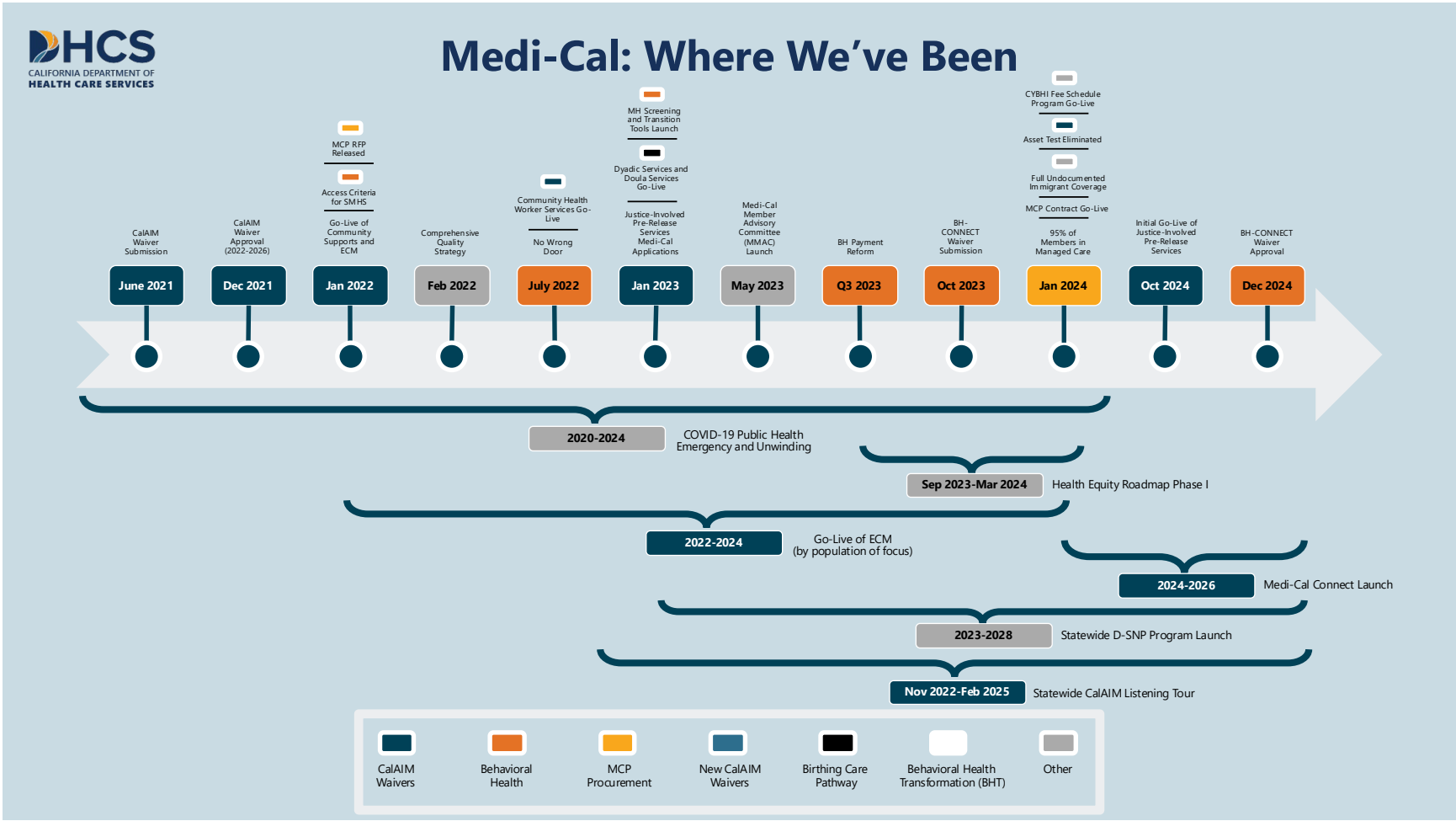


Figure 1: This figure displays a timeline of the actions that California has taken to drive the innovation and transformation of Medi-Cal to improve health care quality, access, and outcomes for its members.

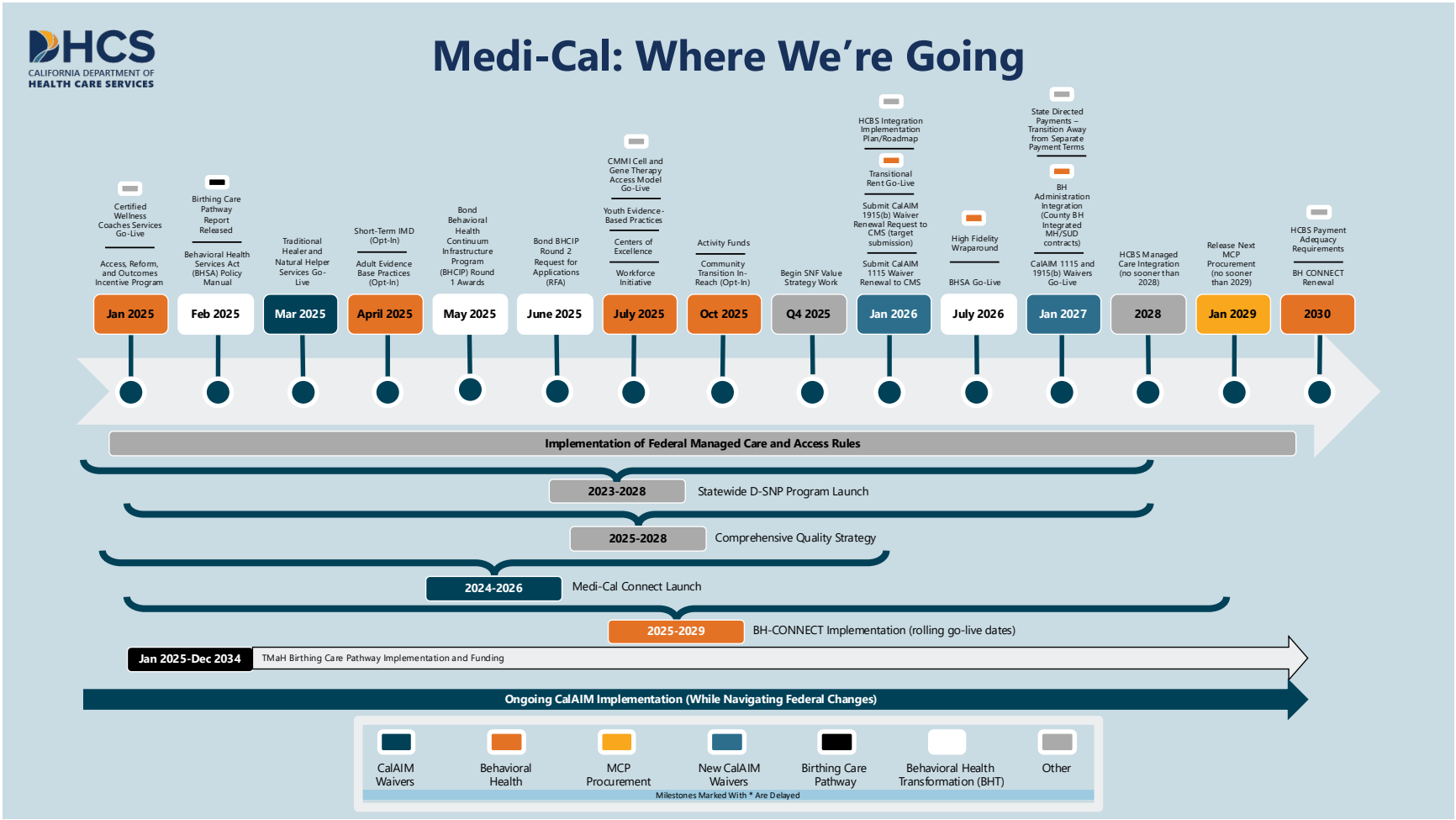


Figure 2: This figure displays a timeline of California's commitment to continue driving the innovation and transformation of Medi-Cal to improve health care quality, access, and outcomes for its members.

CalAIM

CalAIM is driving implementation of bold new reforms to improve the Medi-Cal member experience, deliver person-centered care, identify and address social drivers of health (SDOH), and drive system transformation that focuses on value and outcomes. DHCS designed CalAIM as a multi-year commitment to transforming and strengthening Medi-Cal by offering Californians a more accessible, coordinated, and person-centered approach to maximizing their health and life trajectory.

CalAIM is making broad delivery system, program, and payment changes to address the physical and behavioral health needs of Medi-Cal members, integrate care for Medi-Cal members, and effectively manage costs. It is streamlining service payment and administration and addressing the complex challenges of California's most vulnerable residents: older adults and people with disabilities, people involved with the justice system, those with significant clinical needs, and Californians experiencing or at risk of experiencing homelessness. As part of these efforts, CalAIM built on previous innovations like the Whole Person Care pilots and the Health Home Program to establish a new population health management approach that expands access to services that make health care more comprehensive, including services that address SDOH.

Goals Set:

Through a robust stakeholder engagement process, which included a several months-long, statewide listening tour, DHCS set three primary goals for CalAIM:

- **CalAIM Goal 1:** Identify and manage member risk and need through whole person care approaches and addressing SDOH;
- **CalAIM Goal 2:** Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- **CalAIM Goal 3:** Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

To achieve these goals, CalAIM relies on a broad range of federal Medicaid authorities including through the CalAIM Section 1115 demonstration, the CalAIM Section 1915(b) waiver, Medicaid State Plan authority, and managed care authority.

Goals Met:

California began implementing CalAIM in January 2022 and is making significant, statewide progress toward these goals. Implementation continues today.

CalAIM Goal 1: Identify and manage member risk and need through whole person care approaches and addressing SDOH.

DHCS has implemented a range of CalAIM initiatives through the Medi-Cal managed care and behavioral health delivery systems to advance whole person care and address SDOH. DHCS has also launched more targeted initiatives aimed at addressing structural challenges individuals face when navigating the health care, social services, and criminal justice systems that can function as a driver on health outcomes.

Managed Care Delivery System

To better address Medi-Cal members' SDOH and improve member outcomes, California is implementing Community Supports and ECM. California's **14 Community Supports** are new services provided by Medi-Cal MCPs to address SDOH, which will help Medi-Cal members live healthier lives. Community Supports are substitute services or settings to those required under the California Medicaid State Plan.[4] California received Centers for Medicare and Medicaid Services (CMS) approval to cover 12 Community Supports as in lieu of services (ILOS) under managed care authority and to cover two Community Supports under Section 1115 authority. MCPs may select and offer Community Supports to Medi-Cal members when pre-approved by DHCS as medically appropriate and cost-effective substitutes for covered services or settings under the California Medicaid State Plan. Community Supports include services such as medically-tailored meals, asthma remediation, and housing stabilization-related supports.

Alongside Community Supports, California also launched **ECM**, a statewide Medi-Cal benefit implemented through Medi-Cal MCPs to provide equitable, person-centered, and community-based care management.[5] ECM addresses the clinical and non-clinical needs of the highest-need Medi-Cal members by building trusting relationships with members and providing intensive coordination of physical health, behavioral health, and SDOH services. ECM is delivered by community-based providers with expertise and experience to address the unique needs of different at-risk ECM Populations of Focus,

[4] In December 2024, DHCS received approval of a 15th Community Support, Transitional Rent, through the Section 1115 BH-CONNECT demonstration.

[5] ECM is authorized under federal Medicaid managed care regulations as part of the care coordination and continuity of care responsibilities of MCPs. No Section 1115 or 1915(b) authority is needed for California to operate ECM.

where intensive care management could lead to improved health outcomes, decreases in inappropriate utilization and duplication of services, and coordinated care.

Snapshot: Community Supports and ECM in California[6]

368,000+ Medi-Cal members received Community Supports and **326,000+** Medi-Cal members received ECM from January 1, 2022 through December 31, 2024.

All 58 counties in California offer at least **8** Community Supports.

- **40 counties** (representing 90% of all Medi-Cal MCP members) offer at least **10** Community Supports.
- **24 counties** (representing 41% of all Medi-Cal MCP members) have access to all **14** Community Supports.

Nearly **5,000** Community Supports providers and **4,000+** ECM providers are contracted by Medi-Cal MCPs to offer these services.

9 out of 12 Community Supports are already *demonstrating cost effectiveness within the study period.*

Three Community Supports *show promising early trends.*

All Community Supports studies were associated with *reductions in inpatient and/or emergency department use.*

Preliminary analysis based on early data from July 2022 to June 2024 on the cost effectiveness of the Community Supports authorized as ILOS shows strong results.[7,8] Despite limited experience data being available, California's initial cost-effectiveness analysis shows that all of the 12 ILOS demonstrably are, or will likely be proven to be, cost-effective in the remaining years of the waiver demonstration period if current trends continue. For example, based on DHCS' initial analysis, Housing Deposits show a 31.6% decrease in inpatient, outpatient, emergency room, long-term care, and outpatient mental health services costs and Respite Care shows a 61.3% decrease across inpatient and long-term care services costs. An independent evaluator is conducting a rigorous

[6] ECM and Community Supports Quarterly Implementation Report. Available: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117?item=1.
[7] Community Supports / In Lieu of Services Annual Report, April 2025. Available: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-1915b-Annual-Report-on-ILOS-STC-B20-2025.pdf.
[8] The nine ILOS already demonstrating cost-effectiveness include: Housing Transition Navigation Services, Housing Deposits, Respite Care, Day Habilitation Programs, Nursing Facility Transition/Diversion to

independent evaluation of all Community Supports by 2028, which will examine the cost-effectiveness and other health impacts of Community Supports using comprehensive data.

To bolster the success of these efforts, California invested in community-based delivery system infrastructure and capacity. Through the **Providing Access and Transforming Health (PATH) program**, authorized under the CalAIM Section 1115 demonstration, the state invested $1.85 billion over five years in (1) expanding and sustaining successful Whole Person Care Pilot and Health Home Program services to transition to ECM and Community Supports; and (2) building new infrastructure for the justice-involved pre-release services authorized under CalAIM. Beyond PATH, California also invested $1.5 billion in the delivery system through the **CalAIM Incentive Payment Program (IPP)**. Through IPP, MCPs invested in information technology, data exchange, and other delivery system infrastructure for ECM and Community Supports, built capacity among ECM and Community Supports community-based providers, and promoted improvements in quality outcomes.

Behavioral Health Delivery System

Under CalAIM, DHCS has made unprecedented investments in expanding behavioral health services, housing, and social supports for individuals living with significant behavioral health needs through a broad range of initiatives.

Through the CalAIM Section 1115 demonstration, DHCS continued coverage of **short-term residential treatment services in IMDs to eligible individuals with SUD needs**. The state also initiated newly authorized **Contingency Management services**, a first-in-the-nation, evidence-based, cost-effective treatment for SUD that combines motivational incentives with behavioral health treatments. Through the Medi-Cal state plan, and using Section 1115 and 1915(b) waiver authorities, California also implemented a new **Peer Support Services** benefit.

As part of California's broad managed care reforms in the Medi-Cal Managed Care, DMC-ODS, and Specialty Mental Health Services (SMHS) delivery systems, the state launched new responsibilities for MCPs and BHPs and invested in necessary infrastructure. Key reforms include: a **"No Wrong Door" policy** to ensure members

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Assisted Living Facilities or Residential Care Facilities for the Elderly, Community Transition Services / Nursing Facility Transition to a Home, Personal Care and Homemaker Services, Environmental Accessibility Adaptations, and Sobering Centers. The three remaining ILOS that show utilization and cost reductions in Medicaid covered services, such as emergency room or long-term care, and that are expected to be cost effective over time, include: Housing Tenancy and Sustaining Services, Medically Tailored Meals, and Asthma Remediation.

receive timely mental health services regardless of the delivery system where they seek care; **standardized screening and transition of care tools** to ensure members newly seeking help with mental health are referred to the most appropriate mental health delivery system that best meets their needs, and that members currently receiving care are guided appropriately when transitioning across mental health delivery systems; and **streamlined access criteria** and medical necessity standards for specialty mental health services to improve members' access to services and reduce provider administrative burdens.

Snapshot: Medi-Cal Members' Access to Behavioral Health Services

52 out of 58 counties cover Peer Supports.

- **99%** of all Medi-Cal members live in counties that offer this benefit.

4,000+ members received Contingency Management across 19 counties.

- **21 out of 58 counties** cover Contingency Management. Nearly 90% of all Medi-Cal members live in counties that offer this benefit.
- Medi-Cal members receiving Contingency Management have **notably higher rates of negative urine drug test results (95%)**, as compared to the average rate of 85.3% as reported in the literature.[9]

BHPs earned **$84.8 million in incentive funds** under the CalAIM Behavioral Health Quality Improvement Program (BHQIP) to support capacity building in California's behavioral health delivery systems.

Addressing Structural Challenges

Through CalAIM, DHCS committed to addressing structural challenges individuals face when navigating the health care, social services, and criminal justice systems, and that can have an impact on health outcomes. To achieve this goal, DHCS used its CalAIM Section 1115 demonstration to add new services and coverage options aimed at closing remaining gaps in the care continuum.

To address the significant clinical and social care needs experienced by justice-involved populations, in January 2023, California received first-in-the-nation approval of the

[9] D. Urada et al., "California Drug Medi-Cal Organized Delivery System – Contingency management Interim Evaluation Report," prepared for California Department of Health Care Services, November 2024.

Justice-Involved Reentry Initiative, its Section 1115 Reentry Demonstration, which authorizes DHCS to partner with state and county correctional facilities, BHPs, MCPs, and CBOs to provide **Medi-Cal pre-release and reentry services to facilitate successful community reentry for individuals leaving incarceration**. The Justice-Involved Reentry Initiative covers a targeted set of Medi-Cal services for up to 90 days immediately prior to the expected date of release from a state prison, county jail, or youth correctional facility, and provides intensive care transition management to physical health, behavioral health, and social services to support Medi-Cal members re-entering the community.

In October 2024, California began implementing justice-involved pre-release services in 10 facilities across 3 counties. Since the initial launch, as of July 1, 2025, the Initiative expanded to include 33 state prison sites and an additional 9 county facilities, for a total of 19 county facilities across 10 California counties. As of July 1, 2025, more than 22,000 Medi-Cal members have been identified as eligible for pre-release services as part of the Justice-Involved Reentry Initiative. County correctional facilities can go-live on a quarterly basis, and all California counties are mandated under California state law to go-live by October 1, 2026.

To improve access to culturally responsive care, in October 2024, California received approval to cover **Traditional Healers and Natural Helpers** in the DMC-ODS program, marking the culmination of nearly a decade of collaboration between DHCS, Tribes, and Tribal and Urban Indian partners. This first-in-the-nation approval marks the first time Medi-Cal will cover traditional health care practices, which are deeply rooted in cultural practices that have been shown to improve health outcomes, particularly for individuals with SUDs.[10] In March 2025, DHCS released guidance for traditional health care practices, and these services can now be covered for Medi-Cal members in DMC-ODS counties for the first time. As of June 2025, six Indian Health Care Providers have applied to offer traditional health care practices, and five have been approved by DHCS to offer these services.

CalAIM Goal 2: Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

To achieve this goal, DHCS has implemented policies to streamline the managed care and behavioral health delivery systems and integrate care for all members. DHCS' efforts to streamline and improve Medi-Cal managed care and behavioral health delivery

[10] California received this groundbreaking approval alongside three other states (Arizona, New Mexico, Oregon) under a national policy framework for traditional health care practices released by CMS.

systems are particularly focused on those members who are dually enrolled in both Medi-Cal and Medicare, have complex, co-occurring behavioral health, or long-term care needs.

Managed Care Streamlining and Oversight

Through the CalAIM Section 1115 demonstration and Section 1915(b) waiver approvals in December 2021, DHCS transitioned authority for California's managed care delivery systems—Medi-Cal Managed Care, Dental Managed Care, SMHS, and DMC-ODS—from the state's longstanding Section 1115 demonstration to authority under the CalAIM Section 1915(b) waiver to simplify and align the programs, enhance oversight, and standardize benefits and enrollment into Medi-Cal. Through development and implementation of its new 2024 managed care contract across all MCPs, DHCS instituted new MCP requirements to increase MCP accountability for:

- Improving member access to care, including more culturally competent care;
- Accelerating behavioral and physical health integration;
- Incentivizing primary care use and investment; and
- Executing initiatives related to community investment, engagement with community advisory groups, and transparency.

These include requirements for MCPs to:

- Build partnerships with third-party entities through **Memoranda of Understanding (MOU)** to enhance care coordination, data sharing, and to clarify respective entities' roles and responsibilities. Third-party entities include local health departments, county behavioral health departments, and county child welfare departments. DHCS developed and published nine new MOU templates to facilitate relationships between and among MCPs and their partners. These MOUs are designed to support whole-person care for members by facilitating care coordination and access to community-based resources.
- Maintain a **Community Advisory Committee** that is representative of MCP membership and that serves as a forum to actively engage members in the care they receive through their MCPs, inform the development and implementation of the MCP's Cultural and Linguistically Appropriate Services (CLAS) program, and is designed to empower members to advice and make recommendations to the MCPs on quality of care, reinvestment plans, community health assessments, and other key areas that directly affect members' access and care experience.

- Meaningfully participate in **Local Health Jurisdiction (LHJ) Community Health Assessment (CHA)/Community Health Improvement Plans (CHIP)** by participating on CHA/CHIP governance structures and key meetings (as requested by LHJs), sharing relevant data, and contributing funding and/or in-kind staffing to support CHA/CHIP processes. Under the new Behavioral Health Services Act (BHSA), county behavioral health Integrated Plan policies require county behavioral health agencies to also participate on LHJ CHA/CHIP processes as a way to align local planning processes and further promote cross-sector collaboration among managed care, public health, and behavioral health.
- Demonstrate a commitment to the local communities in which they operate by **reinvesting** a minimum percentage of annual net income to those communities, through the Community Reinvestment policy. MCPs that do not meet specified quality thresholds are required to make additional investments. MCP Community Reinvestments must be informed by the CHAs and are strongly encouraged to be directed towards activities identified in the CHIP and BHSA county behavioral health Integrated Plan processes.

DHCS is committed to increasing efficiency in the managed care program and reducing fragmentation across delivery systems. Under CalAIM, DHCS considered a full integration proposal that would have allowed an MCP, in partnership with one or more BHPs, to apply to bring together physical, behavioral, and oral health benefits under a single entity contracted with DHCS. Due to operational complexities, DHCS did not launch any full integration pilots during the CalAIM waiver period and is considering streamlining the member experience and improving outcomes through more limited integration, such as piloting the integration of oral health benefits into managed care. DHCS welcomes stakeholder feedback on the possibility of piloting the carve-in of dental in select counties.

Coordination and Integration of Care for People Who are Dually Eligible

In 2023, DHCS collaborated with Cal MediConnect plans and CMS to transition those plans and their members to **Medi-Medi Plans**, **which are a type of Medicare Advantage plan for dually eligible members that also include Medi-Cal benefits** (these are referred to in federal parlance as Exclusively Aligned Enrollment Dual Special Needs Plans). These plans coordinate all covered benefits and services for members across both Medicare and Medi-Cal and can include extra benefits, such as dental, hearing, or vision coverage, in addition to what Medi-Cal covers. As of January 2025,

330,000 members were enrolled in Medi-Medi Plans in 12 counties.[11] DHCS expects enrollment to continue to increase as Medi-Medi Plans become available in 30 additional counties in 2026.

CalAIM is also better coordinating care for Medi-Cal members by **integrating long-term care (LTC) benefits into managed care**. Prior to 2023, institutional LTC was carved-in to MCPs for about two-thirds of members, and about two-thirds of dually eligible members and people with disabilities were mandatorily enrolled in Medi-Cal MCPs. Starting in 2023, DHCS expanded the MCP LTC carve-in statewide and expanded statewide the counties where most Medi-Cal members were required to enroll in MCPs.[12] By carving LTC into managed care, and potentially offering Community Supports and ECM, members are provided with stronger care coordination, more uniform coverage of LTSS statewide, and better integrated care across institutional and home- and community-based settings. This may promote increased utilization of community-based care, leading to reduced costs.

In the near future, DHCS is committed to creating an integrated managed long-term services and supports (MLTSS) system for Medi-Cal members. To provide a foundation for comprehensive MLTSS planning efforts, DHCS published the HCBS Gap Analysis report in 2025. The HCBS Gap Analysis report leverages qualitative and quantitative data to identify gaps in the availability of services across geographies and programs. Building upon key findings in the HCBS Gap Analysis report, as well as feedback from a broad array of stakeholders and advocates, DHCS is developing a Multi-Year Roadmap for HCBS that will be published by the end of 2025.

The Multi-Year Roadmap will outline a strategy to integrating select HCBS waiver services into managed care while continuing to support services through fee-for-service, as appropriate. Critically, this effort considers long-term home- and community-based needs across the state and opportunities to scale HCBS providers' capacity in a sustainable way. As part of the effort, DHCS, sister departments that administer various HCBS waiver programs, and stakeholders will consider: (a) expanding HCBS providers' capacity; (b) strengthening partnerships among the state, counties, Medi-Cal MCPs, HCBS providers, and CBOs; (c) payment models that are sustainable and incentivize

[11] CalAIM Integrated Care for Dual Eligibles, 2024. Available at: https://calaim.dhcs.ca.gov/pages/integrated-care-for-dual-eligible-members.

[12] The following LTC benefits were carved in as part of this transition: Skilled Nursing Facility, Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home; Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H) Home; Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N) Home; Adult Subacute Care; and Pediatric Subacute Care.

appropriate care settings; (d) expanding overall access to select waiver services statewide; and (e) identifying key milestones and benchmarks to monitor progress. To date, approximately 1,500 stakeholders comprised of individuals and groups, including members, caregivers, advocates, providers, MCPs, and associations have actively engaged in these important efforts.

Behavioral Health Streamlining

Under **Behavioral Health Administrative Integration**, CalAIM is streamlining the experience of care for members with co-occurring specialty mental health and SUD needs and enhancing efficiency for BHPs and DHCS. As of January 2025, DHCS has executed integrated behavioral health contracts with 17 BHPs (formerly 34 separate mental health plans and DMC-ODS plans or DMC counties), allowing them to operate as a single county-run plan responsible for both SMHS and DMC or DMC-ODS services, including features such as integrated member access lines, provider directories, quality improvement programs, and DHCS compliance reviews. All BHPs in the state are required to transition to integrated contracts by January 1, 2027.

To provide more clarity for providers, DHCS also **redesigned behavioral health documentation requirements** for SUD and mental health services to align more closely with national standards, reduce provider administrative burden, and improve the member experience.

CalAIM Goal 3: Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

As noted above, DHCS has invested in building infrastructure and capacity to improve health outcomes, address whole person care, and drive system transformation through the PATH and IPP infrastructure investment programs, as well as a series of efforts to improve quality, implement payment reform, and streamline administrative processes in the behavioral health delivery system. Specifically, to support BHPs with implementing CalAIM behavioral health reforms, DHCS launched the CalAIM **BHQIP**, which made significant funding available to support new infrastructure and capacity development.

In recognition that building a healthier state requires strong collaboration across health plans, providers, and community-based organizations, CalAIM invests in initiatives to support stronger data exchange and relationship building across stakeholders. Beyond these programs, DHCS is investing in a new Population Health Management Program and a process to facilitate collaboration across local partners specifically for community planning efforts across MCPs, BHPs, and local health jurisdictions.

Under CalAIM, DHCS has deployed **Medi-Cal Connect** to aggregate data from trusted partners such as public health, social services, corrections, and housing agencies to help users understand population-level insights that can inform policy and programs. In July 2025, Medi-Cal Connect launched to external partners, starting with MCPs. MCPs are able to view population level insights for their enrollees, complete pictures of each member's information, and receive risk information from the state-wide Risk Stratification, Segmentation, and Tiering (RSST) algorithm and member level flags for individuals who may be eligible for services or supports. BHPs will go live with Medi-Cal Connect in the last quarter of 2025. This will enable BHPs to access similar functionality as MCPs and also support quality measurement and reporting for key initiatives such as BH-CONNECT and Behavioral Health Transformation, reducing county reporting burden.

To support cross-sector strategic planning alignment, and a common framework of the needs of the community, DHCS requires MCPs conduct meaningful population needs assessment and have a clear population health management strategy. As noted above, MCPs are to fulfill their population needs assessment requirement by meaningfully participating in the CHAs and CHIPs conducted by LHJs. DHCS' vision is for the population needs assessment process to strengthen engagement among MCPs, LHJs, and community stakeholders over time, fostering a deeper understanding of the health and social needs of members and the communities in which they live through cross-sector partnerships. This collaboration will ultimately enhance MCPs' ability to identify needs and strengths within members' communities so that MCPs and their community partners can reduce siloed approaches to population health management and more effectively improve the lives of members.

Through CalAIM, DHCS has also streamlined and standardized how Medi-Cal members access behavioral health services and how services are paid. **Behavioral Health Payment Reform** shifts Medi-Cal specialty behavioral health payment away from Certified Public Expenditure methodologies, which are limited to costs incurred and subject to labor-intensive cost reconciliation, to fee-for-service reimbursement and Current Procedural Terminology coding. These changes are intended to facilitate alternative payment models that reward value, not volume, and better care and quality of life for Medi-Cal members.

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CalAIM touches multiple aspects of the Medi-Cal delivery system, focused on making care more comprehensive, streamlining access to services, and improving the health and quality of outcomes for Medi-Cal members. California continues to invest in the Medi-Cal program and work with members, CBOs, MCPs, BHPs, providers, and other

stakeholders to continue the trajectory of progress and further realize the full potential of the transformation of Medi-Cal ushered in through CalAIM. DHCS is committed to continuing core CalAIM initiatives and will continue to engage stakeholders as part of the planning process.

SECTION 3: CURRENT MEDI-CAL FOCUS AND CONTEXT

California is well on the path to realizing the full potential of CalAIM and is working with BHPs, MCPs, providers, and CBOs to scale CalAIM initiatives and improve care for all Medi-Cal members statewide. California has continued to pursue new opportunities in 2025 to build on the success of CalAIM by advancing new behavioral health and quality initiatives. As California advances these new behavioral health and quality initiatives and considers its priorities for Medi-Cal in the next five years, the state must also be diligent to analyze cost-benefits. California is working to strengthen the program by improving health outcomes while concurrently reducing overall cost pressures in order to contend with an evolving federal policy landscape and state budget pressures.

BH-CONNECT

Building upon the ongoing transformation of the broader health care delivery system, California is pursuing a complementary array of targeted behavioral health innovations to expand and strengthen the continuum of care for Medi-Cal members living with significant behavioral health needs.

In December 2024, California secured approval for a companion Section 1115 demonstration (and various State Plan Amendments), the BH-CONNECT initiative. BH-CONNECT will amplify the state's ongoing behavioral health initiatives, and is informed by the findings from DHCS' comprehensive 2022 assessment of California's behavioral health landscape, Assessing the Continuum of Care for Behavioral Health Services in California. Through the BH-CONNECT Section 1115 demonstration, California secured approval to expand the continuum of behavioral health care, strengthen the behavioral health workforce, and incentivize measurable outcomes through the following initiatives:

Workforce investments to build a robust and diverse behavioral health workforce that includes scholarships, loan repayment programs, recruitment incentives, residency and fellowship expansions, and professional development.

Transitional Rental Assistance to provide up to six months of rental support for eligible Medi-Cal members in the Medi-Cal managed care delivery system who are transitioning from institutions, congregate settings, or homelessness.

Activity Funds to improve access and outcomes for youth involved in child welfare receiving specialty mental health services.

The **Access, Reform, and Outcomes Incentive Program** to reward BHPs for improving access, reducing disparities, and strengthening behavioral health quality improvement.

Community Transition In-Reach services to support members transitioning from long-term institutional stays to ensure continuity of care and successful reintegration into the community.

New flexibility for federal Medi-Cal funding for short-term mental health care provided in high-quality inpatient and residential treatment settings that meet the federal IMD criteria.

In addition to the BH-CONNECT Section 1115 demonstration, California also secured approval for State Plan Amendments to expand coverage of evidence-based practices available under Medi-Cal, including services that are proven to improve outcomes for individuals with the most significant behavioral health conditions when delivered with fidelity. The approved evidence-based practices are Assertive Community Treatment, Forensic Assertive Community Treatment, Coordinated Specialty Care for First Episode Psychosis, Enhanced Community Health Worker Services, Individual Placement and

Support Supported Employment, and Clubhouse Services.[13] By expanding community-based services and integrating evidence-based practices, BH-CONNECT aims to reduce costly emergency department visits, hospitalizations, and institutional stays, including in carceral settings.

BH-CONNECT is a key pillar of Governor Newsom's Mental Health for All Initiative and is strategically aligned with Behavioral Health Transformation efforts underway to modernize California's behavioral health system, expand access to evidence-based service models on a statewide basis, and address the housing needs of Californians with significant behavioral health conditions.

Behavioral Health Transformation

Dovetailing with BH-CONNECT, California is implementing the Behavioral Health Transformation effort to further invest in the SUD and mental health delivery systems. In 2024, California voters approved Proposition 1, which includes:

- Behavioral Health Services Act reforms, funding supports for individuals with SUDs, and prioritizing services for people with significant behavioral health needs; expanding services to promote prevention, early intervention, and treatment; and focusing on outcomes, accountability, and equity; and
- A Behavioral Health Bond to invest $6.4 billion in behavioral health delivery, including $4.4 billion for treatment sites and $2 billion for permanent supportive housing.

Behavioral Health Transformation modernizes behavioral health to improve accountability, increase transparency, and expand the capacity of behavioral health care facilities. DHCS is issuing guidance through the Behavioral Health Services Act County Policy Manual to support counties with go-live implementation effective July 1, 2026.

These robust and complementary transformation efforts that come together through the intersection of CalAIM, BH-CONNECT, and Behavioral Health Transformation initiatives require significant partnerships of local, statewide community partners, including MCPs, BHPs, providers, and CBOs that are continuing to work together with DHCS to build infrastructure and partnerships to achieve California's bold goals. DHCS acknowledges the ongoing efforts of these and other stakeholders across the continuum of care and is committed to soliciting and incorporating stakeholder feedback as implementation continues.

[13] Additional detail around the BH-CONNECT evidence-based practices is available in BHIN 25-009 and the BH-CONNECT Evidence-Based Practice Policy Guide.

Comprehensive Quality Strategy

Building on these new behavioral health transformation efforts, California is also focused on improving quality for Medi-Cal members. In 2025, California released an updated **Comprehensive Quality Strategy**. This strategy will continue the Department's focus on:

- Advancing DHCS' Bold Goals, which are a collection of individual quality measures that advance health equity;
- Improving three main clinical priority areas—children's heath, maternal health, and behavioral health; and
- Promoting population health management, including through the Health Equity Roadmap, value-based care initiatives, and holding plans accountable for member outcomes.

Federal and State Dynamics

As California looks ahead to set priorities for Medi-Cal transformation in the next five years, the state will need to navigate a changing federal and state landscape.

At the **federal** level, key policy priorities that impact Medicaid, including with respect to Section 1115 demonstrations, are shifting and could have significant impacts on the Medi-Cal program. First, the Trump Administration rescinded Biden Administration guidance on health-related social needs, eliminating the roadmap for states seeking new programs to address SDOH, which may have implications for the renewal of certain CalAIM services, such as Short-Term Post-Hospitalization Housing and Recuperative Care (Medical Respite). The Trump Administration also released guidance that announced it will not approve or renew any requests from states for federal matching funds for state expenditures on Designated State Health Programs (DSHP). Finally, CMS' proposed rule seeks to restrict states' abilities to utilize taxes on Medicaid providers and to overturn several key taxes that provide vital support to strengthen and increase funding for the Medi-Cal program, including the managed care organization (MCO) tax and the Hospital Quality Assurance Fee.

On top of these policies advanced by the Trump Administration to date, the federal budget reconciliation bill passed by Congress and signed by President Trump will significantly reduce federal funding for Medi-Cal by tens of billions of dollars, lead to significant losses in health care coverage—with up to 3.4 million Medi-Cal members at risk of losing coverage—and jeopardize the state's health care safety net.

At the **state** level, given significant growth in the Medi-Cal program, the FY 2025–26 budget includes General Fund solutions and statutory changes to align program expenditures with available revenue to maintain a balanced budget and to curb costs into the future. The budget closed the $11.8B General Fund shortfall. Significant budget adjustments to Medi-Cal eligibility, rates, and benefits include:

- A freeze on new enrollment to full-scope coverage for undocumented individuals aged 19 and older effective January 1, 2026.
- $30 monthly premiums for individuals with unsatisfactory immigration status aged 19 to 59, effective July 1, 2027.
- Elimination of full-scope dental coverage for Medi-Cal members with unsatisfactory immigration status, effective July 1, 2026.
- Elimination of Prospective Payment System rates to clinics for state-only funded services provided to individuals with unsatisfactory immigration status, effective July 1, 2026. Instead, clinics will receive reimbursement at the applicable Medi-Cal fee-for-service rate and at the Medi-Cal managed care negotiated rate.
- Elimination of coverage for Glucagon-Like Peptide-1 (GLP-1) drugs for weight loss effective January 1, 2026.
- Reinstatement of the Medi-Cal asset limit for seniors and disabled adults at $130,000 for an individual and $65,000 for each additional household member, effective no sooner than January 1, 2026.
- Elimination of approximately $362 million beginning in 2026–27 and ongoing for dental supplemental payments.
- Implementation of utilization management, step therapy protocols, and prior authorization for prescription drugs.
- Implementation of a pharmacy rebate aggregator to secure state rebates for individuals with unsatisfactory immigration status.
- Elimination of the Workforce and Quality Incentive Program and suspension of the requirement to maintain a backup power system for no fewer than 96 hours for skilled nursing facilities.

The state outlook is more uncertain as the new federal administration implements policies that may broadly impact the U.S. economy and tip the scales toward recession.[14] Dynamic changes at the federal level have directly resulted in a $16 billion reduction in state revenues.[15]

The risks in the state budget and federal landscapes are material as California considers its priorities and plans for Medi-Cal in the next five years. The key guiding principles and core goals proposed in this concept paper (see Section 4) will enable California to manage and navigate these dynamics. Now more than ever, the principles and goals outlined in the next section are essential to serve as a strategic framework for designing data-driven, efficient, value-based, and member-centered policies within the context of reduced federal funding for Medi-Cal.

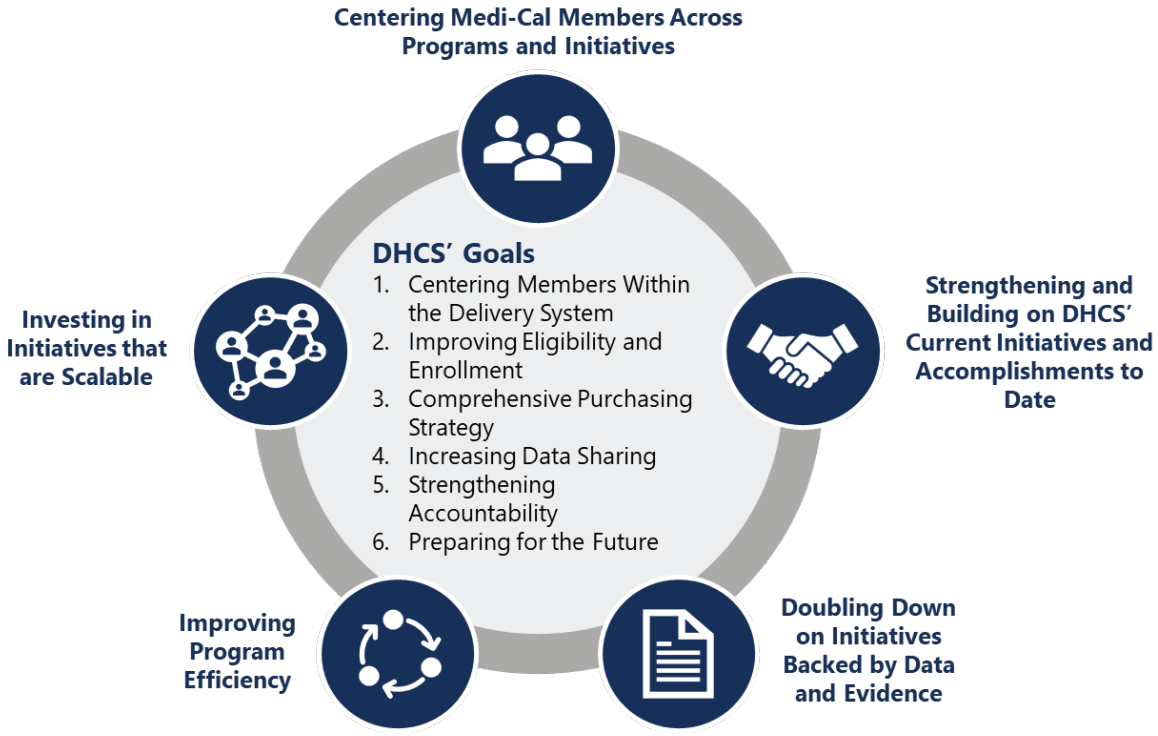
[14] California Budget 2025-26. Available: https://ebudget.ca.gov/.
[15] Despite Trump Slump, Governor Newsom's revised budget delivers on housing, education, water, and jobs. Available: https://www.gov.ca.gov/2025/05/14/despite-trump-slump-governor-newsoms-revised-budget-delivers-on-housing-education-water-and-jobs/.

SECTION 4: LOOKING AHEAD – DEEPENING THE COMMITMENT TO MEDI-CAL MEMBERS

Principles and Goals

As California continues the journey to transform Medi-Cal, DHCS is committed to using guiding principles to shape the Department's goals for Medi-Cal transformation, which in turn will inform the strategic planning and deliberative conversations with stakeholders regarding the renewal of CalAIM. DHCS' principles and goals are described in further detail below.

Continuing Medi-Cal's Transformation: Guiding Principles and Goals



The guiding principles are designed to ensure that DHCS' initiatives are effective, impactful, and sustainable, ultimately leading to better health outcomes for Medi-Cal members and providers. By adhering to these **principles** throughout the CalAIM renewal planning process, DHCS aims to continue driving meaningful improvements in health outcomes and the overall health care experience for all Medi-Cal members.

These guiding **principles** offer a framework for exploring new proposals and initiatives that build upon and align with CalAIM:

Centering Medi-Cal members across programs and initiatives: Placing Medi-Cal members at the heart of DHCS' programs ensures members' needs and experiences drive DHCS policies, initiatives, and implementation approach. This member-centered approach fosters a more responsive and inclusive health care system, with the goal of improving access, health outcomes, and member experience.

Strengthening and building on DHCS' current initiatives and accomplishments to date: DHCS and its partners have collectively established a strong foundation for the future of Medi-Cal transformation, and DHCS recognizes that its partners are undergoing massive change management processes to implement significant new initiatives. By re-committing to the initiatives DHCS has undertaken under CalAIM, the Department will be able to continue momentum and ensure continuity and stability in programs that are making a difference to Medi-Cal members today.

Doubling down on initiatives backed by data and evidence: Utilizing data and evidence to inform DHCS' initiatives ensures that the Department's decisions are grounded in proven strategies and best practices. This evidence-based approach enhances the effectiveness of DHCS' programs, leading to more efficient resource allocation.

Improving program efficiency: Streamlining processes and reducing administrative burdens allows DHCS, providers, plans, and other partners to deliver services more effectively and efficiently. This focus on efficiency helps to maximize the use of available resources, reduce costs, and improve the overall performance of DHCS' programs.

Investing in initiatives that are scalable: By investing in scalable initiatives, DHCS ensures that successful programs can be expanded and replicated across different regions and populations. This scalability allows DHCS to extend the benefits of the Department's initiatives to a larger number of Medi-Cal members and for stakeholders to learn from each other's experiences and progress, promoting equity and access to high-quality care.

Leveraging these guiding principles and in response to stakeholder feedback received during the listening tour and other engagements, DHCS identified several **goals** that will govern DHCS' efforts to continue to transform Medi-Cal for 2027 and beyond:

Centering Members Within the Delivery System: Ground Medi-Cal policies and programs in member-centered design principles and create networks of community-embedded providers to deliver high-quality, culturally responsive, whole-person care that optimizes the member experience.

Improving Eligibility and Enrollment: Help eligible Californians get and keep Medi-Cal coverage through application and eligibility processes that are efficient, accurate, and respectful.

Comprehensive Purchasing Strategy: Establish a comprehensive Medi-Cal purchasing strategy that incentivizes plans and providers to deliver: the right care, at the right time, in the right place, at the right cost.

Increasing Data Sharing: Improve data sharing among plans, providers, and partners within the Medi-Cal ecosystem to support stronger data-informed care, care coordination, and member experiences.

Strengthening Accountability: Strengthen and enforce accountability across the Medi-Cal delivery system (fee-for-service, managed care, and BHPs) to improve member access, experience, quality, and outcomes.

Preparing for the Future: Prepare Medi-Cal to meet the needs of the aging population in 2030 and beyond.

DHCS will continue to engage with stakeholders and further refine these principles and goals as the Department defines and advances these transformation efforts.

SECTION 5: STRENGTHENING CALAIM

DHCS is committed to continuing, expanding, and strengthening CalAIM initiatives to ensure Medi-Cal members can access person-centered care that meets their physical, behavioral, and social needs and receive care in an integrated system that focuses on value and outcomes. Key initiatives, such as ECM, Community Supports, the Justice-Involved Reentry Initiative, DMC-ODS, Contingency Management, and new behavioral health reforms have laid a strong foundation for continued Medi-Cal transformation.

Additionally, over the coming months, DHCS will work with partners to explore potential new proposals that advance DHCS' vision that may require Section 1115 or 1915(b) authority. DHCS' priorities and proposed approach for the CalAIM renewals may evolve based on the dynamic federal and state policy and budget landscape.

Continuing CalAIM

As the CalAIM Section 1115 and 1915(b) waivers expire in December 2026, DHCS has commenced planning for the CalAIM Section 1115 and 1915(b) renewals. These upcoming CalAIM renewals offer California a powerful tool to continue to advance Medi-Cal transformation and DHCS' goals. **The table below provides an overview of the existing initiatives authorized under the CalAIM Section 1115 and 1915(b) waivers for which DHCS will seek continued federal authority beginning January 1, 2027 through December 31, 2031**.

DHCS seeks to continue the state's efforts to transform Medi-Cal through the renewal of existing key CalAIM initiatives. The Department reviewed and assessed which CalAIM initiatives will need to be renewed or sunset and identified opportunities to transition authority from the CalAIM waivers to more permanent state plan, managed care, or other available federal authorities.

The table below outlines DHCS' proposed approach for existing CalAIM initiatives. DHCS will work with partners to identify potential new proposals that advance DHCS' vision and goals outlined above that may require Section 1115 or 1915(b) authority. The proposed approach described below may change based on policy developments at the federal and state levels and is ultimately subject to approval through the state budget process.

Table 1: Approach to CalAIM Section 1115 and 1915(b) Renewals

CalAIM Initiative	Renew Under Section 1115 or 1915(b) Authority	Sunset Section 1115 or 1915(b) Authority
Initiatives Authorized under Section 1115 Authority		
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.	✓[16]	
Short-Term Post-Hospitalization Housing (STPHH): Ongoing supports necessary for recuperation and recovery after exiting an institution.	✓[16]	
Contingency Management: Evidence-based, cost-effective treatment for SUD that combines motivational incentives with behavioral treatments.	✓	
Reentry Services: Targeted Medi-Cal services for justice-involved individuals for up to 90 days prior to release.	✓	
Traditional Healers and Natural Helpers: Culturally appropriate care for members receiving care at Indian Health Service, Tribal, or Urban Indian Organization facilities.	✓	
Dually Eligible Enrollees in Medi-Cal Managed Care: Aligns a dually eligible beneficiary's Medicaid plan with their Medicare Advantage Plan choice, to the extent the Medicare Advantage plan has an affiliated Medicaid plan.	✓	
Managed Care Authority to Limit Plan Choice: Enables the state to limit choice of MCPs in metro, large metro, and urban	✓	

[16] While renewing this initiative under 1115 authority is preferred, one alternate option is to cover all components except room and board under an alternate authority.

CalAIM Initiative	Renew Under Section 1115 or 1915(b) Authority	Sunset Section 1115 or 1915(b) Authority
counties operating under the COHS and Single Plan models.		
DMC-ODS – Waiver of IMD Exclusion for SUD Services: Federal reimbursement for Medicaid services provided to short-term residents of IIMDs receiving SUD services.	✓	
Chiropractic Services from IHS and Tribal Facilities: Chiropractic services furnished by Indian Health Service and tribal providers to Medi-Cal members.	✓	
Community-Based Adult Services: Services and supports for older adults and adults with disabilities to restore or maintain their optimal capacity for self-care and delay/prevent institutionalization.	✓	
Out-of-State Former Foster Care Youth: Medi-Cal coverage for former foster care youth who are under age 26.	✓	
Global Payment Program: Supports public health care systems that provide health care for uninsured Californians through a statewide funding pool.	✓	
Modification of Asset Test for Deemed SSI Populations: Medi-Cal eligibility for individuals in select Deemed SSI populations (Pickle Group, Disabled Adult Child group, Disabled Widow/Widower group) by increasing the asset test.	✓	
PATH Initiative: Funds to support the capacity and infrastructure of community partners to successfully participate in the Medi-Cal delivery system and offer ECM, Community Supports, and pre-release services.		✓
DSHP: DSHP financing used to support portions of the PATH program.		✓

CalAIM Initiative	Renew Under Section 1115 or 1915(b) Authority	Sunset Section 1115 or 1915(b) Authority
Low-Income Pregnant Women: Postpartum benefits for pregnant women with incomes between 109% up to and including 138% of the FPL, that includes all benefits that would otherwise be covered for women with incomes below 109% of the FPL.		✓
Initiatives Authorized under Section 1915(b) Authority		
Medi-Cal Managed Care: Provides coverage for physical health and non-specialty mental health services through Medi-Cal MCPs in all 58 counties through five Medi-Cal managed care models that vary by county or region (County-Organized Health System, Two-Plan, Geographic Managed Care, Regional, and Single Plan).	✓	
Dental Managed Care: Provides coverage for dental services through dental MCPs in Sacramento.[17]	✓	
SMHS: Provides coverage for SMHS by 56 county BHPs in all 58 counties.	✓	
DMC-ODS: Provides coverage for evidence-based SUD treatment services for eligible members residing in participating counties. Counties have the option of participating in the DMC-ODS program.	✓	

DHCS will use all available information, including updated cost effectiveness determinations, outcomes data shared by MCPs and providers, and preliminary findings from the independent evaluator to support the assessment of which Community

[17] Note: DHCS relies on 1915(b) authorities approved for the Medi-Cal Managed Care program to operate the dental integration carve-in pilot for Health Plan San Mateo enrollees, which is distinct from the Dental Managed Care program. Separately, Dental Managed Care in Los Angeles County remains under 1915(a) authority, rather than 1915(b) authority.

Supports to continue, modify, or sunset under Section 1115 authority and ILOS authority.

As part of California's Section 1915(b) waiver approval, CMS approved 12 Community Supports as ILOS.[18] Per 42 CFR § 438.3(e)(2), an ILOS is a service or setting that is provided to an enrollee as a substitute for a covered service or setting under the State Plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting under the State Plan. This regulatory 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 MCP contracts. **The 12 Community Supports covered as ILOS are not dependent on DHCS' current CalAIM Section 1115 or 1915(b) waiver approvals.**

At the time of CMS' approval of the CalAIM Section 1915(b) waiver in 2022, California was the first state to use ILOS authority, rather than waiver authority, to cover a robust set of services that address SDOH and non-medical health needs on a broad scale. As the California's Section 1915(b) waiver approval preceded the guidance and regulations for ILOS, CMS included additional Special Terms and Conditions (STCs) under California's Section 1915(b) waiver regarding monitoring and oversight for ILOS beyond what is required of other states under the federal regulations for ILOS. As part of the upcoming renewal of the Section 1915(b) waiver in 2026, DHCS plans to request the removal of Section 1915(b) STCs related to ILOS as they are now unnecessary with updated ILOS federal guidance and regulations.

[18] The Community Supports approved as ILOS are: Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Respite Services (for caregivers), Day Habilitation Programs, Nursing Facility Transition/Diversion to Assisted Living Facilities or Residential Care Facilities for the Elderly, Community Transition Services/Nursing Facility Transition to a Home, Personal Care and Homemaker Services, Environmental Accessibility Adaptations, Medically Tailored Meals/Medically Supportive Food, Sobering Centers, and Asthma Remediation.

SECTION 6: CONCLUSION

DHCS is excited to move forward with the principles and goals articulated in this concept paper and looks forward to engaging with Medi-Cal members and stakeholders across the continuum of care. DHCS requests that stakeholders submit feedback on this concept paper by Friday, August 22, 2025, to 1115Waiver@dhcs.ca.gov. DHCS will additionally welcome feedback during a series of stakeholder engagement meetings to be held in the summer. Upon integrating input from members and stakeholders, DHCS will continue to evaluate the authorities needed to advance these initiatives and work to secure any necessary federal approvals, including through submission of the CalAIM Section 1115 and 1915(b) waiver renewals.