Nea Hanscomb, Email received on February 19, 2026.

To Whom it Concerns:

I was told by HealthCare Options that MediCal beneficiaries are now “required” to have an Advantage Plan in San Diego.

[redacted]

[redacted]

[redacted]

The responses to my service requests and barriers to care are all grossly non-compliant. This creates conditions that threaten [redacted]. This is against the Lanterman and Olmstead Acts.

This is horrific not just for my family but for all less fortunate people and families in need of care. In our experience CalAIM has been a total failure. The Advantage care plans are NOT coordinating Medi/Medi, providing eligible HCBS mandated services nor following authorization regulations. Regional Centers are not following HCBS authorization procedures or regulations.

[redacted]

Thank you for your consideration,
Nea Hanscomb

Benjamin Renteria, WellSpace Health, Email received on February 25, 2026.

Good afternoon,

I am the Operations Director for an outpatient SUD network of care in the Greater Sacramento area, a life-long Californian, [redacted] Thank you for today's discussion on the 1115 Waiver Renewal, JI Reentry, and BH-CONNECT.

I want to urge DHCS to establish a permanent, state-level sustainability plan for the CCBHC (Certified Community Behavioral Health Clinic) model. CCBHCs are built to do exactly what we are discussing today: they act as comprehensive landing pads for justice-involved reentry, and they are mandated to provide comprehensive care across the lifespan to all persons regardless of their ability to pay. Right now, California has about 27+ CCBHCs actively advancing CalAIM and BH-CONNECT goals on the ground, but the integrated models are surviving on temporary federal SAMHSA grants. We cannot afford to let this capacity diminish. By securing a CCBHC State Planning Grant in 2016, DHCS signaled a clear intent to implement this high-impact model; it is time to follow through on that investment.

The national consensus on this model is undeniable. When states on complete opposite ends of the political spectrum like New York (via the federal demonstration) and Texas (via an 1115 waiver) both agree this is the standard of care that works for their communities, it speaks volumes. Californians deserve this comprehensive care model no less than they do.

Alongside advocates like CBHA and CPCA, I strongly urge DHCS to use the upcoming 1115 Waiver Renewal or the federal Section 223 demonstration to formally integrate and sustain the CCBHC model within our managed care infrastructure.

Don't just take my word for the incredible work happening on the ground. Please take a moment to see the very real difference CCBHCs are making by exploring the National Council for Mental Wellbeing's CCBHC Impact Report Data Highlights

Thank you for your time and work on this.

Respectfully,
Ben Renteria
Director of Healthcare Delivery Operations
SUD Outpatient Treatment (NBH, JST)
WellSpace Health
North Behavioral Health Center | 4441 Auburn Blvd, Sacramento CA 95841
[redacted] / www.wellspacehealth.org

Kathleen Kelly, Family Caregiver Alliance, Email received on February 24, 2026.

Dear DHCS 1115 Waiver Team,

Please find attached Family Caregiver Alliance's public comment on the CalAIM Section 1115 Demonstration Renewal Application (2027–2031). Our letter makes five recommendations focused on embedding caregiver-inclusive design into BridgeCare Pilots, D-SNP alignment, and CalAIM evaluation frameworks. Each recommendation is classified by implementation type for ease of routing. This submission complements FCA's concurrent public comments on SPA Renewal 26-0009, submitted separately.

We welcome the opportunity to discuss these recommendations with DHCS staff.

Respectfully,
Kathleen Kelly
Executive Director
Family Caregiver Alliance / National Center on Caregiving
Genevieve Caruncho-Simpson, MPA-HPM
Senior Advisor, Family Caregiver Alliance
Genevieve D. Caruncho-Simpson, MPA
Senior Advisor, CareNav Health
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February 24, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Sent via email to: 1115waiver@dhcs.ca.gov

Re: Public Comment on CalAIM Section 1115 Demonstration Renewal Application (2027–2031)

Dear Director Baass and DHCS Leadership:

Executive Summary

Family Caregiver Alliance (FCA), the nation's first and longest-serving caregiver support organization, appreciates the opportunity to comment on California's proposed five-year renewal of the CalAIM Section 1115 demonstration. FCA and our statewide network of 11 Caregiver Resource Centers (CRCs) serve more than 40,000 family caregivers annually; approximately 61 percent support dual-eligible beneficiaries. Our work is increasingly integrated with Medi-Cal managed care plans, county partners, and health systems serving older adults and people with dementia and complex conditions in home and community settings.

We strongly support DHCS's commitment to whole-person care, delivery system transformation, and expansion of HCBS under CalAIM. We especially welcome the proposed BridgeCare Pilots and the continued emphasis on Enhanced Care Management (ECM), Community Supports, and integrated care for dually eligible beneficiaries. At the same time, we urge DHCS to more explicitly recognize and operationalize the role of family caregivers as essential infrastructure in the 1115 renewal—particularly within BridgeCare. *Without caregiver-inclusive design, the demonstration will struggle to prevent avoidable institutionalization, reduce high-cost utilization, and sustain Medi-Cal under current fiscal pressures.*

This letter builds on FCA's August 2025 feedback on the DHCS Concept Paper, in which we proposed a budget-neutral, five-year package of caregiver-inclusive enhancements with projected net savings of up to $1.29 billion through utilization offsets. We incorporate that submission's budget-neutrality analysis by reference. We also cross-reference FCA's concurrent comments on SPA Renewal 26-0009 (California's 1915(i) HCBS renewal) and our January 30, 2026 comments on DHCS's draft All Plan Letter on Interoperability Final Rules.

We make five recommendations across three areas:

- Add dyadic caregiver assessment and metrics to BridgeCare design.
- Explicitly leverage CRCs and caregiver-specialist entities as county partners.
- Align BridgeCare with D-SNP and ECM policy levers.
- Add caregiver variables to CalAIM data and evaluation frameworks.
- Strengthen budget-neutrality analysis with caregiver-level data.

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I. The Federal Fiscal and Policy Context for This Renewal

This five-year renewal (2027–2031) will unfold within the budget window of the 2025 budget reconciliation law (H.R. 1, signed July 4, 2025). The Kaiser Family Foundation projects aggregate federal Medicaid spending reductions of approximately $990 billion over ten years (2025–2035). HCBS is disproportionately vulnerable because it remains an optional Medicaid benefit that states can cut, cap, or restrict through waiting lists. A recent CHCS survey of Western state Medicaid agencies (February 2026) found that 77 percent of responding states anticipate reductions in one or more disability services—with caregiver support, case management, and home-based services specifically identified as at risk.

States that demonstrate measurable cost avoidance through community-based alternatives to institutionalization will be best positioned to sustain HCBS under constrained federal financing. National LTSS research consistently shows that caregiver variables are among the strongest predictors of community placement stability, and programs that systematically assess and support caregivers generate nursing facility diversion savings ratios exceeding 15:1 (Georgia Respite Care Study; Washington TSOA/MAC evaluations). California's CalAIM renewal should embed these variables into its demonstration design so that the state's budget-neutrality case to CMS reflects a complete picture of how community-based care works—including the unpaid caregiving infrastructure that sustains it.

The CHCF's January 2026 report, *The Crucial Role of Counties in the Behavioral Health of Californians*, documents that California counties are managing an unprecedented number of simultaneous mandates—CalAIM payment reform, BH-CONNECT, Proposition 1/BHSA, CARE Courts, and new federal managed care rules—with workforce shortages affecting over 90 percent of counties and widespread implementation fatigue. BridgeCare will layer onto this environment. Any realistic design must account for these constraints.

II. BridgeCare Pilots: Promise and Structural Risks

We applaud DHCS for proposing BridgeCare Pilots to provide HCBS and caregiver supports to "near dual" older adults with Medicare coverage, significant health needs, and incomes between 138 and 220 percent FPL. This population is at high risk of impoverishment, Medicare-funded nursing facility stays, and eventual Medi-Cal LTSS enrollment absent home-based supports and caregiver assistance.

FCA strongly supports BridgeCare's core objectives and appreciates that DHCS explicitly includes caregiver supports and the evidence-based CAPABLE model. However, we see three structural risks that should be addressed before finalizing the demonstration design.

County capacity and fiscal pressure

Counties are already balancing major realignment constraints, redetermination-related churn, and rapidly growing LTSS expenditures—IHSS alone is projected to approach $29 billion and roughly 800,000 recipients in 2025–26. Over 90 percent of county behavioral health agencies report challenges recruiting key clinical staff. Assuming that counties can stand up a new near-dual pilot with sophisticated assessment, HCBS contracting, and evaluation infrastructure is optimistic without explicit scaffolding and technical assistance from DHCS and designated partners.

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Fragmented data infrastructure

Most counties lack integrated data systems linking Medicare claims, Medi-Cal eligibility, functional assessments, caregiver status, and spending across payers. CalMHSA has convened only 25 of 58 counties on a semi-statewide EHR. Without specific expectations and support for dyadic data collection, BridgeCare risks becoming a promising but hard-to-evaluate pilot.

Absence of explicit dyadic assessment and caregiver metrics

The BridgeCare description lists caregiver supports and CAPABLE as services but does not yet define how caregiver need will be systematically assessed, incorporated into care plans, or measured as a quality outcome. Clinical research on dementia trajectories underscores why this matters: people with dementia reach end-of-life-equivalent functional impairment (ADL score of 1.92) at 17 months before death—versus 6 months for individuals without dementia—meaning caregivers carry that burden for years. Yet these individuals receive significantly less home health, less hospice (12.5% versus 17.3% in the last month of life), and fewer physician visits. This service underutilization paradox—highest caregiver burden coinciding with lowest service access—is precisely the gap that dyadic assessment in BridgeCare should close.

Washington's TSOA and MAC programs use standardized caregiver assessment (e.g., TCARE) as an eligibility and care-planning tool and have demonstrated reduced ED and hospital use. CMS's GUIDE dementia care model—now operational in 43 states—requires standardized dementia staging and caregiver burden assessment (e.g., Zarit Burden Interview) as core model elements, establishing a federal standard BridgeCare should meet.

Recommendation 1: Add dyadic caregiver assessment and metrics to BridgeCare design

Type: Demonstration design amendment (BridgeCare Pilot protocols and evaluation framework)

We urge DHCS to modify the BridgeCare Pilot description and implementation protocols to:

- Require standardized caregiver assessment at enrollment and at least annually, using a validated tool (e.g., TCARE, Bakas Caregiving Outcomes Scale). California's SB 1249, which updates the Mello–Granlund Older Californians Act and establishes new caregiver-related expectations for health and social services, provides statutory authority for this requirement.
- Incorporate caregiver capacity and strain into the BridgeCare care plan, including caregiver-specific goals and referrals when strain exceeds validated thresholds.
- Add caregiver-related quality and outcome measures (e.g., caregiver strain, dyad stability, nursing facility days avoided) to the BridgeCare evaluation framework.
- Align BridgeCare assessment with the D-SNP CICM framework and CMS GUIDE model standards, creating common infrastructure that supports transition when participants become dually eligible.

DHCS could phase in these requirements over the first two years, focusing initially on participants with dementia or high functional impairment.

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Recommendation 2: Explicitly recognize and leverage CRCs and caregiver-specialist entities as county partners

Type: Sub-regulatory guidance (BridgeCare implementation directives and county opt-in protocols)

To address county capacity challenges, we recommend that DHCS:

- Identify California's Caregiver Resource Centers and other caregiver-specialist organizations as eligible implementation partners. CRCs already operate in every California county and in many regions already contract with Medi-Cal managed care plans and counties, making them natural partners with validated assessment tools and workflows.
- Encourage or require participating counties to include at least one caregiver-focused partner in their implementation plans.
- Offer technical assistance modeled on the PATH initiative, the CalAIM Statewide Older Adult Collaborative, and the CalMHSA scaffolding model for CalAIM Behavioral Health Payment Reform—providing counties with boots-on-the-ground support for BridgeCare implementation.

III. Implications for Integrated Care for Duals and D-SNP Alignment

CalAIM's D-SNP alignment initiatives are crucial for duals integration. As of October 2025, nearly 483,000 dually eligible members are enrolled in aligned plans. BridgeCare creates an important complement by targeting near-dual Medicare beneficiaries who are likely "dual eligible tomorrow" absent effective HCBS and caregiver supports.

The CY 2026 D-SNP Policy Guide's CICM requirements now identify "Members with Documented Dementia Needs" as a specific CICM population, creating a natural clinical and data bridge between BridgeCare (pre-dual) and D-SNP (post-dual) care management. A common dyadic assessment framework spanning both programs would prevent the data discontinuity and care fragmentation that occur at the point of dual eligibility.

Recommendation 3: Align BridgeCare with D-SNP and ECM policy levers

Type: Demonstration design amendment and sub-regulatory guidance (BridgeCare–D-SNP interface protocols and evaluation design)

We recommend that DHCS:

- Clarify how BridgeCare will interface with D-SNPs and ECM when participants become dual eligible, including expectations for coordination and data sharing. DHCS should specify that caregiver assessment data may be exchanged, with appropriate consent, between BridgeCare entities and D-SNPs via FHIR-based Patient Access APIs.
- Explicitly recognize caregiver engagement and dyadic care management as core functions across both BridgeCare and ECM for populations with cognitive impairment, consistent with CalAIM ECM guidance, the D-SNP CICM framework, and CMS's GUIDE model.

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- Design BridgeCare evaluation metrics to produce data compatible with D-SNP CICM performance measurement and CalAIM's Comprehensive Quality Strategy, enabling cross-program outcome demonstration to CMS.

IV. Caregiver Data and Dyadic Metrics Across CalAIM

FCA encourages DHCS to embed caregiver-inclusive data elements more broadly into CalAIM evaluation and reporting. CMS's December 2025 data release reveals that between 2022 and 2023 the share of Medicaid LTSS expenditures devoted to HCBS declined by approximately one percentage point nationally, while institutional spending increased—including 22 percent growth in mental health facility spending. The populations most relevant to CalAIM show the lowest rebalancing ratios: adults 65 and older had only a 67 percent HCBS user ratio, and fully dual-eligible individuals only 76 percent. Without caregiver data elements and dyadic metrics, CalAIM's ability to demonstrate return on investment—and to reverse these trends in California—will be limited.

California has a statutory foundation for this work. SB 1249, which updates the Mello–Granlund Older Californians Act, provides a foundation for requiring health plans to identify and assess family caregivers. DHCS has clear authority under Welfare & Institutions Code § 14184.200 and the CalAIM 1115 waiver to require data elements necessary for implementation, D-SNP integration, and Medi-Cal contract compliance.

Recommendation 4: Add caregiver variables to CalAIM data and evaluation frameworks

Type: Evaluation framework amendment and managed care contract guidance

We urge DHCS to:

- Incorporate caregiver-related variables (e.g., caregiver presence, relationship, hours of unpaid care, strain scores) into CalAIM evaluation designs and routine reporting for ECM, Community Supports, and BridgeCare. These variables should align with USCDI v3 standards and be exchangeable via FHIR-based APIs.
- Encourage managed care plans and counties to use standardized caregiver assessment tools in relevant populations, targeting five regional pilot hubs in CY 2027, statewide scale in CY 2028–2030, and durable data elements in State Plan and MCP contracting by CY 2031.

Recommendation 5: Strengthen budget-neutrality analysis with caregiver-level data

Type: Budget-neutrality methodology (CMS waiver submission)

FCA's August 2025 Concept Paper feedback projected up to $1.29 billion in net savings over the waiver period through caregiver-inclusive utilization offsets—including ED reductions (25–40%), inpatient cost avoidance (15–30%), and nursing facility delay averaging 18–24 months per dyad. We urge DHCS to incorporate caregiver capacity and strain variables into the 1115 renewal's budget-neutrality methodology, so the state's case to CMS reflects the full economic contribution of family caregivers to community-based care delivery.

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Conclusion

FCA appreciates DHCS's continued leadership in advancing whole-person, community-based care through CalAIM. By incorporating caregiver assessment, caregiver-specific services, and dyadic quality metrics—especially within BridgeCare—California can strengthen both the clinical effectiveness and fiscal sustainability of its 1115 demonstration, while aligning with the RAISE National Strategy, CMS GUIDE model, and California's own SB 1249 standards.

We respectfully request that DHCS integrate these recommendations into the final CalAIM Section 1115 renewal application. FCA and our statewide CRC network stand ready to support implementation.

Respectfully submitted,

Kathleen Kelly
Executive Director
Family Caregiver Alliance
National Center on Caregiving

Genevieve Caruncho-Simpson, MPA-HPM
Senior Advisor, Family Caregiver Alliance

Angela Degliantoni, Hospitality House, Email received on February 26, 2026.

Hello,

My name is Angela Degliantoni. I work with a Hospitality House in Nevada County. I am writing in strong support of the proposed CalAIM Section 1115 Demonstration Renewal. As a Community-Based Organization providing Community Supports, and the only recuperative care provider in Nevada County we see firsthand the essential role these services play in improving outcomes for members, strengthening collaboration with community partners, and alleviating pressure on our rural hospital. Since the launch of CalAIM, Community Supports have been transformative for both the individuals we serve and for our agency's capacity to innovate, grow, and meet rising community needs. Renewing the 1115 Demonstration is critical to sustaining these gains, ensuring continuity of care, and expanding access to high-value services for vulnerable populations across the state. I respectfully urge approval of the renewal application.

Stephen Kozak, Hospitality House, Email received on February 26, 2026.

I am employed by Hospitality House, a homelessness services agency in Nevada County that operates an emergency shelter as well as residential properties, street outreach and many other services. We are contracted to provide the 'housing trio' along with Recuperative Care and Short Term Post Hospitalization Housing to our guests and clients. Renewal of the CalAIM program is crucial for us to continue to operate and expand as we work to end the cycle of homelessness for our residents. As the issue of homelessness has become a major crisis in the state of California and the nation at large, we fully support DHCS' efforts to extend and expand services and prevent a situation in which social supports are taken away and untold thousands of residents lose access to housing resources and services. This funding stream has allowed us to continue to operate our shelter and other programs even as other revenue sources have been discontinued or reduced, preventing a catastrophe for the residents of Nevada County. Thank you so much for your efforts.

Deborah McDonald, Hospitality House, Email received on March 2, 2026.

Hospitality House is in support of the proposed shift outside the waiver to ensure the continuity of the Recuperative Care program. In our local community, we can verify that the Recuperative Care program produced a 29.2% reduction in PMPM costs, driven by reduced inpatient, outpatient, emergency department, and long-term care utilization. Looking forward,

Richard Knecht, Integrated Human Services Group, Email received on March 5, 2026.

Requested comments in the 1115 renewal attached here for your consideration. Thank you

Richard Knecht
Managing Partner, Integrated Human Services Group, LLC
[redacted]

March 5, 2026

Dear DHCS CalAIM Team,

We are writing to comment on the renewal application's decision of the Providing Access and Transforming Health (PATH) initiative. Specifically, we ask that DHCS address the absence of a successor to the Collaborative Planning and Implementation (CPI) component of PATH, which is scheduled to sunset in December 2026.

The application presents PATH's sunset as the conclusion of a successful, time-limited capacity-building effort and reports strong statewide metrics in support of that conclusion. We do not dispute those metrics. However, the application does not address what will replace CPI's core function: providing a structured, regional venue where MCPs, CBOs, county agencies, and providers collaborate on CalAIM implementation challenges in real time.

CPI served a role that other PATH components did not. The TA Marketplace delivered resources to individual organizations. CITED provided startup capital. CPI was the connective infrastructure — the space where stakeholders across the CalAIM ecosystem learned from each other's operational experience and built the cross-sector relationships that make contracting, referral, and service coordination work at the local level. At a public hearing on the renewal, Deputy Director Tyler Sadwith acknowledged that DHCS wants to understand how to continue this peer-to-peer learning. The application, however, does not propose a path forward.

Our experience operating CPI-style learning collaboratives at the county level confirms that the need for this infrastructure is not diminishing. As CalAIM expands into new provider sectors, new service categories such as Employment Supports, and new cross-system requirements under H.R. 1, the implementation questions that CPI was designed to address will grow more complex, not less. The current CPI structure helps to keep providers informed on changes to Medi-cal, provide a forum for networking and building a local continuum that allows for capacity building at the local level.

We respectfully request that the renewal application include a framework for continuing CPI's peer-to-peer learning function after December 2026 and we note that existing MCP funding mechanisms, including the Incentive Payment Program, Community Reinvestment obligations under APL 25-004 could be utilized for the funding of this. Additionally, DHCS could incorporate provider network development obligations into MCP contracts for the renewed waiver period that include support for collaborative learning among prospective CalAIM providers, making this an ongoing MCP responsibility rather than a time-limited PATH deliverable. What is needed is DHCS guidance that explicitly authorizes these uses and a commitment to engage stakeholders in designing the successor framework. These would also allow DHCS to continue to monitor local capacity of CalAIM and gain valuable insight from stakeholders. As such a similar format to what exists currently is needed in which consultants are facilitating and not MCP staff.

Thank you for the opportunity to comment.

Olivia Burns, SCAN Foundation, Email received March 5, 2026.

Good morning,

Please find attached comments from The SCAN Foundation in response to the CalAIM Section 1115Demonstration Renewal Application.

Please let me know if there are any questions.

Thank you,
Olivia Burns, MSW (she/her)
Senior Policy Analyst
The SCAN Foundation
[redacted]
www.TheSCANFoundation.org

March 12, 2026

Tyler Sadwith
Department of Health Care Services
Director's Office
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
Delivered via email to: 1115waiver@dhcs.ca.gov

Re: *Medicaid Section 1115 Demonstration Five-Year Renewal Request: Continuing CalAIM Demonstration*

Dear Director Sadwith,

The SCAN Foundation (TSF) appreciates the opportunity to comment on the Department of Health Care Services' (DHCS) *Medicaid Section 1115 Demonstration Five-Year Renewal Request: Continuing CalAIM Demonstration*. Medi-Cal is a critical lifeline for many, and we appreciate DHCS' commitment to ensuring the program is person-centered, equitable, coordinated, and responsive to the needs of its members, especially older adults and people with disabilities. TSF envisions a society where all of us can age well with purpose. We pursue this vision by igniting bold and equitable changes in how older adults age in both home and community. Our grants and impact investments prioritize communities that have been historically marginalized with an emphasis on: older people of color, older adults with lower incomes, and older residents in rural communities.

TSF has long supported the state's efforts to increase access to home and community-based services (HCBS), strengthen integrated care options for people dually eligible for Medicare and Medi-Cal, and advance the state's Master Plan on Aging. We've worked closely with the DHCS Office of Medicare Innovation and Integration (OMII), supporting research and data analysis in recent years to better understand the state's Medicare-only population and levers to improve care. We are pleased to see DHCS draw from this work, as well as the state-funded LTSS Financing Initiative begun through the MPA to elevate innovative strategies, particularly the proposed BridgeCare Pilot, which comes at a pivotal moment for California's aging population. The following comments acknowledge the state's efforts while offering recommendations to strengthen HCBS proposals within the 1115 waiver renewal application.

Section 3.13 – BridgeCare Pilots

Many older Californians lack sufficient resources to afford HCBS, a form of LTSS that enables older adults and people with disabilities to stay in their homes and communities and receive the care that they need. Research we supported on California's middle-income older adult population revealed that by 2033, 89% of Californians age 75 and older will not be able to afford HCBS, a population known as the Forgotten, or Overlooked, Middle. This is especially true for older adults in that group who are "near duals" – those who fall just above income eligibility for Medi-Cal. The research we supported with OMII on California's Medicare-only population showed that 1 in 8 California Medicare beneficiaries, most people of color, are near dual. Near duals often have similar health and care needs to those who are Medi-Cal eligible but are unable to afford HCBS to support those needs. We are pleased to see DHCS propose a solution to address this critical gap in HCBS access through its Bridge Care Pilots proposal, especially as it aligns with MPA initiative #75, focused on building a draft model for a Medicare HCBS demonstration. As the pilot details are further defined, we hope the state uses available data (e.g., clinical, functional, service-use) to identify target populations that will most benefit, shape the service package based on what is most impactful, and quantify potential fiscal impacts for Medi-Cal and Medicare to develop a business case.

Caregiver Supports as Discretionary Services

We appreciate that DHCS has designated a core set of services to guide local program design of the BridgeCare pilots and that local entities will have flexibility in creating their programs via additional discretionary services. Research supported by TSF on California's near dual population revealed that they are more likely to live alone than their higher income counterparts, meaning they are less likely to have family support in the home. However, this does not account for support from loved ones outside the home, such as friends and neighbors. Programs similar to the BridgeCare pilot, such as Vermont's Choices for Care – Moderate Needs Group program or Washington state's Tailored Supports for Older Adults program, include caregiver support services like respite and training and education. We recommend including these types of caregiver support services as an option among the discretionary services.

County Fiscal Responsibility

While TSF supports the goals of the pilot, we are concerned that requiring participating counties to finance the non-federal share could limit uptake. Counties are already facing significant fiscal pressures related to recent state and federal policy changes.

We recognize DHCS proposes the concept of reinvesting a portion of future Medicare savings into local entities, but near-term cash-flow and match requirements may still deter county participation. Additionally, counties use local funds to provide safety-net services to targeted populations. A couple of counties provide contract mode personal care services to people who are unhoused, representing an important link to HCBS for individuals unable to access In-Home Supportive Services. Counties could face a zero-sum choice between maintaining these programs and participating in the BridgeCare pilot, a result that would pit one vulnerable population against another, which must be avoided. We urge DHCS to work with counties to mitigate near-term fiscal barriers until shared savings are available.

Pilot Evaluation

Lessons learned from the pilots will be critical to informing future policy efforts focused on improving HCBS affordability and access. Given the customizable nature of the pilots, outcomes may vary between local entities, and it would be helpful to illustrate any such variations, especially between rural and urban communities. We recommend inclusion of an evaluation approach for the pilots that measures participant outcomes, rates of access among demographic groups, any disparities in waitlist data, and other items as noted in Justice in Aging's Equity Framework for Evaluating California's Medi-Cal Home and Community-Based Services for Older Adults & People with Disabilities.

Ongoing Exploration of LTSS Financing Solutions

Expanding HCBS access to near duals is a critical step toward an LTSS system that serves all Californians. The BridgeCare pilots concept represents an innovative policy lever amid the broader array of options to achieve LTSS for all and signals California's commitment to building a better system. We encourage the state to continue considering additional mechanisms that increase access to HCBS for near duals and the Forgotten/Overlooked Middle, such as Medi-Cal Share of Cost reform and a financing solution for a state LTSS/HCBS benefit.

Section 4 – Initiatives Being Discontinued or Transitioned Under CalAIM Section 1115 Authority – Community-Based Adult Services

TSF supports DHCS' plan to transition the Community-Based Adult Services (CBAS) program from the 1115 waiver to a 1915(i) state plan benefit. The CBAS program provides valuable services to older adults and family caregivers that support aging at home.

Transitioning CBAS to a state plan benefit provides permanency and establishes the program as a standard. However, more is needed to ensure older adults and people with disabilities have access to this program statewide, as CBAS is only available in 28 counties currently. In fact, DHCS Medi-Cal HCBS Gap Analysis identified this as a significant gap, noting CBAS services are most available in larger, more populated counties, with less access in rural areas. We recommend DHCS establish an advisory committee for the CBAS program to inform program implementation and efforts to increase access to CBAS.

Thank you again for the opportunity to provide comments on the *Medicaid Section 1115 Demonstration Five-Year Renewal Request: Continuing CalAIM Demonstration*. We are encouraged by DHCS' ongoing commitment to advancing initiatives that strengthen care and access for older adults and people with disabilities, including those in the Forgotten/Overlooked Middle. [redacted]

Sincerely,

[redacted]

Sarita A. Mohanty, MD, MPH, MBA
President and CEO
The SCAN Foundation

CC: Lauren Gavin Solis, Chief, Office of Medicare Innovation and Integration, Department of Health Care Services; Susan DeMarois, Director, California Department of Aging

Meredith Chillemi, LeadingAge California, Email received on March 5, 2026.

Director Baass, it was a pleasure to see you and chat last week.

All good wishes, Meredith

Meredith Chillemi | Vice President, Regulatory Affairs | LeadingAge California | [redacted]
1315 I Street, Suite 100, Sacramento, CA 95814 | leadingageca.org | [redacted]

March 5, 2026

Department of Health Care Services
Submitted via email

Dear Director Baass:

LeadingAge California appreciates the opportunity to provide stakeholder feedback from the perspective of our mission-driven providers surrounding the CalAIM renewal. Thank you for providing this comment period to provide our input and recommendations for advancing the Department's goals.

LeadingAge California is the state's leading advocate for mission-driven housing, care, and services for older adults. Our over 800 members across the state include providers of affordable senior housing, residential care facilities for the elderly (assisted living), life plan communities, skilled nursing care, home and community-based services, home health, and hospice care. Our members serve at the heart of the historic Medicaid transformation. They are thankful to share their experience and perspectives to solidify and strengthen the future efforts to implement services in California so that older adults have access to age in place in the setting of their choice.

Employment Supports
We are strongly supportive of the proposal to include Employment Supports as a Medi-Cal covered benefit. These services—job readiness assessments, individualized employment planning, job placement, and post-employment supports—are essential for helping Californians enter and remain in the workforce. This is especially critical for older adults aged 55 to 64, many of whom live in affordable housing communities and face unique barriers to employment. This population is often overlooked. They encounter ageism in hiring, they are at increased risk of housing instability, and they may lose Medi-Cal coverage before becoming eligible for Medicare. At the same time, federal Senior Community Service Employment Program (SCSEP) funding is at risk, threatening one of the only existing job training pathways for lower income older adults. Employment Supports within Medi-Cal will be vital to preventing displacement and ensuring individuals can maintain both their health coverage and housing. While we appreciate DHCS' proposal to allow counties or county-based entities to opt in using intergovernmental transfers, we strongly recommend that the state operationalize Employment Supports with guidance that counties contract with community-based organizations (CBOs) and Area Agencies on Aging (AAAs) to operate in this space. These organizations already have deep expertise working with older adults, understanding age-specific employment barriers, and are often more trusted by the populations we most need to engage.

BridgeCare Pilots
We also enthusiastically support the BridgeCare Pilots for "near duals"—older Californians with incomes between 138 and 220 percent of the federal poverty level who have significant health needs but do not qualify for Medi-Cal. This group, now called the "overlooked middle", has long been stranded between the high cost of private care and the strict eligibility rules of Medi-Cal.

We are grateful to see that the state has taken seriously the years of stakeholder work led by the California Department of Aging to design supports for this population. Allowing federal matching funds to support HCBS and caregiver services for older adults who meet nursing facility–level of care but wish

to remain at home is an important and overdue step. We support the proposed core services, including assessments, individualized care planning, care management, personal care, respite, and the CAPABLE program. We also strongly support giving local entities flexibility to tailor discretionary services such as homemaker assistance, adult day programs, transportation, nutrition services, assistive technology, and community transition supports. We also applaud this program's proposed statewide access.

CBAS Transition

Finally, LeadingAge California applauds the proposal to transition CBAS from the 1115 waiver into 1915(i) state plan authority, making it a true entitlement and securing long-term stability for a service that has proven effective in reducing hospitalizations, supporting caregivers, and keeping people in their communities. We support DHCS' commitment to avoiding disruptions in access during implementation and encourage robust technical assistance for CBAS providers.

In closing, these proposals represent meaningful progress toward a more equitable, age-inclusive Medi-Cal system. We urge DHCS to build in strong partnerships with aging services providers—including nonprofit CBOs and AAAs—and to prioritize statewide availability of these essential supports.
Thank you for your commitment to advancing the health and independence of older Californians and considering our recommendations.

Sincerely,

[redacted]

Meredith Chillemi
Vice President, Regulatory Affairs

Brian Rutledge, California Association of Adult Day Services, Email received on March 10, 2026.

Hi Tyler and DHCS colleagues,

Please find our public comment on 1115 renewal attached. We look forward to engaging on the forthcoming 1915(i) proposal where CBAS is transitioned to permanent authority. It's a great move for the program and for LTSS policy. Thank you,

Brian Rutledge, PhD
Executive Director | ([redacted] | caads.org
California Association for Adult Day Services
801 K St Ste 925 Sacramento, CA 95814

March 10, 2026

Department of Health Care Services
Director's Office
Attn: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Submitted via email: 1115waiver@dhcs.ca.gov

RE: CAADS Public Comment on 1115 Demonstration Waiver Renewal

Dear Mr. Sadwith:

The California Association for Adult Day Services (CAADS) is the voice of California's 318 Community Based Adult Services (CBAS) centers that provide person-centered care to 44,000 older and disabled Medi-Cal adults. We respectfully submit the following input in response to a request by the Department of Health Care Services (DHCS) for public comment on DHCS's Medicaid Section 1115 Demonstration Five Year Renewal Request:

- ***Transitioning CBAS to 1915(i) State Plan.*** We strongly supported DHCS's decision to move the CBAS program to a permanent state plan Home and Community Based Services (HCBS) benefit through 1915(i) authority. CBAS has served older adults and people with disabilities since the 1970s and has remained largely unchanged. Because it is such a long-standing, stable program, CAADS has always strongly advocated for CBAS to be rooted in 1915(i) authority rather than the more temporary 1115 demonstration waiver. Transitioning CBAS to permanent authority appropriately recognizes its enduring role within California's HCBS system.

- ***Forthcoming 1915(i) State Plan proposal.*** DHCS has described the CBAS transition to 1915(i) authority as a "lift and shift" with the only intended change to be a new and more permanent federal authority. We appreciate the focus on making no major changes for CBAS providers and CBAS participants and look forward to seeing and sharing thoughts on the full 1915(i) proposal. We thus look forward to engaging on the forthcoming 1915(i) proposal in order to:

    - Sustain and grow General Fund cost savings – 2025 Genworth data demonstrates CBAS currently costs 6 to 8 times less than nursing homes. Given the State's growing financial pressures, CBAS will be an increasingly important tool for controlling the

growth of Medi-Cal and General Fund costs. Protecting and growing the program is a way of delaying or avoiding much higher-cost institutional settings.

- Achieving health care policy goals, including CalAIM implementation – CBAS uses interdisciplinary teams to address clinical and non-clinical issues for high-needs individuals with complex medical and behavioral health challenges. This allows providers to ensure Medi-Cal members receive Whole Person Care and address Social Determinants of Health (SDOH). As ECM and CS providers, CBAS centers are key to CalAIM's current and future success.

- Achieving aging and disability policy goals, including Master Plan for Aging – DHCS recently noted that only 28 of 52 of California counties have access to CBAS and 16 counties have only 1 CBAS center, creating statewide access gaps for HCBS that need filling as California's population ages. CBAS is also critical to achieving Goals 2, 4, and 5 of the Master Plan for Aging. Sustaining and growing the program is critical for enabling California to support older adults and people living with disabilities. We look forward to working with DHCS to ensure the benefit is in fact statewide, including by creating robust network adequacy requirements that hold Managed Care Plans accountable and incentivized to provide CBAS.

We look forward to continued collaboration. Please reach out with any questions.

Sincerely,

[redacted]

Brian Rutledge, PhD
Executive Director

[redacted]

CC
Michelle Baass, Director, DHCS
Susan Philip, Deputy Director, Health Care Delivery Systems, DHCS
Joseph Billingsley, Assistant Deputy Director, Integrated Systems of Care, DHCS

Andrea Maldonado-Odgers, Southern Indian Health Council, Email received on March 10, 2026.

Good morning,

Please see attached a letter from our CEO at Southern Indian Health Council, Inc., Laura I. Caswell.

Thank you.

Best regards,

Together, We Own Wellness!
San Diego Access & Crisis Line: 888-724-7240
988 Suicide and Crisis Hotline: Call, text, or chat by dialing 988
National Suicide Prevention Lifeline: 800-273-TALK (8255)

Attachment not included due to document protections.

Karen Gheorma, Habitat for Humanity Yuba/Sutter, Email received on March 9, 2026.

Dear DHCS,

Habitat for Humanity Yuba/Sutter's Supportive Outreach Services strongly supports the renewal of the CalAIM Section 1115 Demonstration and continuation of its core initiatives addressing the social drivers of health. Programs such as Enhanced Care Management (ECM) and Community Supports are essential components of California's effort to integrate physical health, behavioral health, and housing-related supports for Medi-Cal members with complex needs.

Since the implementation of CalAIM, our organization has helped house 452 individuals experiencing homelessness or housing instability across Yuba, Sutter, and surrounding counties. Many of these individuals were placed in housing through partnerships with community landlords and housing providers, demonstrating how ECM and Community Supports strengthen the broader housing system beyond permanent supportive housing units alone. Through these programs, our team has been able to connect Medi-Cal members with housing navigation, recuperative care, short-term posthospitalization housing, behavioral health services, and other critical supports that stabilize individuals and reduce unnecessary hospital and emergency department utilization. Our Supportive Outreach Services department partners closely with Medi-Cal Managed Care Plans, hospitals, behavioral health providers, and community landlords to deliver housing-linked services that stabilize high-need Medi-Cal members in the community.

We encourage DHCS and CMS to continue and strengthen these authorities beyond 2026 so community-based providers can sustain and expand housing-linked services that improve health outcomes and reduce long-term system costs. We also encourage DHCS to continue exploring opportunities to expand housing-related services under CalAIM, as stable housing remains a foundational component of improving health outcomes and reducing reliance on high-cost emergency and institutional care. Programs such as ECM, Recuperative Care, and Short-Term Post-Hospitalization Housing are essential tools for addressing homelessness and complex health needs
across California.

Sincerely,
Karen Gheorma
Karen Gheorma
Director
Supportive Outreach Services
[redacted]
202 D St. Marysville, CA 95901

Esthefanie Casoverde, Inland Empire Health Plan, Email received March 9, 2026.

Good afternoon,

Please see the Plan's comments regarding the CalAIM 1115 Waiver Renewal.

CalAIM Section 1115 Waiver		
Page #	**Current Language**	**IEHP Feedback**
41	Section 3.12 Employment Supports	• The Plan would like to confirm this new Employment Supports benefit would be administered as a county program with direct funding from the state to the participating counties and not be administered by the MCPs.
48	Recuperative care and short-term post hospitalization housing	• The Plan would like to clarify how the room and board component would be pulled out and how would this impact rates and contracts.

Thank you,
Esthefanie C.
Esthefanie Casoverde,BA
Analyst II - Regulatory Affairs
Compliance
Inland Empire Health Plan
10801 Sixth St.
Rancho Cucamonga, CA 91730
[redacted]

Jason Bloome, Connections, Email received on March 9, 2026.

Hello DHCS,

We are a CS Provider for the CalAIM Assisted Living Facility Transitions (ALFT) for Health Net and Kaiser and were highlighted in the California Health Care Foundation CalAIM Community Hub article. We currently have enrolled 1,300 authorized members with 80% (1040) for SNF Transition which saves the state approximately $2,500/month. The annual Medi-Cal cost savings is approximately: $25 million dollars (1040 x 2500 x 12) and we are growing at about 100 new authorizations each month. SNF Diversion also saves the state money for less utilization for LTSS SNF, hospital or emergency room stays. We think this CS shows solid evidence for the success of CalAIM in saving state and federal dollars. We would be happy to provide more details about this CS at your request.

Kind regards,
Jason
--
Jason Bloome
CEO
Connections - Care Home Consultants
[redacted]
www.connectionscarehomeconsultants.com

Erin Managbanag, Arrowhead Regional Medical Center, Email received on March 9, 2026.

Dear Mr. Sadwith,

On behalf of Arrowhead Regional Medical Center (ARMC), please find the attached letter in support of the Department of Health Care Services' proposal to request five-year renewal of the Global Payment Program (GPP) as part of the CalAIM Section 1115 demonstration renewal application.

If you have any questions, please feel free to contact me directly.

Best,
Erin Managbanag, MBA
Legislative Affairs Program Administrator
Legislative Affairs Department
[redacted]
www.arrowheadregional.org

400 N. Pepper Avenue, Colton, California 92324-1819 | Phone: 909.580.1000
www.arrowheadregional.org

ARROWHEAD REGIONAL MEDICAL CENTER

The Heart of a Healthy Community™

March 9, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814
Submitted via: 1115waiver@dhcs.ca.gov

RE: Support Five-Year Renewal of Global Payment Program in Proposed CalAIM 1115 Section 1115 Demonstration

Mr. Sadwith:

On behalf of Arrowhead Regional Medical Center (ARMC), I am writing in strong support of the Department of Health Care Services' (DHCS) proposal to request a five-year renewal of the Global Payment Program (GPP) as part of the CalAIM Section 1115 demonstration renewal application. Since its launch in 2015, the GPP has been a critical program in supporting our ability to provide value-based care to uninsured patients and our financial stability. With fundamental programmatic changes included in the proposed demonstration, a renewal of the GPP would create greater incentives and opportunities to provide preventive and primary care and manage chronic conditions for uninsured patients, supporting ongoing change and the delivery of value-based care at ARMC.

ARMC is the only county hospital and safety-net provider for San Bernardino County, serving more than 2.2 million residents across a 20,000-square-mile region and providing lifesaving care to many of the county's most vulnerable and underserved populations. As a 456-bed tertiary medical center, ARMC operates a Level I trauma center, regional burn center, comprehensive stroke center, a free-standing inpatient behavioral health center, four family health centers, and more than 40 specialty services. A significant portion of the patients served by ARMC are covered by Medi-Cal or are uninsured, making the hospital a critical provider of care for Medi-Cal beneficiaries and patients without a source of coverage throughout the Inland Empire.

Since 2005, California's 17 public hospital systems have leveraged participation in Medi-Cal 1115 waivers to catalyze significant delivery system transformation, resulting in improved quality and patient outcomes, greater efficiencies within our systems, and stronger care coordination efforts for complex and high-risk patients.

The GPP has been a key program in making this transformation possible by creating strong financial incentives for ARMC to shift uninsured services from the emergency department to primary and preventive care settings. The GPP supports this by converting Medicaid Disproportionate Share Hospital funding, which is traditionally limited to reimbursement for more costly, hospital-based and emergency settings to a more flexible, value-based funding methodology that incentivizes low-cost, high-value services.

At ARMC, we have used the flexibility created under the GPP to expand access to preventive, primary, and specialty care services for uninsured patients while reducing reliance on emergency and inpatient settings for avoidable care. GPP funding has supported a broad range of outpatient services, including RN-only visits, primary and specialty care visits, outpatient mental health and substance use treatment, medication-assisted treatment, referrals to dental care, outpatient surgery, and mental health crisis stabilization services. ARMC has also expanded patient support services such as nutritional education, mobile health clinic visits, and telehealth options to improve access to care across our large and geographically diverse county. These investments have strengthened care coordination and enabled earlier intervention for patients with complex needs, while ensuring access to essential inpatient services including medical/surgical care, behavioral health services, intensive care, trauma care, and burn treatment when higher levels of care are required.

Arrowhead Regional Medical Center supports the changes proposed for the GPP in the 1115 renewal, which would further evolve the program by strengthening the focus on preventive care and chronic disease management and adding risk to earning GPP funding in ways that further incentivize preventive care and delivery system transformation.

If renewed, ARMC would continue building on these efforts by further expanding access to outpatient specialty services, increasing mobile health services and telehealth access for rural and underserved communities, and strengthening care coordination to better manage chronic conditions among uninsured patients throughout San Bernardino County.

For over a decade, the GPP has allowed public hospital systems like ARMC to build a solid foundation for change and provide our uninsured patients with greater access to primary and specialty care. A renewal of the program would sustain these changes and allow us to further strengthen our delivery system transformation efforts. It is also especially critical at a time when we are facing steep cuts to our funding in the Medi-Cal program and expect to see an influx of uninsured patients over the next few years.

For all the reasons stated above, **we strongly support the renewal of the GPP through December 31, 2031.** Thank you for your continued partnership to serve California's Medi-Cal and uninsured patients and support the health care safety net.

Res ectfull ,

[redacted]

Andrew Goldfrach, FACHE
Chief Executive Officer
Arrowhead Regional Medical Center

cc: Michelle Baass, Director, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS

Kimia Pakdaman, Alameda County Health, Email received March 10, 2026.

To Whom It May Concern:

Alameda County Health has the following comments related to the recent CalAIM Section 1115 Waiver application published by DHCS:

- Alameda County Health is in support of the new features of this application, including the employment supports and BridgeCare pilots.
- Alameda County Health commends DHCS for continuing the innovative strategies authorized under the Section 1115 Demonstration application. We support the continuation of reentry services for justice-involved populations 90 days pre-release, aligning dually eligible enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan, and limiting plan choice in certain counties.
- Alameda County Health recommends that cost sharing should be no more than 5% of an individual's monthly income, similar to the upcoming 2028 copayment reforms. (reference: page 47 of application)
- Alameda County supports DHCS's plan to combine recuperative care and short-term posthospitalization housing. We are looking forward to hearing the state's plan for recuperative care, as this is a key service in Alameda County that serves some of our most vulnerable residents. Alameda County requests that the services covered under recuperative care be clear and that the new rates adequately cover these services. Additionally, we request that services be covered for people releasing from inpatient stays and preventing people from having inpatient stays, particularly with referrals via street health medicine programs. (reference: page 49 of application)
- Alameda County Health requests that DHCS finds another pathway to fund PATH-like activities. The funding has been key for starting up many services, both provided by the county and by CBOs. In particular, the PATH Collaborative has been key in bringing stakeholders together into a neutral space, not held by MCPs or the County. We encourage finding additional funding for these types of services to encourage streamlined systems and referrals between sectors. (reference: page 50 of application)

Best,
Kimia
Kimia Pakdaman *(she/her)*
Senior Project Manager – Medi-Cal Strategy
Alameda County Health
1000 San Leandro Boulevard, Suite 300
San Leandro, CA 94577
[redacted]
View my availability for meetings here
Health.AlamedaCountyCA.gov

Richard Rawson, Email received March 11, 2026.

Thank you for the opportunity to respond.

I think the Contingency Management for Stimulant Use Disorder Program (Recovery Inventives) is a hidden jewel in this demonstration project.

Contingency Management has an overwhelming amount of research support in the peer reviewed literature and is viewed as the current standard of care for treatment of individuals addicted to cocaine and methamphetamine as noted in the ASAM/AAAP Guideline of Treatment of Individuals who use stimulants.

The work done in the past 3 years as part of this CalAIM project has been remarkably successful and is the first example of CM being "scaled up" to provide an effective treatment for cocaine/methamphetamine dependence. Over 12000 individuals have recieved treatment. They have been effectively retained in treatment and while in treatment have shown dramatically reduced stimulant use,

This Recovery Incentive program should be continued and expanded. Efforts should be made to modify the CM protocol to attract more people into treatment, to make CM more available in rural efforts and bring together representatives of AI/AN and Black populations to increase recruitment of these individuals. Pregnant and post-partum populations should be given more attention and CM should be available in health settings where these people receive care.

The California Recovery Incentive program is a tremendous success. DHCS should bring together experts and providers and consumers to discuss how to futher expand and improve this excellent program.

Professor Emeritus
Department of Psychiatry and Biobehavioral Science
Geffen School of Medicine
UCLA
[redacted]
Research Professor
Vermont Center on Behavior and Health
University of Vermont
[redacted]

Anthony Mazza, Desert Sage Youth Wellness Center, Email received March 10, 2026.

Good afternoon,

Please continue to support this initiative. This will help our American Indian/Alaska Native youth by increasing engagement, addressing historical trauma, strengthening identidy-based recovery, reducing institutional harm, and improving long-term outcomes.

Thank you,
Anthony Mazza
Cahuilla Band of Indians
Health Systems Administrator
Desert Sage Youth Wellness Center
39990 Faure Rd
Hemet, Ca 92544
[redacted]
For more information, please click any of the icons below.

Karen Severns, Indian Health Services, Email received on March 10, 2026.

Please continue with this much needed program for our patients. Thank you!

Karen S. Severns, PsyD, MSW, LCSW, ACADC, ICAADC, CDP, C.C.M.
Behavioral Health Consultant
Health & Human Services
Indian Health Services
Office of Behavioral Health, California Area Office
39990 Faure Road, Hemet, CA 92544
[redacted], Desert Sage

Wendy Wang, Sycamores, Email received March 10, 2026.

Dear DHCS representatives,

My name is Wendy Wang, Chief Public Policy and Advocacy Officer for Sycamores, a nonprofit organization providing a range of mental health treatment, co-occurring substance use services, child welfare programs, case management, school based mental health and educationally related support, and mobile crisis response services in Southern California.

Sycamores wishes to submit its public comment letter on the draft DHCS 1115 Waiver Renewal Application.

Could you kindly respond to this email to confirm receipt of the letter (and that you are able to open the attachment).

Sincerely,
Wendy Wang, MPP
Chief Public Policy and Advocacy Officer
Sycamores

March 9, 2026

Mr. Tyler Sadwith
State Medicaid Director and Chief Deputy Director, Health Care Programs
California, Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: Medicaid Section 1115 Waiver Renewal

Dear Chief Deputy Director Sadwith,

Sycamores is writing to provide public comment in response to Department of Health Care Services' draft Medicaid Section 1115 Demonstration Five-Year Renewal Request. Based in Southern California for over 120 years, Sycamores provides an array of services along the behavioral health continuum of care to children, young adults, and adults. As a nonprofit organization that contracts with local mental health plans and Medi-Cal managed care plans, Sycamores has first-hand experience with CalAIM implementation at the local level, notably behavioral health payment reform and Enhanced Care Management and Community Support (CS) services.

Sycamores supports the overarching vision and guiding principles outlined in the draft Renewal Application. We recognize that the Section 1115 Waiver Renewal is a fundamental vehicle so that California can sustain the reforms made under CalAIM to better meet the holistic needs of Medi-Cal beneficiaries. In partnership with DHCS, local mental health plans, Medi-Cal managed care plans, community-based providers have played a crucial role in the progress made through CalAIM since its launch several years ago. Community-based organizations contracting with local county mental health plans and Medi-Cal managed care plans have expanded the capacity and enriched the network of providers serving Medi-Cal recipients.

Please see the attached matrix for additional questions and observations corresponding to specific sections of the draft 1115 Waiver Renewal.

Thank you for your consideration of our feedback.

Sincerely,

[redacted]

Wendy Wang, MPP
Chief Public Policy and Advocacy Officer

Sycamores
a better life

SECTION/ HEADING	DOCUMENT PAGE #	QUESTIONS OR COMMENTS
DMC/ODS Waiver of IMD Exclusion for SUD services	21	When will DHCS post the companion 1915 (B) renewal document for stakeholder review and public comment?
County Option to Cover Select Outpatient SUD services	22 31	Why is California seeking new authority for Drug Medi-Cal Organized Delivery System (DMC-ODS) counties to "opt in" to cover mobile crisis services when the DHCS is still implementing the Medi-Cal mobile crisis services benefit? Please articulate more clearly the intersection of what DHCS is seeking under this waiver authority with the current mobile crisis services landscape at the state and local levels.
Employment Services	24	Given that the federal H.R. 1 "work" requirements will affect communities statewide, why is CA DHCS proposing employment services as a county "opt in" Medi-Cal benefit instead of offering it as a statewide benefit? We agree with DHCS' request for funding for initial start-up activities.
Section 3.1 Re-Entry Services for Justice Involved Populations 90-Day Pre-release	28	We support the State's request for continuing authority to continue re-entry services for justice involved populations 90-days pre-release.
Section 3.6 Coverage for Out-of-State Former Foster Youth	35	We strongly agree with the State's position to ask for on-going authority to care for this population who turned 18 before January 2023 until they turn 26.
Section 3.12 Employment Services	42	Why is the CA DHCS proposing to pilot provision of Medi-Cal funded Employment Services? Has or will DHCS consult with CA Department of Rehabilitation on this pilot?
Section 3.12 Employment Services Renewal Request	44	The DHCS proposes to ask CMS to waive statewideness to allow Employment Services to be "piloted" in counties by county-based entities. We recommend that community-based organizations be allowed to participate in this pilot. If they are not allowed to participate, please provide justification.


Sycamores
a better life

Dr. Chrisopher Zubiate, Ever Well Health Systems, Email received on March 10, 2026.

My name is Dr. Christopher Zubiate, DHA, MSW, ASW, FACHDM.

With more than 25 years of distinguished service in the behavioral health field, I appear before you today as a recognized content expert in behavioral health delivery, tribal health programs, federal financing mechanisms, and CMS Section 1115 demonstration waiver regulations.

As President of Ever Well Health Systems, LLC in Pismo Beach, California, I provide executive leadership for an integrated behavioral health and residential care organization committed to clinical excellence, operational efficiency, and equitable service expansion across several counties.

Public sources further affirm my standing. The College for Behavioral Health Leadership describes me as “an esteemed leader in health policy, administration, and practice with over two decades of experience serving California’s disenfranchised populations suffering from persistent mental illness,” noting that my “expertise in healthcare administration and clinical social work, combined with my Native American community background, enables

me to drive inclusive, innovative, and cost-effective systems." The National Indian Council on Aging similarly highlights my founding of community education, social, and healthcare agencies and my management of mental health treatment centers and specialty hospital programs focused on individuals experiencing homelessness, incarceration, or institutionalization.


These roles, together with my conference presentations on cultural competence, therapeutic justice, trauma-informed care, and systems integration, as well as my direct experience with Medi-Cal financing models and prior participation in Section 1115 waiver implementations, position me to offer informed, evidence-based perspectives on the CalAIM renewal.

I appreciate the opportunity to contribute to this important public process and look forward to providing detailed testimony on how the proposed renewal can best advance equitable, integrated, and sustainable behavioral health services for all Californians, including tribal communities and those with complex needs. Thank you.

Please review and forward my comments to CMS
Section 3.1 - Reentry Services for Justice-Involved Populations 90-Days Pre-Release:

- Live-In Re-Entry programs should be listed and covered as a Medi-Cal benefit for a minimum of 90-Days POST RELEASE.
- Eligibility without a funded service array after release is akin to an ice cream cone without any ice cream!
- The Modified Therapuetic Community model excels in defining distinct care levels that include "Live-In" and Live-Out" Re-Entry
- See https://crimesolutions.ojp.gov/modified-therapeutic-community-individuals-mental-illness-and-chemical-abuse-mica-disorders-who

Section 3.2 - DMC-ODS: Waiver of the IMD Exclusion for SUD Services:

- Prop 1 forces beleaguered county mental health plans to acknowledge the reality of today's "mental health" population, i.e. full integration of mental health with SUD. This section should not continue to silo providers and treatment that divorces the co-occurring nature of behavioral health disorders.
- The Department should seek NEW authority to eliminate the IMD Exclusion for Medi-Cal members with a serious mental illness and SUD.
- We need contained care that leads to voluntary congregate care where Medi-Cal work requirements can be achieved in community settings.

- Evidence-based models for co-occurring disorder treatment such as the Modified Therapuetic Community should be referenced on page 29.
- See https://pmc.ncbi.nlm.nih.gov/articles/PMC3058619/ and https://www.sciencedirect.com/science/article/pii/S0740547207001018

Section 3.3 - Peer Support Services (Renamed County Option to Cover Select Outpatient SUD Services UnderRenewal):

- The Department needs to identify specific peer workers as a PARAPROFESSIONAL classification in the application.
- Once this workforce is "certified" these people should be considered paraprofessionals and referred to as such.
- See https://pmc.ncbi.nlm.nih.gov/articles/PMC10476060/ and https://doi.org/10.1016/j.wpsyc.2012.05.009
- Furthermore, the application should include culturally responsive peer support services for tribal and Native American communities aligned with the Indian Health Service Community Health Aide Program (CHAP) and seek federal funding.
- https://tribalselfgov.org/wp-content/uploads/2021/09/TSGAC-Issue-Brief_CHAP_v5_final_09_24_2021.pdf and https://www.ihs.gov/chap/fundingresources/

Section 3.5 - Traditional Healers and Natural Helpers:

- Traditional healing services should be open to Native American and Tribal Medi-Cal members for a full spectrum of behavioral health diagnoses.
- Again, this section should not continue to silo providers and treatment that divorces the co-occurring nature of behavioral health disorders.
- Limits to behavioral health services for SUD diagnoses perpetuates the "drunken Indian" stereotype and grossly denies etiology of generational trauma, loss, and marginalization associated with post-colonial atrocities and modern system failures.
- Reference: Tribal and Indian Health Program Representatives Meeting 2022 - CalAIM Implementation https://www.dhcs.ca.gov/Documents/Tribes-and-Indian-Health-Program-Representatives-Meeting-Presentation-02-24-22.pdf
- See https://pmc.ncbi.nlm.nih.gov/articles/PMC2913884/pdf/nihms191064.pdf and https://pmc.ncbi.nlm.nih.gov/articles/PMC11885593/ and https://www.ihs.gov/sites/chap/themes/responsive2017/display_objects/documents/tpifunding/chaptpilogicmodel2629.pdf

Section 3.13 - BridgeCare Pilot

- Home and Community Based Services (HCBS) should broadly include integrated behavioral and general medical care. Examples shared in this section should specifically reference the following terms, "Medicaid Care Homes" / "Behavioral Health Care Homes" / "Comprehensive Health Integration Framework (CIF) from The National Council.

- See https://pmc.ncbi.nlm.nih.gov/articles/PMC7863583/ and https://www.thenationalcouncil.org/resources/the-comprehensive-health-integration-framework/

Section 4 - Community-Based Adult Services:

- The 1915(i) state plan needs to cover facility-based programs that include integrated behavioral health and general medical care for all Medi-Cal members.
- Furthermore, upon establishment as a state entitlement, the Department should take complete licensing authority away from DSS Community Care Licensing as this constitutes a reimbursable Medi-Cal benefit that should be supported and monitored by healthcare regulators. This will align services to health outcomes and reduce the potential for waste, fraud, and abuse.
- Certification of the MCO tax to fund Medi-Cal services further establishes the need to coordinate and regulate all health and behavioral health care services within the Department, i.e. DHCS cannot spend MCO tax revenue on CBAS and at the same time allow DSS to monitor their providers.
- See https://www.dhcs.ca.gov/services/Documents/1903w3B-and-C-MCO-Tax-2023-2026-Amendment.pdf for CMS letter dated December 20, 2024 outlining concerns over consistency with the 1993 final rule, 58 Fed. Reg. 43156.

DMC-ODS Goals 1 through 8

1. EXPAND this goal beyond SUD to include CO-SUD identification, initiation, initiation, and engagement
2. NO COMMENT
3. AMEND to include “opioid-laced” substances
4. NO COMMENT
5. EXPLORE potential of co-morbid behavioral health conditions contributing to readmission.
6. NO COMMENT
7. SPECIFY workforce development activities tied to treatment capacity expansion.
8. DESCRIBE cost effectiveness in terms of measures that have actionable effect, i.e. ADOPT a logic model to drive beneficiary outcomes.

- See https://www.naccho.org/uploads/downloadable-resources/LMQuickGuide.pdf and https://www.researchgate.net/publication/254357736_The_Logic_Model

Kind Regards,

Dr. Christopher Zubiate, DHA, MSW, FACHDM
President & CEO, Ever Well Health Systems
310 James Way, Suite 250
Pismo Beach, CA 93449
[redacted]

Mary Rivers, Code Tenderloin, Email received March 10, 2026.

Good Afternoon,

You will find the public comment below for Code Tenderloin in SF.
Please let us know if you have any questions.

Warm Regards,
Mary Rivers
Chief Operations Officer
[redacted]
https://www.codetenderloin.org/
Code Tenderloin removes barriers that keep people from securing long term employment — Donate today https://www.codetenderloin.org/donate.

Public Comment from Code Tenderloin in Support of the CalAIM 1115 Demonstration Renewal

Code Tenderloin respectfully submits this comment in strong support of the five-year renewal of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration. As a community-based organization serving individuals experiencing homelessness, poverty, and systemic barriers in San Francisco's Tenderloin neighborhood, we see every day how CalAIM's focus on whole-person care and coordinated services helps reach people who have historically been left out of traditional systems of care.

Many of the individuals we serve live in SRO housing, shelters, or on the street and face overlapping challenges related to behavioral health, chronic illness, trauma, and economic instability. CalAIM has helped strengthen coordination between healthcare providers and community organizations, allowing services to address the root causes of poor health—including housing instability, lack of employment opportunities, and disconnection from care.

Code Tenderloin also supports the proposed BridgeCare Pilots and Employment Supports initiatives. These efforts recognize that stability, economic mobility, and meaningful employment are directly connected to improved health outcomes. Programs that help individuals build skills, secure jobs, and maintain stability play a critical role in long-term recovery and dignity for people experiencing persistent poverty and homelessness.

We encourage the Department of Health Care Services to continue prioritizing partnerships with community-based organizations that are trusted within the communities they serve. Continued investment in care coordination, housing supports, and workforce pathways will help ensure that CalAIM continues to advance health equity and stability for Medi-Cal members across California.

Sincerely,

Code Tenderloin
55 Taylor Street
San Francisco, CA 94102

hello@codetenderloin.org

Darla Clark, Chapa-De Indian Health, Email received March 10, 2026.

Dear DHCS,

Please see that attached letter regarding the CalAIM Section 1115 Waiver and Traditional Healers.

Thank you.
Darla Clark MPA
Chief Operations Officer
Chapa-De Indian Health
[redacted]
chapa-de.org
We acknowledge that we are on the traditional lands of the Nisenan, Miwok and Maidu, past and present, and honor with gratitude the land itself and the Nisenan, Miwok and Maidu people.

CHAPA-DE
INDIAN HEALTH

March 10, 2026

Subject: Tribal Comments on DHCS Notice of Intent to Submit Renewal of the CalAIM Section 1115 Demonstration

Dear Director Baass and Director Sadwith:

On behalf of Chapa-De Indian Health Program, Inc., we submit the following comments in response to the Department of Health Care Services' (DHCS) February 10, 2026 Notice of Intent to Submit a Renewal of the CalAIM Section 1115 Demonstration.

Traditional Healers and Natural Helpers

While Chapa-De Indian Health currently operates within a county that participates in the Drug Medi-Cal Organized Delivery System (DMC-ODS), the existing structure of the Traditional Healer and Natural Helper benefit remains overly limited. Restricting eligibility to individuals with a substance use disorder (SUD) diagnosis and confining service delivery to DMC-ODS unnecessarily constrains the full value of traditional healing practices.

Traditional healing is inherently holistic and supports wellness, prevention, chronic disease management, behavioral health integration, and cultural continuity. These services should not be restricted solely to SUD treatment.

Statewide and Equitable Access

Even for Tribal programs currently included in DMC-ODS, access remains uneven across the state. All Tribal communities deserve equitable access to culturally grounded services, regardless of county-level behavioral health infrastructure.

DHCS should ensure statewide availability of Traditional Healer and Natural Helper services for all Tribal Health Programs.

Reimbursement Structure and Tribal Sovereignty

The current county-by-county reimbursement approach places an unnecessary administrative burden on Tribal Health Programs and undermines Tribal sovereignty. A centralized reimbursement mechanism—like Tribal Medicaid Administrative Activities or the CRIHB Options–Uncompensated Care model—would streamline implementation and promote consistent access statewide.

CHAPA-DE
INDIAN HEALTH

Chiropractic Services and Uncompensated Care

We support DHCS's proposal to continue reimbursement for chiropractic services provided by Indian Health Service and Tribal facilities. However, uncompensated care under the 1115 waiver must not be limited solely to chiropractic services.

Any Medi-Cal optional benefits that are reduced or eliminated under the Indian Health Service Memorandum of Agreement (IHS MOA) must remain eligible for reimbursement under the CRIHB Options–1115 Waiver uncompensated care program, including but not limited to dental, podiatry, audiology, and speech therapy services.

We urge DHCS to:

- Provide statewide authority for Traditional Healer and Natural Helper services;
- Allow Tribal Health Programs to offer these services regardless of county DMC-ODS status; and
- Ensure that rural Tribal communities are not excluded from culturally essential care.
- Expand eligibility to all Medi-Cal members receiving care at Indian Health Programs, regardless of diagnosis; and
- Create a streamlined reimbursement mechanism.

Conclusion

Chapa-De Indian Health supports renewal of the CalAIM Section 1115 Demonstration and urges DHCS to ensure that Traditional Healer and Natural Helper services are equitably available, culturally responsive, and implemented in a manner that respects Tribal sovereignty.

Sincerely,

[redacted]

Darla Clark
Chief Operations Officer

Auburn Health Center 11670 Atwood Road Auburn, CA 95603 (530) 887-2800
Grass Valley Health Center 1350 East Main Street Grass Valley, CA 95945 (530) 477-8545

Virginia Hedrick, CRIHB, Email received on March 10, 2026.

Dear DHCS CalAIM Section 1115 Demonstration Team,

On behalf of the California Rural Indian Health Board (CRIHB), please find attached Tribal Comments in response to the DHCS Notice of Intent to Submit the Renewal of the CalAIM Section 1115 Demonstration.

CRIHB appreciates the opportunity to provide comments and looks forward to continued collaboration with DHCS to ensure the renewal reflects the needs and priorities of American Indian and Alaska Native communities and Tribal health programs.

Please do not hesitate to contact us if you have any questions or need additional information.

Virginia Q Hedrick, MPH (Yurok/Karuk)
Chief Executive Officer
California Rural Indian Health Board
[redacted]

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

March 9, 2026

Subject: Tribal Comments on DHCS Notice of Intent to Submit Renewal of the CalAIM Section 1115 Demonstration

Dear Director Baass and Director Sadwith:

On behalf of the California Rural Indian Health Board (CRIHB), representing 70 member Tribes and 20 Tribal health systems. CRIHB appreciates DHCS's ongoing government-to-government engagement and its recognition of the requirement to seek Tribal advice on Medi-Cal matters that directly affect American Indian and Alaska Native (AIAN) beneficiaries, Indian Health Programs (IHPs). We also commend DHCS for proposing to continue—and potentially expand—several CalAIM initiatives that are critical to advancing health equity and culturally responsive care for Tribal communities.

Traditional Healers and Natural Helpers

CRIHB strongly supports DHCS's proposal to renew federal authority for Traditional Healer and Natural Helper services, as outlined in the notice, and we appreciate DHCS's stated intent to **retain flexibility to cover these services for conditions beyond substance use disorder (SUD) and across additional delivery systems**. As DHCS develops the final renewal application for submission to the Centers for Medicare & Medicaid Services (CMS), CRIHB offers the following recommendations to ensure this benefit is implemented in a manner that fully realizes its potential for AIAN communities:

1. **Broaden Eligibility Beyond SUD and DMC-ODS**
   While California has made important progress by securing approval to reimburse Traditional Healer and Natural Helper services for Medi-Cal members experiencing SUD through the Drug Medi-Cal Organized Delivery System (DMC-ODS), the current scope remains too limited.

Traditional healing practices are inherently holistic and support wellness, prevention, healing, and cultural connection across the full continuum of care. Restricting access to individuals with an SUD diagnosis does not reflect the role these practices play in chronic disease management, behavioral health integration, preventive care, and community well-being.

1020 Sundown Way, Roseville, CA 95661
Phone: 916-929-9761 · Fax: 916-771-9470 · www.crihb.org

CRIHB urges DHCS to operationalize the flexibility referenced in the notice by allowing **all Medi-Cal members receiving care at an Indian Health Program** to access Traditional Healer and Natural Helper services, regardless of diagnosis or delivery system.

2. **Ensure Statewide Access for Tribal Communities**
   Limiting Traditional Healer and Natural Helper services to DMC-ODS counties perpetuates geographic inequities and prevents many Tribal communities from accessing culturally grounded care. All Tribes and Tribal health programs—regardless of whether a county participates in DMC-ODS—should be able to offer these services.

CRIHB recommends that DHCS ensure statewide access so that all AIAN Medi-Cal beneficiaries can benefit equitably.

3. **Implement a Centralized Reimbursement Approach that Upholds Tribal Sovereignty**
   As currently structured, reimbursement for Traditional Healer and Natural Helper services relies heavily on county-level processes, which are administratively burdensome, fragmented, and inconsistent with principles of Tribal sovereignty. Requiring individual county engagement significantly delays implementation—even for IHPs that have already completed DHCS approval—and places unnecessary strain on local agencies.

CRIHB recommends that DHCS establish a **centralized reimbursement mechanism**, similar to Tribal Medicaid Administrative Activities or the CRIHB Options–Uncompensated Care model, to streamline implementation, reduce administrative barriers, and strengthen government-to-government relationships between the State and Tribes.

Chiropractic Services and Uncompensated Care for Medi-Cal Optional Benefits

CRIHB also appreciates DHCS's proposal to continue reimbursement for chiropractic services provided by Indian Health Service and Tribal facilities, which is essential for ensuring that Tribal Health Programs enrolled as IHS Memoranda of Agreement (MOA) clinics can continue to serve their communities. CRIHB seeks explicit assurance that uncompensated care under the 1115 waiver is not limited solely to chiropractic services.

Tribal Health Programs must retain the right to full reimbursement for all Medi-Cal optional benefits provided to eligible beneficiaries, even if those benefits are reduced or eliminated elsewhere in the Medi-Cal program due to budgetary or policy changes.

Waiver language should clearly ensure that any Medi-Cal optional benefits that are no longer reimbursable under the IHS MOA covered services—including, but not limited to, dental, chiropractic, podiatry, audiology, and speech therapy services—remain eligible for reimbursement under the CRIHB Options–1115 Waiver uncompensated care program, regardless of whether a Tribal Health Program operates as an IHS MOA clinic or a Tribal Federally Qualified Health Center.

Support for Renewal of Other CalAIM Authorities

Finally, CRIHB strongly supports DHCS's proposal to renew the full set of CalAIM Section 1115 waiver authorities described in the notice, including Reentry Services, Recovery Incentives, Community Supports, and other initiatives that are critical to maintaining CalAIM's momentum. Preserving these authorities is essential to sustaining progress toward a more coordinated, person-centered, and equitable Medi-Cal delivery system.

We remain committed to working with DHCS to ensure that Traditional Healer and Natural Helper services—and all renewed waiver authorities—are implemented in a manner that is equitable, culturally responsive, and grounded in respect for Tribal sovereignty.

Sincerely,

[redacted]

Virginia Q. Hedrick, MPH (Yurok/Karuk)
Chief Executive Officer
California Rural Indian Health Board, Inc

Deborah Villanueva, American Indian Counseling Center, Email received on March 10, 2026.

Hello CalAIM 1115 Waiver Team,

Thank you for the opportunity to submit comments regarding the proposed renewal of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration being developed by the California Department of Health Care Services for submission to the Centers for Medicare & Medicaid Services.

I am writing from the perspective of a behavioral health clinical supervisor working within a county program that serves American Indian and Alaska Native individuals and families, including youth, adults, and elders living in urban communities. Our work is closely connected with Tribal communities, Urban Indian Organizations, and culturally grounded providers who support Indigenous populations navigating complex behavioral health and social needs.

Overall, I strongly support the renewal of the CalAIM Section 1115 Demonstration and the continuation of initiatives that aim to build a more coordinated, person-centered, and culturally responsive Medi-Cal system. Several of the proposed components have particular significance for American Indian and Alaska Native communities and represent important progress in addressing long-standing disparities in behavioral health access and outcomes.

One of the most meaningful elements of the renewal is the continuation of Traditional Healer and Natural Helper services. For many Indigenous communities, healing is understood through a holistic framework that integrates spiritual, emotional, physical, and relational well-being. Traditional healers, cultural practitioners, elders, and natural helpers play a central role in restoring balance and supporting recovery within families and communities.

Recognizing and reimbursing these services within Medi-Cal helps bridge the historical divide between Western clinical systems and Indigenous healing traditions. When traditional healing is integrated into behavioral health systems, individuals are more likely to engage in care, remain connected to services, and experience healing that reflects their cultural identity and community values.

While the continuation of Traditional Healer and Natural Helper services for substance use disorder treatment is an important step, I strongly encourage the Department to expand these services beyond SUD treatment to include broader behavioral health conditions. American Indian and Alaska Native communities frequently seek traditional healing to address trauma, grief, depression, anxiety, suicide prevention, historical trauma, and community-wide healing following violence or loss. Restricting these services to substance use treatment alone does not fully reflect how health and healing

are understood in Indigenous cultures.

Expanding the authority for traditional healing across behavioral health conditions would allow Tribal health programs, Urban Indian Organizations, and county partners to implement more culturally congruent care models that address the full spectrum of mental health and wellness needs.

Additionally, continued Tribal consultation and partnership will be essential as these initiatives move forward. Tribal health programs and Urban Indian Organizations possess deep cultural knowledge and community trust, and their leadership should remain central to the design, implementation, and evaluation of traditional healing services within Medi-Cal.

Operational guidance will also be critical. Counties and managed care plans will benefit from clear direction regarding how traditional healing services can be incorporated into behavioral health delivery systems, including billing pathways, collaboration models with traditional practitioners, and culturally informed training for providers. Technical assistance in this area would help ensure that the intent of this policy translates into meaningful access for Indigenous communities.

I also want to express strong support for several additional initiatives proposed for continuation, including justice-involved reentry services, peer support services, recovery incentives for stimulant use disorder, and community-based care models. These programs address many of the systemic barriers that disproportionately affect American Indian and Alaska Native populations, including high rates of trauma exposure, involvement with the justice system, and limited access to culturally responsive care.

The continuation of these initiatives, combined with stronger integration of traditional healing practices, represents an important opportunity to advance equity within California's Medi-Cal system and support healing within Indigenous communities.

Thank you again for the opportunity to provide comments on the CalAIM Section 1115; I appreciate the Department's continued commitment to working in partnership with Tribal governments, Indian Health Programs, and Urban Indian Organizations to strengthen culturally grounded approaches to health and behavioral health care.

Kind regards,
Dr. Deborah Villanueva, DSW,MSW, LCSW
Pronouns (She/ Her/ Hers/ Ella)
Mental Health Clinical Supervisor
Prevention and Early Intervention Program
DMH LGBTQIA2-S+ Champion SPA 7
LA County Sexual Assault Councilmember (LAC SAC)

American Indian Counseling Center
10330 Pioneer Blvd., Ste 215
Santa Fe Springs, Ca 90670
[redacted]
Fax: (562) 467-7478
[redacted]
LACDMH_logo_color_300x_png
American Indian Counseling Center acknowledges our presence on the traditional, ancestral and unceded territory of the Gabrielino/Tongva peoples

Davina Cohanghadosh, Jewish Family Service LA, Email received on March 10, 2026.

Good afternoon,

Please find attached comments from Jewish Family Service LA (JFSLA) regarding the CalAIM Section 1115 Demonstration Renewal Application.

Thank you for the opportunity to provide input. Please do not hesitate to reach out if you have any questions.

Best regards,
Davina
Davina Cohanghadosh
Senior Public Policy Associate
[redacted]
jfsla.org
JFS Gunther-Hirsh Family Center
330 N. Fairfax Avenue
Los Angeles, CA 90036

JEWISH FAMILY SERVICE LA

March 10, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
Submitted via email to: 1115waiver@dhcs.ca.gov

Re: CalAIM Section 1115 Demonstration Renewal Application

Dear Director Sadwith:

On behalf of Jewish Family Service LA (JFSLA), I am writing to commend DHCS for moving forward to extend the successful initial CalAIM 1115 Medicaid Waiver for California. We have seen the positive impact the CalAIM 1115 waiver components related to housing services have had on Medi-Cal members experiencing homelessness. These initiatives have helped thousands obtain the supports needed to secure housing and stabilize in permanent homes. While the proposed CalAIM 1115 Waiver for 2027–2031 includes several changes to Medi-Cal, our comments focus specifically on the proposed new BridgeCare Pilots.

The BridgeCare Pilot is essentially an extension of the Medi-Cal waiver Multipurpose Senior Services Program (MSSP) model to support individuals who are near Medi-Cal eligible. JFSLA was one of the original MSSP pilot sites more than 45 years ago and remains one of the largest MSSP providers in the state, serving 825 individuals this past year. MSSP provides comprehensive, clinically driven care management, including professional nursing, social work, and direct supportive services to frail older adults so they may remain safely in their homes and communities. Over the past decades, JFSLA has provided intensive MSSP care management services to more than 10,000 frail older adults. Through coordinated care planning, case management, and targeted supports, MSSP has demonstrated tremendous success in reducing unnecessary institutionalization and stabilizing frail, low-income older adults in the community.

The proposed BridgeCare Pilot will ensure that older adults near MediCal eligible have the same access to the critical services they need to remain living at home in their communities, improving their health and quality of life, and preventing insitutionalization. As noted in the 1115 Waiver application, less than 25% of individuals in the older adult population nearing Medi-Cal eligibility have the resources to address their health challenges. Without adequate resources to address health care needs, including homecare, older adults are at risk of having to choose between paying for health care and paying their housing. BridgeCare offers much needed care at the right time in the right place (at home in their community) for older adults living with “three or more chronic conditions and mobility limitations” who are at increased risk of homelessness.

We fully support and commend the intention of BridgeCare to help older adults remain in their homes, prevent costly institutionalization and impoverishment, and improve health outcomes.

JEWISH FAMILY SERVICE LA

While JFSLA supports the current list of core services that would apply to all pilot sites, we believe that some discretionary services should be included as core services, based on our experience providing MSSP services to a similar population. In particular, nutritional services that are not covered under other Community Supports, and transportation services, are critical to helping individuals safely remain in their homes.

Thank you for the opportunity to provide our comments. If you have any questions, please feel free to contact Lisa Shuger Hublitz, Senior Director of Public Policy and Government Relations at [redacted]

Sincerely,

[redacted]

Eli Veitzer
President and CEO

Nancy Majewski, Natividad, Email received on March 11, 2026.

Hi,

Please see the attached letter of support from Natividad CEO, Dr. Charles Harris, for the CalAIM Section 1115 Demonstration Renewal Application. Please contact us if you have any questions. Thank you.

Nancy Majewski, Director of Managed Care
MANAGED CARE/FINANCIAL COUNSELING
[redacted]| www.natividad.com

Natividad
Inspiring healthy lives.

March 10, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Submitted via: 1115waiver@dhcs.ca.gov

Subject: Support for Five-Year Renewal of the Global Payment Program in the Proposed CalAIM 1115 Section 1115 Demonstration

Dear Mr. Sadwith,

On behalf of Natividad Medical Center, I am writing in strong support of the Department of Health Care Services' (DHCS') proposal to request a five-year renewal of the Global Payment Program (GPP) as part of the CalAIM Section 1115 demonstration renewal application. Since its launch in 2015, the GPP has been a critical program in supporting our ability to provide value-based care to uninsured patients and our financial stability. With fundamental programmatic changes included in the proposed demonstration, a renewal of the GPP would create greater incentives and opportunities to provide preventive and primary care and manage chronic conditions for uninsured patients, supporting ongoing change and the delivery of value-based care at Natividad.

Natividad is the only Level II Trauma Center in Monterey County and is Monterey County's only teaching hospital. Our three-year UCSF affiliated family medicine residency program graduates 10 new physicians each year. Additionally, Natividad trains nursing students, laboratory technicians, and OB techs, etc. Natividad has the only locked inpatient Mental Health Unit in the county. Our Acute Rehabilitation Center is ranked in the top 10% of acute rehabilitation facilities in the country and has been for 7 consecutive years. Natividad has highly qualified interpreters on staff which includes indigenous languages. In 2025, Natividad was awarded the Gage Award Top Quality Improvement Honor by America's Essential Hospitals, a network of more than 350 public hospitals. Natividad had over 11,200 inpatient admissions, over 59,000 emergency visits, over 4,900 outpatient surgeries and approximately 87,500 outpatient visits last fiscal year. Our D'Arrigo Family Specialty Services offers a wide range of specialty care, including comprehensive women's health program, Cardiology, Neurology, Orthopedics, Podiatry, Pulmonary Medicine, and Lactation services. Over 50% of our patients are covered by Medi-Cal.

Since 2005, California's 17 public hospital systems have leveraged participation in Medi-Cal 1115 waivers to catalyze significant delivery system transformation, resulting in improved quality and patient outcomes, greater efficiencies within our systems, and stronger care coordination efforts for complex and high-risk patients.

The GPP has been a key program in making this transformation possible by creating strong financial incentives for Natividad to shift uninsured services from the emergency department to primary and preventive care settings. The GPP supports this by converting Medicaid Disproportionate Share Hospital funding, which is traditionally limited to reimbursement for more costly, hospital-based and emergency settings to a more flexible, value-based funding methodology that incentivizes low-cost, high-value services.

At Natividad, we have used the flexibility created under the GPP to provide the uninsured with preventative, diagnostic and disease management healthcare services. This is done through office visits at the County of Monterey FQHCs and diagnostic services and specialty clinic visits at Natividad. These services are critical for the community, and the community would like to have these services expanded.

Natividad supports the changes proposed for the GPP in the 1115 renewal, which would further evolve the program by strengthening the focus on preventive care and chronic disease management and adding risk to earning GPP funding in ways that further incentivize preventive care and system transformation.

For over a decade, the GPP has allowed public hospital systems like Natividad to build a solid foundation for change and provided our uninsured patients with greater access to primary and specialty care. A renewal of the program would sustain these changes and allow us to further strengthen our delivery system transformation efforts. It is also especially critical at a time when we are facing steep cuts to our funding in the Medi-Cal program and expect to see an influx of uninsured patients over the next few years.

For all of the reasons stated above, **we strongly support the renewal of the GPP through December 31, 2031.** Thank you for your continued partnership to serve California's Medi-Cal and uninsured patients and support the health care safety net.

Sincerely,

[redacted]

Charles Harris MD

CEO

Cc: Michelle Baass, Director, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS

Katherine Kelly, On Lok, Email received March 11, 2026.

Good morning,

On behalf of On Lok, I am pleased to submit the attached comment letter regarding the CalAIM Section 1115 Demonstration Renewal Application.

Thank you,
Katherine
Katherine Kelly (she/her/hers)
DIRECTOR OF GOVERNMENT AFFAIRS • ON LOK
1333 Bush Street, San Francisco, CA 94109
Website: www.onlok.org
[redacted]

March 11, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Submitted via email: 1115waiver@dhcs.ca.gov

Re: CalAIM Section 1115 Demonstration Renewal Application

Dear Director Sadwith,

On Lok is pleased to submit this letter in support of extending California's CalAIM Section 1115 Demonstration Renewal Application, particularly the continuation of Enhanced Care Management (ECM) and Medically Tailored Meals (MTM) under Community Supports.

For 55 years, On Lok has advocated for underserved seniors and provided a comprehensive range of services that enable older adults to age with dignity in their homes and communities, including access to safe and affordable housing. On Lok is a family of nonprofit organizations founded in San Francisco in response to a community need. We founded the Program of All-Inclusive Care for the Elderly (PACE) model and today serve more than 2,000 frail seniors across San Francisco, Southern Alameda, and Santa Clara counties. In addition to PACE, On Lok serves more than 5,000 active older adults annually through the On Lok 30th Street Senior Center — San Francisco's largest multipurpose senior center.

Since 2023, On Lok has contracted with San Francisco Health Plan to provide ECM and MTM to Medi-Cal members with complex medical and social needs. The waiver has enabled the state to implement transformative delivery system reforms centered on whole-person care, care coordination, and addressing health-related social needs. These reforms are particularly critical for low-income seniors and individuals with multiple chronic conditions who rely on Medi-Cal for access to comprehensive, coordinated services.

ECM has proven to be an essential benefit for high-need populations. ECM strengthens coordination across physical health, behavioral health, long-term services and supports, and community-based providers. For seniors with complex conditions, housing instability, or frequent hospital utilization, ECM reduces fragmentation, improves care transitions, and helps prevent avoidable emergency department visits and hospitalizations. The continuation

of ECM under renewed waiver authority is essential to maintaining continuity of care and improving health equity.

MTM similarly addresses the critical intersection between nutrition and health. Many Medi-Cal seniors experience food insecurity alongside chronic illnesses such as diabetes, heart disease, and pulmonary conditions. MTM provides clinically appropriate meals designed to support disease self-management, stabilize chronic conditions, and improve health outcomes. Early evidence demonstrates that medically tailored nutrition interventions can reduce hospitalizations and overall healthcare costs while improving quality of life. For frail seniors living alone, these services are not ancillary — they are foundational to maintaining health and independence.

Together, ECM and MTM represent practical, evidence-based strategies that align with CalAIM's goals of improving outcomes, advancing health equity, and responsibly managing public resources. For organizations like On Lok, these services complement and strengthen the integrated care model that has defined PACE for decades.

We also want to acknowledge our appreciation for the state exploring creative solutions to serve older adults who don't qualify for Medi-Cal, but who could benefit from long-term services and supports. While the BridgeCare Pilot is an important step in that direction, we are concerned about how many counties will be able to take advantage of this program. We are particularly concerned about the cost sharing requirements given immediate and future budget pressures counties are facing due to budget cuts and H.R. 1. In addition, since this is a voluntary program with significant cost-sharing, we perceive that county participation will greatly vary, resulting in inequitable access to these services solely based on where an older adult resides. Lastly, it is important to consider the eligibility criteria for this program and whether it will reach the intended population. Requiring Medicare enrollment as a condition of participation may limit access for near-eligible older adults who are not enrolled in Medicare, and individuals enrolled in Medi-Cal with a prohibitive Share of Cost may result in a continued gap in services for the population this pilot is intended to reach.

We appreciate your leadership and the opportunity to provide input on this important matter.

Sincerely,

[redacted]

Grace Li
Chief Executive Officer
On Lok

P: 415-292-8888
F: 415-292-8745
1333 Bush Street,
San Francisco, CA 94109-5611
www.onlok.org

Asher Rokowsky, Oxford Health Group, March 11, 2026.

Dear dhcs, My company in California operates a few thousand ALW /cal aim ALF beds as well as a few hundred recuperative care beds.

Recuperative Care has barely seen any rate increase in the last five years and it's gotten really tough to stay open. To cut rates any more or increase costs would absolutely cause beds to close down or harm the overall patient experience and outcomes.
We strongly agree with NIMRC's recommendation below.

- NIMRC strongly believes the Recuperative Care Community Support is most appropriate for the Section 1115 waiver. However, we understand that by moving away from temporary waiver authority and into the established ILOS framework—whether it be the 1915(b) or 1915(i)—these vital services are "enshrined in federal Medicaid managed care regulations" and may position recuperative care as a more stable Medicaid option long-term.
- NIMRC is gravely concerned about the loss of reimbursement for room and board services, which is a core component of recuperative care. NIMRC strongly suggests that DHCS identify a funding alternative to reimburse room and board costs for recuperative care programs, which we've estimated to be $66-$92 per day, based on a sampling of providers. Avenues that NIMRC has considered include state-funded wrap-around payments, MCP Community Reinvestment Funds, and Proposition 1 funds.
- We urge DHCS to reconsider implementing an LVN staffing requirement in favor of a model based on the NIMRC Certification program and competency-based training.
- As DHCS seeks to create a model for recuperative care that incorporates the levels of care offered under both recuperative care and STPHH—while sunsetting the latter as a separate Community Support—NIMRC requests that DHCS utilize the existing NIMRC Models of Medical Respite Care as the foundation for the creation of tiers of recuperative care services. Using these established Models of Care will provide a familiar framework for determining a program's model, level of services and subsequent reimbursement rate.

Asher Rokowsky
Principal
[redacted]
F: 323-475-1826
[redacted]
4221 Wilshire Blvd. Suite 392, Los Angeles CA 90010
www.oxfordhealthgroup.com

Talaya Arias, Toiyabe Indian Health Project Inc, Email received March 10, 2026.

Good afternoon,

Please see attachment with Toiyabe Indian Health Project Inc.'s comments in response to the DHCS' Notice of Intent to Submit a Renewal of CalAIM Section 1115 Demonstration.

Thank you.
Talaya Arias | Executive Assistant to the CEO and BOD
Toiyabe Indian Health Project, Inc. | 250 SeeVee Ln, Bishop, CA, 93514
[redacted]

TOIYABE INDIAN HEALTH PROJECT, INC.
250 SEE VEE LANE
BISHOP, CALIFORNIA 93514

March 9, 2026

Dear Director Baass and Director Sadwith:

On behalf of Toiyabe Indian Health Project, Inc., we submit the following comments in response to the Department of Health Care Services' (DHCS) February 10, 2026 Notice of Intent to Submit a Renewal of the CalAIM Section 1115 Demonstration.

While we appreciate DHCS's efforts to renew CalAIM authorities, we must express serious concern regarding the continued exclusion of our Tribal Health Program from access to Traditional Healer and Natural Helper services due solely to our county's non-participation in the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Discriminatory Impact on Rural Tribal Health Programs

Toiyabe Indian Health Project Inc., is located in a rural area of California and is not served by a DMC-ODS county. As a result, DHCS's current structure **categorically excludes our program and our patients from accessing Traditional Healer and Natural Helper services**, despite explicit recognition that these services benefit AIAN communities.

This exclusion is not based on clinical need, program readiness, or Tribal eligibility. Instead, it is based solely on geographic location—a factor outside of Tribal control. As applied, this policy discriminates against rural Tribal Health Programs and perpetuates inequities between urban and rural Tribal communities.

Traditional Healing Is Not County-Dependent

Traditional Healer and Natural Helper services are rooted in Tribal culture, not county behavioral health systems. Conditioning access to these services on DMC-ODS participation elevates county infrastructure over Tribal sovereignty and creates an inequitable, two-tiered system of care for AIAN Medi-Cal beneficiaries.

Failure to Operationalize DHCS's Stated Flexibility

The Notice indicates DHCS seeks to "retain flexibility to cover these services for other conditions beyond SUD and for other delivery systems." However, without explicit statewide implementation, that flexibility remains theoretical and inaccessible to Tribal Health Programs like ours.

ADMINISTRATION
(760) 873-8464
(760) 873-3935 FAX

FISCAL
(760) 873-6111
(760) 872-8152 FAX

CONTRACT CARE
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OPTICAL
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BISHOP MEDICAL CLINIC
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(760) 873-4721
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DENTAL
(760) 873-3443
(760) 873-3889 FAX

COMMUNITY HEALTH/
NUTRITION/ELDERS
(760) 872-2622
(760) 873-6362 FAX

PREVENTIVE MEDICINE
(760) 873-8851
(760) 873-4922 FAX

FAMILY SERVICES DEPARTMENT
(760) 873-6394
(760) 873-3254 FAX

DIALYSIS CENTER
(760) 873-7611
(760) 873-3361 FAX

WIC PROGRAM
(760) 872-3707
(760) 873-6362 FAX

LONE PINE COMMUNITY CLINIC
1150 S. GOODWIN LANE
P. O. BOX 186
LONE PINE, CA 93545
(760) 876-4795
(760) 876-5624 FAX

COLEVILLE CLINIC
73 CAMP ANTELOPE RD.
COLEVILLE, CA 96107
(530) 495-2100
(530) 495-2122 FAX

Traditional healing is inherently holistic and supports wellness, prevention, chronic disease management, behavioral health integration, and cultural continuity. These services should not be restricted solely to SUD treatment.

Centralized Reimbursement and Equity

Requiring Tribal Health Programs to rely on county participation creates fragmented implementation and entrenches inequities. DHCS should adopt a centralized reimbursement approach that allows Tribal Health Programs to directly access reimbursement for Traditional Healer and Natural Helper services, independent of county systems.

We urge DHCS to:

- Provide statewide authority for Traditional Healer and Natural Helper services;
- Allow Tribal Health Programs to offer these services regardless of county DMC-ODS status; and
- Ensure that rural Tribal communities are not excluded from culturally essential care.
- Expand eligibility to all Medi-Cal members receiving care at Indian Health Programs, regardless of diagnosis; and
- Create a streamlined reimbursement mechanism.

Conclusion

Toiyabe Indian Health Project Inc. urges DHCS to correct the discriminatory impact of the current waiver structure and ensure that rural Tribal Health Programs are not excluded from CalAIM benefits solely due to geography.

Equitable access to Traditional Healer and Natural Helper services is not optional—it is essential to fulfilling Medi-Cal's obligation to AIAN communities and honoring government-to-government responsibilities.

Sincerely,

[redacted]

Earl Lent, III
CEO
Toiyabe Indian Health Project, Inc.

Allie Budenz, California Primary Care Association, Email received March 11, 2026.

Dear Mr. Sadwith,

On behalf of the California Primary Care Association (CPCA), representing nearly 2,300 community health center (CHC) sites across the state, we appreciate the opportunity to comment on the 2026 CalAIM 1115 Demonstration Renewal Application for the 2027–2031 waiver period. California's CHCs are essential partners in achieving Medi-Cal's goals of equity, access, and improved outcomes. Sustaining CalAIM's gains while strengthening operational clarity and financing structures will be critical to success in the future waiver period.

Please do not hesitate to contact me at [redacted] with any questions.

Take care,
Allie Budenz
Allie Budenz
She/Her/Hers
Vice President of Health Center Optimization
California Primary Care Association
[redacted]
w. www.cpca.org
a. 1231 I Street, Suite 400, Sacramento, CA 95814

March 11, 2026

Department of Health Care Services
Director's Office
Attn: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Sent via email to: 1115Waiver@dhcs.ca.gov

Re: California Primary Care Association Comments on CalAIM Section 1115 Waiver Renewal Application

Dear Mr. Sadwith,

On behalf of the California Primary Care Association (CPCA), representing nearly 2,300 community health center (CHC) sites across the state, we appreciate the opportunity to comment on the 2026 CalAIM 1115 Demonstration Renewal Application for the 2027–2031 waiver period.

CPCA values our strong partnership with the California Department of Health Care Services (DHCS or Department) and supports the Department's overarching approach to sustain and refine CalAIM's core programs. Given the limited opportunity for significant programmatic expansion at the federal level, we support DHCS's strategy to preserve essential authorities, maintain continuity of coverage and services, and continue advancing whole-person care for Medi-Cal members.

At the same time, this renewal presents an important opportunity to strengthen implementation of existing and proposed programs and ensure that community health centers, especially Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), are fully integrated, appropriately reimbursed, and administratively supported in delivering these services.

I. Support for Renewal of Core 1115 Authorities:

CPCA supports renewal of the key 1115 authorities identified in the application. The following proposals would be strengthened by augmenting the provider network with explicit inclusion of health centers and clarifying reimbursement guidance.

- **Recuperative Care and Short-Term Post-Hospitalization Housing.** These services have demonstrated clear value in improving post-discharge follow-up, reducing avoidable emergency department use and readmissions, and supporting recovery for individuals experiencing homelessness. We support DHCS transitioning the authority for these services from the 1115 wavier to an in-lieu of service (ILOS), making them a permanent benefit.

- **Reentry Services for Justice-Involved (JI) Individuals.** We strongly reiterate our prior recommendation that waiver authority clearly recognize CHCs as core community-based partners in pre-release planning and care coordination. Continuity of care prior to release with the patient's post-release Enhanced Care Management (ECM) program reduces retraumatization, improves outcomes, and lowers long-term costs. Health centers contract with managed care plans extensively to provide ECM throughout the state. DHCS could strengthen JI reentry services by promoting that carcel settings contract with at least one health center in the pre-release engagement and warm handoffs.

- **Proposals to seek authority for Drug Medi-Cal (DMC) counties to opt-in to cover mobile crisis care and contingency management.** CPCA is supportive of programs that expand the use of evidence-based services, including mobile crisis care and contingency management, for people with substance use disorder(s). That said, philosophically, as the distinction between services available in Drug Medi-Cal (DMC) and DMC Organized Delivery System blur so that benefits are available in both, it calls into question the purpose of having two systems. Two distinct DMC systems add complexity, fragments service delivery access, perpetuate inequities based on geography, and disrupts the member experience. Across all delivery systems, DHCS must continue efforts to standardize a seamless delivery system.

II. Support for Renewal of Core 1115 Authorities with Recommendations:

- **Dually Eligible Demonstrations, including Dual-Special Needs Programs (D-SNP) alignment.** CPCA strongly supports DHCS's efforts to improve alignment for dually eligible individuals through D-SNPs. Dual eligible members often require intensive care coordination, interdisciplinary case management, and navigation across Medicare and Medi-Cal systems to manage complex medical and social needs. CHCs serve a large share of individuals who are dually eligible and have extensive experience caring for medically complex populations. Many CHCs also participate as providers in Medi-Cal's ECM program and Medicare's Care Coordination Management (CCM), where they already deliver intensive care coordination, interdisciplinary case management, and whole-person care for individuals with complex needs. As a result, CHCs represent an established care management infrastructure within Medi-Cal that is well positioned to support the care coordination needs of dually eligible members. Ensuring that aligned D-SNP models meaningfully integrate CHCs in the provision of California Integrated Care Management (CICM) will be essential to achieving the goals of improved alignment, reduced fragmentation, and whole-person care for dual eligible members.

  FQHCs and RHCs are paid through a cost-based prospective payment system (PPS) designed to reflect the full cost of delivering comprehensive primary care services during patient visits. However, some activities that are essential to managing complex patients, such as ongoing

care coordination, care planning, and patient monitoring, occur outside of face-to-face medical visits even though they are critical to improving health outcomes and preventing avoidable utilization. Because CHCs frequently serve as the primary care home for dually eligible individuals, these activities are often performed by health center teams in coordination with health plans and community-based providers.

Both Medicare and Medi-Cal have recognized that certain high-value activities may occur outside of a billable visit and have established targeted payment pathways to support them. For example, Medicare provides separate payment for certain care management activities furnished by FQHCs when they occur outside of a qualifying visit, and Medi-Cal similarly reimburses specific activities such as trauma and developmental screenings, and intensive care management (ECM).

Under aligned D-SNP models, however, both primary care and care coordination are administered through Medi-Cal managed care plans, and current implementation has effectively limited payments to the FQHC visit rate without establishing a pathway to support these non-visit care coordination activities. As a result, D-SNP alignment has unintentionally eliminated the Medicare payment pathway that previously supported care management activities furnished by health centers without replacing it.

CPCA Recommendations:

1. Ensure inclusion of essential community providers, including CHCs, as delegates to provide California Integrated Care Management (CICM) in D-SNP models. CPCA recommends that DHCS require D-SNP plans to include CHCs as care management providers, especially when the CHC is an existing ECM provider and when the patient is assigned to the clinic for primary care. Anchoring care coordination in the primary care settings where many dual eligible patients already receive services would strengthen communication between plans and providers, reduce fragmented care management activities, and advance CalAIM's goals of integrated, whole-person care.

2. Establish a supplemental payment pathway for care coordination. CPCA recommends that DHCS establish a supplemental payment mechanism for care coordination services provided to dually eligible members that is paid in addition to the FQHC visit payment and does not require associated costs to be carved out of health center rates. Establishing a comparable add-on payment would allow community health centers to sustainably deliver the intensive care management that dually eligible patients require while preserving the integrity of the FQHC payment methodology.

III. New Proposals: Employment Supports

CPCA supports DHCS's proposal to pilot Medi-Cal funded Employment Supports under the Section 1115 demonstration. Providing job readiness assessments, individualized employment planning, placement assistance, and retention services recognizes the clear connection between a person's economic stability, continued Medicaid coverage, health access and care outcomes. In the context of federal work and community engagement requirements, these supports are particularly important to help Medi-Cal members maintain coverage, remain engaged in care, and avoid unnecessary coverage disruptions that can undermine health and financial stability.

At the same time, CPCA is concerned by the proposal's indication that Employment Supports may be delivered via counties or county-based entities. Implementing this benefit outside of the Medi-Cal managed care infrastructure risks further fragmenting the Medi-Cal system through complicated referrals, uncoordinated systems, taxed county and provider networks, and limited alignment with existing care management and social health programs like ECM and Community Supports, respectively. CPCA urges DHCS to ensure that Employment Supports are operationalized in a manner that promotes integration with MCPs and requires coordination with patients' ECM providers. We recommend that DHCS includes CHCs as participating providers and outlines clear reimbursement pathways – specifically a non-reconcilable carve out of Employment Supports reimbursement from PPS - for participating health centers.

***

California's CHCs are essential partners in achieving Medi-Cal's goals of equity, access, and improved outcomes. Sustaining CalAIM's gains while strengthening operational clarity and financing structures will be critical to success in the 2027–2031 waiver period.

We appreciate the opportunity to comment and look forward to continued collaboration with DHCS as the waiver renewal advances. Please do not hesitate to contact me at [redacted] with any questions.

Respectfully,

[redacted]

Allie Budenz, MPA
Vice President of Health Center Optimization

Julia Gaines, National Institute for Medical Respite Care, Email received on March 11, 2026.

Dear DHCS Policy Team:

Thank you for the opportunity to submit comments on DHCS' CalAIM Section 1115 Waiver Application.

Please see the attached letter from Julia Dobbins, Director of the National Institute for Medical Respite Care (NIMRC), a special initiative of the National Health Care for the Homeless Council.

Thank you,
Julia Gaines
Julia Gaines, MA
Senior Medical Respite Manager, California
[redacted]
National Health Care for the Homeless Council
Learn more about the National Institute for Medical Respite Care (NIMRC)!
Don’t forget to register for our annual HCH Conference in Orlando this June 2026! See here for more
information.

March 12, 2026

California Department of Health Care Services
Attn: Tyler Sadwith, State Medicaid Director
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

RE: Public Comment on the Transition of Recuperative Care from Section 1115 waiver

To the Department of Health Care Services (DHCS):

Thank you for allowing the National Institute for Medical Respite Care (NIMRC), a program of the National Health Care for the Homeless Council, to offer public comment regarding the announcement to transition recuperative care from the Section 1115 waiver to a Medicaid managed care In-Lieu-of-Services (ILOS) authority.

Acknowledging Common Goals
NIMRC strongly believes the Recuperative Care Community Support is most appropriate for the Section 1115 waiver, which is designed to pilot innovative programs and allows for coverage of room and board. However, we understand that DHCS' decision to discontinue recuperative care from the Section 1115 waiver is intended to protect the longevity of recuperative care programs for unhoused Medi-Cal members, which is a shared goal. By moving away from temporary waiver authority and into the established ILOS framework—whether it be the 1915(b) or 1915(i)—these vital services are "enshrined in federal Medicaid managed care regulations" and may establish recuperative care as a more stable Medicaid option.

CONCERN: Coverage of Room and Board
While NIMRC acknowledges the benefits of retaining the medical and support services for recuperative care under an ILOS Authority, we are gravely concerned about the loss of reimbursement for room and board services. As a core component of the recuperative care model of care, it is not possible for programs to continue to provide recuperative care without room and board. Removal of room and board coverage is likely to reduce Medi-Cal reimbursement rates for California's 105 recuperative care providers, who will struggle to sustain the costs of operating their facilities.

Since the inception of CalAIM in 2022, DHCS has encouraged recuperative care providers to expand capacity to meet the state's vision. In turn, programs have utilized capacity building funds to build facilities, hire new staff, and expand beds. Over the past four years, the state, plans, hospitals, and recuperative care programs have worked to integrate recuperative care

services into California's system of care. We are concerned that the rapid expansion of recuperative care beds across the state will soon collapse in the face of these policy changes.

REQUEST: NIMRC strongly suggests that DHCS identify a funding alternative to reimburse room and board costs for recuperative care programs. Avenues that NIMRC has considered include state-funded wrap-around payments, MCP Community Reinvestment Funds, and Proposition 1 funds. The range for this payment for California recuperative care programs is estimated to be $66-$92 per person, per night, according to a sampling of providers. Similar arrangements have been successfully utilized in other states, such as Michigan and Minnesota, to preserve their network of recuperative care providers.

State / Federal	Room and Board Funding Options
Minnesota State Plan $34/day	**Small State-Only Contribution** • Room and board (facility claim) is paid directly by Minnesota Department of Human Services (DHS) from state funds in an amount that equals the medical assistance room and board rate at the time the recuperative care services were provided • Referenced in statute
Michigan State Plan $30/day	**Small State-Only Contribution** • Providers bill for room and board separately from case management and other services through a separate Medicaid fee for service claim (**S9976 Room and Board**) • Some facilities have investments from plans, philanthropies, other sources

CONCERN: Clinical & Staffing Requirements
As NIMRC shared in a previous letter to DHCS on 2/9/26, we are concerned about the proposed requirement for onsite Licensed Vocational Nurses (LVNs). These new clinical and staffing requirements will create additional financial burden for programs who may already be facing a reduced reimbursement rate.

REQUEST: We urge DHCS to reconsider the onsite LVN requirement in favor of a model based on the NIMRC Certification program and competency-based training. This approach will satisfy CMS expectations for clinical rigor while preserving the diverse provider network necessary to serve California's most vulnerable residents.

REQUEST: Additionally, as DHCS seeks to create a model for recuperative care that incorporates the levels of care offered under both recuperative care and STPHH—while sunsetting the latter as a separate Community Support—NIMRC and recuperative care providers throughout the state request that DHCS utilize the existing NIMRC Models of Medical Respite Care as the foundation for the creation of tiers of recuperative care services. Using these established Models of Care will provide a familiar framework for determining a program's model, level of services and subsequent reimbursement rate.

Conclusion

Through this transition process, NIMRC's objective is to maintain the integrity, efficacy, and accessibility of vital recuperative care services. We hope to prevent the loss of recuperative care beds, especially in in rural and under resourced communities. We appreciate DHCS' commitment to preserving recuperative care services for Medi-Cal members and that they remain uninterrupted while you pursue the most appropriate, sustainable authority for these essential programs.

We welcome the opportunity to discuss this further. Please reach out to me directly if you have any questions or would like to schedule a call.

Sincerely,

[redacted]

Julia Dobbins, MSW
Director of Medical Respite Care

Seth Stabinsky, San Louis Obispo County, Email received March 10, 2026.

Good afternoon:

I have two requests for consideration…

1. FFS reimbursement rates and rules make it difficult to get in-reach support for provision of substance use assessments and counseling under JI pre-release services. Is there any way the rates and rules could be raised and adjusted, respectively to match DMC-ODS? Is this something to request for consideration as you submit the renewal application?
2. There are still long-standing delays for intercounty transfers of Medi-Cal services to take effect, leading to interruption of services. We see this as specifically a problem post-release for JI patients who move to a different county. Can anything be done in the context of the renewal to address a more robust way to ensure more rapid ICT services?

Thank you for your work on this outstanding endeavor,
Seth A. Stabinsky, M.D., FACCP, CCHP-A | Sheriff's Chief Medical Officer |
Sheriff's Administration I 1585 Kansas Ave. | San Luis Obispo, CA 93405
[redacted]

Nina Weiler-Harwell, AARP California, Email received March 11, 2026.

Good evening:

We appreciate the opportunity to comment.

Please reach out with any questions.

Nina
Nina Weiler-Harwell, Ph.D | AARP California
Associate Director, Advocacy & Community Engagement
[redacted]

AARP California

1415 L Street, #960 | Sacramento, CA 95814
1-866-448-3614 | 916-446-2223 | TTY: 1-877-434-7598
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facebook.com/ca

March 12, 2026

Tyler Sadwith, State Medicaid Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413
Submitted Via E-Mail: 1115waiver@dhcs.ca.gov

Re: AARP Comments on the CalAIM Section 1115 Demonstration Renewal Application

Dear Director Sadwith:

On behalf of AARP's 3.2 million members in California, I am writing in response to the Department of Health Care Services' (DHCS) request for public comment on its Medicaid Section 1115 Demonstration Five Year Renewal Request: Continuing CalAIM Demonstration ("CalAIM Renewal").

The following comments prioritize equitable health access and are focused on areas in the CalAIM Demonstration that impact older adult Medi-Cal members:

- **Transition of Community-Based Adult Services (CBAS) program to 1915i State Plan HCBS**
  We strongly support the Department's decision to move the CBAS program to a permanent state plan HCBS benefit through 1915(i) authority. AARP has been a strong supporter of CBAS since its inception because it helps to keep older Californians living in their homes and communities, and gives caregivers time away for respite, work, and personal matters. We look forward to working with the Department on implementation that will ensure the benefit is in fact statewide, including drafting robust network adequacy requirements that will hold managed care plans accountable and incentivize them to provide this service.

- **BridgeCare Pilot**
  AARP appreciates the Department's effort to address the needs of older adults who fall just above Medi-Cal's financial eligibility thresholds, many of whom currently have significant care needs but limited options for accessing long-term services and supports. At the same time, several aspects of the proposed BridgeCare Pilot raise questions about access to services for both Medicare and Medi-Cal recipients.

First, local entities are already facing financial pressures, resulting in gaps in LTSS access for existing Medi-Cal members. AARP is concerned that incentivizing participation in the BridgeCare Pilot could unintentionally divert resources away from an already strained system. At the same time, we believe that financial pressures and limited reimbursement structures could make participation difficult for many local entities, raising questions about whether the pilot will be broadly utilized. As the Department continues to refine the proposal, additional clarity would be helpful regarding how participation will be supported. For example, will Medicare savings resulting from the pilot be used to offset participating entities' expenditures? Are there other incentives or supports the Department is considering to help make participation financially viable for local entities?

We also have concerns about how certain eligibility criteria may affect access. Requiring Medicare enrollment as a condition of participation may limit access for near-eligible older adults who are not enrolled in Medicare, including women and individuals from underserved communities who may already face challenges navigating available coverage options. Similarly, limiting participation to individuals enrolled in Medi-Cal with a share of cost may leave out individuals who technically qualify for the program but do not enroll because the required contribution is prohibitively high.

- **Modification of Asset Test for Deemed SSI Population**
  AARP supports the request to modify the asset test for the deemed SSI population in alignment with the reinstatement of the asset test of $130,000 for an individual in 2025, which applies to non-MAGI Medi-Cal populations. We ask the Department to apply all current protections in the State Plan Amendment to the deemed SSI population. These include holding individuals harmless for any transfer of assets during the period of time when assets were eliminated when determining long-term care eligibility, and requiring asset reporting only at the enrollee's first Medi-Cal renewal in 2027.

- **Employment Supports**
  AARP supports DHCS' proposal to offer a new service for counties to help Medi-Cal expansion adults meet the new Medi-Cal work and community engagement requirements ("work requirements"). We agree that additional supports are needed to ensure continued eligibility for Medi-Cal coverage at application and renewal for the approximately 9 percent of people who are not already working or have exemptions.

- **Renewal of the Justice-Involved Initiative**
  We strongly support the renewal of the Justice-Involved Reentry Initiative. Extending Medi-Cal coverage for critical services help ensure the health and stability of individuals as they reenter their communities. In 2022, 1.2 million older Americans were released from the criminal justice system. This population is disproportionately Black and Latino. Older adults are one of the fastest growing demographics in U.S. prisons: the share of the U.S. prison population aged 55 or older rose from 3 percent in 1991 to 15 percent in 2021. This was due to an increase in arrests of older adults, as well as the aging of individuals serving lengthy sentences. Consequently, more individuals are exiting incarceration later in life.

Incarceration contributes to poor economic outcomes and decreased longevity for people from communities of color, particularly Black men. Experts have increasingly recognized the need to address the significant challenges for older prisoners, their families, and their communities when they are released. These challenges include accessing employment, housing, and health care.

In addition to continued work on statewide implementation of the initiative, we recommend that reentry planning and services should include the integration of home and community-based services and supports to better address the needs of the high proportion of incarcerated older adults and people with disabilities.

If you have any questions about AARP's comments, please contact Nina Weiler-Harwell, Ph.D., Associate Director, Advocacy and Community Engagement, [redacted] or [redacted]

Sincerely,

[redacted]

Rafi Nazarians
Advocacy Director

CC:
Michelle Baass, Director, DHCS
Susan Philip, Deputy Director, Health Care Delivery Systems, DHCS
Joseph Billingsley, Assistant Deputy Director, Integrated Systems of Care, DHCS
Laure Solis, Chief, Office of Medicare Innovation and Integration, DHCS

Heather Regan' Plowman, Adventist Health, Email received March 12, 2026.

To whom it may concern;

I currently work at a recuperative care facility, in a rural area in northern California. Cutting the funding for recuperative care facilities would be detrimental to helping the community we serve. We work with the unhoused population and some who have unsafe living conditions due to lack of income, as well as lack of housing opportunities in this county. This would cut staff and it would cause a lack of support for our community that relies on this type of support. To be honest we need more recuperative care facilities and a raise of the reimbursement to sustain the cost, because our facilities are barely surviving.

Thank you for this opportunity,

Heather Regan' Plowman | Patient Care Coordinator (Outpatient)/
Housing Navigator | Adventist Health | Project Restoration | Lower Lake, Ca 95457
[redacted]

Krista Armenta-Belen, American Indian Health & Services, Email received March 11, 2026.

Haku na ka ščho ha shɨk'ɨn,

I am writing to you today as both a tribal citizen of a federally recognized California Tribe and a long time Indian Health provider/ administrator within Urban and Tribal behavioral health to provide comment related to proposed plans to extend1115 waiver programs, specifically the TRADITIONAL HEALER AND NATURAL HELPER BENEFIT.

I make one overarching request: that the Traditional Healing benefit more appropriately apply/extend to ALL Native Medi-Cal beneficiaries instead of continuing with the present limitation of only those with a Substance Use Disorder diagnosis. As written, the benefit already extends "flexibility" for DMC-ODS to cover these services for other conditions beyond SUD, and we ask that this allowance be explicitly exercised and written into the renewal. This request is in-line with an overabundance of comments provided to DMC-ODS during tribal consultation and urban confer and aligns with suitable application of our traditional healing practices meant for our at-risk communities already experiencing disproportionate health disparities. These traditional practices align with well-studied CDC early intervention and critical universal prevention strategies for violence, chronic illness, suicide, and many more health needs and limiting its application exclusively to SUD creates an unnecessary access barrier to our beneficiaries seeking whole person and culturally responsive care.

kaqhina'š,

Krista Armenta-Belen, DBH, LMFT
Chief Behavioral Health Officer
[redacted]
American Indian Health & Services
4141 State St. | Santa Barbara, CA 93110
Scheduling (805)836-2955
www.aihscorp.org

Naomi Gentile Ramirez, CA Behavioral Health Planning Council, Email received March 11, 2026.

Good afternoon,

The California Behavioral Health Planning Council's (CBHPC) Systems and Medicaid (SMC) Committee has prepared a recommendation letter for the renewal of the CalAIM Section 1115 Waiver. The letter is attached for your convenience. The Council thanks the Department of Health Care Services (DHCS) for the opportunity to provide comments for the CalAIM Section 1115 Waiver.

[redacted]

Thank you.

Naomi Gentile Ramirez (She/Her)
Chief of Operations
CA Behavioral Health Planning Council
[redacted]
MS 2706 P.O. Box 997413
Sacramento, CA 95899-7413
[redacted]
Find us on Facebook @cbhpc.ca.gov
Or Visit the CBHPC Webpage

California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

CHAIRPERSON
Tony Vartan

EXECUTIVE OFFICER
Jenny Bayardo

March 11, 2026

Department of Health Care Services

Director's Office

Attention: Tyler Sadwith

P.O. Box 997413, MS 0000

Sacramento, California 95899-7413

RE: CalAIM Section 1115 Demonstration Waiver Renewal Application

ADDRESS
P.O. Box 997413
Sacramento, CA
95899-7413

PHONE
(916) 701-8211

FAX
(916) 319-8030

MS 2706

Dear Mr. Sadwith,

The California Behavioral Health Planning Council (CBHPC) serves as an advisory body to the Legislature and the Administration on behavioral health policies and priorities, as outlined in Welfare and Institutions Code §§ 5771 and 5772. In alignment with its statutory responsibilities under the Behavioral Health Services Act (BHSA) §§ 5604.2 (a), 5610 (a) (1), 5610 (b) (1), and 5664 (a), the Council plays a critical role in reviewing county performance outcome data, advising on reporting requirements, and collaborating with state agencies to improve and standardize behavioral health practices.

The Council's Systems and Medicaid Committee (SMC) has been involved in the stakeholder process to develop the initial CalAIM 1915(b) and 1115 Waivers for 2020-2025. Since then, the committee has engaged county behavioral health departments, provider organizations, individuals with lived experience, and the Department of Health Care Services (DHCS) to evaluate the implementation of CalAIM programs and provide meaningful feedback and best practices to the state. The committee has reviewed the CalAIM Section 1115 Demonstration Waiver Renewal Application released by DHCS on February 10, 2026, and offers support and recommendations for the draft CalAIM 1115 Waiver in this letter.

The Council supports the following behavioral health initiatives proposed in the CalAIM Section 1115 Waiver Application:

- Reentry Services for Justice-Involved Populations: **We strongly recommend the continuation of reentry services.** These services will improve care within an integrated delivery system for justice-involved populations with behavioral health conditions. These services are especially critical for the continuation of services once an incarcerated individual is released into the community, given the historical difficulties for this population to access and retain behavioral health services and prevent recidivism.

- Traditional Healers and Natural Helpers: The Council supports the continuation of this Benefit to support California's large tribal population and other communities that benefit from and utilize these supports. These services reduce long-standing barriers to care and strengthen culturally responsive, person-centered care by expanding access to healing practices that reflect the cultural values, traditions, and lived experiences of the communities served. The Benefit recognizes the importance of cultural identity in the promotion of health equity, wellness, and recovery, which builds trust between these communities and the health care system. Therefore, **we recommend that DHCS maintain flexibility in service provision for individuals with mental health and substance use disorder conditions and allow this service across multiple care delivery systems.**

- Coverage for Out-of-State Former Foster Care Youth: Foster: Medi-Cal coverage for out-of-state former foster youth is an essential equity strategy to ensure young adults maintain access to behavioral health services during a period of significant vulnerability. These individuals often face high rates of depression, anxiety, trauma-related disorders, and substance use during the transition to adulthood without stable familial or community supports, which heightens the need for these services. Medi-Cal coverage may help prevent service gaps that could lead to crisis, homelessness, justice-involvement, and worsening health outcomes. Therefore, **the Council supports and recommends the continuation of coverage of care for out-of-state former**

foster youth to ensure this vulnerable population has access to the services and supports they need.

- Recovery Incentives: The Council supports the expansion of evidence-based substance use disorder interventions that improve health outcomes for Medi-Cal members with significant behavioral health conditions. This program will expand coverage and high-quality care to individuals with significant behavioral health needs and supports continuity of care in the behavioral health system. **We support the proposed modification to expand waivers of statewideness and comparability, as well as the expenditure authority to offer this benefit in Drug Medi-Cal (DMC) counties.**

The Council expresses support for the following programs proposed in the CalAIM Section 1115 Waiver Application, after further examination of the details for each program:

- Employment Supports: The Council appreciates efforts to include employment supports in the waiver to support individuals with behavioral health conditions who seek employment as a form of recovery, as well as promote stability and minimize the impact of potentially losing Medi-Cal coverage for members subject to work requirements under H.R.1. **The Council recommends that DHCS provide a crosswalk and guidance on how employment services under the CalAIM Section 1115 Waiver will compare to employment supports under the BH-CONNECT Initiative.**

- BridgeCare Pilots: The Council supports BridgeCare Pilots in concept, as the program aims to provide older adults who are “near dual-eligible” with the services and supports they need to reduce the risk of institutionalization. While this proposal appears to align with CalAIM’s goals of improving access and outcomes for individuals with significant behavioral health needs and hard-to-reach populations, we would like to further examine the program’s details and plan for implementation.

- Drug Medi-Cal Organized Delivery System (DMC-ODS) Institute for Mental Disease (IMD) Waiver requested in the CalAIM 1915(b) waiver: The Council supports this proposed Benefit in concept. We

would like to review the CalAIM 1915(b) waiver to understand how this Benefit is structured.

The Council has outlined concerns and recommendations for the following programs proposed to be modified, discontinued, or transitioned to another authority:

- County Option to Cover Select Outpatient SUD Services: While the Council supports the additional SUD services to be offered in the Drug Medi-Cal system, we have concerns about the modification that would enable these services as a county opt-in benefit, particularly for mobile crisis services. Mobile crisis services are critical to reducing unnecessary hospital and emergency department visits, which are costly and often inappropriate. Additionally, these services are critical to minimizing law enforcement involvement (LE), as LE may not be properly trained in mental health or substance use response. This can result in traumatizing incidents for marginalized populations. The opt-in nature of mobile crisis services may result in variability in services offered, depending on individual county decisions. There is a need to support mobile crisis services through an integrated service delivery model. **Therefore, the Council strongly recommends that mobile crisis services remain as a statewide benefit.**

- Recuperative Care and Short-Term Post-Hospitalization Housing: The Council notes that these services have historically excluded individuals with behavioral health conditions, some of which intersect with physical recovery. **The Council recommends requiring Memorandums of Understanding (MOUs) and that DHCS provide clear direction on including behavioral health clients in services, as well as on how financing supports beneficiary access to care.**

- The Providing Access and Transforming Health (PATH) Initiative: While we understand that the original intent of PATH was to provide time-limited support to community-based providers to prepare them for Enhanced Care Management (ECM) and Community Supports, discontinuing this initiative could undermine the behavioral health infrastructure and support for justice-involved populations. The loss of this program at this time would significantly affect community-

based organizations and other entities that rely on infrastructure and training support. Therefore, **the Council recommends that DHCS create alternative funding pathways to support infrastructure for the justice-involved population and/or provide guidance and technical assistance to help local entities navigate this change, ensuring that infrastructure and care support this population.**

- Designated State Health Program (DSHP): We understand that the Centers for Medicare and Medicaid (CMS) has indicated it will no longer approve DSHPs, following the conclusion of the PATH initiative. **The Council recommends that DHCS strategize and identify ways to fill the gaps created by the continuation of this program to minimize the potential impact on justice-involved populations living with significant behavioral health conditions.**

The Council appreciates the opportunity to provide feedback on the draft CalAIM Section 1115 Demonstration Waiver Renewal Application, and we look forward to continuing our partnership in shaping policies that promote equity, access, and improved outcomes for individuals served by the public behavioral health system. For questions, please contact Jenny Bayardo, Executive Officer, at [redacted]

Sincerely,

[redacted]

Jenny Bayardo
Executive Officer

Cc: Paula Wilhelm, Deputy Director, Behavioral Health, DHCS
Erika Cristo, Assistant Deputy Director, Behavioral Health, DHCS
Ivan Bhardwaj, Chief, Medi-Cal Behavioral Health Policy Division, DHCS

Mira Morton, California Children's Hospital Association, Email received on March 11, 2026.

I have attached CCHA's comments on the state's CalAIM Section 1115 demonstration renewal application. Please let me know if you have any questions.

Thanks,

Mira
Mira Morton
Vice President of Government Affairs
California Children's Hospital Association
[redacted]

CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION

1215 K STREET, SUITE 2005
SACRAMENTO, CA 95814
916.552.7111
www.ccha.org

March 11, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
Sent via email: 1115waiver@dhcs.ca.gov

SUBJECT: CALAIM SECTION 1115 DEMONSTRATION RENEWAL APPLICATION

Dear Director Sadwith:

On behalf of the state's eight freestanding non-profit children's hospitals, I appreciate the opportunity to comment on the proposed renewal of the CalAIM Section 1115 Demonstration. We strongly support the continuation of CalAIM's whole-person care approach and, specifically, the ongoing implementation of Enhanced Care Management (ECM) and Community Supports for Medi-Cal members with complex health needs.

Children with medical complexity, including those served through the California Children's Services (CCS) program, often require care from multiple pediatric specialists, hospital systems, and community programs. Over the past several years, several children's hospitals across California have made significant investments to develop ECM programs focused on this population. Hospitals have built multidisciplinary care management teams, hired and trained community health workers and peer support specialists, established referral pathways from pediatric specialty clinics, and partnered with Medi-Cal managed care plans to enroll children with complex medical and social needs.

For medically complex children, ECM provides critical care coordination across multiple systems, while Community Supports help address the social and environmental factors that directly affect their health outcomes. Many children with complex medical conditions experience significant social needs, including housing instability, transportation barriers, food insecurity, and other challenges that can make it difficult to safely manage complex conditions at home. Together, ECM and Community Supports help CCS patients navigate fragmented systems and stabilize care for some of Medi-Cal's most vulnerable children.

Participating children's hospitals have seen particularly strong engagement with ECM programs among their CCS patients. Because pediatric specialty providers often maintain long-standing relationships with children and their caregivers, referrals from children's hospitals frequently result in high enrollment and sustained participation in ECM services.

Longer engagement in ECM allows care teams to stabilize care and better address complex medical and social needs over time.

Maintaining federal authority for these benefits is essential to sustaining and expanding the progress that has already been made. Continued federal approval of the CalAIM demonstration will allow pediatric ECM programs to continue maturing and reaching additional CCS youth who can benefit from more coordinated care across systems. California's children's hospitals look forward to continuing to partner with the state to improve care coordination, strengthen community supports, and improve outcomes for Medi-Cal's most medically complex pediatric patients.

Sincerely,

Mira Morton
Vice President of Government Affairs

Diana Boyer, CWDA, Email received on March 11, 2026.

Please find attached our comments on the proposal. Thank you for the opportunity to comment.

Diana Boyer | Managing Director, Research and Policy Development
[redacted] | cwda.org
@CWDA_CA

CWDA
Advancing Human Services
for the Welfare of *All* Californians

March 11, 2026

RE: CalAIM Section 1115 Demonstration Renewal Application

Submitted via Email: 1115waiver@dhcs.ca.gov

CWDA appreciates the opportunity to submit comments in support of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration. We have seen many benefits to Medi-Cal populations served under the current demonstration for the individuals and families served through county human services agencies, including foster children/youth, adoptive children and families, older adults, and individuals experiencing homelessness.
CWDA respectfully submits the following comments:

Employment Supports

CWDA appreciates the Department's focus on creating meaningful opportunities for impacted populations to meet the new work and community engagement requirements. Counties have long supported individuals served across CalWORKs, CalFresh, and Medi-Cal, and we recognize that long-term stability requires more than a work requirement alone. Effective employment support also includes education assistance, job readiness services, resume development, interview preparation, and supportive services, such as, transportation help and clothing, and ongoing case management.

We strongly support the proposal allowing counties or county-based entities to opt in to providing Employment Supports and would appreciate clarification regarding who may serve as providers. For example, it would be helpful to understand whether providers may include manage care plans, workforce development boards, community-based organizations, contracted employment specialists, community colleges, adult education programs, or other local workforce partners. A clear understanding is necessary to avoid creating parallel systems and can align new responsibilities within existing local structures whenever possible. Locating Employment Supports within county public entities, while allowing the inclusion of a diverse group of providers where needed, promotes a seamless transition between eligibility determination and employment services. Counties are uniquely positioned to coordinate across safety net programs while supporting the whole person. With appropriate clarity and flexibility, this approach can reduce fragmentation, strengthen client engagement, and improve continuity of coverage.

We also request clarification of the source of the 50 percent Medi-Cal non-federal match should counties or county agencies opt into this opportunity, and whether it is expected that counties or other county-based entities will need to identify local fund sources for this match. As the Department is aware, counties are experiencing fiscal strains locally, which makes match requirements extraordinarily difficult to find and commit to. Please also clarify if entities must be enrolled Medi-Cal providers, as county human service agencies do not currently have this status and our county agencies would need technical assistance and administrative support to bill to

Medi-Cal. We would also like clarification of whether these Employment Supports will be available to both individuals in managed care plans and fee-for-service.

As the discussion moves forward, counties request flexibility in how Employment Supports are designed and delivered. Workforce conditions, community-based capacity and partnerships, and service capacity vary widely across the state. Opt-in counties should be able to tailor the mix of services they provide based on local labor markets, existing workforce systems, and the needs of their Medi-Cal populations. Counties should also be allowed to leverage other, existing systems with case management responsibilities such as workforce development boards, transition age youth housing programs. This flexibility will allow counties to maximize effectiveness and avoid duplicating services that already exist in the community.

Additionally, while we understand that Employment Supports are structured as a Medi-Cal covered benefit and therefore intended for enrolled beneficiaries, we request clarification on whether there may be flexibility for opt-in counties to also support applicants who are subject to work and community engagement requirements. Applicants face unique challenges, as they may be required to demonstrate compliance prior to enrollment. Without early assistance, some individuals could struggle to meet these requirements and be prevented from accessing coverage altogether. Exploring innovative approaches to provide limited pre-enrollment supports, or to align with existing county-funded workforce services at application, could improve access, reduce churn, and help eligible individuals enroll in a timely manner.

BridgeCare Pilot

Again, CWDA appreciates this proposal to provide comprehensive services to Medicare beneficiaries between 138 to 220 percent of federal poverty level (FPL) who are not eligible for Medi-Cal but lack resources for long-term services and supports — the "near duals". These are individuals that our county adult service programs, particularly our Adult Protective Services (APS) program, encounter regularly and struggle to assist in connecting them to needed physical and behavioral health services, including personal care services as they are not generally eligible for the In-Home Supportive Services (IHSS) program. The BridgeCare pilot also has great potential to mitigate against poor health and social outcomes, which can lead to higher costs to state and local governments.

Similar to our comments related to Employment Supports, CWDA seeks clarification of what county entity or entities DHCS envisions will be eligible and encouraged to apply as a pilot implementing entity, the permissible sources of the non-federal 50 percent Medi-Cal match, and whether Medi-Cal certification will be required. DHCS has indicated its intention to request federal approval to reinvest a portion of Medicare savings that may result from the BridgeCare Pilots to offset the cost to local entities. We appreciate this opportunity but stress that up-front investment may be necessary given current county fiscal constraints.

Additionally, we ask DHCS to consider removing the eligibility to only serve Medicare beneficiaries, and allow pilot entities to additionally serve non-Medicare enrollees. This change would enable entities to reach the most vulnerable populations—often women and persons of color—who lack the resources

PATH Sunset and CPI

The application sunsets PATH in December 2026, including the Collaborative Planning and Implementation (CPI) peer-to-peer learning model. The application presents this as a mission accomplished based on statewide utilization metrics, but those metrics measure service delivery volume, not the maturity or sustainability of the provider network. This concern was raised during one of the public hearings, and we appreciate the acknowledgement by Deputy Director Tyler Sadwith that DHCS continues to evaluate PATH and CPI outcomes to understand how to continue CPI's peer-to-peer learning. However, the CalAIM application does not reflect this plan.
CWDA encourages the department to continue both PATH and CPI. Feedback from county human service leaderships regarding CalAIM, and the required Memorandums of Understanding for child welfare and IHSS in particular, indicate that progress on those MOUs and building relationships with the managed care plans remains slow, and a common concern raised continues to be lack of local providers for Enhanced Care Management (ECM) with the expertise to serve child welfare and older adult populations.

The CPI in particular has enabled relationship-building and best practice exchange across agencies and managed care plans. If the CPI does not continue in its current format, we highly encourage DHCS to consider and propose a successor framework for collaborative learning infrastructure, and these should continue to be facilitated by independent consultants rather than managed care plan staff. For both PATH and CPI-successors, the existing MCP funding mechanisms — IPP and Community Reinvestment under APL 25-004 — could support this without new federal authority. Additionally, DHCS could incorporate provider network development obligations into MCP contracts for the renewed waiver period that include support for collaborative learning among prospective CalAIM providers, making this an ongoing MCP responsibility rather than a time-limited PATH deliverable. This would also allow DHCS to continue to monitor local CalAIM capacity and sustainability in the next phase and gain valuable insight from stakeholders.

Coverage for Out-of-State Former Foster Care Youth

CWDA supports the proposed extension of Medi-Cal coverage for former foster youth from out-of-state, enabling them to receive Medi-Cal in California up to age 26. Continuity in their health and behavioral health care services is vital to their transition into adulthood, and without such support, research shows that these youth are at higher risk for undesired outcomes including homelessness and incarceration. The proposal would enable these young individuals to receive access to life-saving services that will smooth their transition to adulthood and provides parity with former foster youth served in California's child welfare system.

Traditional Healers and Natural Helpers

CWDA supports the proposal's intent to continue the current pilot to support services offered through Traditional Healers and Natural Helpers (THNH). This benefit is currently offered to Medi-Cal members who receive coverage from DMC-ODS counties, meet DMC-ODS access criteria, and receive care from a participating IHS facility, a facility operated by Tribes or Tribal organizations (Tribal Facilities), or a facility operated by UIO facilities. County feedback indicates concerns that the eligibility criteria remains narrow and encourages DHCS to consider broadening this criteria. Counties also encourage the department to provide additional technical assistance and support to

DMC-ODS counties and service providers to promote improved coordination, program/service awareness of the benefit, and increase referral pathways.

Recuperative Care/Post-Hospitalization Short-Term Housing

CWDA supports the proposal "to create a model for recuperative care that incorporates the levels of care offered under both recuperative care and short-term hospitalization housing, and sunset short-term post hospitalization housing as a separate Community Support." We support transitioning recuperative care into a Medicaid managed care In Lieu of Services (ILOS) authority to permanently preserve this important benefit that has achieved positive outcomes for Medi-Cal beneficiaries. We also understand the challenges of continuing short-term post hospitalization housing as a community support and appreciate the department's efforts to otherwise maintain housing and recuperative care supports through CalAIM.

We further encourage DHCS to consider pursuing 1915i or other authorities to design and expand housing-related services and supports, inclusive of personal care services, for older adults who need assistance with daily living. County APS programs often struggle to secure assisted living arrangements for low-income clients who have experienced abuse, neglect and exploitation and additional programming is needed to ensure these individuals can age safely and with dignity in community-based settings when remaining at home is no longer a safe option.

Again, thank you for this opportunity to comment and please do not hesitate to reach out with any questions to Diana Boyer, Managing Director, Research and Policy Development, [redacted]

Anne Rubin, Adventist Health Clear Lake, Email received March 12, 2026.

Hello,

I am writing to ask DHCS to reconsider the proposed amendments to the 1115 Waiver.

Mandating LVN staffing will be cost prohibitive as we already are struggling to sustain the Recuperative Service at our two shelters.
It is also not necessary as our staff is trained and certified to handle the level of care we provide.

Patients with higher levels of need are promptly referred to facilities able to accommodate those
needs.
As things stand today, the reimbursement does not meet the cost of providing these much needed services.

Our unhoused patients depend on having a place to heal and recuperate after surgery or illness.
While at our shelters we also work on helping them find permanent housing.
This has had a significant positive impact in our community.

Thank you for your attention.

Anne Rubin| Analyst | Community Health
Adventist Health Clear Lake| 15090 Lakeshore Dr. |Clearlake, CA 95422
[redacted]
AdventistHealthClearLake.org

Wendy Bisaccio, Adventist Health Clear Lake, Email received March 12, 2026.

To whom it may concern,

I manage a recuperative care facility in a very rural and financially challenged county in northern California. Many of my residents are medically fragile, elderly and unhoused. They are not capable of connecting with medical and social services due to barriers of transportation (found in remote areas), communication (no phone), finical (little or no income), and mobility (from health conditions or unwilling to leave belongings for fear of theft).

The services we provide give stability as well as both emotional and technical support and they navigate how to engage in services.

With the exponential rises in the cost of food, heating, water and rent, the income from billing for recuperative care barely covers overhead. Any loss in funding would lead to a loss of essential staff and/or the loss of beds.

I am unclear about your reasoning for requiring an LVN onsite. As many recuperative care facilities are not licensed and do not have medical directors to guide care and policy, any nursing staff would be limited in their ability to provide medical care. LVNs hold a very task oriented license and are no more capable of less costly staff (community health workers, peer support providers or those with lived experience) to assess changes in medical condition and the need to intervene to promote health or preserve life. Many facilities currently do not have LVN onsite and have proven their programs promote health and reduce cost to the
communities they serve.

Wendy Bisaccio RN
Adventist Health Clearlake Hospital

Rea Pañares, CACHI, Email received on March 12, 2026.

Please see attached letter. Thank you for the opportunity to submit comment!

Rea Pañares
Executive Director, CACHI
www.cachi.org
[redacted]

March 10, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
—*Sent via email*—

Dear Director Sadwith,

The California Accountable Communities for Health Initiative (CACHI) supports a statewide network of 36 Accountable Communities for Health (ACHs) that serve as local infrastructure for cross-sector collaboration between health systems, managed care plans, public health departments, community-based organizations, and residents. For more than a decade, ACHs have helped communities operationalize state health transformation efforts by translating policy into local implementation, strengthening clinical-community partnerships, and aligning partners around shared strategies to address the social drivers of health. ACHs play an important role in supporting CalAIM implementation by convening stakeholders, building community capacity, and helping health plans and providers engage communities more effectively. We appreciate the opportunity to provide comments on the proposed renewal of the CalAIM 1115 waiver and offer perspectives from communities across California working to advance Medi-Cal transformation on the ground.

CACHI strongly supports the waiver renewal as a vital step toward a healthier California and appreciates DHCS's continued leadership in advancing Medi-Cal transformation through CalAIM. However, we believe the draft renewal request does not yet fully acknowledge or support several of the most important levers for long-term systems transformation and health equity. Drawing on the experience of ACHs working across California, we urge DHCS to strengthen the waiver by: (1) supporting local collaborative infrastructure, (2) more clearly requiring community-centered governance, and (3) centering population-health metrics that measure improvements in health and equity rather than clinical processes alone. Across California, Accountable Communities for Health are already demonstrating how these elements can strengthen CalAIM implementation by aligning health plans, community organizations, public health, and residents around shared priorities and coordinated action.

Collaborative infrastructure: While CACHI supports the continued expansion of CalAIM services described in the waiver request, successful implementation depends on local infrastructure that can coordinate partners across sectors, meaningfully engage community members, and help systems work together effectively. ACHs across the state have demonstrated how trusted cross-sector collaboration can accelerate implementation and reduce fragmentation between health systems, community-based organizations, and public agencies.

Conversely, when collaborative infrastructure is absent, even well-designed initiatives can struggle due to lack of alignment, trust, and shared strategy. At a time of shrinking budgets, including the sunsetting of PATH implementation funding, it is especially important to sustain the local partnerships and coordination capacity needed to carry this work forward.

Community-centered governance: The draft application appropriately emphasizes the importance of "person-centered care," but meaningful systems transformation also requires community-centered governance. In the same way that DHCS has required Managed Care Plans to demonstrate how they are incorporating community priorities through the Community Reinvestment Initiative, Medi-Cal transformation efforts should ensure that community members play meaningful roles not only in advising on clinical services but also in shaping broader priorities, strategies, and implementation. Across California, ACHs have shown how governance models that include residents, community organizations, and system leaders as partners can help ensure that initiatives remain grounded in community needs and build long-term trust.

Population-health metrics: The metrics and evaluation framework described in the renewal application focuses primarily on access to and utilization of services. While these measures are important, they do not capture improvements in health status, the functioning of local health systems, or the strength of partnerships that enable sustainable change. Medi-Cal is a highly regulated program, and payers and providers respond strongly to the signals embedded in measurement frameworks. By incorporating population-health outcomes and measures of system collaboration and equity, DHCS could more clearly signal the importance of improving health at scale and building highly coordinated, community-responsive health ecosystems.

Thank you for the opportunity to provide input. We would welcome the opportunity to share additional lessons from the ACH Network and to support DHCS as the state continues advancing CalAIM and Medi-Cal transformation.

Sincerely,

[redacted]

Rea Pañares
Executive Director, CACHI

Katie Rodriguez, California Association of Public Hospitals and Health Systems (CAPH), Email received on March 12, 2026.

Please find CAPH's 1115 Waiver comment letter attached. Please reach out with any questions. Thank you.

Katie Rodriguez
Vice President of Policy & Government Relations
California Association of Public Hospitals and Health Systems (CAPH)
70 Washington Street, Suite 215
Oakland, CA 94607
[redacted]
caph.org/ | safetynetinstitute.org/

CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Submitted via: 1115waiver@dhcs.ca.gov

Subject: Support for Five-Year Renewal of the Global Payment Program in the Proposed CalAIM 1115 Section 1115 Demonstration

Dear Mr. Sadwith,

On behalf of the members of the California Association of Public Hospitals and Health Systems (CAPH) and the millions of patients they serve, I am writing in strong support of the Department of Health Care Services' (DHCS') proposal to request a five-year renewal of the Global Payment Program (GPP) as part of the CalAIM Section 1115 demonstration renewal application.

California's 17 public hospital systems, which include county-operated and affiliated facilities and the five University of California health systems, are the core of the state's health care safety net. Despite representing only six percent of all hospitals statewide, public hospital systems provide 35 percent of all Medi-Cal and uninsured hospital care. Since 2005, California's public hospital systems have leveraged participation in Medi-Cal 1115 waivers to catalyze significant delivery system transformation, resulting in improved quality and patient outcomes, greater efficiency, and stronger care coordination.

Since its launch in 2015, the GPP has been a critical program in supporting public hospital systems' ability to provide value-based care to uninsured patients while maintaining financial stability. With fundamental programmatic changes included in the proposed demonstration, a renewal of the GPP would create greater incentives and opportunities to provide preventive and primary care and manage chronic conditions for uninsured patients, supporting the evolution of value-based care in public hospital systems and keeping Californians healthy.

The GPP has been a key program in making this transformation possible by creating strong financial incentives to shift uninsured services from the emergency department to primary and preventive care settings. It does this by converting Medicaid Disproportionate Share Hospital funding, which is traditionally limited to reimbursement for care in more costly, hospital-based and emergency settings, to a more flexible, value-based funding methodology that incentivizes low-cost, high-value services.

CAPH supports the changes proposed for the GPP in the 1115 renewal, which would further strengthen and evolve the program in three fundamental ways:

1. *Create new incentives to further expand the program's focus on prevention, chronic disease management, and behavioral health.*
   New services would be added to the program to further support these goals, including leveraging consumer-facing technologies to assist with personalized treatment plans and real-time patient monitoring where possible.

2. *Add risk to the program to intensify incentives to deliver value-based care.*
   The GPP incentivizes the provision of higher-value services through a points-based structure. While this approach has proven effective in shifting service delivery under the program over time, the new design would further encourage change by placing a portion of GPP funding at risk. It would tie the funding to the provision of new and existing preventive care and chronic disease management services and/or to the achievement of quality and/or utilization outcomes.

3. *Incentivize specific system transformation efforts aligned with federal priorities.*
   A sub-pool would be created to incentivize system transformation in certain areas, such as restructuring population and care management approaches to improve health, wellness, and chronic disease management; developing and implementing system-wide efforts that reduce harmful practices, including overprescribing; and advancing research to inform future health policies and programs, in areas like nutrition or environmental exposures, which are connected to overall health outcomes.

For over a decade, the GPP has allowed public hospital systems to build a solid foundation for change and provide uninsured patients with greater access to primary and specialty care. A renewal of the program would sustain these positive changes and further strengthen delivery system transformation efforts. Its renewal is especially critical at a time when we are facing steep funding cuts in the Medi-Cal program and expect to see an influx of uninsured patients over the next few years.

For all of the reasons stated above, **we strongly support the renewal of the GPP through December 31, 2031.** Thank you for your continued partnership to serve California's Medi-Cal and uninsured patients and support the health care safety net.

Sincerely,

[redacted]

Erica Murray
President and CEO
California Association of Public Hospitals and Health Systems (CAPH)

Cc: Michelle Baass, Director, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS

Tiffany Huyenh-Cho, Justice in Aging, Email received on March 11, 2026.

Hello,

Please find attached comments from Justice in Aging. Please reach out if you have any questions about our comments.

Tiffany Huyenh-Cho (she/her/hers)
(TI-fuh-nee WIN Choh)
Director, California Medicare and Medicaid Advocacy
Justice in Aging
[redacted]
Get all our latest resources and policy news. Sign up for our network.

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

March 11, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Submitted Via E-Mail: 1115waiver@dhcs.ca.gov

Re: Public Comments on CalAIM Section 1115 Demonstration Renewal Application

Dear Mr. Sadwith,

We are writing in response to Department of Health Care Services' (DHCS) request for public comment on its Medicaid Section 1115 Demonstration Five Year Renewal Request: Continuing CalAIM Demonstration ("CalAIM Renewal).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, housing and the courts for older adults with limited resources. We have decades of experience with Medicaid and Medi-Cal, with a focus on equitable health access. Our comments below are focused on areas in the CalAIM Demonstration that impact older adult Medi-Cal members.

1. **Modification of Asset Test for Deemed SSI Population**
   We support the request to modify the asset test for the deemed SSI population in alignment with the California 2025 Budget reinstatement of the asset test for other non-MAGI Medi-Cal populations. **We ask the Department to apply all current protections in the State Plan Amendment to the Deemed SSI population.** These include holding individuals harmless for any transfer of assets during the period of time when assets were eliminated when determining long-term care eligibility, and requiring asset reporting only at the enrollee's first Medi-Cal renewal in 2027.

2. **Employment Supports**
   We commend the Department's proposal to offer a new service for counties to help Medi-Cal expansion adults meet the new Medi-Cal work and community engagement requirements ("work requirements"). We agree that additional supports are needed to ensure continued eligibility for Medi-Cal coverage at application and renewal for the approximately 9% of people who are not already working or meet exemptions.[1] While,

[1] California Health Care Foundation, Do Medi-Cal Enrollees Work? - Policy at a Glance, January 24, 2025.

the vast majority of adults in the Expansion group are either working or would meet exemptions from work requirements, some people will need additional support to find and maintain employment.

Because work requirements pose a high risk for coverage losses, we recommend that the state ensure this service is available to all eligible applicants by making the following changes to the proposed benefit:

- **Do Not Waive Statewideness:** Employment supports should be offered to all eligible Medi-Cal members and applicants regardless of where they live in the state. Making these new supports available statewide is critical to preventing geographic disparities from being embedded from the outset of program design. Limiting supports by county could perpetuate regional disparities where residents of certain counties have better supports and resources to manage H.R. 1's work requirements and others do not. This would increase disparities in access to health care. Making employment supports mandatory in all counties is also in the county's interest, reducing the number of uninsured residents who would rely on county-funded clinic systems and indigent care programs. At a minimum, we suggest DHCS pilot Employment Supports to a subset of counties and expand statewide in a phased in process, with statewideness a year after initial launch.
- **Create a Mandatory Core Package of Supports:** While different regions in the state may require different types of supports, the state should create a minimum mandatory package of core pre-employment and employment-sustaining services, including job training services, that all counties must offer members.
- **Remove Reasonable Promptness Waiver** in as much as it may be used to cap the number of eligible impacted Medi-Cal members and applicants who can access the Employment Supports benefit. If the Department is requesting a cap on utilization, including a limit on eligibility, we ask that the Department make those limits transparent and available for public comment.
- **Ensure Supports are Accessible and Person-Centered:** Employment supports must be culturally competent and appropriately tailored to each person's needs, abilities, and circumstances. For example, older adults age 50-64 may need different support compared to younger populations, such as counseling to combat age discrimination and job training to address gaps due to long periods of absence from employment. 64% of adults age 50 and over report seeing or experiencing age discrimination in the workplace.[2] Older adults with

[2] Rebecca Perron, Age Discrimination Holds Steady Among Older Workers, AARP, January 27, 2026.

intersectional identities, such as limited English proficiency, will need multidimensional support.

3. **BridgeCare Pilot**

We appreciate the Department's creative approach to addressing the unaffordable Long-Term Services and Supports (LTSS) needs of older adults who are just above Medi-Cal financial eligibility limits. These near-eligible older adults have health and functional needs similar to Medi-Cal eligible individuals. However, without access to Medi-Cal covered LTSS, they often go without care, leading to poor health outcomes, reduced mobility, increased risk of falls, and higher risk of hospitalization.[3]

We strongly recommend the Department include an evaluation approach for the BridgeCare pilot measuring access among demographic groups (age, race/ethnicity, language, gender, among other data points), outcomes, and any disparities in waiting list times.[4] While we strongly support extending access to LTSS to this high-needs group of older adults, we have several concerns and questions regarding the current proposal for consideration. First, given the financial pressures on local entities that result in large gaps in LTSS access for current Medi-Cal members, we are concerned that incentivizing entities to participate in this Pilot may lead to diversion of resources away from an already strained system.

We are also concerned that this optional benefit is unlikely to be used by the proposed local entities due to pre-existing financial pressures and limited reimbursements. Will reimbursed state-designated shared Medicare savings resulting from the Pilot go towards offsetting participating entities' expenditures? What other incentives or supports will be available to participating local entities?

With regard to eligibility for the pilot, we urge DHCS to remove Medicare enrollment as an eligibility criterion for this benefit since there are near-eligible older adults who are not enrolled in Medicare. These individuals would be left with no LTSS access. This population is disproportionately immigrants and women and women of color.[5]

We also oppose limiting access to this Pilot based on Medi-Cal Share of Cost enrollment. Eligibility in this pilot should be based solely on meeting financial and

[3] NORC, "Analyzing the Health Needs and care gaps for older adults on the cusp of Medicaid financial eligibility," (2024);
[4] Amber Christ and Hagar Dickman, An Equity Framework for Evaluating California's Medi-Cal Home and Community-Based Services for Older Adults & People with Disabilities, Justice in Aging, December 2022.
[5] Benzing, Laura et. al, "How States Can Support Individuals in the Long-Term Services and Supports Gap," (July. 24, 2024).

level of care criteria. Because the Share of Cost calculation means paying more than 67% of one's monthly income on medical expenses, many people do not apply for Medi-Cal with a share of cost, knowing they will not meet it. The overwhelming majority of people living in the community with a Share of Cost do not meet their Share of Cost.[6]

We urge the Department to prioritize reforming the Medi-Cal Share of Cost program and set the maintenance need level at 138% of the federal poverty level—the income level required for Aged & Disabled Medi-Cal eligibility. Share of Cost Reform is an equitable, state-wide solution that will achieve the same goals of this proposed pilot by ensuring near eligible individuals can access LTSS programs without needing to impoverish themselves by living on $600/month, as currently required.

We ask the Department to provide additional information regarding this proposal, including:

- Additional details on the structure of the proposed cost sharing scheme for Pilot participation.
- Additional information about the request to waive Reasonable promptness. Does the Department intent to limit the number of Pilot participants? Does the Department intend to create a prioritization policy in place to guide participating counties' handling of potential waitlists?
- Clarification on the local entities eligible to participate in this program.

4. **Transition of Community Based Adult Services (CBAS) program to 1915i State Plan HCBS**

We strongly support the Department's decision to move the CBAS program to a permanent state plan HCBS benefit through 1915(i) authority. However, expanding the program beyond the 28 counties where the program is currently available will require investments and policy changes including drafting robust network adequacy requirements that will hold managed care plans accountable and incentivized to provide this service. **We recommend DHCS establish an advisory committee for the CBAS program to inform program implementation and efforts to increase access to CBAS.** We look forward to working with the Department on implementation that will ensure the benefit is in fact statewide.

5. **Recuperative Care/Post-Hospitalization Short-Term Housing**

We support the Department's decision to move the Recuperative Care community support to a more permanent authority, and to simplify community supports offerings by sunsetting the Post-Hospitalization Short-Term Housing service. We encourage the

[6] Only 7% of people living in the community meet their Share of Cost. California Health and Human Services, Population Distribution for Medi-Cal Enrollees by Share of Cost, last accessed March 3, 2026.

Department to use the 1915i authority to ensure that the service is available statewide to eligible individuals who require this essential support.

6. **Renewal of the Justice-Involved Initiative**
   We strongly support the renewal of the Justice-Involved Reentry Initiative. Extending Medi-Cal coverage for critical services help ensure the health and stability of individuals as they reenter their communities. We encourage the Department to continue working on state-wide implementation of the Initiative. We also encourage the Department to work on integrating home and community-based services and supports into reentry planning and reentry services, to better address the needs of the high proportion of incarcerated older adults and people with disabilities.

7. **Mandatory Medicare Advantage Plan Alignment**
   We support the continued renewal of this authority in the interests of furthering integration for dually eligible individuals. We look forward to continuing to work with the Department to ensure integration includes robust consumer protections, person-centered care, and robust oversight and accountability.

We look forward to our continued collaboration. If you have any questions, please reach out to Justice in Aging below.

Sincerely,

[redacted]
Hagar Dickman
Director, CA LTSS Advocacy
[redacted]

[redacted]
Tiffany Huyenh-Cho
Director, CA Medicare & Medicaid Advocacy
[redacted]

CC
Michelle Baass, Director, DHCS
Susan Philip, Deputy Director, Health Care Delivery Systems, DHCS
Joseph Billingsley, Assistant Deputy Director, Integrated Systems of Care, DHCS
Laure Solis, Chief, Office of Medicare Innovation and Integration, DHCS

Selina De La Peña, Fresno American Indian Health Project, Email received on March 11, 2026.

Greetings,

On behalf of the Fresno American Indian Health Project, please see the attached letter responding to the request for comments regarding the CalAIM Section 1115 Waiver - Traditional Healer and Natural Helper.

Please feel free to contact me if you have any questions.

Best Regards,

Selina De La Peña, MBA
Chief Executive Officer
Fresno American Indian Health Project
[redacted]

FAIHP
Fresno American Indian Health Project

March 11, 2026

Subject: Comment on CalAIM Section 1115 Demonstration Renewal – Traditional Healer and Natural Helper Services

Dear Director and DHCS Leadership,

Fresno American Indian Health Project appreciates the opportunity to provide comments on the proposed renewal of the CalAIM Section 1115 Demonstration Waiver.

As an Urban Indian Organization (UIO), we provide culturally grounded health services to American Indian and Alaska Native (AI/AN) community members living in urban areas. We strongly support the inclusion of Traditional Healer and Natural Helper services within Medi-Cal, as they reflect longstanding cultural practices that support healing, prevention, and community well-being. Based on early implementation experience, we offer the following observations for DHCS consideration.

Assessment Requirements
Current requirements for ASAM assessments can create administrative challenges for UIOs that are not structured to conduct these assessments internally. In practice, this requirement can delay access to Traditional Healer and Natural Helper services. We encourage DHCS to explore greater flexibility in the assessment approaches that would allow for timely access to culturally grounded care while maintaining appropriate clinical standards.

Eligibility Limitations
Eligibility for Traditional Healer and Natural Helper services is currently limited to individuals with a Substance Use Disorder diagnosis. Many community members seeking these services are experiencing mental health needs, trauma, or other wellness concerns that fall outside this diagnosis. Expanding eligibility to include broader range of behavioral health conditions would better align with the holistic nature of traditional healing practices and support prevention and early intervention.

Implementation Through Counties
UIOs are working closely with counties to establish contracting and reimbursement processes. However, implementation timelines and requirements vary across counties, creating delays in service rollout and additional administrative burdens for providers. Continued collaboration between DHCS, counties, and Indian health providers will be important to support more consistent statewide implementation.

Traditional healing practices are an essential component of culturally grounded care for AI/AN communities. We appreciate DHCS' efforts to recognize these services within Medi-Cal and look forward to continued partnership to ensure this benefit is accessible, effective, and responsive to the needs of the communities it is intended to serve.

Sincerely,

[redacted]

Selina De La Peña, MBA
Chief Executive Officer

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Phone: 559.320.0490 • Fax: 559.320.0494
www.faihp.org

Richard Rawson, Email received March 11, 2026.

Additional information on Recovery Incentives Program.

Contingency management is highly cost effective (even when limiting cost savings to the health care costs.
https://pubmed.ncbi.nlm.nih.gov/41807076/

Richard Rawson, PhD., Professor Emeritus
Department of Psychiatry and Biobehavioral Sciences
Geffen School of Medicine
UCLA
[redacted]

Research Professor
Vermont Center for Behavior and Health
University of Vermont
[redacted]

Todd Hacker, Harbor Care Foundation, Email received on March 11, 2026.

California Department of Health Care Services
Attn: Tyler Sadwith
State Medicaid Director
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

RE: Public Comment on the Transition of Recuperative Care from Section 1115 Waiver

Dear Director Sadwith,

On behalf of Harbor Care Foundation, we appreciate the opportunity to provide public comment regarding the proposed transition of Recuperative Care from the Section 1115 waiver authority to the Medi-Cal Managed Care In-Lieu-of-Services (ILOS) framework under California Department of Health Care Services.

Harbor Care Foundation operates two recuperative care centers in Los Angeles County serving individuals experiencing homelessness who are discharged from hospitals but still require a safe, medically supported environment to recover. Our program works closely with hospitals, managed care plans, and community partners to stabilize patients and connect them with long-term housing and supportive services.

Recognizing Shared Goals
We recognize and appreciate DHCS's efforts to ensure the long-term sustainability of recuperative care services for Medi-Cal members experiencing homelessness. Integrating recuperative care into the established Medicaid managed care regulatory framework may provide greater long-term stability for these programs and the individuals they serve. However, as an organization operating on the front lines of care delivery, we believe that several aspects of the proposed transition must be carefully addressed to prevent unintended consequences that could jeopardize the availability of recuperative care beds across California.

Concern: Coverage of Room and Board
Room and board are foundational components of the recuperative care model. Without safe shelter, meals, and supportive supervision, it is not possible to effectively deliver posthospital medical recovery services for individuals experiencing homelessness.

If room and board costs are removed from reimbursement structures under the ILOS authority, recuperative care providers will face significant financial gaps. For organizations like Harbor Care Foundation, the costs associated with housing, meals, facility operations, and supportive services represent a substantial portion of the daily expense required to care for each participant.

Since the launch of CalAIM in 2022, the State has encouraged providers to expand capacity. Harbor Care Foundation and many other providers across California have responded to that call by investing in facilities, hiring staff, and expanding beds to meet the growing demand for these services. We increased our bed capacity from 30 beds in 2022 to 59 beds in 2025.

Without a sustainable funding solution for room and board, these investments—and the network of more than one hundred recuperative care providers across California—are at risk.

Request: Establish a Funding Mechanism for Room and Board
We respectfully request that DHCS identify a dedicated funding mechanism to support room and board costs associated with recuperative care services.
Potential options may include:

- State-funded wrap-around payments
- Managed Care Plan Community Reinvestment Funds
- Allocation of resources from California Proposition 1
- Other state-supported funding streams that ensure stable program operations

Based on provider experience across California, room and board costs typically range between $66 and $92 per person per night, making a supplemental payment essential to maintaining operational viability.

Concern: Clinical and Staffing Requirements
We also share concerns regarding the proposed requirement for onsite Licensed Vocational Nurses (LVNs). While clinical oversight is an important component of high-quality care, imposing new staffing mandates without corresponding reimbursement increases will create significant financial pressure on providers.

Recuperative care programs operate successfully across diverse models, many of which rely on strong partnerships with community health providers and competency-based training for staff. We have partnered with health clinics to provide medical care and oversight for our recuperative care residents, and this arrangement has been very successful.

Request: Flexible Clinical Models and Tiered Levels of Care
We encourage DHCS to adopt a flexible framework that recognizes varying levels of recuperative care services and allows providers to operate within models that meet clinical standards while remaining financially sustainable.

A tiered model based on established national best practices would allow providers to deliver appropriate levels of care while aligning reimbursement rates with service intensity.

Demonstrated Outcomes and System Impact

Recuperative care programs provide measurable benefits to both patients and the health care system. Harbor Care Foundation's outcomes demonstrate the effectiveness of this model:

- 82% of program participants were successfully placed into stable housing in 2025
- Reduced hospital readmissions through safe post-discharge recovery
- Improved management of chronic health conditions
- Increased connection to primary care, behavioral health services, and benefits
- Greater stability for individuals transitioning from homelessness

These outcomes not only improve individual health and well-being but also reduce costly emergency department visits and hospital readmissions.

Recuperative care programs serve as a critical bridge between hospitals, community health providers, and the housing system. Sustaining these services is essential to achieving California's broader goals of improving health outcomes and addressing homelessness.

Conclusion

Harbor Care Foundation appreciates DHCS's commitment to preserving recuperative care services for Medi-Cal members and recognizes the complexity of establishing a sustainable long-term funding structure.

However, without a reliable reimbursement mechanism for room and board and flexible clinical requirements, many providers may struggle to maintain operations, potentially leading to a reduction in recuperative care beds across the state.

We respectfully urge DHCS to work collaboratively with providers, managed care plans, and community partners to develop solutions that preserve the integrity, accessibility, and sustainability of recuperative care programs. We welcome the opportunity to discuss these issues further and share additional insights from our experience delivering these critical services.

Sincerely,

Todd Hacker
CFO/General Manager
818-925-1451 Admissions
818-925-1460 Main
[redacted]
www.harborcares.org
Harbor Care Foundation, Inc.
11134 Sepulveda Blvd.
Mission Hills, CA 91345

Manie Grewal, REDF, Email received on March 11, 2026.

Dear Director Sadwith,

Please see attached.

We welcome a conversation about whole person care, and how we address the social determinant of employment for our beneficiaries.

Best,

Manie Grewal
Head of Policy
[redacted]
mailing address:
150 Sutter Street #267
San Francisco, CA 94104
We have offices in San Francisco and Los Angeles, and team members around the country.

REDF
An investment that works.

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

March 11, 2026

RE: CalAIM Section 1115 Demonstration Renewal Application

Dear Director Tyler Sadwith,

On behalf of REDF (the Roberts Enterprise Development Fund), I write to support the CalAim Section 1115 Demonstration Renewal Submission, and to offer comments on the section related to employment supports.

REDF is a pioneering venture philanthropy accelerating a national movement of employment social enterprises (ESEs). ESEs are transformative businesses that are not only creating jobs but are also building an inclusive economy by hiring individuals who face systemic barriers to employment, including many with behavioral health and other health conditions. There are almost 300 in the state.

Independent research shows that the ESE model works. It leads to greater economic security and mobility and a significant rate of return to society - $2.23 in benefits for every $1 invested. Since 1997, REDF has invested in 175 ESEs in the State of California. To date, those businesses have earned over $1 billion in revenue that they have reinvested to employ and build the skills of more than 45,000 Californians, including with 30 percent hired between 2021 and 2023.

The CalAim Section 1115 Demonstration Renewal Submission requests "Employment Supports services delivered to MediCal members who are subject to work and community engagement reporting requirements to prepare for, obtain, and maintain employment. This initiative builds on the state's Whole Person Care Program that provided employment assistance focused on helping enrollees develop skills and connections that would improve their chance of obtaining employment." REDF enthusiastically supports the stated request to cover "vocational training, subsidized work placements, and case management", along with the services detailed to support individuals to apply for and secure employment, and the services to support individuals who have secured employment to sustain it.

REDF serves as program lead for the CalOSBA California Regional Initiative for Social Enterprise (CA RISE) to accelerate economic mobility and inclusion for individuals that experience employment barriers. Case studies of ESEs in manufacturing, health care and other sectors demonstrate the power of ESEs in meeting the stated objectives of this waiver, in addition to data on the results achieved by ESEs.

We strongly urge the Department to include the services and supports provided to people working in ESEs in the waiver request as appropriate, and as a recommended option for counties; and integrate ESEs into implementation of the waiver when it is received.

Please let us know how we can be of further support.

Sincerely,

[redacted]

Manie Grewal
REDF Head of Policy

redf.org

Mailing Address: 150 Sutter Street #267, San Francisco, CA 94104
SF Office: 785 Market Street, Suite 1200, San Francisco, CA 94103 | 415-561-6677
LA Office: 801 S. Grand Avenue, Suite 725, Los Angeles, CA 90017 | 415-561-6677

Brenda Goldstein, LifeLong Medical, Email Received March 11, 2026.

Please see attached letter regarding for inclusion in the Publc Comment for the Recuperative Care transition from the 1115 Waiver to ILOS.

Thank you.

Brenda Goldstein, MPH
Chief of Integrated Services
Pronouns: She/Her
Administrative Offices
P.O. Box 11247
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www.lifelongmedical.org

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LifeLong Richmond Health Center • LifeLong William Jenkins Health Center • LifeLong Urgent Care San Pablo
LifeLong Marin Adult Day Health Center • LifeLong Pinole Health Center • LifeLong Rodeo Health Center
LifeLong School-Based Health Services

March 11, 2026

California Department of Health Care Services
Attn: Tyler Sadwith, State Medicaid Director
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: Public Comment on Transition of Recuperative Care from Section 1115 Waiver

Dear DHCS:

Thank you for allowing public comments on the plan to transition recuperative care from the Section 1115 waiver to a Medicaid Managed Care In-Lieu-of-Services (ILOS) authority. LifeLong Medical Care is an FQHC with years of experience providing recuperative care in Alameda County. We understand that the transfer of the program to the ILOS authority is a strategic decision focused on firmly establishing the services in federal regulation which will help to stabilize this as a Medicaid option.

Our main concerns regarding this transition are as follows:

1. Payment for room and board is essential for recuperative care providers. We cannot afford to forgo reimbursement for rent, repairs, food, etc. These are core components of recuperative care which we estimate to cost approximately $85/day, per patient. DHCS must find a funding alternative to reimburse for these expenses.
2. The proposed requirement for onsite Licensed Vocational Nurses will create additional financial burdens for programs. We support recuperative care programs adherence to the guidelines/model developed by the National Institute for Medical Respite Care (NIMRC). This is a solid model, based on established standards, training and with opportunity for communities to develop and grow recuperative care models to meet the needs and resources of their local communities.
3. As DHCS moves towards establishing distinct levels of recuperative care we request that you use the NIMRC Models of Medical Respite Care as the foundation for a tiered model. NIMRC's standards are nationally accepted and provide a solid foundation for high quality recuperative care.

Thank you so much for your consideration of our input. We are pleased to work in partnership with the state to assure that high quality, financially sustainable recuperative care is available in our community. If you are ever in East Bay and have interest in visiting our recuperative care program, we would be delighted to host you!

Res ectfull

[redacted]

Brenda Goldstein, MPH
Chief of Integrated Services

Debra Draves, Master•Care Plan, Email received on March 12, 2026.

Thank you for the opportunity to present our comments and feedback.

Please find our attachment.

Yours truly,
Debra P Draves, CEO
Master•Care, Inc.

[redacted]
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855.836.6355 Office
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Master•Care
Senior Care • Health Care • Managed Care

DHCS Assisted Living Waiver Comment Letter:

A Case for Structural Reform

Submitted by Master•Care | March 2026

March 12, 2026
Submitted via email: ALWP.IR@dhcs.ca.gov and 1115waiver@dhcs.ca.gov

Dear DHCS Colleagues:

We truly appreciate the opportunity to submit comments on the California Department of Health Care Services (DHCS) Assisted Living Waiver (ALW) program. These comments are offered in the context of the CalAIM 1115 waiver renewal and reflect our experience as a provider currently operating under the ALFT program with operational insight relevant to the ALW program's continued structure and performance.

We commend DHCS for its ongoing collaboration with stakeholders to refine this critical work. While transformational efforts take time, they also require collaboration — working together to address challenges while reinforcing successful strategies.

The CalAIM ALFT program has enabled Managed Care Plans, ALFT providers, and assisted living providers to directly compare the program specifics of the legacy ALWP with those of the refreshed ALFT model. This, in turn, affords the entire care continuum the opportunity to identify what is working well in each program and to critically examine areas where improvements would benefit all.

In response to the opportunity for reflection, we respectfully submit the following considerations for your review:

The ALW Framework — Sound in Theory, Constrained in Practice

The foundational premise of the Assisted Living Waiver is sound and supported by evidence: transitioning Medi-Cal members from skilled nursing facilities to well-supported assisted living settings reduces institutional costs, improves quality of life, and — when executed well — demonstrably reduces downstream utilization. Emergency department visits decline. Acute care admissions decrease. SNF readmission rates fall. The program's objective is the right one.

The challenge is not the theory - it lies in execution. Four structural constraints currently limit the ALW's ability to fully realize its intended outcomes:

1. Difficulty attracting high-quality assisted living providers
2. Failure to require in-person assessments
3. Reliance on telehealth as the primary modality for ongoing care management
4. The current ALW tier structure and associated tiered reimbursement model

Master•Care, by leveraging CalAIM mandates prescribed by DHCS, has built a robust assisted living network of more than 1,000 high-quality providers in just three years. This network spans a wide range of specialties and facility sizes and has facilitated the successful, stable transition of nearly 2,000 managed care members since 2023. The success is evident not only in these outcomes but also in the economics of each transition: by using a granular scoring system rather than the standard ALW tiers, Master•Care has consistently generated significant savings over the daily tier rates.

While each structural constraint affects program performance, the assessment framework functions as the system's upstream control point. CalAIM directives, as mandated by DHCS, emphasize "in-person/person-centered" care. For complex transitions involving vulnerable Californians, assessment precision is critical and directly determines placement accuracy.

Post-transition, effective care management sustains the placement's appropriateness and enables a rapid response to changes in condition that may require relocation. In-person care management is also far better positioned to detect early signs of declining provider quality and to relocate members proactively, before issues escalate into adverse events or avoidable higher-level care.

Each of these constraints can be addressed through targeted program reform.

What the Evidence Confirms

An Intermediary Structure Attracts Quality Providers

Expanded, quality-vetted provider networks unlock the most powerful aspect of senior housing: the ability to carefully match care needs, cultural preferences, social needs, activity level, and safety requirements to each individual so that the new community truly feels like home.

Broad and diverse networks — including board-and-care facilities, specialty memory care communities, culturally specific operators, and behavioral-health-capable settings — produce better placement matches and reduce the likelihood that vulnerable, often elderly individuals will need to be relocated unnecessarily.

By removing the requirement for Medi-Cal credentialing and direct claims submission, interest from high-quality assisted living providers increases dramatically. Conversely, the benefit to payers—whether state agencies or managed care plans—is relief from contracting with thousands of disparate providers, many of whom deliver excellent care but are not sophisticated business operators and may have limited administrative capacity.

Thus, the Network Lead Entity model—where an intermediary rigorously vets assisted living providers, manages all Supplemental Billing Agreement changes, processes claims, and pays providers—represents a fundamentally stronger and more scalable architecture than the CCA model used in the ALWP, and is vastly superior in its ability to ensure quality, accountability, and network growth.

What the Evidence Confirms

In-Person/Person-Centered Care Generates Better Outcomes

Master·Care's experience operating under the CalAIM ALFT Community Support — and the data emerging from expanded provider networks, the positive outcomes afforded by in-person assessment, and ongoing in-person care management — points toward a consistent set of structural features that correlate with better placement outcomes. Programs demonstrating stronger long-term placement stability and lower post-placement utilization tend to share three characteristics:

- Granular, in-person assessment methodology. Assessment approaches that assign specific values to individual ADL care needs, conducted in person, produce more accurate cost modeling, more appropriate placements, and more defensible program documentation. The propensity to round up disappears when there is no tier to round up to.
- Real-time compliance and quality monitoring. Programs that incorporate active CCLD compliance data into their facility vetting process can identify quality concerns before placement rather than after — protecting members and reducing transfer-related disruption.
- Ongoing in-person care management. Members receiving regular in-person contact demonstrate higher placement stability, earlier identification of emerging conditions, and lower rates of avoidable acute care utilization.

What the Data Reveals about Care Costs and Rates

Master·Care has developed a proprietary assessment methodology that prices care at the individual ADL and diagnostic level rather than assigning members to broad tiers. The difference in cost accuracy between tier assignment and assessment-driven pricing is substantial and stems directly from the program's underlying execution structure. The following representative sample from our active caseload demonstrates how the two models perform when applied to identical clinical profiles, comparing each member's actual daily rate under our methodology with the rate that would be generated under the ALW tier structure.

Member	Type	Clinical Profile	MasterCare Daily	ALW Tier Rate 2025	Annual Savings to Plan
M, b. 1963	Diversion	Autism / BPD / CHF / CKD / Neuropathy — dressing, bathing, toileting, O2/CPAP	$159.54	$179.58 (T-IV)	$7,315/yr
F, b. 1944	Diversion	HTN / Neuropathy — bathing, grooming, escorts	$59.84	$95.69 (T-I)	$13,085/yr
M, b. 1950	Transition	Neurocognitive d/o / HTN / DM II / Dysphagia / Epilepsy — Hoyer lift, 2-person assist	$157.76	$179.58 (T-IV)	$7,964/yr
F, b. 1927	Diversion	Dementia / HTN / CKD — aggressive & wandering behaviors, cognitive support	$197.76	$270.80 (T-V)	$26,660/yr
		AVERAGE ANNUAL SAVINGS PER MEMBER, ACROSS ALL FOUR CASES:			**$13,756/yr**

In each case, savings to the plans are realized through more precise assessment, not through any reduction of services. The existing tier model rounds members up to the nearest category, while a granular methodology prices actual care needs.

Variables that do affect the cost of care—such as higher operating costs in certain zip codes and differences in facility structure and overhead—are also factored into pricing, whereas they are entirely absent from the ALW tier structure. This is another important feature that assisted living providers value, as it reflects the true economics of their operations.

This model and pricing structure align more closely with ICD-10 coding conventions and enable more accurate forecasting, budgeting, and long-term cost modeling.

What We Propose

Master•Care requests a 60-minute meeting with DHCS ALWP leadership to present our operational data, share field observations, and propose a formal comparative study—contrasting ALW tier-based reimbursement with assessment-driven models currently operating under CalAIM—to both inform the waiver renewal process and facilitate the evolution of ALWP to CalAIM ALFT.

Our intent is not to critique the program, but to offer evidence-based insights that can inform its continued improvement. These improvements directly benefit the state, the plans, and—most critically—the thousands of Californians on the ALW waitlist who remain unserved.

Debra Draves
Co-Founder & CEO, Master•Care, Inc.
[redacted]

Rebecca Zuchowski, Mom's Meals, Email received March 12, 2026.

Good Afternoon,

On behalf of Mom's Meals, please find attached our full letter regarding the CalAIM Section 1115 Demonstration Waiver Five-Year Renewal.

Mom's Meals looks forward to continuing to support DHCS in advancing community-based services that help Californians remain healthy and independent in their homes. Please don't hesitate to reach out if we can provide any additional information.

Best,
REBECCA ZUCHOWSKI, PHD, MPH
Policy Research Analyst
3210 SE Corporate Woods Dr.
Ankeny, Iowa 50021
[redacted]
www.momsmeals.com

March 12, 2026

California Department of Health Care Services
Attn: CalAIM Demonstration Renewal Public Comment
Sacramento, CA

RE: CalAIM Section 1115 Demonstration Waiver Five-Year Renewal

Purfoods LLC, d/b/a Mom's Meals ("Mom's Meals"), appreciates the opportunity to provide comments on the California Department of Health Care Services' (DHCS) request to renew the CalAIM Section 1115 demonstration waiver. We commend DHCS for its continued commitment to advancing whole-person care and making innovative services and supports available to Medi-Cal members and other high-need populations.

Since 1999, Mom's Meals has been dedicated to making quality nutrition accessible to individuals managing chronic conditions, recovering from hospital stays, or seeking to maintain independence at home. Our expertise includes fully prepared, refrigerated, medically tailored, home-delivered meals (HDM) to any address nationwide, oral nutritional supplements, produce and pantry boxes, nutrition education, counseling, other forms of nutrition support, and personalized engagement. With over two decades of experience supporting Medicaid, Medicare Advantage and other programs in the state of California, we support thousands of people across every county in the state each year.

Mom's Meals respectfully submits the following comments regarding the CalAIM Section 1115 waiver renewal proposal.

1. Continued Support for Community Supports and the Role of Nutrition Services

Mom's Meals supports the continued availability of 12 of the 14 Community Supports, including medically tailored meals, through Medi-Cal managed care plans as In Lieu of Services (ILOS). MTMs are one of the most utilized services under the current waiver program and represent an important step toward addressing chronic condition management, care transitions, maternal health and independence at home for older adults with nutritional needs.

However, as ILOS services are optional for managed care plans, access to services, such as MTMs, could become inconsistent across the state, and service designs and eligibility criteria could also become inconsistent across MCPs. As California transitions from Community Supports under the CalAIM umbrella to ILOS, we would ask that the DHCS consider statewide best-practice guidance for MCPs on program availability, design, and eligibility, based on lessons learned in the Community Supports program.

2. BridgeCare Pilots Should Include Nutrition Services and Home-Delivered Meals

Mom's Meals supports DHCS' proposal to establish BridgeCare Pilots designed to provide home- and community-based services and caregiver supports for older adults with significant health needs whose incomes exceed Medi-Cal eligibility thresholds. Because the target population includes individuals with chronic conditions and functional limitations who may struggle with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), nutrition services should be designated as a core component of BridgeCare pilots and include medically tailored home-delivered meals.

Reliable access to clinically appropriate meals can help manage chronic conditions, reduce the risk of malnutrition, improve medication adherence, and decrease avoidable hospitalizations and emergency department visits.[i] Providing medically tailored meals may also offer a more clinically appropriate solution than relying solely on personal care assistance for meal preparation, particularly for individuals requiring specialized therapeutic diets. Unlike meals prepared informally under meal preparation supports, medically tailored home-delivered meals are designed by registered dietitians and structured to meet established nutrition standards, with each meal providing approximately one-third of the recommended daily intake (DRI) for key nutrients. This helps ensure consistent nutritional adequacy and alignment with clinical dietary needs.

Nutrition services also directly support one of the primary goals of the BridgeCare pilots: strengthening support for family caregivers. Meal delivery can reduce caregiver burden by eliminating the need for grocery shopping, meal planning, and food preparation, allowing caregivers to focus on other critical supports.[ii]

3. Pilot Implementation and Provider Participation

Mom's Meals recognizes that BridgeCare will initially be implemented through pilots in select counties or regions. Pilot implementation provides an important opportunity to evaluate the impact of home- and community-based services, including nutrition supports, for individuals who fall just above Medi-Cal eligibility thresholds. This population often faces significant health needs but may lack access to the Community Supports available through Medi-Cal managed care plans, and would not have access to future ILOS programs from MCPs. We encourage DHCS to pilot testing medically tailored meals, along with other HCBS services. This work can demonstrate how medically tailored home-delivered meals can impact aging in place, improved health outcomes, reduced caregiver burden and reduced healthcare utilization and cost.

As DHCS develops the list of state-approved BridgeCare services, Mom's Meals also encourages the department to ensure open and inclusive provider participation. Allowing qualified providers, including nutrition providers and medically tailored meal organizations, to participate alongside community-based organizations can help ensure that beneficiaries statewide have access to the full range of services needed to meet health needs.

4. Transition of Community-Based Adult Services (CBAS) and the Role of Nutrition

Mom's Meals supports DHCS' proposal to transition Community-Based Adult Services (CBAS) from the CalAIM Section 1115 demonstration to Section 1915(i) state plan authority. As DHCS strengthens the CBAS benefit, it will be important to ensure that nutrition services extend beyond education alone. Many CBAS participants have functional limitations affecting their ability to shop for groceries or safely prepare meals.[iii] For these individuals, nutrition education by itself may not be sufficient to ensure consistent access to appropriate food.

Incorporating home-delivered meals as a complementary support can help translate nutrition education into consistent dietary adherence while reinforcing the goals of CBAS to help individuals maintain independence and remain safely in their communities**.**

The CalAIM initiative represents an important effort to advance whole-person care and integrate health-related social supports into the Medi-Cal delivery system. Mom's Meals supports the continued evolution of CalAIM through the Section 1115 waiver renewal and appreciates DHCS' efforts to expand access to home- and community-based services.

Ensuring that nutrition services, including medically tailored home-delivered meals, are incorporated into initiatives such as the BridgeCare pilots and the broader HCBS system can help improve health outcomes, strengthen caregiver support, and promote long-term independence for older adults and individuals with chronic conditions.

Mom's Meals appreciates the opportunity to provide comment and welcomes the opportunity to serve as a resource to DHCS as the department continues to refine and implement these initiatives. Our registered dietitian and chef-designed meals support individuals managing conditions such as heart disease, diabetes, kidney disease, and cancer. Mom's Meals partners with health plans, health systems, and state and local governments to incorporate medically tailored meals into comprehensive care plans that may also include care management and nutrition education. In California, Mom's Meals partners with more than 20 Managed Care Plans as a Community Supports provider and supports numerous PACE centers and community organizations. Over the past year, we delivered more than 6.4 million meals to over 45,000 individuals across the state. Mom's Meals looks forward to continuing to support DHCS in advancing community-based services that help Californians remain healthy and independent in their homes.

Sincerely,

[redacted]

Catherine Macpherson, MS, RD
Senior VP and Chief Nutrition Officer

[redacted]

[i] Macpherson, C., Frist, W. H., & Gillen, E. (2025). Medically tailored meals: A case for federal policy action. *Healthcare*, *13*(22), 2899. https://doi.org/10.3390/healthcare13222899

[ii] Balkan, E., Gadbois, E. A., Tucher, E. L., Bernard, K. P., & Thomas, K. S. (2025). Home-delivered nutrition services for older adults under the Older Americans Act. *JAMA Network Open, 8*(9), e2534747. https://doi.org/10.1001/jamanetworkopen.2025.34747

[iii] Evans, A., Banks, K., Jennings, R., Nehme, E., Nemec, C., Sharma, S., Hussaini, A., & Yaroch, A. (2015). Increasing access to healthful foods: A qualitative study with residents of low-income communities. *International Journal of Behavioral Nutrition and Physical Activity, 12*(Suppl 1), S5. https://doi.org/10.1186/1479-5868-12-S1-S5

Heather Frawley, Adventist Health Clearlake, Email received March 12, 2026.

To Tyler Sadwith, State Medicaid Director, and the California Department of Health Care Services:

My name is Heather Frawley. I am a program manager running a software platform that connects people experiencing housing instability to case management programs in Lake County, California. Every single day, I work alongside recuperative care providers, Medi-Cal members, and the most vulnerable people in our communities. I am writing to add my voice as a public comment regarding the proposed transition of Recuperative Care from the Section 1115 waiver to a Medicaid managed care In-Lieu-of-Services (ILOS) authority.

I support the concerns and requests raised by the National Institute for Medical Respite Care (NIMRC). Fully. And here's why this matters to ME — and to the people I serve.

CONCERN #1: WE CANNOT LOSE ROOM AND BOARD COVERAGE.
Recuperative care without a roof and a bed? That's not care. That's a waiting room.

Room and board is the foundation of the recuperative care model. You cannot help someone heal if they have nowhere to sleep. Removing reimbursement for room and board puts 105 California recuperative care providers at serious financial risk — many of whom expanded their capacity because DHCS encouraged them to do exactly that under CalAIM.

We asked them to grow. They did. Now we cannot pull the rug out from under them.

I urge DHCS to identify alternative funding to cover room and board costs — whether that's state-funded wrap-around payments, MCP Community Reinvestment Funds, or Proposition 1 funds. States like Michigan and Minnesota have made it work. California can too.

CONCERN #2: THE ONSITE LVN REQUIREMENT WILL HURT PROVIDERS.
I get it — clinical standards matter. If you didn't document it, it didn't happen. Quality care requires qualified staff.

BUT. Mandating onsite Licensed Vocational Nurses (LVNs) adds significant financial burden to programs that are already facing reduced reimbursement rates. That's a double hit. And it risks shrinking the very provider network we need to serve our most vulnerable Medi-Cal members.

I strongly support NIMRC's recommendation to use competency-based training and the NIMRC Certification program instead. It meets clinical rigor. It keeps providers in the game. Siloed care is not the best care — and neither is care that disappears because providers can't afford to stay open.

CONCERN #3: USE THE TOOLS THAT ALREADY EXIST.
Why reinvent the wheel when NIMRC already built a great one?

As DHCS works to create a tiered recuperative care model, I urge you to use the existing NIMRC Models of Medical Respite Care as the framework. These models are proven. They're familiar to providers. And they give a clear, fair structure for determining levels of service and reimbursement rates.

Teamwork makes the dream work — and that means building on what the field has already created together.

I am asking DHCS to protect this critical safety net. Recuperative care beds save lives. They reduce unnecessary hospital readmissions. They help people get back on their feet — and STAY there.

Please don't let these programs collapse because of a policy transition that didn't fully account for the real-world impact on providers, clients, and communities.

Thank you for the opportunity to comment. I welcome any follow-up conversation.

Respectfully submitted,

Heather J. Frawley
Heather J. Frawley, MHA | Program Manager |Integrated Care
Adventist Health Clearlake| 15090 Lakeshore Drive, Suite E | Clearlake, CA 95422
[redacted]| AdventistHealth.org
Book time to meet with me
Our life is like a garden. Our every thought, word & deeds are “The Seeds” that sooner or later bare Karmic fruit. Whether we harvest flowers or weeds depends on the quliaty of our actions.
By: David P. Bruce – Seeing a Higher Purpose

Karli Holkko, CalPACE, Email received March 12, 2026.

Dear Mr. Sadwith,

On behalf of the California PACE Association (CalPACE), please find attached our comments on the *Medicaid Section 1115 Demonstration Five-Year Renewal Request: Continuing CalAIM Demonstration (CalAIM Renewal)*.

We appreciate the opportunity to provide feedback and thank the Department for its continued work to strengthen Medi-Cal and expand access to coordinated, community-based care for older adults and individuals with complex needs.

Please feel free to reach out if CalPACE can provide any additional information or clarification.

Kind regards,

Karli Holkko
Director of Government Affairs, CalPACE
[redacted] www.calpace.org
[redacted]
1315 I Street, Suite 100, Sacramento, CA 95814

March 12, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Submitted Via E-Mail: 1115waiver@dhcs.ca.gov

Re: Public Comments on CalAIM Section 1115 Demonstration Renewal Application

Dear Mr. Sadwith,

The California PACE Association (CalPACE) appreciates the opportunity to provide feedback on the Medicaid Section 1115 Demonstration Five Year Renewal Request: Continuing CalAIM Demonstration (CalAIM Renewal). CalPACE values the Department's ongoing efforts to strengthen Medi-Cal and expand access to coordinated, community-based care for older adults and individuals with complex needs.

Transition of CBAS to 1915(i) State Plan Authority

CalPACE strongly supports the Department's proposal to transition the Community-Based Adult Services (CBAS) program from the CalAIM 1115 Demonstration Waiver into a permanent 1915(i) Home and Community-Based Services State Plan Authority. Establishing CBAS as a state plan benefit will provide long-term stability for a program that plays an important role in helping older adults and individuals with disabilities remain safely in the community.

As the Department advances this transition, CalPACE encourages continued stakeholder engagement to ensure the benefit is implemented successfully statewide. In particular, the Department may wish to consider establishing an ongoing stakeholder forum or advisory structure to support implementation and ensure that providers, plans, and consumers have opportunities to provide feedback.

Because CBAS will continue to operate within the broader Medi-Cal managed care delivery system, ensuring clear expectations for managed care plans around network adequacy and access

will be critical. Strong monitoring and accountability structures will help ensure equitable access to CBAS services across the state.

BridgeCare Pilot

CalPACE appreciates the Department's effort to address the needs of older adults who fall just above Medi-Cal financial eligibility thresholds through the proposed BridgeCare Pilot. Many individuals in this population have significant health and functional needs but lack access to affordable long-term services and supports. Expanding access to coordinated, community-based care for individuals with complex needs is central to CalPACE's mission, and we strongly support efforts that help ensure older Californians can obtain the services necessary to remain safely in their homes and communities.

Integrated Care Models

As the Department considers the future of the CalAIM waiver and related programs, CalPACE encourages continued recognition of the value of fully integrated care models that coordinate medical, behavioral health, and long-term services and supports.

Programs such as PACE demonstrate the benefits of integrating these services under a single accountable provider, resulting in improved health outcomes, reduced hospitalizations, and greater ability for older adults to remain living safely in their communities. Ensuring that new initiatives under the waiver complement and align with existing integrated models will help strengthen California's overall system of care for older adults and individuals with complex needs.

Thank you for the opportunity to provide comments on the CalAIM Renewal proposal. CalPACE appreciates the Department's continued leadership in advancing policies that strengthen Medi-Cal and expand access to community-based care for Californians with complex needs. We welcome the opportunity to serve as a resource as DHCS advances its vision for a more coordinated and sustainable system of care for older adults and individuals with disabilities.

Sincerely,

Val Sheehan, CEO
California PACE Association

Michaela Hollis, Alignment Health, Email received March 12, 2026.

To whom it may concern,

On behalf of Alignment Health, thank you for the opportunity to submit comments on the Department of Health Care Services' request for feedback on the five-year renewal of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration. Alignment Health serves more than 227,000 beneficiaries and approximately 75,000 Medicare-Medicaid dual-eligible individuals in California through our Medicare Advantage plans. We appreciate your consideration of the attached comment letter and welcome continued dialogue with DHCS as the state refines implementation and evaluation of these policies.

Should you have any questions, please don't hesitate to contact us.

Best,

Michaela
MICHAELA HOLLIS
Director, Government Affairs
[redacted]
alignmenthealth.com
Alignment Health
1100 W. Town & Country Rd., Suite 1600
Orange, CA 92868

Alignment Health™

March 12, 2026

Tyler Sadwith
State Medicaid Director
Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Re: CalAIM Section 1115 Demonstration Renewal Application

Submitted via 1115waiver@dhcs.ca.gov

Dear Mr. Sadwith:

On behalf of Alignment Health, thank you for the opportunity to provide comments on the Department of Health Care Services' request for feedback on the five-year renewal of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration.

Alignment Health serves more than 227,000 beneficiaries and approximately 75,000 Medicare-Medicaid dual-eligible individuals in California through our Medicare Advantage plans, working with trusted local clinicians to deliver coordinated care through a senior-focused model supported by 24/7 clinical support, technology-enabled care management, and local provider partnerships. All of our California members are enrolled in plans rated four stars or higher by the Centers for Medicare & Medicaid Services (CMS). Through an integrated model that combines coverage, care delivery, and technology, we focus on improving outcomes for Medicare beneficiaries, particularly chronically ill and vulnerable populations, including dual-eligible seniors.

According to the DHCS Office of Medicare Innovation and Integration (OMII) Q2–Q4 2024 Health Risk Assessment (HRA) and Individualized Care Plan (ICP) performance results, Alignment consistently ranked as the top overall performer across quarterly HRA measures and ranked first in two quarters and second in one quarter on ICP measures. These results reflect our continued focus on high-quality care coordination for vulnerable beneficiaries.

DHCS is requesting federal approval for continued Section 1115 demonstration expenditure and waiver authorities that support initiatives beyond traditional Medi-Cal State Plan authority. Specifically, under Section 3.9 – Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage – DHCS proposes to renew expenditure authority that permits alignment of a dually eligible member's Medi-Cal plan with their Medicare Advantage enrollment when the MA organization has an affiliated Medi-Cal plan. Because Section 1115 demonstration authority is intended to test delivery system innovations and generate evidence for future policymaking, the renewal period presents an especially important opportunity to assess both intended and unintended beneficiary impacts of current implementation.

Alignment appreciates California's goal of improving Medicare-Medi-Cal coordination and recognizes the importance of simplifying beneficiary navigation across Medicare and Medi-Cal coverage systems. DHCS' broader efforts to improve coordination and integration across

programs are important and commendable. At the same time, we believe the renewal process presents an important opportunity to evaluate whether current implementation is fully achieving intended beneficiary goals across access, quality, and continuity of care.

Background

In 2023, CalAIM implemented the Exclusively Aligned Enrollment (EAE), or "Medi-Medi," policy. This policy allows certain plans to continue serving existing dual-eligible members while prohibiting those plans from enrolling new dual-eligible beneficiaries. Beginning in contract year 2025, DHCS further limited enrollment by allowing new dual-eligible beneficiaries to enroll only in D-SNPs affiliated with a Medi-Cal plan in each county. As a result, some Medicare-focused plans (including high-performing D-SNPs without an affiliated Medi-Cal plan) are no longer able to enroll new dual-eligible beneficiaries in affected counties.

While intended to strengthen integration, these policies materially narrow the range of Medicare plan options available to many dual-eligible seniors in California. Some excluded plans, including high-performing Medicare-focused D-SNPs, have demonstrated strong quality performance, high engagement, and favorable clinical outcomes among dual-eligible populations. Alignment's own California experience reflects prior authorization denial rates below two percent, strong care coordination performance, and hospitalization rates (149 per 1,000 members in 2024) materially below broader Medicare averages.

We believe seniors should continue to have the ability to choose the plan that best fits their medical, linguistic, and cultural needs. Limiting available options may reduce beneficiary confidence and make it more difficult for vulnerable populations to access care models that have demonstrated strong performance for seniors with complex needs

These policies may also increase the likelihood of provider disruption for some beneficiaries. Many remaining plans operate within provider and network structures that differ from Medicare-focused delivery models (designed primarily around Medi-Cal networks), which may create changes in established care relationships for some beneficiaries, such as physicians, specialists, and care teams. Changes in established patient-provider relationships can contribute to fragmented care experiences and may affect outcomes for medically complex beneficiaries.

Excluding high-performing, culturally responsive Medicare-focused plans may also have disproportionate implications for certain communities, including lower-income populations, communities of color, and non-English-speaking seniors who rely heavily on trusted provider relationships and locally tailored care models.

Recent external analyses have also raised questions about whether implementation may reduce competition and beneficiary plan choice in certain markets.[1] As these policies continue to reshape the market, some Medicare-focused plans with strong quality performance and established provider relationships are no longer able to enroll new dual-eligible beneficiaries in affected counties, even where those plans have demonstrated strong local performance. California also faces increasing fiscal pressure within Medi-Cal as recent federal policy changes affecting Medicaid financing place greater scrutiny on state spending. In a more constrained fiscal environment, preserving access to high-performing Medicare-focused care models may

[1] https://www.marinij.com/2025/10/26/marin-voice-vulnerable-seniors-deserve-real-choice-in-health-care/

help support better outcomes for high-need populations while complementing state efforts to manage costs and improve care coordination.

Evaluation Hypotheses for Waiver Renewal

Alignment Health appreciates DHCS' commitment to conducting an independent evaluation of the Medi-Cal Matching Plan Policy as part of the CalAIM Section 1115 renewal. As DHCS develops hypotheses and evaluation methods for dually eligible populations, we encourage the state to ensure that the evaluation fully captures beneficiary impacts across access, quality, and continuity of care.

Expand Evaluation Metrics Beyond Plan Switching

Evaluation metrics should extend beyond plan switching and enrollment patterns. Measuring churn and beneficiary satisfaction alone may not fully capture the consequences of EAE implementation. The evaluation should assess whether beneficiaries lose access to higher-quality or more specialized Medicare options because of alignment requirements.

Assess Impacts on Plan Quality and Specialized Care

The evaluation should examine whether beneficiaries aligned under EAE retain access to plans with strong quality performance, including differences in Star Ratings, care coordination outcomes, and supplemental benefit structures. It should also assess whether beneficiaries continue to have access to specialized clinical programs and culturally responsive services that may not be equally available across all plan types, including those that primarily Medicaid-focused or national plans.

Evaluate Continuity of Provider Relationships

The evaluation should assess whether beneficiaries aligned through EAE experience changes in primary care, specialist, hospital, or care team relationships relative to prior enrollment patterns. Continuity of care is especially important for medically complex dual-eligible populations.

Examine Equity Impacts

The evaluation should examine whether EAE implementation disproportionately affects lower-income Californians, communities of color, and individuals with limited English proficiency. These populations already face substantial disparities and may rely heavily on plans with culturally competent care models and trusted provider networks.

We also encourage DHCS to ensure that evaluation methods, interim findings, and final results related to dual-eligible alignment are made publicly available so stakeholders can better understand how these policies affect beneficiary experience and access over time.
Alignment stands ready to work with DHCS and the independent evaluator to help ensure the demonstration captures the full range of outcomes associated with these policies, including impacts on access to care, quality of services, continuity of care, and beneficiary experience.

Conclusion

As DHCS seeks renewal of current expenditure authority, the demonstration's next phase should include a transparent evaluation of how alignment policies affect beneficiary choice, continuity of care, and access to high-quality coordinated services across different local markets.

Careful evaluation is particularly important where implementation materially affects beneficiary plan availability, continuity of care, and access to high-quality coordinated services across different local markets. A complete assessment will help ensure that CalAIM continues advancing integration goals while also protecting access to high-quality care for California's most vulnerable seniors.

Thank you for your consideration of these comments. Alignment Health welcomes continued dialogue with DHCS as the state refines implementation and evaluation of these policies. If you have any questions, please contact Matt Eyles, EVP, Government & Business Strategy, at [redacted]

Sincerely,

Matthew Eyles
Executive VP, Government & Business Strategy

Jia Chen, CCAPP, Email received March 12, 2026.

To whom it may concern,

Please see attached comments regarding the waiver renewal.

Bests,

Jia Chen (She/Her)
Grants and Data Engagement Supervisor
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2400 Marconi Ave., Suite C | Sacramento, CA 95821
5861 Cherry Ave., Ste. 301 | Long Beach, CA 90805

California Consortium of Addiction Programs and Professionals

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Sacramento, CA 95821

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Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

RE: CalAIM Section 1115 Demonstration Renewal Application

Dear Director Sadwith,

On behalf of the California Consortium of Addiction Programs and Professionals (CCAPP), the largest statewide consortium of community-based for-profit and nonprofit substance use disorder (SUD) treatment agencies and addiction-focused professionals, we appreciate the opportunity to provide comment on the CalAIM Section 1115 Demonstration Renewal Application.

CCAPP recognizes the Department of Health Care Services' continued leadership in advancing a comprehensive, person-centered behavioral health system through the CalAIM initiative. We appreciate that the renewal proposes to maintain the core framework of the current demonstration while expanding several important initiatives that support individuals with substance use disorders in their treatment and recovery journeys. In particular, CCAPP is supportive of the proposed expansion of several SUD-related initiatives within the renewal.

The option for Drug Medi-Cal (DMC) counties to opt-in to select outpatient SUD services and the Recovery Incentives program, currently only available through the Drug Medi-Cal Organized Delivery System (DMC-ODS), represents a meaningful step toward strengthening recovery-oriented systems of care. Both these initiatives align closely with CCAPP's values in closing gaps in our care continuum and reflect our commitment to evidence-based care.

In addition, CCAPP is extremely supportive of the newly proposed Employment Supports initiative. Employment is a critical element of building recovery capital, which research has consistently shown to be foundational to sustained recovery. Stable employment not only provides financial stability but also fosters purpose, structure, and community connection, which are key factors that contribute to long-term recovery outcomes.

As the Department develops this initiative, CCAPP encourages explicit recognition of the role that recovery community organizations (RCOs) and recovery community centers (RCCs), including models such as recovery cafes, can play in advancing employment supports. These spaces often operate at the nexus of community connection and recovery support and are uniquely positioned to host life-skill and workforce development services. Within these environments, individuals in recovery frequently receive assistance with resume development,

job applications, and educational advancement, in addition to employment retention support through community connectiveness activities. Because RCCs serve as trusted gathering places within the recovery ecosystem, they are especially effective in engaging individuals who may otherwise face barriers to accessing traditional workforce development programs.

In this context, it is equally important to continue advancing parity in the recognition and integration of recovery support service providers who maintain these important spaces. While peer support specialists and community health workers, roles that can include individuals with lived experience of substance use disorders, have gained increasing recognition within behavioral health delivery frameworks, SUD peer professionals are still frequently categorized broadly as “other qualified providers.” This lack of recognition can limit the visibility and integration of SUD peer professionals within the system when the SUD community requires recovery support as much as their mental health equivalents.

As the state expands reocvery-oriented services, including new initiatives such as employment support and broader recovery service offerings under DMC and DMC-ODS, CCAPP encourages the Department to ensure that SUD peer professionals are clearly recognized and integrated as essential providers within these services. Doing so would more fully reflect the spirit and goals of the CalAIM demonstration by centering lived experience and community-based recovery supports within the Medi-Cal system.

California has made significant progress in building a more comprehensive system through CalAIM, CCAPP looks forward to continued collaboration with DHCS to ensure recovery supports and the community-based recovery infrastructure are fully leveraged to improve outcomes for Californians.

Thank you for the opportunity to provide comment and for your ongoing leadership in strengthening California's behavioral health system.

Sincerely,

[redacted]

Pete Nielsen
President and Chief Executive Officer

Jason Moriarty, Partners in Care Foundation, Email received March 12, 2026.

Mr. Sadwith,

Please see the attached comment in support of the 1115 Waiver Renewal on behalf of Partners in Care Foundation.

Jason Moriarty, JD
Senior Director - Quality and Compliance
Partners in Care Foundation
732 Mott St., Suite 150 | San Fernando, CA 91340
[redacted] | www.picf.org

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

CalAIM Section 1115 Waiver Renewal – Enhanced Care Management and Community Supports

Partners in Care Foundation strongly supports renewal of California's CalAIM Section 1115 demonstration and the continued authorization of Enhanced Care Management (ECM) and Community Supports (CS) as core components of Medi-Cal's delivery system.

ECM and CS provide critical services for members with complex medical, behavioral health, and social needs whose conditions often worsen when those needs go unaddressed. These programs help prevent repeated reliance on emergency rooms, hospitalizations, psychiatric crises, homelessness, and other costly safety-net systems by providing sustained, person-centered support that connects medical care with the social services people need to stabilize.

In our experience both as a direct service provider and as a Hub for dozens of community-based organizations, we have seen ECM and CS demonstrate their value through relationship-based engagement with members whose needs cannot be resolved through isolated referrals or short-term interventions. community-based organizations are especially well positioned to deliver these services because they bring trusted relationships, cultural and community knowledge, and the ability to engage people who may be disconnected from traditional systems of care. Hub models further strengthen this approach by connecting community-based organizations to managed care plans and providing infrastructure such as care coordination support, credentialing, billing, data reporting, and quality oversight.

One ECM member connected with Partners shortly after the birth of her child while facing serious postpartum mental health challenges and difficulty navigating the healthcare system. Without coordinated support, she was at risk of becoming disconnected from both medical and behavioral health care during a critical time for her and her newborn. Through consistent engagement, the ECM care team helped reconnect her to care and stabilize the challenges affecting her health and well-being. With the right supports in place, she was able to re-engage in treatment, strengthen her ability to care for her child, and move forward with greater stability and confidence. This kind of relationship-based support helps ensure that vulnerable families remain connected to care during critical life transitions, improving stability and long-term health outcomes.

Another member enrolled while experiencing homelessness, serious mental illness, and significant difficulty managing daily living needs. Without stable housing or coordinated care, her health conditions were worsening and engagement with the healthcare system was inconsistent. Partners worked closely with the member through ECM and CS to stabilize the conditions affecting her health, helping secure permanent housing and coordinating the medical and in-home supports needed for her to live safely. With stable housing and consistent care coordination, she was able to reconnect with healthcare providers, follow treatment plans, and begin managing her health more effectively.

What had once been a cycle of instability shifted toward safety, engagement in care, and the ability to live with greater independence and dignity. Experiences like this demonstrate how ECM helps stabilize vulnerable members by connecting medical, behavioral health, and social supports when they are needed most. These outcomes are strengthened through close collaboration among Medi-Cal managed care plans, medical providers, and community-based organizations. Enhanced Care Management and Community Supports help members build more consistent connections to care, move away from fragmented and crisis-driven utilization, and achieve better long-term stability. Renewal of the CalAIM Section 1115 demonstration is essential to preserving and strengthening this more integrated, person-centered approach to care, including the important role of community-based organizations and Hub infrastructure in reaching members with the most complex needs.

Sincerely,

[redacted]

Selene Betancourt, California Pan-Ethnic Health Network (CPEHN), Email received March 12, 2026.

Hello,

Please find CPEHN's attached comments.

Thank you,

Selene
Selene Betancourt (She | Her)
Associate Policy Director
California Pan-Ethnic Health Network (CPEHN)
[redacted]
Website | Twitter | Facebook

2991 Sacramento St. #298
Berkeley, CA 94702

California Pan-Ethnic HEALTH NETWORK

March 12, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
Via email: 1115waiver@dhcs.ca.gov

Re: CalAIM Section 1115 Demonstration Renewal Application

Dear Director Sadwith,

On behalf of the California Pan-Ethnic Health Network (CPEHN), we appreciate the opportunity to provide feedback on the Department's renewal request of the CalAIM Section 1115 demonstration. We write to express our support for the proposed Employment Supports initiative, which would establish Employment Supports as a covered Medi-Cal benefit for individuals subject to work and community engagement requirements. We also write to express our support for the Department's proposal to renew the Traditional Healers and Natural Helpers initiative.

While the majority of Medi-Cal members are already working or engaged in qualifying activities, a significant number of individuals will need meaningful support in obtaining and maintaining employment. This includes not only helping individuals obtain employment, but supporting those who may cycle in and out of work due to health, caregiving, or other barriers to maintaining eligibility over time. It is essential that California utilize all available strategies to support the whole-person health of Medi-Cal enrollees during this period of significant program changes to maintain continuity of care.

To support a strong development and implementation process, CPEHN recommends that DHCS:

- Share key lessons learned from the Whole Person Care Pilots and the CalWORKS Welfare-to-Work Program, including what worked, what did not, and for which populations. Articulate how those lessons are informing the design of the Employment Supports initiative.
- Provide information on the services and programs delivered through the Whole Person Care Pilots, including an analysis of which services were most effective for Medi-Cal enrollees.
- Ensure counties receive adequate funding for start-up costs to support successful implementation and encourage the maximum number of counties to opt in.
- Engage stakeholders and advocates throughout the development and implementation process to ensure the program is designed to meet the needs of enrollees, including ensuring services are culturally and linguistically responsive.

CPEHN supports the DHCS' goals for this initiative and looks forward to future opportunities to provide more substantive feedback as the program is further developed.

Additionally, CPEHN supports DHCS' proposal to renew the Traditional Healers and Natural Helpers initiative. Traditional healing practices provided by traditional healers and natural helpers are built upon the deep heritage of traditions in the Native American community. These practices are a fundamental element of Indian Health Care that help patients achieve wellness and healing and restores emotional balance and one's relationship with the environment. This is an important initiative that will have a positive impact on the health of Californians.

California Pan-Ethnic HEALTH NETWORK

We appreciate the opportunity to comment and welcome continued engagement with the Department as this work moves forward.

Sincerely,

[redacted]

Selene Betancourt
Associate Policy Director
California Pan-Ethnic Health Network

Corey Hashida, Steinberg Institute, Email received March 12, 2026.

Good morning,

Attached are the Steinberg Institute's comments on the proposed CalAIM Section 1115 Waiver Renewal. Please let me know if you have any questions.

Best,
--
Corey Hashida, MPP
Associate Director of Fiscal and Policy Analysis
Steinberg Institute
[redacted]

March 12, 2026

Michelle Baass, Director
Department of Health Care Services
Deputy Director's Office, Behavioral Health
P.O. Box 997413
Sacramento, CA 95899-7413

Re: Comments on Proposed Renewal of the CalAIM Section 1115 Demonstration Waiver

Dear Director Baass,

On behalf of the Steinberg Institute, we appreciate the opportunity to provide comments on DHCS' proposal to renew California's CalAIM Section 1115 demonstration waiver. We commend DHCS for its continued leadership in transforming Medi-Cal into a more coordinated, person-centered system of care that addresses the physical, behavioral, and social needs of Medi-Cal members. The CalAIM initiative has already produced meaningful improvements in care coordination, access to behavioral health services, and support for individuals with complex needs.

As DHCS looks toward the next phase of CalAIM, we appreciate the department's commitment to building on the progress achieved during the current demonstration period. We offer the following comments and recommendations to strengthen the proposed renewal and support successful implementation across California's behavioral health system.

Preserving Access to Mobile Crisis Services Is Critical.

We recommend the state maintain mobile crisis services as a state-mandated Medi-Cal benefit rather than shifting to a county-optional benefit. Mobile crisis services are a critical component of a modern behavioral health crisis continuum and help ensure that individuals experiencing behavioral health emergencies receive timely, community-based care rather than defaulting to emergency departments, inpatient settings, or law enforcement responses. The state is also actively implementing a comprehensive crisis response framework—with mobile crisis services as a central focus—under AB 988.

Moving this Medi-Cal benefit to a county-optional model risks creating uneven access across the state and could undermine progress toward a consistent statewide crisis response system. In addition, shifting responsibility for the nonfederal share of Medi-Cal cost to counties—combined with the loss of enhanced federal funding for mobile crisis services—places new financial pressure on local crisis response systems and will ultimately make it harder for people in crisis to receive the right care at the right time. We urge the state to maintain its financial commitment to mobile crisis services and seek backfill for lost federal funds.

In addition, given ongoing legislative deliberation about this proposal in the current state budget process, we believe it is premature to incorporate this change into the CalAIM waiver renewal at this time.

Support for Employment Supports Initiative.

We applaud DHCS for proposing the new Employment Supports Initiative under CalAIM. Securing meaningful employment is a powerful driver of recovery and long-term stability for individuals living with behavioral health conditions. Expanding access to employment services and supports can help individuals achieve greater independence, improve health outcomes, and strengthen community integration.

In addition—given the proposed waiver renewal's recognition that the CalAIM Justice-Involved Initiative will be critical to implementing work and community engagement requirements associated with federal policy changes due to H.R.1.—and how important securing employment is for individuals leaving incarceration, **we encourage DHCS to consider integrating the Employment Supports Initiative with the Justice-Involved Reentry Initiative's 90-day pre-release package of services.** Doing so would help ensure that individuals who are about to reenter the community after incarceration have access to meaningful pathways to employment and economic stability as soon as possible.

Support for Renewal and Expansion of Recovery Incentives and Outpatient SUD services.

We applaud DHCS' proposal to renew the Recovery Incentives Initiative and expand Recovery Incentives and outpatient SUD services to counties that do not currently participate in the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Recovery Incentives have been shown to be effective in supporting individuals with stimulant use disorder through improving engagement in treatment, and the expanded set of SUD services provided through DMC-ODS has brought comprehensive treatment to individuals residing in most of the state. However, service gaps remain for people who live in certain parts of the state. This proposal helps bridge that gap to ensure that comprehensive care is provided to individuals residing in counties that opt-in to this proposal.

We are also impressed with the proposed evaluation of the Recovery Incentives Initiative, particularly the goal of developing recommendations to expand Recovery Incentives into additional settings such as Federally Qualified Health Centers, mobile units, street medicine programs, and telehealth. Expanding access to Recovery Incentives in these settings would help reach individuals who may otherwise face barriers to engaging in traditional treatment programs for stimulant use. We also support the proposal's goal to increase enrollment in Recovery Incentives among individuals transitioning from medical and correctional settings, where the risk of relapse and overdose can be particularly high.

Systems—and Providers—Still Need Funding to Build Capacity.

Start-up funding to build infrastructure and capacity—particularly through the Providing Access and Transforming Health (PATH) Initiative—has been vital for providers, counties, and community-based organizations to implement CalAIM's suite of services. While the PATH Initiative is ending, stakeholders on the ground still report a need for this funding. **We strongly encourage the state to seek renewal of the PATH Initiative—or propose a similar mechanism that allows the state to continue**

providing funding for capacity building to local entities—to ensure the rollout of CalAIM can continue to move forward. This request could be packaged and aligned with the proposed waiver renewal's request for start-up funding to implement the Employment Supports and BridgeCare Initiatives.

Planning for the Future of BH-CONNECT.

We understand that the federal government will not approve continuation of the Designated State Health Program (DSHP) financing mechanism going forward. However, given that DSHP is what allows the state to leverage additional funding through the BH-CONNECT Initiative for critical behavioral health models of care such as Assertive Community Treatment, **we strongly encourage DHCS to develop a long-term plan to sustain key components of the BH-CONNECT Initiative beyond its five-year window—and without reliance on DSHP.** Identifying an alternative funding approach will be essential to maintaining BH-CONNECT's progress toward creating a comprehensive system of care for individuals with serious mental illness.

Proposed Waiver Renewal Brings County Financing and Implementation Challenges.

DHCS should carefully consider the cumulative financial impact on counties due to the proposed waiver renewal's focus on optional county services that do not come with additional funding for the nonfederal Medi-Cal share of cost. Our county partners are being asked to voluntarily take on significant new responsibilities and costs under the proposed waiver renewal—including implementing the Employment Supports Initiative, expanding Recovery Incentives additional outpatient SUD services (for non–DMC-ODS counties), and providing mobile crisis services if that Medi-Cal benefit becomes optional.

At a time when county behavioral health resources are already stretched thin due to major initiatives like the Behavioral Health Transformation (BHT), these additional financial obligations may make it difficult for counties to opt into or fully implement these initiatives which may jeopardize how impactful they are on a statewide basis.

We encourage DHCS to explore alternative approaches for financing the nonfederal share of these initiatives—and examine the feasibility of making them mandatory statewide. One potential option is to consider having Medi-Cal managed care plans provide certain services referenced in this proposed waiver renewal—particularly the Employment Supports Initiative which may align with the current package of Community Supports that managed care plans already provide—which could reduce the financial burden on counties and improve the likelihood that these initiatives are impactful statewide.

Support for Performance Measures and Continuous Improvement.

As CalAIM continues to roll out, it will remain important for DHCS to demonstrate the initiative's positive impacts through robust performance measures and transparent reporting. We support the inclusion of clear performance measures in the proposed waiver renewal.

We also recommend that DHCS ensure that the proposed CalAIM measures align, where possible, with the measures developed for the implementation of Proposition 1 and the BHT. Aligning these measurement frameworks can help reduce duplication, improve data comparability, and provide a clearer picture of how California's behavioral health reforms are working together to improve outcomes. For example, BHT measures related to employment outcomes could be aligned

with the Employment Supports Initiative to assess whether individuals receiving services under this initiative ultimately secure and maintain employment.

Thank you for the opportunity to provide comments on the CalAIM Section 1115 Demonstration Waiver Renewal. The Steinberg Institute appreciates DHCS' continued leadership in advancing the CalAIM vision and strengthening California's behavioral health system. We believe the proposed waiver renewal provides an important opportunity to build on CalAIM's successes going forward.

As always, the Steinberg Institute is ready to assist you in any way we can. Should you have any questions about our recommendations, please feel free to contact me at [redacted]

Sincerely,

[redacted]

Corey Hashida
Associate Director of Fiscal and Policy Analysis

Zara Zaidi, Alameda Health Consortium, Email received March 12, 2026.

Hello,

On behalf of Alameda Health Consortium, I would like to submit written comments on the CalAIM Section 1115 Demonstration Renewal Application.

Best,

Zara Zaidi
Zara Zaidi
Senior Manager, Health Policy and Government Affairs
Alameda Health Consortium
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ALAMEDA HEALTH CONSORTIUM

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Asian Health Services | Axis Community Health | Bay Area Community Health
Baywell Health | La Clínica | LifeLong Medical Care | Native American Health Center
Tiburcio Vasquez Health Center

March 12, 2026

Department of Health Care Services
Director's Office
Attn: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Sent via email to: 1115Waiver@dhcs.ca.gov

Re: Alameda Health Consortium (AHC) Comments on CalAIM Section 1115 Waiver Renewal Application

Dear Mr. Sadwith,

On behalf of Alameda Health Consortium, we appreciate the opportunity to comment on the 2026 CalAIM 1115 Demonstration Renewal Application for the 2027–2031 waiver period.

Alameda Health Consortium (AHC) is the regional association of eight community health centers (CHCs) in Alameda County, six of which are unionized, and all of which are certified as federally qualified health centers (FQHCs). Collectively, our health centers employ more than 2,200 workers and serve over 200,000 patients at over 100 clinic sites and 21 mobile units throughout Alameda County – and nearly 300,000 across the greater East Bay. An economic analysis conducted by Capital Link found that in 2023, AHC member health centers:

- generated $89M in tax revenues, including $18.6M in state and local tax revenues;
- were responsible for $585.2M in spending;
- lowered costs for health center Medi-Cal patients by 22%; and
- generated $284.7M in savings to Medi-Cal.

Alameda Health Consortium member health centers also play a significant role in implementing CalAIM's whole-person care framework through Enhanced Care Management (ECM) and Community Supports (CS). AHC and its 8 FQHCs all serve as ECM providers, delivering intensive care coordination for Medi-Cal members with complex medical, behavioral health, and social needs. Through the Community Health Center Network's (CHCN) Care Neighborhood program, an established complex care management model introduced in 2013, community health workers embedded in health centers support highest-need patients by connecting them to housing, food, transportation, and other essential resources that impact health outcomes. CHCN administers the program to support consistent implementation across health centers, provide training and technical assistance, and integrate care management data into clinical workflows. Upwards of 50 community health workers at 17 clinic sites serve 9,000 ECM patients annually.

Additionally, as contracted providers of Alameda County's Recipe4Health program, many of AHC's member health centers provide the Medically Supportive Food Community Support; two health centers (LifeLong Medical Care and Tiburcio Vasquez) are contracted Community Supports providers

for Housing; and one (LifeLong) is a contracted Community Support provider for Recuperative Care (Medical Respite). AHC member clinics' embracing of both ECM and Community Supports reflect their commitment to advancing seamless patient experiences across the medical, mental health, and substance use delivery system and highlight the importance of strengthening FQHC integration across the behavioral health continuum to advance equitable, coordinated, whole-person care for Medi-Cal members.

AHC supports the Department of Health Care Services' (DHCS or Department) overarching approach to sustain and refine CalAIM's core programs. Given the limited opportunity for significant programmatic expansion at the federal level, we echo comments submitted by our state sister organization, California Primary Care Association, in support of DHCS's strategy to preserve essential authorities, maintain continuity of coverage and services, and continue advancing whole-person care for Medi-Cal members.

We also share CPCA's comments that this renewal presents an important opportunity to strengthen implementation of existing and proposed programs and ensure that community health centers, especially FQHCs like AHC's member CHCs, are fully integrated, appropriately reimbursed, and administratively supported in delivering these services.

I. Support for Renewal of Core 1115 Authorities:

AHC supports renewal of the key 1115 authorities identified in the application. The following proposals would be strengthened by augmenting the provider network with explicit inclusion of health centers and clarifying reimbursement guidance.

- **Recuperative Care and Short-Term Post-Hospitalization Housing.** These services have demonstrated clear value in improving post-discharge follow-up, reducing avoidable emergency department use and readmissions, and supporting recovery for individuals experiencing homelessness. We support DHCS transitioning the authority for these services from the 1115 wavier to an in-lieu of service (ILOS), making them a permanent benefit.

- **Reentry Services for Justice-Involved (JI) Individuals.** We strongly reiterate our prior recommendation that waiver authority clearly recognize CHCs as core community-based partners in pre-release planning and care coordination. Continuity of care prior to release with the patient's post-release Enhanced Care Management (ECM) program reduces retraumatization, improves outcomes, and lowers long-term costs. Health centers contract with managed care plans extensively to provide ECM throughout the state. DHCS could strengthen JI reentry services by promoting that carcel settings contract with at least one health center in the pre-release engagement and warm handoffs.

- **Proposals to seek authority for Drug Medi-Cal (DMC) counties to opt-in to cover mobile crisis care and contingency management.** AHC is supportive of programs that expand the use of evidence-based services, including mobile crisis care and contingency management, for people with substance use disorder(s). That said, philosophically, as the distinction between services available in Drug Medi-Cal (DMC) and DMC Organized Delivery System blur so that benefits are available in

both, it calls into question the purpose of having two systems. Two distinct DMC systems add complexity, fragments service delivery access, perpetuate inequities based on geography, and disrupts the member experience. Across all delivery systems, DHCS should continue efforts to standardize a seamless delivery system.

II. Support for Renewal of Core 1115 Authorities with Recommendations:

- **Dually Eligible Demonstrations, including Dual-Special Needs Programs (D-SNP) alignment.** AHC strongly supports DHCS's efforts to improve alignment for dually eligible individuals through D-SNPs. Dual eligible members often require intensive care coordination, interdisciplinary case management, and navigation across Medicare and Medi-Cal systems to manage complex medical and social needs. CHCs serve a large share of individuals who are dually eligible and have extensive experience caring for medically complex populations. As detailed above, all eight of AHC's CHCs participate as providers in Medi-Cal's ECM program, and all eight are included in the first year of Alameda Alliance for Health's (AAH) D-SNP plan in 2026. Accordingly, AHC's member clinics already deliver intensive care coordination, interdisciplinary case management, and whole-person care for individuals with complex needs. As a result, they have developed an established care management infrastructure within Medi-Cal that is well positioned to support the care coordination needs of dually eligible members. Ensuring that aligned D-SNP models meaningfully integrate CHCs in the provision of California Integrated Care Management (CICM) will be essential to achieving the goals of improved alignment, reduced fragmentation, and whole-person care for dual eligible members.

FQHCs and RHCs are paid through a cost-based prospective payment system (PPS) designed to reflect the full cost of delivering comprehensive primary care services during patient visits. However, some activities that are essential to managing complex patients, such as ongoing care coordination, care planning, and patient monitoring, occur outside of face-to-face medical visits even though they are critical to improving health outcomes and preventing avoidable utilization. Because CHCs frequently serve as the primary care home for dually eligible individuals, these activities are often performed by health center teams in coordination with health plans and community-based providers.

Both Medicare and Medi-Cal have recognized that certain high-value activities may occur outside of a billable visit and have established targeted payment pathways to support them. For example, Medicare provides separate payment for certain care management activities furnished by FQHCs when they occur outside of a qualifying visit, and Medi-Cal similarly reimburses specific activities such as trauma and developmental screenings, and intensive care management (ECM).

Under aligned D-SNP models, however, both primary care and care coordination are administered through Medi-Cal managed care plans, and current implementation has effectively limited payments to the FQHC visit rate without establishing a pathway to support these non-visit care coordination activities. As a result, D-SNP alignment has unintentionally eliminated the Medicare payment pathway that previously supported care management activities furnished by health centers without replacing it.

AHC Recommendations:

1. Ensure inclusion of essential community providers, including CHCs, as delegates to provide California Integrated Care Management (CICM) in D-SNP models. AHC recommends that DHCS require D-SNP plans to include CHCs as care management providers, especially when the CHC is an existing ECM provider and when the patient is assigned to the clinic for primary care. Anchoring care coordination in the primary care settings where many dual eligible patients already receive services would strengthen communication between plans and providers, reduce fragmented care management activities, and advance CalAIM's goals of integrated, whole-person care.

2. Establish a supplemental payment pathway for care coordination. AHC recommends that DHCS establish a supplemental payment mechanism for care coordination services provided to dually eligible members that is paid in addition to the FQHC visit payment and does not require associated costs to be carved out of health center rates. Establishing a comparable add-on payment would allow community health centers to sustainably deliver the intensive care management that dually eligible patients require while preserving the integrity of the FQHC payment methodology.

III. New Proposals: Employment Supports

AHC supports DHCS's proposal to pilot Medi-Cal funded Employment Supports under the Section 1115 demonstration. Providing job readiness assessments, individualized employment planning, placement assistance, and retention services recognizes the clear connection between a person's economic stability, continued Medicaid coverage, health access and care outcomes. In the context of federal work and community engagement requirements, these supports are particularly important to help Medi-Cal members maintain coverage, remain engaged in care, and avoid unnecessary coverage disruptions that can undermine health and financial stability.

At the same time, AHC is concerned by the proposal's indication that Employment Supports may be delivered via counties or county-based entities. Implementing this benefit outside of the Medi-Cal managed care infrastructure risks further fragmenting the Medi-Cal system through complicated referrals, uncoordinated systems, taxed county and provider networks, and limited alignment with existing care management and social health programs like ECM and Community Supports, respectively. AHC urges DHCS to ensure that Employment Supports are operationalized in a manner that promotes integration with MCPs and requires coordination with patients' ECM providers. We recommend that DHCS includes CHCs as participating providers and outlines clear reimbursement pathways – specifically a non-reconcilable carve out of Employment Supports reimbursement from PPS - for participating health centers.

***

California's CHCs are essential partners in achieving Medi-Cal's goals of equity, access, and improved outcomes. Sustaining CalAIM's gains while strengthening operational clarity and financing structures will be critical to success in the 2027–2031 waiver period.

We appreciate the opportunity to comment and look forward to continued collaboration with DHCS as the waiver renewal advances. Please do not hesitate to contact me at [redacted] with any questions.

Respectfully,

03/12/2026

Nancy Behm, Rooted Life, Email received on March 12, 2026.

Hello,

Please see attached public comment from Rooted Life. We provide CalAIM services in San Diego and Imperial Counties.

Thank you,

Nancy Behm, MPH
Project Director
[redacted]
www.rootedlifesd.com

ROOTED LIFE
COMMUNITY COMFORT GROWTH

March 12, 2026

Subject: Feedback on CalAIM Section 1115 Demonstration Renewal Application

Thank you for inviting stakeholders and service providers to share input on the CalAIM Section 1115 Demonstration Renewal Application. We appreciate DHCS' continued efforts to improve health outcomes, quality and coordination of care for individuals who are unhoused, justice-involved, or with substance-use disorders.

Rooted Life provides Enhanced Care Management and Housing-related Community Supports (including Recuperative Care and Short-Term Post-Hospitalization Housing (STPHH)) to Medi-Cal beneficiaries in San Diego and Imperial Counties, supporting adults experiencing homelessness with a qualifying health condition, adults at risk for avoidable system utilization, adults with serious mental illness or substance use disorders and those transitioning from incarceration with a qualifying health condition. Rooted Life is an IPP and CITED recipient and active participant in both counties' CPI groups.

Rooted Life entered the CalAIM space to significantly expand access to recuperative care services in both counties. We are encouraged to see the preliminary findings that "recuperative care and short-term posthospitalization housing resulted in 29.2 and 10.6 percent reductions, respectively, in aggregate per member per month (PMPM) costs due to decreases in inpatient, outpatient, emergency department (ED), and long-term care costs." We see recuperative care as an essential part of the housing and healthcare continuums - for cost-savings, but also stabilization, equity, and access to longer-term supports.

We hope to see continued support and unrestricted offering of Recuperative Care and the Housing Trio to Medi-Cal beneficiaries in 2027 and beyond in both San Diego and Imperial Counties, and throughout the state.

SECTION 3 - CALAIM DEMONSTRATION FIVE YEAR RENEWAL REQUEST

We are encouraged to see and support the inclusion of Employment Supports to help Medi-Cal beneficiaries maintain their health care coverage and case management (and even recuperative care stay), and potentially enhance their quality of life. We support the counties we operate in opting-in to cover this benefit "to address barriers to employment, support sustained workforce participation, and promote economic stability among Medi-Cal members.".

SECTION 4 – INITIATIVES BEING DISCONTINUED OR TRANSITIONED UNDER CALAIM SECTION 1115 AUTHORITY

We recognize the need to reconsider the funding authority and structure of Recuperative Care and STPHH. We support DHCS' efforts to continue investing in recuperative care as a long-term, permanent option in the in-lieu-of services menu.

We are in alignment with NIMRC's concerns and recommendations surrounding the proposed funding authority changes that warrant the removal of coverage for Room and Board. Room and Board is the majority of our rate of service for both Recuperative Care and STPHH. If payment for Room and Board is no longer an option, it seems highly unlikely that reimbursement rates will be sufficient to remain open. We, along with NIMRC, encourage DHCS to consider reimbursing Room and Board costs through state-funded wrap payments.

With the sunsetting of STPHH and the need to change or even enhance the services under Recuperative Care to not include Room and Board, we ask DHCS to remain true to the purpose of Recuperative Care is - a safe place for someone experiencing homelessness to discharge quicker and rest after a hospitalization. We join NIMRC in requesting that DHCS utilize the existing NIMRC Models of Medical Respite Care as the foundation for the creation of tiers of recuperative care services - honoring those models that do not have clinical staff as part of their team. Using these established Models of Care will provide a familiar framework for determining a program's model, level of services and subsequent reimbursement rate. Each of the four models serve a critical role in the housing and healthcare continuum, as not all members will need to access all levels of those care models, and not all providers, including ourselves, can easily pivot to increase the intensity of their care model.

Thank you for your consideration of our comments and for your continued commitment to improving and sustaining services for Medi-Cal beneficiaries to improve their health and wellbeing.

Thank you,

[redacted]

Shannan Wilson
Chief Strategy Officer

[redacted]

Meg Sevilla, Transitions Clinic Network, Email received March 12, 2026.

Good afternoon,

Transitions Clinic Network (TCN) appreciates the opportunity to provide comment on the proposed CalAIM 1115 Demonstration Renewal Application. Attached to this message is a letter with our comments through the collective voice of our TCN clinic sites that are contracted Justice Involved (JI) Enhanced Care Management (ECM) providers who have first-hand experience of participating in CalAIM through this, and other CalAIM initiatives.

We additionally wanted to share an Op-Ed published in the San Francisco Chronicle by our Executive Director, Dr. Shira Shavit, and Associate Director, Anna Steiner, titled, "Medicaid Cuts Will Make Reentry to Society for Incarcerated People Even Harder," which can be found here.

TCN looks forward to seeing the next steps of this renewal process unfold, and again, appreciates the opportunity to have our comments be considered in the process.

Thank you,

Meg Sevilla (she/her/they/them)
Contracts and Grants Program Manager
Transitions Clinic Network
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Department of Health Care Services Director's Office
Attn: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

March 12, 2026

The Transitions Clinic Network (TCN) appreciates the opportunity to provide comments on the proposed CalAIM 1115 Demonstration Renewal Application. TCN is a California-based, community-based organization changing health systems to better care for the health needs of people returning home from incarceration. The TCN model, in which a Community Health Worker (CHW) with lived experience of incarceration is embedded in a Federally-Qualified Health Center or other primary care team, is an evidence-based model that has been shown to engage patients reentering the community from jail or prison in primary care, reduce preventable hospitalizations and emergency room visits, shorten hospital stays, and reduce days reincarcerated.[1,2]

Our comments within this document are submitted through the collective voice of our TCN clinic sites that are contracted Justice Involved (JI) Enhanced Care Management (ECM) providers that have first-hand experience of participating in CalAIM through this, as well as other CalAIM initiatives. With the vested interest in both the implementation and sustainability of our CalAIM programs and the overarching ability to comprehensively and effectively serve the reentry population in the communities we serve across the state, TCN appreciates the ability to provide comment on this proposed renewal application.

TCN commends and supports DHCS's goal to renew the JI initiatives to continue to address the identified need of enhanced care coordination of those returning to the community from incarceration that also addresses their social drivers of health. As you know, this population has historically been excluded from systematic efforts to improve health care service delivery despite disproportionately high risk of hospitalizations and death from preventative causes upon release from incarceration. TCN also supports adding Employment Supports as covered benefit and requests additional funding to develop the infrastructure necessary to implement this critical benefit, with the goal of making it statewide (rather than county dependent).

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TCN provides the following comments and recommendations to DHCS for consideration:

Reentry Services for Justice-Involved Populations 90-Days Pre-Release

As previously stated, TCN commends the overarching goals of the JI CalAIM initiative and has a vested interest in supporting the effectiveness and sustainability of both the 90-day pre-release Medi-Cal eligibility and JI Enhanced Care Management Population of Focus (PoF). TCN is excited about the renewal and in moving forward suggests that DHCS consider the gap in care from pre to post release. For instance, 14,086 incarcerated individuals received medications pre-release indicating that they have chronic conditions and a need for care post release. Yet only 3,200 eligible JI clients successfully were enrolled in ECM. These data indicate that referrals from prison and jail to community programs infrequently lead to successful ECM enrollment post-release, revealing gaps in community engagement that limit the initiative's ability to achieve its goals of improved post-release care and health related outcomes.

For this proposed renewal period, TCN encourages DHCS to consider the experience of the TCN and our 21 primary care health systems during the implementation of JI ECM in effort to improve CalAIM JI Initiative 2.0.

The following are notes from calls, trainings and technical assistance provided to our TCN sites participating in JI-ECM. Sites noted:

- **Patient complexity and unique needs of JI population:** Patients served under the JI-ECM population have uniquely complex and specific needs compared to other populations of focus, and successful ECM programs require specialized staffing models, increased and sustained funding, and comprehensive program infrastructure to effectively serve the reentry population. Our sites report challenges in integrating the JI-ECM program into existing ECM POFs programs and acknowledge that they often do not have the staffing, administrative or leadership support or funding needed to adequately support the JI population.

- **Administrative burden:** JI ECM providers have faced extreme administrative burden, as compared to other POFs, while attempting to work with varying processes and workflows across multiple health plans as well as different prison and jail systems (amount depending on the counties they serve). This includes, but is not limited to, navigating Medi-Cal and MCP enrollment issues, authorization/reauthorization, billing processes, and reentry care planning and warm hand off

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processes. With further consideration that processes will presumably be additionally complicated by forthcoming Medi-Cal work requirements, TCN stresses that efforts to better streamline processes across Managed Care Plans (MCPs), CDCR and county jails will be imperative to the sustainability of JI-ECM programs and for JI-ECM providers to build the appropriate capacity to serve those returning home.

- **Enrollment status**: TCN JI-ECM contracted clinics have reported frequently experiencing issues with patients that do not have an active Medi-Cal status and/or MCP enrollment upon release while attempting to enroll in ECM services and provide care post-release. This can cause long, up to 2-month delays in enrollment into ECM post-release which can be dangerous to this uniquely vulnerable population. This reportedly happens more frequently with those that have experienced long-term incarceration and therefore have not been recently enrolled in an MCP, and unfortunately, this group is typically older and sicker than those who experience short-term incarceration. While FFS bundle 6 may cover some costs to ECM providers post-release to connect with clients, significant barriers to utilizing this mechanism exist, including lack of understanding of billing mechanisms and technical support available. TCN recommends establishing statewide, standardized requirements to help address these issues, such as presumptive eligibility for the target population, standardizing enrollment mechanisms across plans, and revisiting the activation of plan pre-release.

- **Warm hand-offs are variable** and are lacking meaningful in person interactions. Access to patients pre-release is minimal and Lead Care Managers (LCMs) and Community Health Workers (CHWs) are unable to build trusted relationships to ensure that they are able to follow patients successfully into the community.

Employment Supports

TCN supports the proposed addition of employment supports as a covered benefit to help those eligible for Medi-Cal both access and retain their Medi-Cal status to receive critical health and social services in the face of the forthcoming federally mandated work requirements.

Employment Supports should be offered as a statewide covered benefit rather than an opt-in program to ensure equity and consistency across California, particularly in light of work requirements proposed under HR1 and recent Medicaid changes. Justice-involved populations often move from county to county, and it is already very complicated to support their eligibility and

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enrollment into ECM services. Statewide coverage guarantees that all eligible individuals have equal access to support that can help them meet new employment-related requirements, whereas variability across counties would further reduce access for this population.

Employment is a key determinant of successful reentry (and now retaining Medicaid), and consistent support reduces unemployment, housing instability, and recidivism. Statewide implementation ensures that individuals leaving incarceration have immediate access to employment services, rather than relying on local discretion or availability, which is critical for meeting HR1's work expectations and achieving positive post-release outcomes.

As the JI initiative implementation has proved to present unique procedural difficulties with the navigation of members' Medi-Cal status and MCP enrollment, TCN suggests that DHCS dedicate resources specifically to support the implementation of this proposed benefit for the JI population to help address their unique needs and additional challenges with employment.

Providing Access and Transforming Health (PATH) Initiative:
TCN appreciates the goals of the PATH initiative and celebrates the infrastructure built so-far as well as the support mechanisms that have been made available to community-based organizations through this funding. TCN strongly advocates for additional resources to be allocated to continue to support the capacity and infrastructure building of on-the-ground providers as many challenges are still faced and the successes of PATH are yet to fully translate to the reality of providing care in the community.

While pre-release, carceral-based activities have achieved significant successes, post-release services remain weaker, and the infrastructure to support justice-involved individuals returning to the community is still underdeveloped. Continued PATH funding is critical to strengthen these post-release supports, enabling California to invest in evidence-based models such as hiring CHWs with lived experience of incarceration that have been shown to improve engagement, health outcomes, and successful reentry. With HR1 and other emerging barriers to enrolling in and maintaining Medi-Cal coverage, CHWs and robust community-based health care staff are essential to help justice-involved individuals navigate the increasingly complex insurance landscape. Maintaining and expanding PATH resources ensures the state can build on proven programs while addressing persistent gaps in post-release care, advancing both health equity and population health goals.

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TCN also recognizes the continued importance of PATH funding to build the infrastructure for services that are closely connected to health outcomes of individuals returning from incarceration, including housing supports. However there remains a significant lack of funding and coordinated support for housing, which is critical to successful and healthy transitions back to the community. TCN encourages the state to consider allocating ongoing PATH funds for individuals upon release, especially those with high-risk medical needs and disabilities, recognizing that stable supportive housing is foundational to improving health outcomes and supporting successful reentry.

Finally, TCN recommends that the California Department of Health Care Services (DHCS) and the State of California reinvest cost savings generated through successful interventions at the carceral system level directly into community-based providers. *Reinvesting these savings would strengthen the network of Justice-Involved (JI) community providers by supporting workforce development, including the hiring of Community Health Workers (CHWs) with lived experience of incarceration, and by expanding investments in critical reentry supports such as housing, clothing, food, and employment services.*

This approach aligns with the goals of CalAIM to build community-based care infrastructure and address social drivers of health and would not require additional state funding or a new budget appropriation, as these reinvestments are already an existing provision of CalAIM policy.

Thank you for taking the time to consider our comments. For any follow-up questions, please reach out to the Transitions Clinic Network by contacting Meghan Sevilla, Contracts and Grants Program Manager, at [redacted]

Sincerely,

[redacted]

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References

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2. Wang EA, Lin H, Aminawung JA, et al. Propensity-matched study of enhanced primary care on contact with the criminal justice system among individuals recently released from prison to New Haven. *BMJ Open*. 2019;9(5). doi:10.1136/bmjopen-2018-028097

Louise Nakada, Alameda Health System, March 12, 2026.

Hello,

Please see the attached support letter from Alameda Health System.

Thank you,

Louise
Louise Nakada (she/her/hers) | Manager
Public Affairs and Community Engagement (PACE)
Alameda Health System
15400 Foothill Blvd. | San Leandro, CA 94578
[redacted]
AlamedaHealthSystem.org
Follow us on Facebook, Twitter, Instagram, Youtube, and LinkedIn

ALAMEDA HEALTH SYSTEM

March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Submitted via: 1115waiver@dhcs.ca.gov

Subject: Support for Five-Year Renewal of the Global Payment Program in the Proposed CalAIM 1115 Section 1115 Demonstration

Dear Mr. Sadwith,

On behalf of Alameda Health System, I am writing in strong support of the Department of Health Care Services' (DHCS') proposal to request a five-year renewal of the Global Payment Program (GPP) as part of the CalAIM Section 1115 demonstration renewal application. Since its launch in 2015, the GPP has been a critical program in supporting our ability to provide value-based care to uninsured patients and our financial stability. With fundamental programmatic changes included in the proposed demonstration, a renewal of the GPP would create greater incentives and opportunities to provide preventive and primary care and manage chronic conditions for uninsured patients, supporting ongoing change and the delivery of value-based care at Alameda Health System.

Alameda Health System is the safety-net, integrated health care provider serving Alameda County. The system includes three acute care hospitals, an affiliate acute care hospital, a psychiatric hospital, four ambulatory care wellness centers, five post-acute facilities, and the only adult Level 1 Trauma Center and psychiatric emergency department in Alameda County. AHS serves approximately 130,000 patients annually, and 60% of its payor mix is comprised of Medi-Cal beneficiaries.

Since 2005, California's 17 public hospital systems have leveraged participation in Medi-Cal 1115 waivers to catalyze significant delivery system transformation, resulting in improved quality and patient outcomes, greater efficiencies within our systems, and stronger care coordination efforts for complex and high-risk patients.

The GPP has been a key program in making this transformation possible by creating strong financial incentives for Alameda Health System to shift uninsured services from the emergency department to primary and preventive care settings. The GPP supports this by converting Medicaid Disproportionate Share Hospital funding, which is traditionally limited to reimbursement for more costly, hospital-based and emergency settings to a more flexible, value-based funding methodology that incentivizes low-cost, high-value services.

At Alameda Health System, we have used the flexibility created under the GPP to focus on preventive care, care coordination, and community-based services that improve patient outcomes. This approach helps us reduce

avoidable emergency department visits and hospitalizations, helping us manage our limited resources more efficiently while advancing health equity.

Alameda Health System supports the changes proposed for the GPP in the 1115 renewal, which would further evolve the program by strengthening the focus on preventive care and chronic disease management and adding risk to earning GPP funding in ways that further incentivize preventive care and system transformation.

If GPP is renewed as proposed, Alameda Health System can further expand preventive and primary care, strengthen care coordination and case management, integrate behavioral health services, and improve quality of care for underserved populations.

For over a decade, the GPP has allowed public hospital systems like Alameda Health System to build a solid foundation for change and provided our uninsured patients with greater access to primary and specialty care. A renewal of the program would sustain these changes and allow us to further strengthen our delivery system transformation efforts. It is also especially critical at a time when we are facing steep cuts to our funding in the Medi-Cal program and expect to see an influx of uninsured patients over the next few years.

For all of the reasons stated above, **we strongly support the renewal of the GPP through December 31, 2031.** Thank you for your continued partnership to serve California's Medi-Cal and uninsured patients and support the health care safety net.

Sincerely,

James Jackson
Chief Executive Officer
Alameda Health System

Cc: Michelle Baass, Director, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS

William Barcellona, America's Physician Groups, Email received March 12, 2026.

Please accept APG's comments on the California CalAIM Section 1115 Demonstration Renewal Application.

Best,

Bill

March 12, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Submitted via email: 1115waiver@dhcs.ca.gov.

Re: Comments on California CalAIM Section 1115 Demonstration Renewal Application

America's Physician Groups (APG) appreciates the opportunity to comment on California's application to the Centers for Medicare & Medicaid Services to renew and amend the CalAIM Section 1115 Demonstration Waiver. APG is a national association representing more than 340 physician organizations that practice in value-based and capitated models of care. While APG's membership is national, the organization was founded in California and many of our members serve the Medi-Cal program, collectively caring for more than 5 million Medi-Cal beneficiaries and over 1.7 million Medicare Advantage enrollees. Our members have extensive experience delivering coordinated care for complex populations, including dually eligible individuals.

Executive Summary

APG supports California's continued use of the Section 1115 waiver to advance the CalAIM initiative and strengthen integrated care delivery for Medi-Cal beneficiaries. Based on the operational experience of physician organizations participating in capitated and delegated care models, we offer several recommendations to improve implementation and provider participation. Specifically, APG encourages DHCS to allow flexibility in the Default Enrollment Pilot's provider network overlap requirements so that high-performing Medicare Advantage provider organizations with dual-eligible expertise can participate in aligned D-SNP programs. We also urge DHCS to reconsider the current Medi-Cal Medical Loss Ratio (MLR) framework applied to risk-bearing provider organizations. Finally, as DHCS evaluates potential limited-plan models in certain counties, the Department should carefully assess impacts on provider networks and encourage transparent value-based contracting approaches—such as the model utilized by CalOptima Health—that promote predictable payment structures and performance-based incentives for risk-bearing physician organizations.

We support DHCS's continued use of the Section 1115 waiver to advance whole-person care and delivery system transformation. However, we encourage DHCS to address several operational issues related to implementation, financing stability, and provider participation.

Our comments are organized by section titles in the Department's Application:

1. Section 3.9 – Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan

Several APG capitated-delegated members function as risk-bearing organizations within the California Medicare Advantage (MA) market and consistently produce high 5-Star quality performance rankings through close alignment with MA plans. Our members strongly support the Alignment Initiative, just as they supported the Coordinated Care Initiative (CCI) that led to the original Financial Alignment Demonstrations (FAD) implemented in seven counties. APG is pleased to offer suggestions to help optimize MCP provider networks that serve dually eligible members and ensure that MCP Models of Care realize their full potential to deliver integrated care.

a. Default Enrollment Pilot and 90% overlap network requirement

While federal rules require substantial alignment to ensure continuity of care, it is our understanding that a 90 percent overlap is not strictly required. APG respects the goal of California's Default Enrollment Pilot to facilitate movement of members into the integrated care that aligned D-SNPs promise. We also congratulate the ongoing success of the plans participating in the Default Enrollment Pilot in San Diego and San Mateo counties, including:

- Community Health Group (CHG) in San Diego
- Health Plan of San Mateo (HPSM) in San Mateo
- Kaiser Permanente in San Mateo

Moving forward, we urge DHCS to balance its approach relating to provider overlap and continuity with the value of ensuring that MCPs build robust provider networks with deep experience caring for dual eligible populations and collaborating effectively with plans to optimize Models of Care and STAR performance. This strategy proved valuable during the CalMediConnect demonstration and has contributed to the continued success of strong and responsive plan networks in San Diego and San Mateo counties.

In light of this experience in mature markets, we recommend that DHCS balance Medi-Cal provider overlap with the equally important goal of ensuring that plans also contract with providers that have a track record of achieving strong quality performance, member satisfaction, effective Models of Care, and robust compliance programs in Medicare Advantage.

Provider organizations with strong performance experience serving dual eligibles do not always have the infrastructure or network composition necessary to manage the broader Medi-Cal population. Allowing MCPs to maintain specialized dual-eligible capable networks may therefore improve quality outcomes for this population.

Recommendation: DHCS should allow flexibility in evaluating network alignment under the Default Enrollment Pilot so that Medi-Cal managed care plans can incorporate high-performing Medicare Advantage provider organizations with demonstrated expertise serving dual eligible populations, even where strict provider overlap thresholds may not be met.

b. Consistency in Medical Loss Ratio Reporting and Compliance

Two different standards now exist for capitated-delegated provider organizations that serve Medicare Advantage and Medi-Cal populations. In Medicare Advantage, CMS recognizes and incorporates the four-part test for risk-bearing provider organizations that meet the elements of that test. CMS does not recognize the four-part test under Medi-Cal, instead requiring reliance on third-party vendor guidance.

This disconnect creates a disincentive for experienced Medicare Advantage provider organizations to participate in aligned duals programs and complicates delegation oversight for MCPs that must also meet provider overlap requirements. The result has been additional operational complexity during the ramp-up of the duals alignment initiative in areas where experienced MA providers have not historically participated in Medi-Cal networks.

CMS has previously indicated to APG that California is not necessarily required to rely on the existing MLR compliance framework and could consider an alternative model.

Recommendation: APG encourages DHCS to use the waiver renewal as an opportunity to adopt an alternative approach to MLR treatment for risk-bearing delegated provider organizations that more closely aligns with the Medicare Advantage framework and removes barriers to participation by experienced dual-eligible providers.

2. Section 3.10 – Managed Care Authority to Limit Plan Choice in Certain Counties

APG notes that DHCS seeks to renew expenditure authority for payments to managed care entities that would otherwise not meet statutory requirements requiring at least two managed care plans from which members can choose. APG strongly encourages DHCS to engage stakeholders, advocates, and providers in any counties where such models may be implemented to ensure successful implementation.

Throughout CalAIM, managed care plans and their provider networks have invested substantial time and resources in advancing CalAIM goals, expanding CalAIM services and benefits, and implementing TRI payments to providers. These investments have supported expanded access to care and improved care coordination for Medi-Cal beneficiaries.

Any transition to a limited-plan model should carefully consider potential disruption to existing provider networks and care management arrangements that have developed under CalAIM.

Our members have substantial experience contracting with Medi-Cal managed care plans over several decades, and we have observed that certain contracting approaches better support

alignment between plans and risk-bearing physician organizations. One example is the approach used by CalOptima Health in Orange County, which illustrates how transparent contracting structures can support strong provider participation in Medi-Cal managed care.

CalOptima utilizes a contracting framework with its risk-bearing physician organization networks that combines a standardized base payment structure with clearly defined quality and performance incentives. This structure promotes alignment around program goals, increases transparency in financial arrangements, and supports accountability for quality outcomes. For physician organizations assuming financial and utilization risk, predictability in contracting arrangements is particularly important.

As DHCS continues to expand value-based payment approaches under CalAIM, we encourage the Department to consider contracting models that incorporate these principles—transparent base payment methodologies combined with performance-based incentives—as a way to promote strong provider participation and sustained delivery system performance in Medi-Cal.

Recommendation: As DHCS evaluates limited-plan models and other managed care program changes, the Department should work closely with plans, physician organizations, and other stakeholders to assess potential impacts on provider networks and care delivery infrastructure. DHCS should also encourage contracting approaches that promote transparency, predictable payment structures, and performance-based incentives—principles reflected in successful Medi-Cal managed care contracting models such as the approach used by CalOptima Health.

Conclusion

APG appreciates the Department's continued leadership in advancing delivery system transformation through the CalAIM initiative and the Section 1115 demonstration waiver. California has long been a national leader in developing integrated care models for complex populations, particularly for dually eligible beneficiaries. As the state seeks to expand and refine these initiatives, it will be essential to ensure that waiver policies support strong provider participation, stable financing structures, and care delivery models that reward high-performing organizations with demonstrated experience serving vulnerable populations.

APG would welcome the opportunity to participate in any stakeholder discussions or technical workgroups that DHCS may convene regarding dual-eligible alignment, network design, or related implementation issues under the renewed CalAIM demonstration.

Our members remain deeply committed to the success of Medi-Cal and to the continued advancement of whole-person care for California's most complex patients. We appreciate the opportunity to provide these comments and look forward to continued collaboration with the Department as the CalAIM demonstration evolves. Please do not hesitate to contact APG if we can provide additional operational insight from physician organizations participating in Medi-Cal managed care delivery.

Respectfully submitted,

America's Physician Groups
William Barcellona, Esq., MHA
EVP for Government Affairs
America's Physician Groups
[redacted]

Stephanie Thornton, BluePath Health, Email received March 12, 2026.

Dear DHCS,

Thank you for the opportunity to provide comments on the five-year renewal request of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration.

BluePath Health is honored to support the efforts of CalAIM, and looks forward to continuing to partner with DHCS on implementing these critical programs. Please do not hesitate to reach out with any questions.

Best,

Stephanie Thornton
--
Stephanie Thornton
she/her/hers
Director | BluePath Health
[redacted]
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[redacted]@[redacted]
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March 12, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Dear Director Sadwith,

On behalf of BluePath Health, thank you for the opportunity to provide comment on the draft renewal request for the CalAIM 1115 Demonstration Waiver. We are grateful for the commitment of DHCS to continuing and building on the success of CalAIM in partnership with providers and Medi-Cal members.

BluePath Health is proud to serve as the facilitator of the Alameda and Tri Counties CalAIM PATH Collaboratives, provide services as a vendor on the Technical Assistance Marketplace, and support San Luis Obispo and Fresno counties with PATH Justice-Involved Capacity Building Program. We are a health care consulting firm based in the Bay Area, leading numerous Enhanced Care Management (ECM) and Community Supports providers' CalAIM implementation efforts.

We were grateful for the opportunity to share public comments in August 2025 on the *Continuing the Transformation of Medi-Cal: Concept Paper*. In our comments, we emphasized the following priorities:

- Continuation of all fourteen Community Supports, with proactive cost effectiveness analysis and investment in expansion of services to more members
- Support for community-based providers offering ECM and Community Supports, including financial support to enable continued provision of services and cohort learning to enhance development and dissemination of best practices
- Integration of CalAIM with existing data sharing and exchange initiatives, including MCP CHA/CHIP participation, Medi-Cal Connect, the California Data Exchange Framework, and Rural Health Transformation
- Gathering stakeholder feedback to ensure provider and Medi-Cal member voices are represented in the waiver renewal plan
- Leveraging CalAIM as an opportunity to continue connecting eligible members to services while mitigating the impact of work requirements and more frequent redeterminations on Medi-Cal members
- Seeking continued authority for the Justice-Involved Reentry Initiative to ensure adequate support as regions launch pre-release services in 2026

BluePath Health is pleased to see our recommendations reflected in the draft renewal request, and we would like to reiterate the continued relevance of those comments in this current planning stage. We thank DHCS for their dedication to maintaining the momentum of CalAIM and ensuring that providers can continue the programs that they have built.

As DHCS finalizes the renewal request for submission to CMS, we offer the following considerations:

Recuperative Care and Short-Term Post Hospitalization Housing

DHCS should offer a vision for service delivery and the coverage of room and board expenses for Recuperative Care. We appreciate the commitment of DHCS to continuing to offer Recuperative Care and Short-Term Post Hospitalization Housing as one continuum of services under Recuperative Care. As written, the draft renewal request does not clarify how service provision would change under new ILOS and waiver authority or how the room and board component could be financed separately from the ILOS service. We encourage DHCS to provide further clarifying guidance regarding, as many current Community Supports providers have expressed confusion about the future of these services.

Employment Supports

We are highly supportive of the Employment Supports proposal and urge DHCS to consider additional funding support to Counties to enable participation in pilot programs. We applaud the effort by DHCS to design additional supports to help Medi-Cal members keep their coverage through workforce participation. While Counties are well-positioned to serve as leaders for this Medi-Cal service, they are already facing increasing demands to administer new programs such as Transitional Rent and BHSA, and preparing to provide care for a growing uninsured population. DHCS may consider technical assistance funding or additional state-granted matching funds beyond the federal match to support Counties to participate in Employment Supports. Otherwise, the number of pilots may be low and inequitably distributed across the state.

BridgeCare Pilots

DHCS should consider additional strategies to best position BridgeCare Pilots for CMS approval. Through working with older adult serving providers through the PATH Technical Assistance Marketplace, we know the value of high-quality home and community-based care for older adults. We support DHCS in seeking waiver approval for BridgeCare Pilots to enable community-based providers to offer services to the "near-dual" population. We are hopeful that this will be approved by CMS and look forward to any opportunities to collaborate with the state to support providers in implementation, particularly in leveraging data sharing guidance and technical assistance to identify "near-dual" eligible members and link them to services. Similar to the Employment Supports proposal, DHCS should consider technical assistance and implementation funding to support diverse geographic participation in BridgeCare Pilots.

BluePath Health is grateful for the opportunity to provide these comments. We look forward to continued partnership with DHCS to ensure the continued success of CalAIM through the current waiver period and the next one. For any questions regarding our comments, please do not hesitate to reach out to Stephanie Thornton, Policy Director, at [redacted]

Sincerely,

BluePath Health

Pauline Shatara, California Advocates for Nursing Home Reform, Email received March 12, 2026.

Thank you for the opportunity to comment on the CalAIM Section 1115 Demonstration Renewal Application. Attached are CANHR's comments.

Best regards,

Pauline Shatara, Deputy Director
Pronouns: She/Her/Hers
California Advocates for Nursing Home Reform
1803 6th Street
Berkeley, CA 94710
[redacted]
(800) 474-1116 (toll-free; consumers only)
Fax: (415) 777-2904

CALIFORNIA ADVOCATES FOR NURSING HOME REFORM
1803 6th Street • Berkeley California 94710
(800) 474 - 1116 • www.canhr.org • canhrmail@canhr.org

Re: CalAIM Section 1115 Demonstration Renewal Application

California Advocates for Nursing Home Reform (CANHR) is committed to protecting the rights of older adults and individuals with disabilities who rely on California's home and community-based services (HCBS) for their care needs. CANHR has reviewed the Department's CalAIM Section 1115 Demonstration Renewal Application, and while we appreciate efforts to expand HCBS services, there are some issues of concern that we would like to bring to attention.

BridgeCare Pilots

CANHR opposes creating a new parallel HCBS program, and strongly recommends a focus on strengthening existing HCBS infrastructure, while exploring existing options to serve higher income at-risk seniors. CANHR strongly recommends that DHCS not create a new, separate parallel program structure to serve the HCBS needs of older adults, when one already exists. DHCS should abandon the creation of a parallel program and instead focus on improving, strengthening, and expanding access to existing HCBS programs.

DHCS efforts could be better spent on finding ways to broaden the pathway into existing programs for individuals with higher income, and on strengthening programs. This effort to create from the ground up programs which mimic HCBS is an inefficient use of state budget resources. This proposal creates several challenges that will likely create greater barriers for older adults. It is CANHR's position that proposed BridgeCare Pilots:

- **Exacerbate existing provider shortages.** California is facing a workforce crisis in home and community-based care. A new, separate program will compete for the same limited pool of providers, exacerbating shortages and potentially drawing resources away from established, high-need populations.

- **Further complicate an already complex system.** Adding another layer to the already complicated web of HCBS options makes navigation harder for members. A streamlined system is superior to a fragmented one, and DHCS' time and energy would be better spent on eliminating current barriers to HCBS programs, by reducing administrative burdens on beneficiaries and providers. Advocates have provided DHCS with many ideas on how to improve beneficiary enrollment, navigation, and assessment. These suggestions should be further explored before DHCS builds yet another patchworked system that does not fully meet the needs of the population.

- **Do not address existing unresolved quality and operational concerns.** DHCS has been made aware of the many quality of care and programmatic issues within the current HCBS system such as painfully slow provider enrollment processes in the ALW program, a lack of real grievance procedures within many HCBS programs, and years-long waitlists. Long waiting lists for Medicaid Home and Community-Based Services (HCBS) are widely considered to violate the "integration mandate" of the Supreme Court's 1999 Olmstead v. L.C. decision. Creating a new program, rather than fixing the foundation, risks replicating the same deficiencies in oversight, enrollment, and service delivery.

- **Are not an effective use of limited state funding for HCBS.** Instead of investing in the overhead costs of creating an entirely new program, DHCS should invest in expanding access to existing programs by streamlining enrollment, standardizing the provider enrollment process and investing in workforce development.

- **Cost sharing creates an inequitable eligibility process.** Allowing certain counties to change the rules for cost sharing for certain high need individuals further exacerbates an already inequitable system that leaves thousands of low income older adults without community based care options. We strongly urge the Department to instead consider opening pathways to HCBS for higher income individuals across the state, such as through Share of Cost reform, which would increase the Maintenance Need for higher income individuals in the community on par with the 138 percent FPL.

Finally, if the Department does move forward with establishing BridgeCare Pilots, we strongly urge the use of a transparent process, including direct, meaningful involvement of advocates in the design of any new assessment criteria, operational policies, and application processes.

Recuperative Care and Short-Term Post Hospitalization Housing

CANHR is alarmed at a rising number of Medi-Cal members who are inappropriately placed at recuperative care sites from hospitals as an alternative to skilled nursing placement, or from nursing homes when their Medicare days have ended. These sites are often completely inappropriate for older adults with significant needs for support with Activities of Daily Living. In some of the most disturbing stories, individuals who are non-ambulatory or completely incontinent, have been approved by their Plan to be placed in Recuperative Care.

As the Department is aware, Recuperative Care cannot provide support with ADLs unless at a licensed facility, and is short-term, limited to 6 months within a 12 month period. As such, Plans who place high-need members at these sites are intentionally placing vulnerable older adults at sites that are detrimental to their health and safety, and that ultimately cannot serve their needs long term. The Department must issue directives to Plans about the appropriateness of placement sites for individuals with nursing home level of care needs, and absolutely prohibit discharge of individuals with these needs to Recuperative Care sites.

Reconsideration of the 2026 Sunset of the CalAIM Providing Access and Transforming Health (PATH) Initiative

The Department should reconsider the sunsetting of the PATH initiative, as we believe that it will result in premature cessation of essential infrastructure building, causing a significant disservice to the members that Enhanced Care Management (ECM) and Community Supports are intended to serve. CANHR regularly hears from consumers who are experiencing unnecessary delays in receiving needed ECM or Community Support services because Plans lack adequate provider networks. Some Plans are using out-of-state providers with no on the ground knowledge of California's resources and services, resulting in poor quality support for very high-risk and vulnerable populations. Additionally, the heavy reliance on for-profit and inexperienced providers, some with no previous experience actually serving people through Care Management, has led to a large number of members who do not actually receive the services and support they were promised.

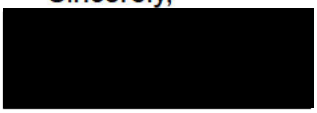
CANHR urges the Department to continue efforts to build the capacity of California-based providers, but to refocus those efforts on rural areas that still have a dearth of providers, and on non-profit, Tribal, or well established community-based entities with proven track records of supporting people in system navigation.

Community-Based Adult Services (CBAS)

CANHR strongly supports DHCS' efforts to make these important services available statewide. Expansion will greatly benefit Medi-Cal beneficiaries particularly in rural areas where there are currently no CBAS providers. CANHR is concerned that moving CBAS into an 1115 waiver may create confusion for Counties who base the application of Spousal Impoverishment protections on beneficiary participation in certain waiver programs. DHCS must ensure that Spousal Impoverishment protections are transitioned over for married or RDP beneficiaries who use CBAS, as is currently available through the 1915c waiver, and ensure future beneficiaries can access these protections through CBAS once in the 1115 waiver. The most effective way to ensure these protections continue would be for DHCS to release an updated All County Welfare Directors Letter outlining the updated programs which demonstrate eligibility for Spousal Impoverishment.

We sincerely appreciate the opportunity to provide commentary on this waiver proposal, and to continue to work with the Department to improve the availability of programs which support older adults and people with disabilities in avoiding institutionalization.

Sincerely,



Pauline Shatara
CANHR, Deputy Director

Victoria Jump, California Association of Area Agencies on Aging, Email received March 12, 2026.

Please find attached comments regarding the 1115 waiver renewal from the California Association of Area Agencies on Aging.

Regards,

Victoria
Victoria Jump
Acting Chief Deputy Director
[redacted]
510 S. Vermont Avenue
Los Angeles, CA 90020

March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

Submitted via email to 1115waiver@dhcs.ca.gov.

Re: Public Comments on CalAIM Section 1115 Demonstration Renewal Application

Dear Chief Deputy Director Sadwith,

On behalf of the California Association of Area Agencies on Aging (C4A), we appreciate the opportunity to provide comments on the Department of Health Care Services' request to renew the CalAIM Section 1115 Demonstration.

C4A represents California's network of Area Agencies on Aging (AAAs), which serve older adults, adults with disabilities, and family caregivers in every region of the state through programs funded under the Older Americans Act and the Older Californians Act. AAAs also operate and partner in Aging and Disability Resource Centers (ADRCs) that serve as trusted entry points for individuals seeking assistance navigating complex health and long-term services and supports systems (LTSS), including Medi-Cal.

As CalAIM continues to evolve, the community-based infrastructure provided by the aging network will remain an important partner in helping individuals successfully access Medi-Cal services and LTSS. Strengthening coordination between Medi-Cal programs and the aging network will be critical to ensuring individuals are able to navigate services and remain safe in their homes and communities.

C4A offers the following comments on several proposals included in the renewal request.

Community-Based Adult Services (CBAS)
C4A supports the Department's proposal to transition Community-Based Adult Services (CBAS) to

a permanent 1915(i) Home and Community-Based Services State Benefit Plan. Establishing a stable structure for CBAS is an important step toward preserving access to this essential service for individuals with complex health and functional needs, while also supporting family caregivers.

As this transition moves forward, it will be important to ensure the benefit remains available statewide and that network adequacy standards support sufficient provider capacity across all regions in California. Without adequate provider capacity and geographic access, individuals in rural or underserved communities may face significant barriers to receiving CBAS services.

BridgeCare Pilot

C4A appreciates the Department's effort to address the needs of individuals who fall just above the Medi-Cal financial eligibility thresholds yet still require long-term services and supports. Many older adults and individuals with disabilities in this population have significant care needs but limited options for accessing affordable services that help them remain safely in the community.

At the same time, several aspects of the proposed BridgeCare Pilot raise questions regarding implementation. Local entities that support long-term services and supports systems, including AAAs and community-based organizations, are already operating within constrained resources while attempting to meet growing demand for services. As the Department continues refining this proposal, adding additional clarity regarding program financing, participant expectations and administrative responsibilities will be important to ensure successful implementation.

C4A also encourages the Department to consider how eligibility criteria, particularly those related to Medicare enrollment and Medi-Cal Share of Cost participation, may affect access for individuals with significant care needs. Structural barriers within the current Share of Cost program may exclude individuals who otherwise benefit from participation in the pilot.

Modification of Asset Test for Deemed SSI Population

C4A supports the proposal to modify the asset test for the deemed SSI population in alignment with asset policies recently adopted for other non-MAGI Medi-Cal populations. Aligning eligibility rules across Medi-Cal populations can help reduce confusion for beneficiaries and promote greater consistency within the program.

As this change is implemented, we encourage the Department to ensure that the same consumer protections included in the State Plan Amendment, such as holding individuals harmless for asset transfers made during the period when the asset limit was eliminated and delaying asset reporting until renewal in 2027, are applied consistently where permissible under federal eligibility requirements.

Employment Supports

C4A appreciates the Department's proposal to establish employment supports to assist Medi-Cal

expansion adults in meeting federal work and community engagement requirements. Ensuring individuals have access to meaningful employment and training supports will be critical to helping Medi-Cal members maintain coverage.

As this benefit is developed, we encourage the Department to ensure statewide availability and establish a core set of employment and pre-employment services that are consistently available across counties.

Program design should also consider the needs of older adults and individuals with disabilities, who may face unique barriers to employment and may require specialized supports to participate successfully.

Recuperative Care
C4A supports the Department's proposal to move Recuperative Care to a more permanent authority while sunsetting the Post-Hospitalization Short-Term Housing service. Ensuring recuperative care services remain available statewide will help individuals safely recover following hospitalization and reduce avoidable institutional placements and hospital readmissions. Maintaining sufficient provider capacity and geographic availability will be essential to ensuring this service remains accessible.

Justice-Involved Initiative
C4A supports the renewal of the Justice-Involved Reentry Initiative, which extends Medi-Cal coverage for critical services during the reentry process.

As this initiative continues to expand, it will be important to recognize the growing number of older adults and individuals with disabilities within incarcerated populations. Incorporating home and community-based services into reentry planning can help ensure individuals have the supports necessary to successfully transition back into their communities and avoid unnecessary institutionalization

Mandatory Medicare Advantage Alignment
C4A supports continued renewal of the Medicare Advantage alignment authority as an important step toward improving care integration for individuals dually eligible for Medicare and Medi-Cal. As integration efforts continue, it will be important to ensure strong consumer protections, person-centered care models, and meaningful oversight mechanisms that promote accountability while preserving beneficiary choice.

Strengthening LTSS Navigation and System Coordination
As CalAIM continues to expand community-based services, ensuring individuals can successfully navigate the LTSS system will become increasingly important.

California's aging network, including AAAs and Aging and Disability Resource Centers (ADRCs) already serves as a primary entry point for many older adults and individuals with disabilities seeking assistance with long-term services and supports. Strengthening coordination between Medi-Cal managed care plans, Enhanced Care Management providers, and the aging network could help reduce system fragmentation and ensure beneficiaries are connected to appropriate community-based services.

Exploring opportunities to more formally integrate ADRCs and the aging network into Medi-Cal's navigation and referral infrastructure could improve access to services and support more effective care coordination for individuals with complex needs.

As CalAIM continues to expand community-based services, leveraging existing ADRC infrastructure as part of the state's "No Wrong Door" access system could help ensure beneficiaries are able to navigate Medi-Cal and LTSS programs more effectively

Conclusion

California's aging population continues to grow, and demand for long-term services and supports will increase significantly in the coming years. Ensuring Medi-Cal policies support strong community-based infrastructure will be essential to meeting this demand.

AAAs and ADRCs play a critical role in helping individuals understand their options, navigate complex service systems, and access the supports necessary to age and live with dignity in their homes and communities.

C4A appreciates the opportunity to provide comments on the CalAIM Demonstration renewal and looks forward to continued collaboration with DHCS.

Respectfully,

[redacted]

Christina Mills, Executive Director
California Association of Area Agencies on Aging (C4A)

Elissa Feld, CBHDA, Email received March 12, 2026.

Good afternoon DHCS Colleagues,

Thank you for the opportunity to provide comments on the proposed CalAIM Section 1115 Demonstration Renewal Application. CBHDA appreciates the Department's continued support for the critical programs authorized under this waiver and county behavioral health plans look forward to continuing to strengthen and expand systems of care.

-Elissa
Elissa Feld
Director of Policy
[redacted]

March 12, 2026

Michelle Baass, Director
California Department of Health Care Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95899-7413

Mr. Tyler Sadwith, State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95899-7413

Submitted via email to 1115waiver@dhcs.ca.gov.
Subject: CalAIM Section 1115 Demonstration Renewal Application

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Dear Ms. Baass and Mr. Sadwith:

The County Behavioral Health Directors Association (CBHDA), representing county behavioral health plans, appreciates the opportunity to provide comment and feedback on the state's CalAIM Section 1115 Demonstration Application Renewal. CBHDA expresses our gratitude that the Department of Health Care Services (DHCS) has proposed a five-year renewal period of waiver and expenditure authorities granted through the Section 1115 waiver. Since the approval of the Section 1115 waiver in 2021, County Behavioral Health Plans (BHPs) have developed and implemented successful programs under this authority. CBHDA is encouraged to see that the proposed renewal continues to support and build upon the initiatives counties have advanced over the past five years.

Reentry Services for Justice-Involved Populations 90-Days Pre-Release

The Reentry Services for Justice-Involved Populations initiative is instrumental in supporting justice-involved individuals. The continuation of this component in the waiver ensures access to critical pre- and post-release services for individuals reentering communities after incarceration. These resources enable BHPs to maintain and enhance access to high

quality behavioral health services across the state. We thank the Department for its continued investment in the health and well-being of justice-involved populations.

DMC-ODS: Waiver of the IMD Exclusion for SUD Services

California was the first state in the nation to design and receive federal approval from the Centers for Medicare & Medicaid Services (CMS) to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver, fundamentally transforming how Medicaid covers substance use disorder (SUD) treatment. Through this waiver, California moved beyond a limited benefit structure and built a full continuum of evidence-based SUD services aligned with the American Society of Addiction Medicine (ASAM) criteria, allowing BHPs to provide residential treatment, withdrawal management, medication-assisted treatment, and recovery services under Medicaid. This innovation positioned California as a national leader in Medicaid SUD treatment, significantly expanding access to care and creating a model that other states have since looked to when designing their own systems.

California's DMC-ODS waiver also represented an important step toward addressing the long-standing inequities created by the federal Institutions for Mental Diseases (IMD) exclusion, which limits Medicaid reimbursement for substance use disorder treatment in residential facilities larger than 16 beds. The IMD exclusion reflects a longstanding inequity in federal policy, restricting Medicaid coverage for behavioral health treatment in ways that have never been imposed on physical health services. Through the waiver, California was able to secure federal flexibility to allow Medi-Cal reimbursement for services delivered in these facilities, helping expand access to clinically appropriate levels of care for individuals with substance use disorders.

This renewal will continue the waiver of the IMD exclusion under the DMC-ODS program, which remains critical to maintaining access to residential SUD treatment services across the behavioral health continuum of care. Maintaining this authority provides stability for treatment providers and the broader health delivery system and supports California's continued progress toward expanding access to evidence-based treatment services for individuals with substance use disorders.

County Option to Cover Select Outpatient SUD Services

California's proposal to allow Drug Medi-Cal (DMC) State Plan counties to opt in to cover select outpatient SUD services including care coordination, recovery services, withdrawal management, and partial hospitalization, will help strengthen the SUD treatment continuum and improve coordination of care. Strengthening outpatient services in DMC

State Plan counties reflects a continued commitment to expanding access to treatment and supporting individuals and helps reduce disparities in access to SUD treatment across California. These services play a critical role in helping communities build more comprehensive and coordinated behavioral health systems. In particular, the ability to cover case management services will help improve coordination across providers, support navigation of complex care needs, and enhance continuity of care within the broader behavioral health system.

Recovery Incentives

Recovery incentives, also known as contingency management, remain one of the most effective evidence-based approaches to treat stimulant use disorder. California's Recovery Incentives Program has helped integrate contingency management into the substance use disorder treatment continuum and expand access to this evidence-based intervention across participating counties. CBHDA strongly supports the continuation of this benefit and appreciates the state's commitment to maintaining access to this effective treatment approach.

Many individuals experiencing stimulant use disorder also have significant co-occurring mental health conditions, making coordinated treatment essential. However, administrative requirements to obtain certification to provide both mental health and substance use disorder services can be complex and time-intensive, limiting opportunities for providers to deliver integrated care. Identifying ways for programs to more easily offer both mental health and SUD services, including evidence-based interventions such as contingency management, would support individuals in receiving these services within the programs where they are already engaged in care. CBHDA encourages the state to explore opportunities to streamline certification and related administrative processes so these services can be more readily delivered within mental health settings.

Traditional Healers & Natural Helpers

California has sought federal authority on multiple occasions to allow traditional healer services within its Medicaid program, recognizing the importance of expanding access to culturally responsive behavioral health services. DHCS is requesting an extension of the existing expenditure authority for Traditional Healer and Natural Helper services under the CalAIM Section 1115 demonstration to continue providing eligible Medi-Cal members with access to culturally based care through IHS facilities, Tribal health clinics, and Urban Indian Organizations under DMC-ODS. Providing traditional healer services within California's behavioral health system acknowledges the important role that trusted community leaders

and culturally grounded practices can play in supporting individuals' recovery. By broadening the types of providers who can participate in the system, the state is able to better reach underserved populations and promote earlier engagement in services. CBHDA would like to express our appreciation of DHCS' ongoing support in advancing culturally responsive substance use disorder services and support the continuation of this benefit.

Coverage for Out-of-State Former Foster Care Youth

DHCS is seeking continued authority under the CalAIM Section 1115 demonstration to extend Medi-Cal coverage for former foster youth under age 26 who aged out of foster care in another state and were enrolled in Medicaid at the time. This authority ensures Medi-Cal coverage for young adults with complex needs, many of whom have experienced significant childhood trauma or adverse childhood experiences. We commend DHCS's commitment to maintaining access to medically necessary care for this vulnerable population and to strengthening supports that promote stability and long-term well-being for former foster youth across California.

Global Payment System

Public hospital systems play a critical role in serving Medi-Cal members, including those with complex behavioral health needs. Maintaining stable programs that strengthen coordination between safety-net providers and behavioral health systems will remain important as the State continues advancing CalAIM's goals. The continuation of the Global Payment Program (GPP) is seeking to expand its focus on prevention, chronic disease management, and behavioral health. These proposed changes will further strengthen incentives that support ongoing system transformation and value-based care across California's health care safety net. CBHDA appreciates the proposal to continue the GPP and supports its continuation given the important role it has played in strengthening health care delivery systems and supporting providers that serve low-income and uninsured Californians.

Employment Supports

DHCS is seeking authority under the CalAIM Section 1115 demonstration for Employment Supports, which assists individuals in meeting work and community engagement reporting requirements tied to Medi-Cal eligibility at application and renewal. CBHDA recognizes and appreciates the State's efforts to support Med-Cal members in obtaining and maintaining employment in alignment with forthcoming federal requirements tied to Medicaid eligibility. The loss of Medi-Cal eligibility can have significant impacts on both beneficiaries and the broader behavioral health system. Individuals who lose coverage will lose access to

preventative and ongoing health care, increasing the likelihood of acute episodes requiring higher levels of care. CBHDA appreciates the Department's continued efforts to implement supports that help individuals maintain Medi-Cal coverage and preserve access to critical health care services.

BridgeCare Pilot

The renewal also proposes a BridgeCare pilot under Section 1115 demonstration authority to provide a targeted set of home-and community-based services (HCBS) and caregiver supports for individuals who are "near dual eligible." CBHDA recognizes the role that initiatives like BridgeCare play in supporting individuals with complex health and behavioral health needs across the Medi-Cal system. As the BridgeCare pilot is further developed, additional clarity regarding program structure, financing mechanisms, and operational responsibilities will remain critical to support effective implementation.

Recuperative Care and Short-Term Post-Hospitalization Housing

In response to evolving federal policy, California is proposing to transition Recuperative Care from Section 1115 demonstration authority to In Lieu of Services (ILOS) and sunset Short-Term Post-Hospitalization Housing. These two Community Supports have successfully demonstrated results in reducing utilization of higher-cost services across the Medi-Cal system. As DHCS considers the future design of Recuperative Care under ILOS authority, CBHDA encourages the Department to engage stakeholders, including BHPs, early in the development of the updated service model to help ensure continuity of access.

Providing Access and Transforming Health (PATH)

The Providing Access and Transforming Health (PATH) initiative has advanced the statewide implementation of Enhanced Care Management (ECM) and Community Supports (CS) under CalAIM through time-limited infrastructure funding, technical assistance, and collaborative implementation efforts involving counties, providers, and Medi-Cal managed care plans. These efforts have helped establish more consistent processes across the Medi-Cal delivery system, including the development of standardized ECM referral pathways and other tools designed to strengthen coordination among system partners. As DHCS proposes to sunset the PATH initiative as part of the waiver renewal, CBHDA encourages the Department to consider whether additional resources will be needed to help ensure that these implementation improvements are sustained and continue to support coordination across the Medi-Cal delivery system.

* * *

Thank you for your consideration of our comments and recommendations. Please contact our team directly at [redacted] if we can answer any questions or provide any additional information to clarify our comments in this letter.

Sincerely,

[redacted]

Elissa Feld
Director of Policy

Cc: Paula Wilhelm, Deputy Director, Department of Health Care Services
Ivan Bhardwaj, Chief, Department of Health Care Services
Stephanie Welch, Deputy Secretary, California Health and Human Services Agency
Brendan McCarthy, California State Association of Counties

Mariya Kalina, California Collaborative for Long-Term Services and Supports (CCLTSS), Email received March 12, 2026.

Good Morning,

I hope this email finds you well.

On behalf of the California Collaborative for Long-Term Services and Supports (CCLTSS), please see our comment letter (attached) regarding the DHCS CalAIM Section 1115 Demonstration Renewal Application.

We appreciate the opportunity to provide feedback and look forward to continued engagement with the department as the renewal process moves forward. Please don't hesitate to reach out if any additional information would be helpful.

Warmly,
Mariya
Mariya Kalina
Executive Director, California Collaborative for Long-Term Services and Supports (CCLTSS)
[redacted]

March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

Submitted via email to 1115waiver@dhcs.ca.gov.

Re: Public Comments on CalAIM Section 1115 Demonstration Renewal Application

Dear Chief Deputy Director Sadwith,

On behalf of the California Collaborative for Long-Term Services and Supports (CCLTSS), a statewide coalition of aging, disability, consumer, provider, and advocacy organizations working to strengthen California's long-term services and supports (LTSS) system, we write to express appreciation for the opportunity to comment on the Department of Health Care Services' (DHCS) Medicaid Section 1115 Demonstration Five-Year Renewal Request and to share feedback informed by CCLTSS members. These comments are offered in the spirit of strengthening Medi-Cal and improving access to LTSS for older adults and people with disabilities as the state continues to advance the goals of CalAIM, strengthen community-based systems of care, and support the broader vision outlined in California's Master Plan for Aging.

Community-Based Adult Services (CBAS)
We strongly support the Department's proposal to transition the Community-Based Adult Services (CBAS) program to a permanent home- and community-based services (HCBS) benefit under 1915(i) state plan authority. This transition represents an important step toward strengthening the long-term sustainability of the program and ensuring continued access to this critical service.

As this transition moves forward, members have expressed interest in continued opportunities for stakeholder engagement to help inform implementation. For example, the Department may wish to consider establishing an advisory group or stakeholder forum focused on CBAS implementation. Such a structure could provide a venue for

ongoing dialogue with consumers, providers, plans, and advocates as the Department works to expand access and ensure the benefit is implemented successfully statewide.

In addition, ensuring that managed care plans are equipped and accountable for supporting access to CBAS will be important as the program transitions to state plan authority. Clear network adequacy expectations, monitoring mechanisms, and accountability structures may help ensure that Medi-Cal members across the state are able to access CBAS services consistently and equitably.

BridgeCare Pilot

We appreciate the Department's effort to address the needs of older adults who fall just above Medi-Cal's financial eligibility thresholds, many of whom have significant care needs but limited options for accessing LTSS. At the same time, several aspects of the proposed BridgeCare Pilot raise questions about how the program would work in practice. As the Department continues refining the proposal, Collaborative members have identified several areas where additional clarification or policy exploration may help strengthen the program's ability to achieve its intended goals.

First, given the financial pressures already facing local entities and the existing gaps in LTSS access for Medi-Cal members, we are concerned that incentivizing participation in the BridgeCare Pilot could divert resources away from an already strained system. These same financial pressures and limited reimbursement structures may also make participation difficult for potential local partners, raising questions about whether the pilot will be broadly utilized. Additional clarity would be helpful regarding how participation will be supported. For example, will Medicare savings resulting from the pilot be used to offset participating entities' expenditures? Are there other incentives or supports the Department is considering to help make participation financially viable?

In addition, several members have raised questions about whether certain eligibility requirements could unintentionally limit participation among individuals the pilot is intended to serve. For example, requiring Medicare enrollment as a condition of participation may limit access for near-eligible older adults who are not enrolled in Medicare, including individuals who face barriers related to immigration status or gaps in work history. Similarly, limiting participation to individuals enrolled in Medi-Cal with a Share of Cost may leave out individuals who technically qualify for the program but do not enroll because the required contribution is prohibitively high.

Members have also expressed interest in understanding how the Department intends to evaluate the pilot over time. Establishing clear evaluation metrics - such as measures related to access, service utilization, health outcomes, and potential disparities across demographic groups - could help ensure the program generates meaningful insights to inform future policy decisions and program design.

More broadly, we believe these challenges highlight the need to revisit the structure of the Medi-Cal Share of Cost program. Raising the maintenance need level to 138 percent of the federal poverty level (the income threshold used for Aged and Disabled Medi-Cal eligibility) would provide a more equitable statewide solution by allowing

near-eligible individuals to access LTSS supports without being required to spend down the majority of their income in order to qualify.

Modification of Asset Test for Deemed SSI Population
Collaborative members also support the proposal to modify the asset test for the deemed SSI population in alignment with the California 2025 Budget reinstatement of the asset test for other non-MAGI Medi-Cal populations. Aligning eligibility policies across populations will help maintain consistency within Medi-Cal and reduce administrative complexity for beneficiaries.

As this change is implemented, we encourage DHCS to ensure that all protections included in the State Plan Amendment are applied to the deemed SSI population as well. This includes holding individuals harmless for asset transfers made during the period when the asset limit was eliminated and requiring asset reporting only at the enrollee's first Medi-Cal renewal in 2027. These protections will help prevent unintended coverage disruptions for individuals with significant health and long-term care needs.

Employment Supports
We appreciate the Department's proposal to establish employment supports to assist Medi-Cal expansion adults in meeting new work and community engagement requirements under H.R. 1. As this new benefit is developed, it will be important to ensure equitable access across the state. Limiting availability to certain counties could create geographic disparities in access to the supports needed to maintain Medi-Cal coverage, particularly if individuals in some regions have access to employment assistance while others do not. Ensuring that employment supports are available statewide would help prevent these disparities from being built into the program from the outset and support consistent access to coverage for Medi-Cal members across California.

At the same time, while regional flexibility may be appropriate, it may be helpful for the Department to establish a core set of employment and pre-employment supports that would be available to all eligible Medi-Cal members. A baseline package of services (such as job readiness support, training opportunities, and assistance with maintaining employment) could help ensure a consistent level of support across counties while still allowing local programs to tailor services to community needs.

As the Department continues to refine the proposal, additional clarity regarding how access to these supports will be structured would also be helpful. If the Department is considering a waiver of reasonable promptness or other mechanisms that could limit participation, transparency around how those limits would operate would be important to ensure stakeholders understand how eligibility and access will be determined.

Finally, it will be important that employment supports are designed to be accessible, culturally competent, and responsive to the diverse needs of Medi-Cal beneficiaries. For example, older adults between the ages of 50 and 64 may face unique barriers in the labor market, including age discrimination and gaps in employment history that require different types of training or counseling. Tailoring services to reflect these realities, as well as the needs of individuals with limited English proficiency or other

barriers to employment, will be critical to ensuring the program is effective and equitable.

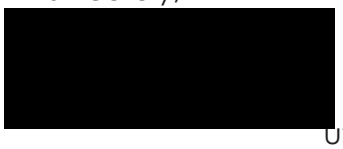
Recuperative Care
We support the Department's proposal to move the Recuperative Care community support to a more permanent authority while sunsetting the Post-Hospitalization Short-Term Housing service. Ensuring that recuperative care remains available statewide will be critical for individuals who need short-term stabilization and recovery support following hospitalization.

Justice-Involved Initiative
The Collaborative supports renewal of the Justice-Involved Reentry Initiative. Extending Medi-Cal coverage for critical services during the reentry process can help promote health stability and improve outcomes for individuals returning to their communities. However, given the growing number of older adults and individuals with disabilities within incarcerated populations, we would encourage the Department to consider how HCBS can be incorporated into reentry planning and service delivery. Early connection to HCBS may help ensure that individuals with functional needs are able to safely transition back into their communities with appropriate supports in place.

Mandatory Medicare Advantage Alignment
We support the continued renewal of the Medicare Advantage alignment authority as an important step toward improving care integration for individuals dually eligible for Medicare and Medi-Cal. As this work continues, we look forward to collaborating with DHCS to ensure that integration efforts include strong consumer protections, person-centered care models, and robust oversight and accountability.

Thank you again for the opportunity to provide comments on the CalAIM Demonstration renewal and for the Department's continued engagement with stakeholders throughout this process. On behalf CCLTSS, We look forward to ongoing collaboration to strengthen Medi-Cal and ensure access to LTSS for older adults and people with disabilities across California.

Sincerely,



utive Director
California Collaborative for Long-Term Services and Supports (CCLTSS)

CC: Michelle Baass, Director, DHCS
Susan Philip, Deputy Director, Health Care Delivery Systems, DHCS
Joseph Billingsley, Assistant Deputy Director, Integrated Systems of Care, DHCS
Lauren Solis, Chief, Office of Medicare Innovation and Integration, DHCS

Jack Anderson, County Health Executives Association of California (CHEAC), Email received March 12, 2026.

Greetings,

Please see attached for comments on the CalAIM Section 1115 Demonstration Renewal Application from the County Health Executives Association of California (CHEAC), representing our local health departments statewide.

Should you have any questions regarding our comments, please contact us. Thank you.

Sincerely,
Jack Anderson, MPA, MPH
Senior Fiscal & Policy Analyst
County Health Executives Association of California (CHEAC)
[redacted]
www.cheac.org

CHEAC
Improving the Health of all Californians

March 12, 2026

California Department of Health Care Services (DHCS)
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Submitted via email: 1115waiver@dhcs.ca.gov

RE: CalAIM Section 1115 Demonstration Renewal Application

To Whom It May Concern:

On behalf of the County Health Executives Association of California (CHEAC), the statewide organization representing local health departments (LHDs), we appreciate the opportunity to provide comments on the state's Medicaid Section 1115 Demonstration Five-Year Renewal Request Application. Please see CHEAC's comments below:

Justice-Involved Initiative
CHEAC expresses support for the state's continued commitment to serving justice-involved populations through the CalAIM Section 1115 Demonstration Renewal. LHDs, in coordination with local partners, recognize the significant opportunity this initiative provides to improve health outcomes, reduce recidivism, and strengthen coordinated transitions for individuals returning to the community from carceral settings.

Specifically, CHEAC supports the 90-day pre-release in-reach period that is essential for establishing early engagement and ensuring continuity of care. Jurisdictions that have implemented this service have seen firsthand how early, structured in-reach enables timely care planning, particularly for individuals with complex behavioral health and chronic health needs, and facilitates stronger post-release connections with local health, social services, and community-based providers.

As part of the Justice-Involved Initiative, CHEAC recommends DHCS preserve and clarify flexibility allowing Health Risk Assessments (HRAs) to be completed alongside other required intake or initial evaluation processes. Additionally, CHEAC recommends DHCS incorporate tracking of metrics related to the social determinants of health (SDOH) for this population, including housing stability, employment, and recidivism, to enable comprehensive evaluation of program effectiveness and inform program improvements.

Employment Supports
CHEAC is supportive of the Employment Supports services proposed in the demonstration application. With new federal Medicaid work requirements under H.R. 1 set to take effect

beginning in 2027, it will be increasingly important that Employment Supports reduce barriers to participation and help prevent unnecessary coverage loss.

We recommend expanding access to non-labor-based job pathways, adding conflict management skill-building within individualized job coaching, and integrating behavioral health linkages as part of this effort. A robust and flexible employment support structure will better position individuals with complex needs to maintain stability under these forthcoming federal policy changes.

Global Payment Program
CHEAC expresses support for inclusion of the Global Payment Program (GPP) in the state's Section 1115 demonstration renewal. Since the initiation of this program, GPP has been critical in supporting public hospitals' ability to provide value-based care to patients without health insurance and promote financial stability among health systems. CHEAC supports renewing GPP with proposed programmatic modifications to include preventive care and chronic disease management services.

PATH Initiative
The CalAIM Providing Access and Transforming Health (PATH) Initiative has played an essential role in building community partnerships and strengthening local capacity and infrastructure to advance the objectives of the state's current waiver demonstration. CHEAC acknowledges that recent federal policy changes have limited the state's ability to continue financing the PATH Initiative as currently structured.

However, CHEAC urges DHCS to identify alternative avenues to sustain this important work. Continued investment through the PATH CITED Initiative remains critical, particularly to maintain capacity that supports coordinated care management, warm handoffs, and engagement in care among complex and vulnerable populations. Similarly, the conclusion of the PATH Collaborative Planning & Implementation (CPI) Initiative may lead to gaps in technical assistance and provider input on key Medi-Cal services such as ECM and Community Supports.

To preserve momentum and ensure continuity, CHEAC recommends DHCS establish opportunities for CPI-like stakeholder engagement to keep delivery system improvements aligned with the needs of Medi-Cal members and providers.

Thank you for the opportunity to provide comments on the CalAIM Section 1115 Demonstration Renewal Application. CHEAC looks forward to continued partnership with DHCS to strengthen Medi-Cal services and improve outcomes for communities across California.

Should you have any questions about our comments, please contact me at [redacted]

Sincerely,

Michelle Gibbons
Executive Director
County Health Executives Association of California (CHEAC)

Justin Garrett, California State Association of Counties (CSAC), Email received on March 12, 2026.

Hi,

Attached are comments from the California State Association of Counties (CSAC) on the 1115 waiver renewal.

Thank you,

Justin
Justin Garrett
Senior Legislative Advocate
[redacted]
The Voice of California's 58 Counties
www.counties.org

California State Association of Counties®
1100 K Street, Suite 101 | Sacramento, CA 95814

March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Submitted via email: 1115waiver@dhcs.ca.gov

RE: CalAIM Section 1115 Demonstration Renewal Application

Dear Mr. Sadwith,

On behalf of the California State Association of Counties (CSAC), representing all 58 California counties, I am writing to share feedback on the state's CalAIM Section 1115 Demonstration Renewal Application. The current demonstration has created opportunities for counties and other entities to provide enhanced and tailored services to meet the health care needs of our state's diverse population.

CSAC has comments on several of the new and continued elements included in the renewal application.

- **Justice Involved Initiative** – CSAC supports this initiative that has provided meaningful opportunities to serve justice-involved individuals pre- and post-release. Continuing this initiative, and specifically the 90-day pre-release in-reach period, will allow for further efforts to improve health outcomes, enhance coordination, and reduce recidivism for this population.
- **Global Payment Program (GPP)** – CSAC supports this important tool that public hospitals utilize to provide value-based care to uninsured patients. Renewing the GPP will allow for continued opportunities to provide preventative and specialty care for those without insurance during a time when that population may significantly increase due to other changes in the Medicaid program.
- **DMC-ODS: Waiver** – CSAC supports the continuation of this waiver that transformed how substance use disorder (SUD) treatment was covered and addressed iniquities created by the federal Institutions for Mental Diseases (IMD)

exclusion. Renewing this waiver will allow for stability for treatment providers and maintained access to SUD treatment across the behavioral health continuum of care.

- **Out-of-State Former Foster Care Youth Coverage** – CSAC supports the extension of Medi-Cal coverage for former foster youth up to age 26 who are from out-of-state. The transition years from foster care to adulthood are a critical time and stable health and behavioral health coverage during those years is essential to improving health, well-being, and stability.
- **Employment Supports** – CSAC supports this new initiative that would allow counties to assist individuals in finding opportunities to meet the new work and community engagement requirements. Counties are well positioned to coordinate and provide these supports but also face significant safety net program fiscal challenges. As this proposal is further developed, it would be helpful to get clarity on who may serve as providers and what sources can be used for the non-federal match. Counties would also appreciate flexibility of local program design and delivery and the ability to serve applicants who also must meet the new requirements.
- **BridgeCare Pilot** – CSAC appreciates the opportunities provided by this new initiative to provide comprehensive services to the population known as "near duals." As this proposal is further developed, it would be helpful to get clarity on who may serve as providers and what sources can be used for the non-federal match. In addition, CSAC wants to highlight the need for upfront investments in advance of the state reinvesting savings given the safety net fiscal challenges facing counties.
- **PATH Initiative** – CSAC encourages DHCS to identify alternative resources that could be utilized to meet the aims of the Providing Access and Transforming Health (PATH) initiative that is proposed to sunset. This will allow the important collaboration and coordination work that occurred under this initiative to continue.

Thank you for the opportunity to submit comments. Counties appreciate DHCS's leadership and partnership in supporting innovative ways to meet the health care needs of our state's Medi-Cal population.

Sincerely,

Justin Garrett
Senior Legislative Advocate

Frank Porter, Housing El Dorado, Email received March 12, 2026.

Please include the attached letter in the application for the CalAIM renewal application.

Thank you,

Frank Porter, Vice-President
Housing El Dorado
[redacted]
www.housingeldorado.org
Click here for the latest HED news

Housing El Dorado

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
1115waiver@dhcs.ca.gov

Subject: CalAIM Section 1115 Demonstration Renewal Application

Our small community based non-profit provides Community Support services under a CalAIM contract with Anthem Blue Cross. The CalAIM contract enables us to provide case management, housing deposits and tenancy sustaining services to clients who are or have been unhoused.

Many of these clients have been without permanent affordable housing for years with limited access to services. As rural community residents, our clients often experience gaps or a lack of services and housing options. The CalAIM Community Support services have made it possible for us to house more clients faster than ever before, and keep them housed and reduce the burden on emergency services in our community.

The funding from this contract not only allows us to provide the services above but allows us to much effectively weave together other resources and services for the unhoused, such as our winter shelter, street outreach, shower program and our homelessness prevention program.

Especially in rural communities such as ours, the consequences of losing the CalAIM funding would be dire and would have a disproportionately negative impact on especially vulnerable rural residents of El Dorado County.

I urge you to sustain the critically important CalAIM program.

Sincerely,
Frank Porter
Executive Vice-President

Heather Summers, County of San Diego, Health & Human Services Agency, Email received March 12, 2026.

Dear DHCS,

Attached are the County of San Diego CalAIM Section 1115 Demonstration Renewal Application comments for consideration and review. If you have any questions, you're welcome to reach out directly to me. Wishing you the best as you move forward with the renewal application.

Best regards,

Heather
Heather Summers, EdD, MSW, Deputy Director
Pronouns: she/her/hers
Clinical and Safety Net Coordination
County of San Diego, Health & Human Services Agency
[redacted]
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We value your opinion! Please click on the link to complete a 1 minute Customer Service Experience Survey.

County of San Diego HHSA Comments on DHCS CalAIM Waiver Renewal

Date: March 12, 2026

To: Department of Health Care Services (DHCS)

From: County of San Diego Health and Human Services Agency *(via email to DHCS)*

Subject: CalAIM Section 1115 Waiver Renewal

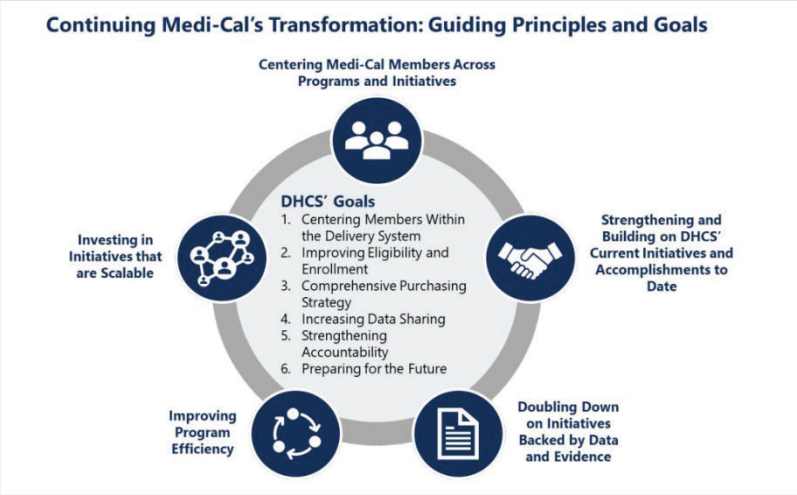
Dear DHCS Leadership,

The County of San Diego Health and Human Services Agency (HHSA) appreciates the opportunity to provide comments on the CalAIM Section 1115 Demonstration Renewal Application. HHSA commends DHCS for its continued leadership in transforming Medi-Cal and for the substantial progress achieved under CalAIM to date. HHSA looks forward to working in partnership to explore opportunities to advance DHCS' vision and improve the health and wellbeing of San Diego County residents.

To strengthen the Waiver Renewal Application, enhance operational clarity, and ensure equitable and successful implementation for Medi-Cal members across California, HHSA prioritized the following targeted recommendations with *page numbers* for easy reference to the DHCS' Waiver Renewal Application:

1) Stakeholder Engagement Post PATH CPI Sunset: Maintain Member Centered Input Channels

Recommendation: As PATH CPI Collaboratives sunset, HHSA encourages DHCS to continue structured stakeholder engagement (e.g., listening sessions) to ensure the continuation of member centered delivery system design and capture operational feedback from Enhanced Care Management (ECM) and Community Supports providers. *(Introduction; pp. 6–7)*



Requested DHCS Actions

- Establish ongoing listening sessions and feedback loops with counties, plans, providers, and members, ensuring alignment with CalAIM's delivery system goals. *(p. 6–7)*

2) Community Supports: Preserve Access to & Reduce Barriers in Recuperative Care + Short Term Post Hospitalization Housing

Recommendation: As DHCS consolidates Short-Term Post-Hospitalization Housing into a tiered Recuperative Care model (and transitions under ILOS authority), HHSA encourages DHCS to preserve all existing services and revisit pre-authorization to ease timely referrals. Also consider Recuperative Care models for Older Adults and specifically post behavioral health hospitalization to ensure appropriate pathways for SMI/SUD populations. HHSA also encourages DHCS to provide specific guidance on eligibility criteria to help standardize the authorization process *(Section 4, p. 48–49)*

Rationale & Operational Realities

- **Access pathways differ:** Community based providers typically encounter less barriers when referring people to Short-Term Post Hospitalization Housing than when trying to refer people to Recuperative Care, while hospitals still encounter barriers to acceptance, hospitals are more successful at transitioning individuals into Recuperative Care; the updated Recuperative Care service should ensure both community based providers and hospitals are able to connect eligible individuals to Recuperative Care services. *(p. 48–49)*
- **Timeliness barrier:** Current authorization processes can delay placements; revisiting criteria and workflows can speed transitions and reduce ED/inpatient utilization. *(p. 49)*
- **Behavioral health transitions:** A BHS specific Recuperative Care pathway would improve continuity post psychiatric/SUD hospitalization. *(p. 49)*
- **Transitions for Older-Adults:** to support Older Adults, Personal Care Services are an essential component of the array of care provided. *(p. 49)*

Requested DHCS Actions

- Develop and publish pre-authorization revisions and operational guidance to streamline Recuperative Care referrals from both community-based organizations and hospital sources. *(p. 49)*
- Ensure the consolidated model retains all service elements currently available under Short-Term Post-Hospitalization Housing and Recuperative Care. *(p. 49)*

- Explore a post behavioral health hospitalization tier within Recuperative Care, with tailored admission criteria and supports. *(p. 49)*
- Include Personal Care Services in the array of care to meet the needs of Older Adults. *(p. 49)*

3) Employment Supports

Recommendation: HHSA encourages DHCS to provide full operational and fiscal clarity for the proposed Employment Supports benefit to avoid unfunded mandates or cost shifting. Distinguish clearly from Individual Placement and Support (IPS) Model (an evidence-based practice (EBP) under BH-CONNECT), map agency responsibilities (DHCS, Department of Rehabilitation, CalWORKs), and integrate supports for individuals experiencing homelessness (documentation/technology/transportation). Define exemption screening for members with disability, SMI, SUD, and homelessness to prevent misclassification and avoidable coverage loss. *(Section 3 & 3.12; p. 24 & 41–43)*

Rationale & Details

- **Program differentiation:** Identify differences between Employment Supports and the IPS EBP benefit under BHCONNECT; clarify intended populations (non-MH/SUD vs. broader cohorts). *(p. 24)*
- **Inter-agency roles:** Clarify how Department of Rehabilitation responsibilities intersect; map financing/co-financing and administrative duties across agencies; note other funding streams (e.g., CalWORKs). *(p. 41)*
- **Operational burdens for unhoused:** Many unhoused individuals lack documentation, technology, or transportation needed for work requirement reporting; build supports to meet these standards. *(p. 41)*
- **Care integration:** Employment Supports should include referrals to housing navigation, ECM, Community Supports, and street outreach teams; employment stability depends on housing stability. *(p. 42)*
- **Exemptions and safeguards:** Many unhoused individuals meet exemptions due to disability, SMI, and SUD; DHCS should clearly define exemption screening and integrate homelessness into determinations to prevent misclassification as “non-exempt.” *(p. 43)*

Requested DHCS Actions

- Issue guidance distinguishing Employment Supports from IPS/EBPs and specifying the intended population. *(p. 24)*

- Create and publish a financing map with Department of Rehabilitation/California Department of Social Services (CDSS)/CalWORKs clarifying responsibilities, cost sharing, and admin funding. *(p. 41)*
- Integrate homelessness supports (documentation, technology, transportation) and formal referral pathways into program operations. *(pp. 41–42)*
- Codify exemption screening processes that explicitly consider homelessness, SMI, and SUD to prevent inappropriate work requirements and coverage loss. *(p. 43)*

4) BridgeCare Pilots

Recommendation: HHSA supports the establishment of BridgeCare Pilots to improve outcomes for individuals just above the Medi-Cal threshold. Services that will be available through BridgeCare Pilots for the population that require extra support to remain in their home safely, but do not meet Medi-Cal eligibility is critical for the growing aging population. The BridgeCare Pilots will fill a critical gap and help people remain in their home and reduce the need for a higher, more costly level of care. Services that should be provided at a minimum through the BridgeCare Pilot include personal care services, respite, care management, CAPABLE program, homemaker services, Adult Day Care, nutritional services, and transportation. (p. 44-47)

HHSA suggests coordinating with California Department of Social Services (CDSS) to implement tiered behavioral health rates for Adult Residential Facilities (ARF)/ Residential Care Facilities for the Elderly (RCFE) to stabilize community placements for adults and older adults with SMI, addressing parity issues and reducing county “patch funding” burdens. *(Section 3.13; p. 44)*

Requested DHCS Actions

- Recognize Personal Care Services and CAPABLE as high value components within BridgeCare and support county participation. *(p. 44)*
- Coordinate with CDSS to design tiered BH rates (analogous to Regional Center tiers) to stabilize ARF/RCFE placements for SMI cohorts and alleviate patch funding pressures. *(p. 44)*

5) Justice-Involved Reentry Initiative: Expand BH-CONNECT Community Transition In-Reach Services Across All Correctional Settings

Recommendation: HHSA encourages DHCS to extend the BH-CONNECT Community Transition In-Reach benefit to all correctional settings to complement the Justice-

Involved Reentry Initiative Behavioral Health Links component. HHSA expects this expansion will make the benefit more meaningful and increase county options. HHSA also encourages DHCS to enhance the bundled rates and allow for additional in-reach by JI ECM providers. It often takes providers several meetings with individuals to build trust and report before they agree to accept services. JI ECM providers should have the ability to bill for at least 3 in-reach meetings with individuals prior to release to support successful connection to ECM. *(Section 3.1; p. 25)*

Requested DHCS Actions

- Authorize BH-CONNECT In-Reach Services in all correctional settings, with clear county enrollment processes and operational supports. *(p. 25)*

6) SUD: Fully Fund Outreach/Engagement and Invest in Evidence-Based Interventions

Recommendation: HHSA encourages DHCS to recognize outreach and engagement as core access functions that should be fully funded for Medi-Cal eligibles regardless of enrollment status; also standardize fidelity and reporting statewide. Invest in research & development and pilots to expand evidence-based interventions for stimulant use disorder, including Medication Assisted Treatment (MAT). *(Sections 3.3 & 3.4; pp. 30–32)*

Requested DHCS Actions

- Include outreach/engagement in covered services with appropriate reimbursement and flexible engagement models. *(p. 30)*
- Establish and publish a fidelity framework and uniform reporting standards for county and plan compliance. *(p. 30)*
- Fund pilots and innovations for stimulant use disorder care, including MAT pathways. *(p. 32)*

7) Traditional Healers/Natural Helpers

Recommendation: HHSA encourages DHCS to pair the Traditional Healer/Natural Helper benefit with culturally responsive outreach and supports, including technical assistance (operations/billing) for Tribal partners, and expand the benefit beyond SUD to include Specialty Mental Health. *(Section 3.5; p. 34)*

Requested DHCS Actions

- Launch a Technical Assistance (TA) program for Tribal partners focused on operations, billing, documentation, and provider enrollment. *(p. 34)*
- Modify benefit scope to include Specialty Mental Health conditions in addition to SUD, with clear coverage criteria and rates. *(p. 34)*

8) Extend Medi-Cal to *All* Former Foster Youth Under 26

Recommendation: HHSA encourages DHCS to extend Medi-Cal to all former foster youth under age 26, including those who turned 18 prior to January 1, 2023. Limiting eligibility to out of state former foster youth who turned 18 on or after January 1, 2023, leaves earlier age outs without equitable access. All former foster youth experience similar health needs regardless of when or where they left care; a uniform policy advances CalAIM's goals and reduces administrative burden tied to cohort-based eligibility. *(Section 3.6, p. 35)*

Rationale & Details

- **Equity and continuity:** Earlier age outs are a similarly vulnerable cohort; uniform coverage avoids differential outcomes based solely on birth date or state of care. *(p. 35)*
- **Administrative simplification:** Removing cohort distinctions streamlines eligibility operations and reduces county/provider burden. *(p. 35)*

Requested DHCS Actions

- Update eligibility policy and guidance to apply the extension uniformly to all former foster youth under 26. *(p. 35)*
- Create and publish implementation protocols that remove date cohort checks and clarify documentation requirements for counties and plans. *(p. 35)*

9) Strengthen GPP to Incentivize BH Integration

Recommendation: HHSA encourages DHCS to explicitly incentivize behavioral health integration in the Global Payment Program (GPP) with measures tied to high need SMI/SUD cohorts (e.g., Follow-Up After Hospitalization (FUH)/ Follow-Up After Emergency Department Visit for Mental Illness (FUM), screening/treatment, MAT initiation and engagement) and include workforce development incentives for behavioral health specialty recruitment and retention and peer support specialists. *(Section 3.11; p. 39)*

Requested DHCS Actions

- Add BHS specific process/outcome measures (FUH/FUM, screening/treatment, MAT initiation/engagement) to GPP performance frameworks. *(p. 39)*
- Create GPP linked workforce incentives and support for peer specialists to build capacity for integrated care. *(p. 39)*

10) Reconsider Asset Test Modification for Deemed SSI Populations

Recommendation: HHSA encourages DHCS to reevaluate the reinstatement of the $130k asset limit for deemed SSI populations, as it would likely reduce older adults' access to Medi-Cal. *(Section 3.8; p. 36)*

Requested DHCS Actions

- Conduct impact analysis on older adult access and consider mitigations or alternatives that preserve coverage while meeting policy goals. *(p. 36)*

11) Create a PATH Sustainability Plan

Recommendation: As PATH funding grants sunset, HHSA encourages DHCS to develop a PATH sustainability plan to prevent service cliffs. *(Section 4; p. 49-50)*

Rationale & Details

- **Funding cliff risk:** Many providers serving unhoused individuals rely on PATH; a sustainability plan is needed. *(p. 50)*

Requested DHCS Actions

- With active engagement of stakeholders, HHSA encourages DHCS to develop a PATH replacement plan detailing funding sources, timelines, and technical assistance for providers. *(p. 50)*

The County of San Diego HHSA is committed to partnering with DHCS to ensure the success of CalAIM and to advance equitable, person-centered care for Medi-Cal members. We appreciate your consideration and welcome further discussion.

With any questions or concerns, please contact Heather Summers, EdD, MSW, Deputy Director, Clinical and Safety Net Coordination at [redacted]

M. Lisa Hayes, California Foundation for Independent Living Centers (CFILC), Email received March 12, 2026.

Dear Director Sadwith,

The California Foundation for Independent Living Centers (CFILC) appreciates the opportunity to provide comments on the CalAIM Section 1115 Demonstration Waiver renewal application.

Please find CFILC's comments attached for your consideration. We appreciate DHCS's leadership in advancing policies that support community-based services and look forward to continued collaboration to ensure Californians with disabilities and older adults can live independently in their communities.

Sincerely,

M. Lisa Hayes | Executive Director
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March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

Submitted via email to 1115waiver@dhcs.ca.gov

Re: Public Comments on CalAIM Section 1115 Demonstration Renewal Application

The California Foundation for Independent Living Centers (CFILC) appreciates the opportunity to provide comments on the CalAIM Section 1115 Demonstration Waiver renewal application. CFILC is a statewide membership organization representing California's Independent Living Centers (ILCs), which are community-based, disability-led organizations that provide services and advocacy to help people with disabilities live independently in their communities.

Independent Living Centers serve individuals with disabilities of all ages, including older adults, Medi-Cal beneficiaries with complex health needs, justice-involved individuals reentering the community, and people with access and functional needs (AFN). As such, ILCs are deeply connected to many of the core goals of CalAIM, including improving care coordination, addressing social drivers of health, and preventing unnecessary institutionalization.

CFILC strongly supports the continuation of CalAIM programs through the proposed waiver renewal. At the same time, our network's experience implementing services alongside managed care plans highlights several opportunities to strengthen the program and ensure it fully serves people with disabilities and older adults.

Enhanced Care Management (ECM) and Partnerships with Disability-Led Community-Based Organizations

Enhanced Care Management has significant potential to improve outcomes for Medi-Cal beneficiaries with complex needs. However, our experience suggests that stronger partnerships with disability-led community-based organizations are essential to fully realize ECM's goals.

Independent Living Centers regularly provide services that intersect with ECM functions, including care coordination, housing navigation, benefits support, and transitions from institutional settings to the community. Yet many managed care plans have chosen to perform ECM internally rather than contracting with community partners that have deep expertise serving people with disabilities.

When community-based organizations are engaged only to provide specific services, such as home modifications or housing support, reimbursement structures often fail to cover the administrative and coordination activities required to successfully deliver those services. Intake, travel, coordination with contractors, follow-up visits, and consumer support are essential components of effective service delivery but are frequently not reimbursed.

CFILC encourages DHCS to strengthen expectations for managed care plans to partner with disability-led organizations, including Independent Living Centers, as part of ECM and Community Supports networks. These partnerships are critical to ensuring that services are culturally competent, accessible, and responsive to the needs of people with disabilities.

Community Supports and Home Accessibility

CFILC strongly supports maintaining and expanding Community Supports as part of CalAIM. Services such as housing transition navigation, tenancy supports, and home modifications play a vital role in helping people remain safely in their homes and communities.

However, we encourage DHCS to strengthen the accessibility lens applied to these programs. Accessible housing remains extremely limited across California, and individuals with disabilities are often unable to benefit from housing supports because accessible units are not available. Minor home modifications are a particularly important tool for preventing institutionalization. Yet reimbursement levels often do not

reflect the actual cost of making a home accessible, particularly when modifications must accommodate mobility devices or other accessibility needs.

CFILC recommends that DHCS continue to support home modification services within Community Supports while evaluating whether reimbursement levels adequately reflect the true costs associated with accessibility improvements and the coordination required to implement them.

Behavioral Health Integration
CFILC supports the continuation of behavioral health and substance use disorder initiatives within the waiver. Many consumers served by Independent Living Centers experience co-occurring physical disabilities and behavioral health conditions, and integrated supports are essential to promoting stability and independence.

We encourage DHCS to explore opportunities to pilot additional behavioral health supports delivered in community settings, including partnerships with Independent Living Centers. Because ILCs are located in communities and are designed to be accessible and welcoming environments, they can help reduce transportation barriers and create a more integrated “one-stop” model of support for individuals with complex needs.

Justice-Involved Reentry Services
CFILC strongly supports the continuation of Medi-Cal services prior to release for justice-involved individuals. Early connection to care and support services can significantly improve reentry outcomes.

However, individuals with significant physical disabilities often require additional time to secure appropriate housing and accessibility modifications. Our network has encountered situations in which individuals who use wheelchairs or have other mobility needs faced delayed release because accessible transitional housing could not be identified within the limited planning timeframe.

We encourage DHCS to consider whether the current 90-day pre-release window is sufficient for individuals with significant accessibility needs. A longer planning period, or additional flexibility for these cases, could help ensure that individuals with disabilities can safely transition into the community upon release.

BridgeCare Pilot for "Duals-to-Be"
CFILC appreciates the concept behind the proposed BridgeCare pilot for individuals approaching eligibility for both Medicare and Medi-Cal. Many families struggle to navigate this transition period, and earlier coordination could improve continuity of care.

However, additional clarity regarding implementation will be important. It will be critical to ensure that participation does not unintentionally divert resources from existing programs serving individuals with high needs. Careful planning and stakeholder engagement will be necessary to ensure the pilot strengthens, rather than strains, the current system.

Employment Supports
CFILC supports efforts to strengthen employment opportunities for Medi-Cal beneficiaries with disabilities. Access to meaningful employment can improve health outcomes, financial stability, and community participation.

As employment initiatives are developed, we encourage DHCS to engage a broad range of partners, including disability-led organizations such as Independent Living Centers, to ensure that services are responsive to the diverse needs of people with disabilities across California. Community-based organizations with lived experience can provide valuable insight into effective strategies for supporting employment and independence.

Access and Functional Needs in Disaster Preparedness and Recovery
Recent disasters, including the devastating fires in Southern California, have highlighted the significant challenges faced by individuals with access and functional needs during and after emergencies. Many people with disabilities continue to experience long-term disruptions to housing, health care access, and community supports well after disasters occur.

CFILC encourages DHCS to ensure that disaster preparedness and recovery planning within Medi-Cal programs fully incorporates the needs of individuals with access and functional needs. Disability-led organizations, including Independent Living Centers, should be engaged as partners in designing and implementing these efforts.

Conclusion
CalAIM represents a significant opportunity to strengthen California's health and community support systems. Independent Living Centers stand ready to partner with DHCS and managed care plans to ensure that these initiatives reach individuals with disabilities, older adults, and other populations who rely on community-based supports.

CFILC appreciates DHCS's leadership in advancing these efforts and encourages continued engagement with disability-led organizations to ensure that CalAIM's goals are fully realized.

Sincerely,

[redacted]

M. Lisa Hayes
Executive Director
California Foundation for Independent Living Centers

Daniel Dickerson, Email received March 12, 2026.

Hi

Thank you for the opportunity to provide public comments regarding Native American traditional healers and natural helpers. I believe this program will make a significant impact as it relates to ensuring that Native American people receive culturally appropriate substance use treatment. As a substance use provider in Indian Country, I routinely come across barriers to being able to bill for traditional practices for Native Americans, which I believe decrease the potential for Native Americans to achieve and sustain sobriety. I recommend extending this benefit and evaluation, and for further work to be done to include more community partners and leaders "to the table" to help optimize the potential for this program to have a meaningful impact in Indian Country. Also, extending this benefit to other areas of health will further enhance the ability for this initiative to decrease the impact of various health disparities this population experiences throughout the state of California.

Julia Silas, Homebase, Email received March 12, 2026.

Hello,

Please find attached comments on the proposed CalAIM Section 1115 Waiver Renewal from the Corporation for Supportive Housing, Homebase, and Klurfeld Consulting.

Thank you - Julie Silas
--
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Advancing Solutions to Homelessness
Stay in touch with Homebase through our newsletter!

To:	Department of Health Care Services, Director's Office
Attn:	Tyler Sadwith
From:	Julie Silas, Homebase, Cheryl Winter, Corporation for Supportive Housing (CSH), and Alison Klurfeld, Klurfeld Consulting
Date:	March 12, 2026
Re:	CalAIM Section 1115 Demonstration Renewal Application

Homebase, CSH, and Klurfeld Consulting commend DHCS for moving forward to extend the successful initial CalAIM 1115 Medicaid Waiver for California. As organizations working in the field of homelessness and housing solutions, we have seen the positive impact the CalAIM 1115 waiver components related to housing services have had on Medi-Cal members experiencing homelessness. These components have helped thousands obtain supports needed to find housing and stabilize in permanent housing.

While the CalAIM 1115 Waiver for 2027-2031 would implement multiple changes to Medi-Cal, we are commenting on several key components that would be particularly impactful for people experiencing homelessness or housing instability:

1. Recuperative care and short-term post-hospitalization housing
2. Proposed new Employment Supports
3. Justice-Involved Reentry Initiative
4. Proposed new BridgeCare Pilots
5. The Community-Based Adult Services (CBAS) program

1. Recuperative Care and Short-Term Post-Hospitalization Housing

Homebase, CSH, and Klurfeld Consulting want to commend DHCS for recognizing the value and importance of recuperative care and short-term post-hospitalization housing. In fact, a 2024/2025 MCP survey found that recuperative care was one of the Community Supports rated most highly in terms of perceived value for member health or well-being and perceived cost-effectiveness.[1] With preliminary findings showing that these two Community Supports have resulted in 29.2% (recuperative care) and 10.6% (short-term post-hospitalization housing) reductions in per member/per month costs – due to decreased inpatient and outpatient emergency department

[1] 1115 Waiver application at page 58.

utilization and long-term care costs[2] – we are relieved to see that the State is committed to continue recuperative care and short-term post-hospitalization housing.

We also appreciate the effort to transfer the benefits from a pilot innovation under an 1115 Waiver to a permanent component of California's Medi-Cal program as an "In lieu of services" (ILOS) benefit. We have deep concerns that, in the proposed transfer to ILOS, the programs will no longer cover the associated room and board costs of recuperative care through federally-funded Medicaid. While we appreciate that California will seek "to cover recuperative care in alignment with federal requirements,"[3] and that the State plans to request federal technical assistance, "to identify the most appropriate authority for recuperative care and ensure coverage of these services remains uninterrupted,"[4] the proposed services without room and board are not recuperative care. Just as the State has recognized that people must have a safe place to sleep while recovering from illness, services alone without the safe place to rest will not allow people to recover; the state will fail to achieve the positive results of recuperative care noted above.

Recommendation: We urge the Department to identify a funding alternative to reimburse room and board costs for recuperative care programs and work with providers and other States seeking to include recuperative care in their Medicaid programs to arrive at solutions that incorporate the full scope of recuperative care benefits, including room and board. Continued comprehensive funding for recuperative care will reduce the likelihood of unnecessary rehospitalization and traumatic returns to unsheltered homelessness for Medi-Cal members.

2. New Employment Supports

Homebase, CSH, and Klurfeld Consulting are very happy to see that DHCS is proposing to add a new benefit, called "Employment Supports," in the 1115 Waiver Renewal, which, if approved, would provide Medi-Cal coverage to help eligible beneficiaries train, seek, find, and retain employment opportunities, helping them to find meaningful work in their communities, enabling them to meet the upcoming Medicaid work and community engagement requirements (set to go into effect on 1/1/27), and preventing them from losing essential health coverage as a result.

For the 9% of the Medi-Cal expansion population that is not already working or meeting exemptions,[5] the State intends to "further support expansion adults in obtaining or maintaining employment, and in alignment with CMS' priority of connecting adult expansion members to employment support services, California proposes to include Employment Supports as a Medi-Cal covered benefit."[6] The State also

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[2] 1115 Waiver application at page 48

[3] 1115 Waiver application at pages 48-49.

[4] 1115 Waiver application at page 49.

[5] 1115 Waiver application at page 41.

[6] 1115 Waiver application at page 42.

writes that this will help individuals keep their Medi-Cal coverage, supporting ongoing continuity of care – in addition to employment goals.

Recommendation: Make Employment Supports available statewide

While DHCS proposes that counties will be able to "opt-in," Homebase, CSH, and Klurfeld Consulting would urge DHCS to revise the CalAIM 1115 Waiver Renewal to offer Employment Supports consistently through the state rather than opt-in. By making Employment Supports a statewide benefit, Medi-Cal members who are eligible for Employment Supports will have access to them, regardless of what part of the state they live in. Without this option, the likelihood of people losing health coverage altogether is much higher. It would be unconscionable to provide help meeting new federal eligibility requirements to Medi-Cal members in some parts of the state and not others.

At a minimum, the benefit should be "opt-out" for Counties, rather than "opt-in." As you know, during the initial CalAIM 1115 Waiver, all of the housing-related Community Supports were offered by all counties from the initial launch of Community Supports. We believe given the importance of Employment Supports, especially with HR 1 new community engagement requirements to maintain Medi-Cal and CalFRESH, that the State should require that all Counties offer the new benefit. If the State cannot mandate statewide participation based on the match required by Counties to cover what the federal government will not cover, at a minimum making Employment Supports an opt-out benefit will still allow counties to retain some flexibility to opt-out and/or phase the benefit in over time, rather than require them to take an affirmative action to opt-in.

Recommendation: Consistent with other evidence-based employment services programs, Homebase, CSH, and Klurfeld Consulting would recommend additional services to include under the Employment Supports benefit **(in bold below)**:

Pre-employment Services:

- Helping individuals find and apply for jobs, including access to listings, job linkage/referrals to local workforce, resume writing workshops, and interview coaching;
- Supporting individuals in connecting to high school graduation, General Education Programs, vocational training, and college degree programs; and
- Individual one-on-one job coaching.
- **Assistance with identifying and contacting references to include in applications and/or interviews;**
- **Support obtaining necessary documentation (i.e. birth certificates, IDs, social security cards);**
- **Person-centered employment planning, similar to the best practices promoted in Individual Placement Support Supported Employment programs;**
- **Financial and health literacy;**
- **Skills training for resumes, applications, and interviews (individual and group training);**
- **Supporting individuals in connecting to apprenticeship programs; and**

- **Benefits education and planning.**

Employment Sustaining Service s— Homebase, CSH, and Klurfeld Consulting would recommend supporting individuals who have secured a job to maintain their employment through the following services (**additions in bold below**):

- Individual one-on-one job coaching;
- Financial and health literacy supports, and
- Assistance with linking to high quality childcare, school programs, and transportation assistance.
- **Support during new employee probationary periods, which might include assistance developing annual goals, preparation for employee reviews, support responding to employer feedback, and other job skills that arise during the first 3-6 months of new employment;**
- **Person-centered employment planning, similar to the best practices promoted in Individual Placement Support Supported Employment programs;**
- **Negotiation with employers;**
- **Asset Development; and**
- **Benefits education and planning.**

We feel strongly that employment sustaining services will help Medi-Cal members retain employment, which in many instances will enable them to obtain workplace health insurance. With benefits education and planning, Medi-Cal members will also be able to have smoother transitions from Medi-Cal to employer-based insurance.

Recommendation: Finally, should Employment Supports not receive CMS approval through the 1115 Waiver, we urge DHCS to add Employment Supports as an ILOS Community Support. For all of the reasons stated above, as well as the good outcomes evidence-based employment services offer to people's well-being, we urge inclusion of these services through ILOS so that fewer people are at risk of losing Medi-Cal's comprehensive health coverage under H.R. 1.

3. Strengthening the Justice-Involved Reentry Initiative

CSH, HomeBase, and Klurfeld Consulting strongly support 1115 Waiver Renewal of the Justice-Involved Reentry Initiative and recommend additional elements to strengthen the Initiative. As DHCS stated, the initiative serves many Californians who otherwise would struggle to gain meaningful access to health care and other services critical to preventing people from recidivating. Since a disproportionate number of people in prison and jails or on parole and Post-Release Community Supervision have experienced homelessness after release, the Initiative plays an important role in connecting people to services they need to avoid recidivism and remain healthy.

Recommendation: CSH, Homebase, and Klurfeld Consulting recommend i**ncluding as services housing navigation and housing deposits for people at risk of experiencing homelessness upon discharge** from incarceration (to include people experiencing homelessness upon arrest or conviction and people

who have nowhere to live upon discharge, based on COMPASS or other assessments). As stated in the DHCS framework, these services have helped Californians exit homelessness; housing deposits are specifically tied to over a 30% decrease in health costs. Providers offering these services to people in the community should be able to offer the same services to people still incarcerated.

Recommendation: Since the justice-involved population is at higher risk of homelessness and higher risk of mortality, behavioral health conditions, comorbid health conditions, and frequent use of emergency rooms and hospitalizations, we further recommend **prioritizing those at risk of returning to or experiencing homelessness for Justice-Involved Reentry Services as well**.

Recommendation: We also encourage the Department to work on **integrating home and community-based services and supports into reentry planning and reentry services**, to better address the needs of the high proportion of incarcerated older adults and people with disabilities.

4. New Pilot Program - BridgeCare

The proposed BridgeCare Pilot will ensure that older adults have access to services they need to live at home in their communities, improve their health quality, and prevent them from entering homelessness. As noted in the 1115 Waiver Renewal application, fewer than 25% of individuals in the older adult population nearing Medi-Cal eligibility have the resources to address their health challenges.[7] Without adequate resources to address health care needs, including homecare, older adults are at risk of having to choose between paying for health care and paying their housing. BridgeCare offers much needed care at the right time in the right place (at home in their community) for older adults living with "three or more chronic conditions and mobility limitations" who are at increased risk of homelessness.

CSH, Homebase, and Klurfeld Consulting celebrate the intention of BridgeCare, to **help older adults remain in their homes**, prevent costly institutionalization and impoverishment, while also improving health outcomes. While we recognize that the Pilot will only be available to folks who meet the skilled nursing facility level of care, if they are able to stay in their own homes and receive necessary care, the option is important for individuals who will be able to participate in the Pilot.

CSH, Homebase, and Klurfeld Consulting appreciate the DHCS list of core and discretionary services that would be incorporated into the BridgeCare Pilot.

Core Services to all Pilot Participants:

- Assessments (health, psychosocial, caregiver needs and health and related-social needs)
- Development of individualized BridgeCare plan of care
- BridgeCare care management
- Personal Care Services

[7] 1115 Waiver application at pages 44.

- Respite for caregivers
- CAPABLE program[8]

Discretionary Services that may be included in Pilots:

- Homemaker Services
- Adult Day Care
- Assistive Technology
- Communication: Device and Translation/Interpretation
- Community Transition Services
- Consultative Clinical Services
- Nutritional Services
- Social Support
- Transportation

Recommendation: CSH, Homebase, and Klurfeld Consulting support the current list of Core Services that would apply to all Pilot sites. We also believe that some of the Discretionary Services should be included in the Core Services, such as:

- Nutritional Services that are not covered under other Community Supports; and
- Transportation Services.

Older adults seeking to stay in their homes in the community should be able to get nutrition supports that are needed that are not currently covered under the medically-tailored meals Community Supports. Similarly, transportation to medical appointments and other places is a critical service that enables individuals to access care when they need it, reducing the risk of delayed care and medical conditions worsening before treatment.

The BridgeCare pilot is intended to serve individuals with low incomes who likely don't have easy means of transportation. Homebase and CSH believe that transportation should be considered a Core Service for any participant in BridgeCare, rather than discretionary. CSH, Homebase, and Klurfeld Consulting believe that transportation—to medical appointments as well non-medical transportation—should be considered a Core Service for any participant in BridgeCare, rather than discretionary, which would require some members to take extra steps to access transportation services in counties that do not opt to cover transportation under BridgeCare. Especially for older adults, any extra steps are likely to be a barrier and result in many members being unable to access transportation and therefore unable to get to their medical appointments and other places that are critical for their health and well-being- including getting access to groceries in food deserts and/or getting access to county agencies to access additional benefits. If transportation is a Core Service, it will minimize the extra effort members

[8] See DHCS full 1115 Waiver application, page 46, to learn more about the CAPABLE program.

would have to take to ensure they can attend their appointments and other needs consistently and safely.

5. The Community Based Adult Services (CBAS) Transition

Finally, we applaud the proposal to transition CBAS from the 1115 waiver into 1915(i) state plan authority, making it a true entitlement and securing long-term stability for a service that has proven effective in reducing hospitalizations, supporting caregivers, and keeping people in their communities. We support DHCS' commitment to avoiding disruptions in access during implementation and encourage robust technical assistance for CBAS providers.

____

Thank you for the opportunity to comment on the Medicaid Section 1115 Demonstration Five-Year Renewal Request: Continuing CalAIM Demonstration. Please do not hesitate to contact us to discuss our feedback – [redacted]

Katie Andrew, Local Health Plans of California's (LHPC), Email received March 12, 2026.

Hello—

Please find attached Local Health Plans of California's (LHPC) comments on California's CalAIM Section 1115 Demonstration Renewal Application. We look forward to continuing to partner closely with DHCS in the next waiver period. Please reach out with any questions that you may have.

Take care,

Katie
Katie Andrew | Director of Government Affairs, Quality & Behavioral Health
1201 K Street, Suite 1840, Sacramento, CA 95814
[redacted] | www.lhpc.org

March 12, 2026

Tyler Sadwith, State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Submitted Via Email: 1115waiver@dhcs.ca.gov

RE: CalAIM Section 1115 Demonstration Renewal Application

Dear Director Sadwith,

On behalf of the Local Health Plans of California (LHPC), the statewide trade association representing all 17 of California's non-for-profit and community-based health plans who collectively cover over 9.1 million Medi-Cal members, we appreciate the opportunity to submit comments on the renewal request for California's Section 1115 demonstration waiver. Local plans are committed to working in close partnership with the California Department of Health Care Services (DHCS) to ensure that the next phase of CalAIM builds upon the significant progress already achieved while maintaining operational feasibility and sustainability for the Medi-Cal delivery system.

Local plans commend DHCS for its leadership in advancing CalAIM and for seeking to extend this important work through the proposed five-year Section 1115 Demonstration Renewal. CalAIM has catalyzed meaningful transformation within the Medi-Cal program by strengthening care coordination, expanding access to community-based services, and integrating traditional health care with the social supports to address the underlying drivers of poor health outcomes. Local plans have served as key partners throughout implementation, including in advancing initiatives such as Enhanced Care Management (ECM) and Community Supports (CS), and we remain committed to continuing these efforts to ensure Medi-Cal members receive coordinated, high-quality care that addresses the needs of the whole person. The continuation of CalAIM through this waiver renewal represents an important opportunity to stabilize and refine these initiatives while incorporating lessons learned from the initial implementation period. With that goal in mind, we provide comments below on key aspects of the renewal.

Global Payment Program
LHPC is in strong support of continuing and building upon the successes achieved through the Global Payment Program (GPP). GPP has demonstrated to be effective in incentivizing high-quality, value-based, cost-effective care, as well as having proven to be an important source of funding for our designated public hospital system partners. We appreciate DHCS' vision to put additional focus on preventive care, primary care, and disease management in the next demonstration period.

Recuperative Care and Short-Term Post-Hospitalization Housing
Local plans support DHCS's proposal to create a model for recuperative care that incorporates the levels of care offered under both recuperative care and short-term hospitalization housing by sunsetting short-term post-hospitalization housing as a separate CS and transitioning federal authority for recuperative care from Section 1115 waiver authority to Medicaid managed care ILOS authority. These services play a critical role in helping members safely transition from acute care settings while addressing housing instability that can undermine recovery and long-term health outcomes.

Given the operational complexity associated with these services, it is critical that managed care plans be actively engaged in the development and refinement of these policies. Some operational considerations for local plans include ensuring feasibility of the recuperative care operational framework, assessing the potential plan impact in terms of contractual obligations, and necessitating further guidance for reimbursement structures, documentation standards, and program oversight. Early collaboration with plans will help ensure that implementation approaches are administratively workable, aligned with program requirements, and capable of supporting consistent access to services for Medi-Cal members.

Justice-Involved Reentry Services
Local plans strongly support the continuation of reentry services for justice-involved individuals beginning 90 days prior to release from incarceration. These services are critical to ensuring continuity of care upon release, including timely activation of Medi-Cal coverage and uninterrupted access to essential medications, behavioral health services, and care coordination. However, ECM providers have reported ongoing challenges when attempting to engage justice-impacted members immediately following release. In some cases, a member's Medi-Cal eligibility appears to remain on hold, as though the individual were still incarcerated. Changes to anticipated release dates may contribute to delays in updating eligibility systems, which in turn can delay access to essential care and create administrative barriers for providers working to support these individuals during a critical transition period.

Local plans commend DHCS for its commitment to cross-system coordination and respectfully request the DHCS' assistance in reviewing the Justice-Involved portal to ensure it is properly interfacing with county eligibility systems. Addressing these system alignment issues in the next iteration of the initiative will help ensure that justice-impacted individuals can access care without delay upon returning to their communities.

Employment Supports Benefit
The proposed employment supports benefit presents an important opportunity to strengthen economic stability and long-term health outcomes for Medi-Cal members. To support successful implementation, we respectfully request additional clarification from DHCS regarding:

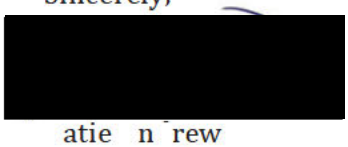
- The anticipated entity to administer the employment supports benefit;
- Clarification on the role of Medi-Cal managed care plans in authorizing, coordinating, and/or referring members to these services; and
- How the benefit will align with and support the community engagement objectives and requirements within H.R. 1.

Providing clarity on program administration and integration with existing care coordination supports will help ensure that the benefit complements ongoing CalAIM initiatives and can be implemented efficiently across the Medi-Cal delivery system.

Local plans strongly support the continuation of CalAIM through the Section 1115 demonstration renewal and recognize the significant progress DHCS has achieved in transforming the Medi-Cal program. We also look forward to working with the Department as you conceptualize the continuation and expansion of the dental integration pilot currently being conducted in San Mateo County. We encourage DHCS to engage local plans as collaborative thought partners to inform the restructuring, development, and implementation of the initiatives, new and continuing, included within the renewal. Local plans can offer important insights on population-level service coordination strategies, operational implementation considerations, data sharing and oversight infrastructure, and approaches to promote program sustainability and improved member outcomes. By leveraging the experience and infrastructure of local plans, the state can strengthen program implementation, support effective coordination across delivery systems, and maximize the impact of CalAIM's investments in whole-person care. As the state moves into the next phase of CalAIM, sustained collaboration between DHCS and local plans will be essential to ensure policies are operationally feasible, fiscally sustainable, and capable of delivering meaningful improvements in health outcomes for Medi-Cal members.

Local plans remain committed to partnering with DHCS to ensure that the next phase of CalAIM continues to advance California's leadership in innovative, person-centered care while maintaining a strong and sustainable delivery system for the communities we serve. Thank you for the opportunity to provide these comments, and we look forward to continued collaboration.

Sincerely,



atie n rew
Director of Government Affairs, Quality & Behavioral Health
Local Health Plans of California

Padraic McCoy, Pinoleville Pomo Nation, Email received March 12, 2026.

To whom it may concern:

On behalf of the Pinoleville Pomo Nation, please see the attached comment letter regarding DHCS's 1115 Demonstration Renewal Application and the DHCS Traditional Health Care Program. Please feel free to contact Tribal leadership or me with any questions. I have copied the Tribal Chairperson and Vice-Chairperson here.

Kind regards,

Padraic I. McCoy
Pinoleville Pomo Nation General Counsel

Padraic I. McCoy
Ocotillo Law & Policy Partners, LLP
198 2nd Avenue, Suite 2B
Niwot, CO 80544

PINOLEVILLE POMO NATION

500 B. Pinoleville Ukiah, CA 95482
phone: 707-463-1454 fax: 707-463-6601

Pinoleville Pomo Nation
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Ukiah, California 95482

March 12, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
1115waiver@dhcs.ca.gov

Re: CalAIM Section 1115 Demonstration Renewal Application/Traditional Health Care Program

Dear Director Sadwith:

The Pinoleville Pomo Nation is a federally recognized Indian tribe and sovereign government located in Mendocino County, California, and it possesses a government-to-government relationship with the United States and the State of California. We write to support DHCS's request to CMS of an extension, for the longest permissible period, to the DHCS Traditional Health Care Program (i.e., Traditional Healers and Natural Helpers) (THCP) for Medi-Cal members with an SUD, and, notably, to retain flexibility to cover these services for other conditions beyond SUD and for other delivery systems. We also urge DHCS to work with counties and other payors to ensure that Indian Health Care Programs (IHCP) may bill, as outlined in DHCS BHIN 25-036, for allowable services.

As you know, the Nation operates health and community services programs, including New Life Clinic in Ukiah, California, for the benefit of its Tribal citizens and others with an SUD. The Nation recently successfully opted into the THCP and has commenced providing traditional health care services to patients.

The THCP Should be Extended in Time. Traditional healing practices have been central to tribal health systems since time immemorial and remain an essential component of how tribal communities address health and wellness today. The THCP program represents an important recognition by the State of California that culturally grounded care improves outcomes for Native and other patients. Extending the program is also consistent with longstanding federal and state policies supporting tribal self-determination in health care. Federal law, including the Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act, reflects Congress's policy that Indian tribes should be empowered to design and administer health care programs that meet the needs of their communities. These statutes embody the federal government's trust responsibility to Indian

tribes and support tribal authority to incorporate culturally appropriate care into health delivery systems. Programs such as the THP initiative align with these principles by acknowledging that tribes possess unique cultural knowledge and traditional healing systems that play a critical role in improving health outcomes for all people. Programs that allow tribes to incorporate traditional healing practices into Medi-Cal services therefore have the potential to significantly improve access to culturally appropriate care and also to reduce long-standing health disparities experienced by Native communities.

The THCP Should be Expanded in Scope. In addition, the Nation strongly recommends that the scope of allowable THCP services be expanded beyond substance use disorder and addiction services. Traditional healing practices are inherently holistic and are commonly used to address a wide range of mental health, behavioral health, and physical health conditions. Limiting the THCP program to substance use disorder treatment does not reflect how traditional healing is actually practiced within tribal communities. Expanding the scope of the program would allow tribes to integrate traditional care more effectively across the full continuum of health services provided to Native and other patients and would help ensure that Medi-Cal services for American Indian and Alaska Native beneficiaries are culturally appropriate and responsive to community needs.

THCP Billings Challenges Should be Resolved. Finally, the Nation respectfully encourages DHCS to address the billing and reimbursement challenges that tribes have encountered when attempting to bill for THCP services. In practice, tribes have experienced difficulties navigating billing processes involving county behavioral health plans and Medi-Cal managed care organizations. Improved coordination among DHCS, counties, and managed care entities, along with clearer billing guidance and streamlined reimbursement pathways, would greatly assist tribes in successfully implementing the program and ensuring that traditional services are sustainably integrated into tribal health systems. Finaly, the Nation respectfully encourages DHCS to continue engaging in meaningful government-to-government tribal consultation regarding the future development and implementation of the THCP program. Ongoing consultation will help ensure that the program evolves in a way that reflects the needs, traditions, and health priorities of California's tribal communities.

The Pinoleville Pomo Nation appreciates DHCS's efforts to recognize and support traditional healing practices within the Medi-Cal program.

Thank you for the opportunity to provide these comments.

Sincerely,

[redacted]

Pinoleville Pomo Nation

By:

Matt Libucha, The Sierra Network, Email received March 12, 2026.

Dear DHCS:

Thank you for the opportunity to comment on the CalAIM Section 1115 renewal application. I am writing on behalf of The Sierra Network, a referral network that works with Residential Care Facilities for the Elderly across California. I am writing to address Section 3.13, the proposed BridgeCare Pilots. We support the program's goal of reaching the "near dual" population before they spend down into Medi-Cal. We also believe the proposal has two gaps that will limit how well the program works in practice.

1. RCFE residential care should be a discretionary BridgeCare service.

The application frames the BridgeCare population's options as either staying at home with HCBS or entering a nursing facility. That is not how the real continuum of care works in California. Between those two endpoints sits a large network of licensed RCFEs that already serve older adults at a skilled nursing facility level of care, at a fraction of the cost of SNF placement.

The state's own Assisted Living Waiver has been demonstrating this for years. RCFEs provide 24-hour supervision, ADL assistance, medication management, meals, and social engagement in a residential setting. These are the exact services BridgeCare is trying to deliver, just organized differently than a home-based model.

The application acknowledges that informal caregiving supports are strained for this population. For a person who is moderately to severely frail, lives alone, and has no reliable caregiver, home-based HCBS may not be enough. If BridgeCare does not cover any residential care option, that person's only covered pathway when home-based services fall short is the nursing facility. That is the outcome the program exists to prevent.

Adding RCFE care to the discretionary services list would not force any local entity to include it. It would simply allow local entities the option to build residential care into their pilot design where it makes sense. This fits within the core-plus-discretionary framework the application already uses.

2. The opt-in structure needs real incentives, or BridgeCare will repeat the problems of Community Supports.

BridgeCare depends on local entities volunteering to participate, designing their own service packages, and putting up the non-federal share. This is structurally similar to how Community Supports were rolled out under CalAIM, and DHCS should look hard at how that has actually played out before replicating the model.

On paper, Community Supports are available in most California counties. In practice,

implementation has been deeply uneven. In multiple counties, managed care plans have elected to offer Community Supports but set provider reimbursement rates so low that few or no providers actually deliver the services. The benefit exists in the plan's filing with DHCS but does not exist for the member who needs it. We hear this consistently from the RCFE operators in our network.

BridgeCare's design layers additional risk on top of this pattern. Local entities can set their own enrollment caps and create waitlists. If a handful of entities opt in with small caps, the program will not produce enough data to evaluate the hypotheses the application describes, particularly the Medicare savings analysis that depends on comparing expected and actual expenditures across a meaningful population.

We urge DHCS to study why Community Supports adoption has lagged in practice and apply those lessons to BridgeCare's incentive design before the pilots launch.

Matt Libucha
The Sierra Network

Rubie Gonzalez-Parra, Los Angeles County Department of Health Services, Email received on March 12, 2026.

Good Morning,

I am writing to submit feedback on the renewal request of the CalAIM Section 1115 demonstration on behalf of Los Angeles County health systems (Health Services, Public Health, Mental Health), and the Department of Homeless Services and Housing (HSH). If you have any questions, please contact the Government Relations staff, copied in this email, and included in the letter.

Best,

Rubie Gonzalez-Parra (She/Her)
Legislative Analyst, Government Relations Unit
Los Angeles County Department of Health Services
[redacted]

Attachment not included due to document protections.

Cheryl L. Winter, CSH, Email received March 12, 2026.

Dear Director Sadwith and DHCS staff,

We deeply appreciate the opportunity to comment on the CalAIM Section 1115 Demonstration Renewal Application. I am pleased to submit the attached comment letter on behalf of organizations who are members of the statewide Aging and Disability Homelessness Advocacy Coalition and the L.A. based CalAIM Coalition of homeless service providers.

Please do not hesitate to reach out with any questions or to discuss our recommendations.

Sincerely,

Cheryl L. Winter (she, her, hers), MPH, LICSW
Associate Director, California State Policy, CSH
San Francisco, CA
[redacted]
Visit csh.org, the source for supportive housing resources, news, events and more.

March 12, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
Submitted via email to: 1115waiver@dhcs.ca.gov

Re: CalAIM Section 1115 Demonstration Renewal Application

Dear Director Sadwith:

The undersigned organizations are members of two coalitions: the statewide Aging and Disability Homelessness Advocacy Coalition (ADHAC), made up of people with lived experience of homelessness, service providers, advocacy organizations, local government agencies, and policy experts on aging, affordable housing, and homelessness from across California; and the LA CalAIM Coalition, made up of service providers who are delivering CalAIM services to people experiencing homelessness in Los Angeles. We appreciate the opportunity to provide feedback on the CalAIM 1115 Waiver renewal.

We commend DHCS for moving forward to extend the successful initial CalAIM 1115 Medicaid Waiver for California. We have seen the positive impact the CalAIM 1115 waiver components related to housing services have had on Medi-Cal members experiencing homelessness and housing instability. CalAIM services have helped thousands of Medi-Cal members experiencing homelessness find housing and stabilize in permanent housing.

While the CalAIM 1115 Waiver for 2027-2031 would implement multiple changes to Medi-Cal, we are commenting on several key components that would be particularly impactful for older adults and people living with disabilities who are experiencing homelessness or housing instability:

1. Recuperative Care and Short-Term Post-Hospitalization Housing
2. Proposed new Employment Supports benefit
3. Justice-Involved Reentry Initiative
4. Proposed new BridgeCare Pilots
5. The Community Based Adult Services (CBAS) program

1. Recuperative Care and Short-Term Post-Hospitalization Housing

While recuperative care and short-term post-hospitalization housing would not be covered under a renewal or new 1115 Waiver under the DHCS framework, we commend DHCS for recognizing the value and importance of such services and transferring them as one Community Support in Medi-Cal's "in lieu of services" (ILOS) to join many of the other successful CalAIM ILOS Community Supports.

We have concerns, however, that in the proposed transfer to ILOS, the programs will no longer cover the associated room and board costs of recuperative care through federally-funded Medicaid. While we appreciate that California will seek "to cover recuperative care in alignment with federal

requirements"[1] and that the State plans to request federal technical assistance "to identify the most appropriate authority for recuperative care and ensure coverage of these services remains uninterrupted for Medi-Cal members," [2] the proposed services without room and board are not recuperative care. Just as the State has recognized that people must have a safe place to sleep while recovering from illness, services alone without the safe place to rest will not allow people to recover which could jeopardize the positive results recuperative care has achieved to date.

Recommendation: Work to identify alternatives to cover room and board costs.

We urge the Department to identify a funding alternative to reimburse room and board costs for recuperative care programs and to work with providers and other States seeking to include recuperative care in their Medicaid programs to arrive at solutions that incorporate the full scope of recuperative care benefits, including room and board. Continued comprehensive funding for recuperative care will reduce the likelihood of unnecessary rehospitalization and traumatic returns to unsheltered homelessness for Medi-Cal members.

2. New Employment Supports

We are very happy to see that DHCS is proposing to add a new benefit, called "Employment Supports," which, if approved, would provide Medi-Cal coverage to help eligible beneficiaries train, seek, find, and retain employment opportunities, helping them to have meaningful work in their communities, enabling them to meet the upcoming Medicaid work and community engagement requirements (set to go into effect on 1/1/27), and preventing them from losing essential health coverage as a result.

Recommendation: Make Employment Supports available statewide.

While DHCS proposes that counties will be able to "opt-in," we urge DHCS to revise the CalAIM 1115 Waiver Renewal to offer Employment Supports consistently through the state rather than opt-in. By making Employment Supports a statewide benefit, Medi-Cal members who are eligible for Employment Supports will have access to them, regardless of what part of the state they live in. Without this option, the likelihood of people losing health coverage altogether is much higher. It would be unconscionable to provide help meeting new federal eligibility requirements to Medi-Cal members in some parts of the state and not others.

At a minimum, the benefit should be "opt-out" for Counties, rather than "opt-in." As you know, during the initial CalAIM 1115 Waiver, all of the housing-related Community Supports were offered by all counties from the initial launch of Community Supports. We believe given the importance of Employment Supports, especially with HR 1 new community engagement requirements to maintain Medi-Cal and CalFRESH, that the State should require that all Counties offer the new benefit. If the State cannot mandate statewide participation based on the match required by Counties to cover what the federal government will not cover, at a minimum making Employment Supports an opt-out benefit will still allow counties to retain some flexibility to opt-out and/or phase the benefit in over time, rather than require them to take an affirmative action to opt-in.

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[1] 1115 Waiver application at pages 48-49.

[2] 1115 Waiver application at page 49.

Recommendation: Consistent with other evidence-based employment services programs, we recommend additional services to include **(in bold below)**:

Pre-employment Services:

- Helping individuals find and apply for jobs, including access to listings, job linkage/referrals to local workforce, resume writing workshops, and interview coaching;
- Supporting individuals in connecting to high school graduation, General Education Programs, vocational training, and college degree programs; and
- Individual one-on-one job coaching.
- **Assistance with identifying and contacting references to include in applications and/or interviews;**
- **Support obtaining necessary documentation (i.e. birth certificates, IDs, social security cards);**
- **Person-centered employment planning, similar to the best practices promoted in Individual Placement Support Supported Employment programs;**
- **Financial and health literacy;**
- **Skills training for resumes, applications and interviews (individual and group training);**
- **Supporting individuals in connecting to apprenticeship programs; and**
- **Benefits education and planning.**

Employment Sustaining Services: Supporting individuals who have secured a job to maintain their employment through

- Individual one-on-one job coaching;
- Financial and health literacy supports;
- Assistance with linking to high quality childcare, school programs, and transportation assistance.
- **Support during new employee probationary periods, which might include assistance developing annual goals, preparation for employee reviews, support responding to employer feedback, and other job skills that arise during the first 3-6 months of new employment;**
- **Person-centered employment planning, similar to the best practices promoted in Individual Placement Support Supported Employment programs;**
- **Negotiation with employers;**
- **Asset development; and**
- **Benefits education and planning.**

We feel strongly that employment sustaining services will help Medi-Cal members retain employment, which in many instances will enable them to obtain workplace health insurance. With benefits education and planning, Medi-Cal members will also be able to have smoother transitions from Medi-Cal to employer-based insurance.

Recommendation: Finally, should Employment Supports not receive CMS approval through the 1115 Waiver, we urge DHCS to add Employment Supports as an ILOS Community Support. For the reasons stated above, as well as the good outcomes evidence-based employment services offer to people's well-being, we urge inclusion of these services through ILOS if not federally approved as a benefit.

3. Strengthening the Justice-Involved Reentry Initiative

We strongly support renewal of the Justice-Involved Reentry Initiative and recommend additional strengthening of the Initiative in a renewal of the Waiver. As DHCS stated, this initiative is serving many Californians who otherwise would struggle to gain meaningful access to health care and other services critical to preventing people from recidivating. Since a disproportionate number of people in prison and jails or on parole and Post-Release Community Supervision have experienced homelessness after release, this Initiative can play an important role in connecting people to services they need to avoid recidivism and remain healthy.

Recommendation: We recommend **including as services housing navigation and housing deposits for people at risk of experiencing homelessness upon discharge** from incarceration (to include people experiencing homelessness upon arrest or conviction and people who have nowhere to live upon discharge, based on COMPAS or other assessments). As stated in the DHCS framework, these services have helped Californians exit homelessness; housing deposits are specifically tied to a significant decrease (30%) in healthcare costs. Providers offering these services to people in the community should be able to offer these services to people still incarcerated. When services are not available until someone is released, people reentering community exit into homelessness and are often lost to follow up before Medi-Cal managed care plans (MCPs) can authorize a service and before providers can connect with them to provide the service.

Recommendation: Since the justice-involved population that is at higher risk of homelessness is also at higher risk of mortality, behavioral health conditions, comorbid health conditions, and frequent use of emergency rooms and hospitalizations, we further recommend **prioritizing those at risk of returning to or experiencing homelessness for Justice-Involved Reentry Services as well**.

Recommendation: We also encourage the Department to work on integrating home and community-based services and supports into reentry planning and reentry services, to better address the needs of the high proportion of incarcerated older adults and people with disabilities.

4. New Pilot Program - BridgeCare

The proposed BridgeCare Pilots will ensure that older adults have access to services they need to live at home in their communities, improve their health quality, and prevent them from entering homelessness. As noted in the 1115 Waiver application, less than 25% of individuals in the older adult population nearing Medi-Cal eligibility have the resources to address their health challenges.[3] Without adequate resources to address health care needs, including homecare, older adults are at risk of having to choose between paying for health care and paying for their housing. BridgeCare offers much needed care at the right time in the right place (at home in their community) for older adults living with "three or more chronic conditions and mobility limitations" who are at increased risk of homelessness.

We celebrate the intention of BridgeCare, to **help older adults remain in their homes**, prevent costly institutionalization and impoverishment, while also improving health outcomes.

[3] 1115 Waiver application at pages 44.

We appreciate the DHCS list of core and discretionary services that would be incorporated into the BridgeCare Pilot.

Core Services to all Pilot Participants:

- Assessments (health, psychosocial, caregiver needs and health and related-social needs)
- Development of individualized BridgeCare plan of care
- BridgeCare care management
- Personal Care Services
- Respite for caregivers
- CAPABLE program[4]

Discretionary Services that may be included in Pilots:

- Homemaker Services
- Adult Day Care
- Assistive Technology
- Communication: Device and Translation/Interpretation
- Community Transition Services
- Consultative Clinical Services
- Nutritional Services
- Social Support
- Transportation

Recommendation: We support the current list of Core Services that would apply to all Pilot sites. We also believe that some of the Discretionary Services should be included in the Core Services, such as:

- Nutritional Services; and
- Transportation Services.

Older adults seeking to stay in their homes in the community should be able to get the nutrition supports they need to stay healthy in their community. For the Medi-Cal eligible population, we have seen how important nutrition supports and medically-tailored meals have been through CalAIM Community Supports. We recommend that nutrition supports be a Core Service for BridgeCare eligible individuals given that they are not eligible for Community Supports and other Medi-Cal services.

Similarly, transportation to medical appointments is a critical service that enables individuals to access care when they need it, reducing the risk of delayed care and medical conditions worsening before treatment. The BridgeCare pilot is intended to serve individuals with low-incomes who likely don't have easy means of transportation to get to a medical appointment. We believe that transportation should be considered a Core Service for any participant in BridgeCare, rather than discretionary.

[4] See DHCS full 1115 Waiver application, page 46.

5. CBAS Transition

Finally, we applaud the proposal to transition CBAS from the 1115 waiver into 1915(i) state plan authority, making it a true entitlement and securing long-term stability for a service that has proven effective in reducing hospitalizations, supporting caregivers, and keeping people in their communities. We support DHCS' commitment to avoiding disruptions in access during implementation and encourage robust technical assistance for CBAS providers.

Thank you for the opportunity to comment on the Medicaid Section 1115 Demonstration Five-Year Renewal Request: Continuing CalAIM Demonstration. Please do not hesitate to contact us to discuss our feedback.

Sincerely,

Members of the statewide Aging & Disability Homelessness Advocacy Coalition and the LA CalAIM Coalition

CARDEA HEALTH

CSH

DOWNTOWN WOMEN'S CENTER

FMWC

HOMEBRIDGE

JEWISH FAMILY SERVICE LA

National Alliance to End Homelessness

SHIELDS for families

believing, building, becoming

Senior Services Coalition of Alameda County

UNITED WAY Greater Los Angeles

Kelsey Avery, Healthcare in Action (HIA), Email March 12, 2026.

Good afternoon,

Healthcare in Action (HIA), an affiliate of SCAN, appreciates the opportunity to provide feedback on the CalAIM Section 1115 demonstration renewal application. Please see attached and do not hesitate to contact me with any questions.

Thanks,

Kelsey Avery
Director, State Government Affairs
SCAN Group
Pacific Time Zone
[redacted]

March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

RE: Healthcare in Action Comments on CalAIM Section 1115 Demonstration Renewal Application

Submitted via email to 1115waiver@dhcs.ca.gov.

Dear Director Sadwith:

Healthcare in Action (HIA) appreciates the opportunity to provide feedback to the Department of Health Care Services (DHCS) on its CalAIM renewal application. HIA shares DHCS's commitment under CalAIM to a more coordinated, person-centered, and equitable health system that works for all Californians.

HIA is California's largest street medicine group, with 22 street medicine teams working across six California counties – Los Angeles, Orange, Riverside, San Bernadino, San Diego, and San Mateo – to provide services to unhoused individuals. As a street medicine provider, HIA does not have a brick-and-mortar geographic anchor. Instead, HIA uses fully equipped mobile health vans to directly outreach to unhoused individuals and provide services where they reside – including tents, cars, shelters, and temporary housing. By bringing consistent, respectful care to the places unhoused individuals already are, we help remove barriers that keep our patients from getting well.

HIA's clinicians and community health workers provide services that reflect the needs of the unhoused population, such as mental health care, substance use disorder (SUD) treatment, wound care, chronic disease care, enhanced care management (ECM), and community supports (CS). Foundational to the HIA model is the social support, enabled by ECM and CS, provided by the lead care managers and peer navigators (PNs) we pair with each patient. **ECM and CS are vital to HIA's whole-person care model for our unhoused patients, and we commend DHCS for continuing these services beyond December 31, 2026.** As DHCS looks to the future of CalAIM, HIA would like to offer recommendations to simplify and advance the ECM and CS benefits.

Incorporating ECM and CS into the Standard of Care for Unhoused Individuals

HIA's model demonstrates that providing comprehensive care to unhoused individuals requires seamlessly integrating clinical services, ECM, and CS. Rather than viewing these components as distinct benefits provided individually to our unhoused patients, we believe they are more appropriately thought of as a single, comprehensive service that more closely aligns with a patient-centered medical home model. Viewing clinical and social services for unhoused patients through this lens opens the door to more creative, value-based payment approaches. For

example, providers serving unhoused patients should be directly incentivized to invest in full integration of clinical services, ECM, and CS to improve health and housing outcomes, and/or indirectly incentivized to integrate services using outcomes-based incentive payments. **HIA encourages DHCS to evaluate payment approaches to drive toward quality and outcome goals, especially for unhoused individuals, as ECM and CS mature.**

There are also steps DHCS can take to encourage integration of ECM and CS on a smaller scale. Today, one of HIA's health plan partners allows our PNs to provide **both** ECM and CS services. We have found that patients tend to prefer this arrangement, as it provides a single point of contact and accountability. Furthermore, having a single PN can lead to improved care coordination and higher operational efficiency. But today, most patients have multiple PNs to provide ECM and CS. **HIA encourages DHCS to explore opportunities to support further connections between, if not outright integration of, ECM and CS.**

Standardizing ECM and CS Documentation and Reporting Across Counties and Health Plans
A persistent challenge to realizing the full potential of ECM and CS lies in the associated operational, productivity, and billing challenges. HIA currently works with seven health plans, each with different documentation and billing requirements – and plan requirements can differ even within a single managed care organization based on a patient's county of residence. Some health plans require us to use different billing codes, places of service, and/or unit amounts for the same services, creating complicated billing guidelines for our teams to follow. In addition, some health plans accept notes from our electronic medical record (EMR), while others require double documentation in separate platforms that also may not be consistent across plans and counties. Relatedly, reimbursement rates and structures vary by health plan and county.

While we acknowledge the need to demonstrate that a Medi-Cal service has been provided, these inefficiencies detract from patient care and have led to staff burnout and turnover. In fact, HIA has had successful peer navigators leave their roles due to the time-consuming nature of duplicative documentation. **HIA recommends greater standardization of documentation requirements for ECM and CS across all counties and all health plans, including a requirement that plans accept EMR submissions.**

Improving Access to Community Supports
Today, some health plans set highly prescriptive CS requirements, limiting HIA's ability to address patients' essential needs for successful permanent housing. For example, some plans limit CS funds to paying for security deposits and may not allow CS funds to be used for other essentials like application fees, cleaning supplies, or pet deposits. Plan authorization periods also can pose challenges for housing support needs that are simultaneously time sensitive and difficult to predict – for instance, a one-month plan authorization window is a very limited timeframe to support patients with all the necessary move-in coordination efforts. **HIA recommends DHCS continue refining the requirements and parameters for CS authorization to ensure timely, reliable, and equitable access to these services.**

Ensuring Sustainable Reimbursement for Street Medicine
Finally, as critical as ECM and CS are to providing comprehensive, high-quality care to unhoused individuals, HIA relies on a street medicine chassis to deliver these services. The cost of delivering mobile addiction, mental health, and medical services to unhoused individuals far

exceeds Medi-Cal reimbursements. But delivering these essential services directly to patients where they reside fosters the trust and healing that lead to positive health and housing outcomes. **A sustainable street medicine funding model is needed to ensure HIA and other street medicine providers can continue delivering both high-quality social support and medical care.**

Supporting Unhoused Individuals Under H.R. 1's Work and Community Engagement Requirements

HIA applauds DHCS for using the CalAIM renewal application to propose a new Employment Supports initiative to assist individuals with meeting work and community engagement reporting requirements established under the federal H.R. 1. HIA has serious concerns regarding the potential impact of these requirements on continuity of Medi-Cal coverage for our unhoused patients.

As DHCS knows, health and homelessness are deeply intertwined. According to a 2023 report from the University of California at San Francisco's Benioff Homelessness and Housing Initiative, homelessness is nearly synonymous with poor health status.[1] Almost two-thirds of unhoused Californians contacted by the UCSF researchers reported a chronic disease, while over one-third of respondents reported a limitation in an activity of daily living. Two-thirds of respondents also reported symptoms of mental illness, including serious depression, anxiety, trouble concentrating or remembering, and hallucinations.

H.R. 1 outlined several exemptions to work and community engagement requirements based on an individual's health conditions, such as disability status, behavioral health needs, and serious and complex medical conditions. Many of HIA's patients have a health condition that will exempt them from work and community engagement requirements. However, due to factors such as an unstable mailing address, inconsistent phone and internet access, and difficulty establishing and maintaining care, unhoused individuals will face an even greater struggle than other Medi-Cal beneficiaries in documenting that they qualify for an exemption.

HIA is strongly committed to helping our patients demonstrate both exemptions from and compliance with work and community engagement requirements under H.R. 1. DHCS has several opportunities to ensure DHCS's efforts to prevent unnecessary disruptions in Medi-Cal coverage reflect the realities facing people experiencing homelessness.

Implement the Proposed Employment Supports Initiative Under CalAIM Renewal

Unhoused Californians are particularly disconnected from the labor market, but many seek jobs. According to UCSF's 2023 California homelessness study,[2] 44% of unhoused Californians were looking for employment. Among the population that will be subject to H.R. 1's work and community engagement requirements, 55% were seeking work.

To maximize the impact of the proposed Employment Support initiative, HIA strongly encourages DHCS to leverage its existing ECM and CS providers to provide the new

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[1] *Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness.* UCSF Benioff Homelessness and Housing Initiative. June 2023. Available at: https://homelessness.ucsf.edu/sites/default/files/2025-12/CASPEH_Report_62023.pdf.

[2] Ibid.

employment support services. People experiencing homelessness are a long-standing population of focus under CalAIM, which means street medicine providers like HIA have demonstrated competency in navigating this population's unique health and socioeconomic needs. HIA has diligently developed deep, trusted relationships with our unhoused patients that will be fundamental to employment supports having the desired impact. HIA recommends that DHCS facilitate the necessary workforce upskilling to implement this initiative through dedicated grants and trainings to trusted community providers. HIA supports DHCS's proposed Employment Supports initiative, and we stand ready to implement the initiative once approved.

Increase Support for the SSI/SSDI Application Process

Nearly half of people experiencing homelessness qualify for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).[3] Allowable exemptions under H.R. 1's work and community engagement requirement exemptions make properly documenting unhoused individuals' disability status and supporting them through the SSI/SSDI eligibility process an even greater imperative. The SSI/SSDI process is complicated and arduous, and people experiencing homelessness need substantial assistance through what are often multiple application attempts.

Today, HIA supports our patients through the SSI/SSDI application process by providing needed health care services and by making appointments and gathering documentation for the longitudinal clinical care record that underpins a disability qualification. Once an HIA patient qualifies for SSI/SSDI and is receiving the associated income, HIA often leverages the CS "housing trio"[4] to support the member in obtaining and maintaining housing. While existing funding sources certainly help organizations like HIA dedicate resources to assisting our patients with the SSI/SSDI application process, its time- and labor-intensive nature means the level of reimbursement does not match the level of effort.

DHCS has an opportunity to help more unhoused individuals access the SSI/SSDI benefits to which they are entitled while simultaneously establishing these individuals' eligibility for an exemption from Medi-Cal work and community engagement requirements. **HIA encourages DHCS to develop an initiative to support organizations that navigate patients through a lengthy, burdensome SSI/SSDI application process that would otherwise be nearly impossible to complete alone.**

Ensure Robust, Proactive Exemption Processes

As described previously, HIA believes many of our unhoused patients will qualify for one or more of the exemptions from work and community engagement requirements. **HIA strongly encourages DHCS to make every effort to develop robust upstream administrative processes that proactively apply these exemptions.** Unhoused individuals should only be asked to actively demonstrate their qualification for an exemption after all reasonable state data sources have been exhausted.

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[3] *Social Security Programs Disability Programs and People Experiencing Homelessness.* Nicholas, J. & Hale, T.W. May 2021. Available at: https://www.ssa.gov/policy/docs/ssb/v81n2/v81n2p1.html.

[4] The "housing trio" is comprised of housing transition navigation services, housing deposits, and housing tenancy and sustaining services.

We understand such an approach requires DHCS to invest in new system capabilities and innovative analytic approaches. **HIA and our affiliate, SCAN Health Plan, recently developed a robust methodology to identify unhoused older adults based on a combination of Z codes, claims, member services call transcripts, and primary care engagement data – we would be happy to share our approach and lessons learned with DHCS as the Department considers its own needs.**

HIA appreciates the opportunity to share our perspective on the power of CalAIM to change the lives of people experiencing homelessness. HIA is deeply committed to improving the lives of people experiencing homelessness through quality, holistic care, and we stand ready to help demonstrate the value of CalAIM in delivering on this mission.

Sincerely,

Indu Subaiya, MD, MBA
Chief Executive Officer
Healthcare in Action

Erika Oduro, Inland Empire Health Plan, Email received March 12, 2026.

Good evening,

Please see the Plan's comments related to the CalAIM 1115 Waiver Renewal attached.

Please let us know if there are any questions.

Erika
Erika Oduro,MAOL, CHC
Manager, Regulatory Affairs - Medi-Cal
Compliance
Inland Empire Health Plan
10801 Sixth St.
Rancho Cucamonga, CA 91730
[redacted]

We heal and inspire the human spirit.

March 12, 2026

Department of Health Care Services
Director's Office
Attn: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

VIA ELECTRONIC MAIL
1115Waiver@dhcs.ca.gov

RE: CalAIM Section 1115 Waiver

Dear Director Sadwith,

On behalf of Inland Empire Health Plan (IEHP), thank you for the opportunity to comment on the proposed California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration Renewal Application. This important opportunity builds upon best practices and lessons learned over the past five years to reduce complexity, improve quality outcomes and enhance program effectiveness through value-based initiatives that deliver meaningful results for members and communities across the state. With our mission to heal and inspire the human spirit, IEHP serves over 1.4 million members across Riverside and San Bernardino counties and is among the top ten largest Medicaid health plans and the largest not-for-profit Medicare-Medicaid public plan in the nation. Through the provisions of CalAIM, IEHP remains deeply committed to serving the most vulnerable populations, while ensuring that program sustainability and appropriate oversight remain integral to how services are delivered.

The Inland Empire represents one of California's fastest growing and most diverse regions, characterized by substantial social vulnerabilities, evolving healthcare infrastructure, and unique demographic patterns. Residents experience disproportionately high rates of chronic disease, behavioral health needs, and social determinants of health challenges, compounded by barriers such as provider shortages and few integrated health system resources. In the spirit of IEHP's continued partnership with DHCS, we offer the following recommendations and considerations to help position California and its managed care plans for successful implementation of CalAIM over the next five years, informed by IEHP's experience and lessons learned to date.

Employment Supports

As Employment Supports is currently envisioned, it is important that program design reflects the unique labor market conditions of each region. In the Inland Empire, federal policies such as trade tariffs and immigration regulations as well as the increasing automation associated with artificial intelligence are expected to continue shaping job availability, unemployment trends, and overall

economic growth. These challenges are compounded by a concentration of warehouse, logistics, and service sector jobs characterized by variable hours, seasonal work, and income volatility that can lead to Medi-Cal eligibility churn; limited access to vocational training, adult education, and workforce development programs that restrict job access present additional barriers to the development and implementation of Employment Supports.

Given CMS' preliminary guidance regarding managed care plans' roles in community engagement requirements, including the potential for plans to refer Medicaid/Medi-Cal managed care enrollees to employment supports, IEHP respectfully requests that forthcoming program guidance clearly specify whether the Employment Supports benefit will be administered through Medi-Cal managed care plans or whether it is intended to operate as a county-administered program supported through direct state funding to the counties. Furthermore, for counties that elect to opt in, IEHP requests that DHCS provide technical assistance to ensure expectations are clearly defined for counties, plans, and stakeholders.

To maximize resources, reduce duplication and better support sustainable employment for Medi-Cal members, IEHP requests that any new Employment Supports consider necessary coordination with existing federal, state, and local workforce development and job training programs. Contracting mechanisms and mandatory data sharing frameworks will also be critical to enable coordinated case management across employment, health, and social services systems. IEHP also recommends incorporating metrics beyond job placement and retention such as reductions in Medi-Cal coverage loss, decreases in avoidable emergency and hospital utilization, increased Earned Income Tax Credit utilization, and improvements in financial security. Clarification is also requested regarding whether transportation will be a covered cost for these services and how utilization oversight will be structured.

Justice-Involved Reentry Services

IEHP supports the continuation and enhancement of Section 1115 authority to provide targeted Medi-Cal services to eligible justice-involved populations 90 days pre-release from incarceration. We appreciate DHCS' acknowledgment that a number of operational challenges have arisen during implementation, particularly with the Justice-Involved Screening Portal. Consistent with the goals of the initiative to ensure continuity of care for individuals transitioning from incarceration to the community, IEHP remains dedicated to ensuring individuals can be connected seamlessly to ECM providers and other essential services upon release. IEHP commends DHCS for its ongoing commitment to addressing the challenges identified by counties and stakeholders and respectfully requests that managed care plans be actively engaged in the process of identifying and implementing solutions to resolve these issues.

IEHP requests that reentry service delivery models include flexible attribution and payment structures that support its delegated ECM networks, including county behavioral health providers, federally qualified health centers (FQHCs), and CBOs. Successful reentry requires real-time data exchange among county jails, state prisons, probation departments, behavioral health systems, and managed care plans. IEHP requests that DHCS establish clear legal frameworks and technical standards for bidirectional data sharing under HIPAA and 42 CFR Part 2, including automated Medi-

Cal eligibility verification and enrollment triggers and support the development of predictive analytics to identify high need individuals for prerelease outreach.

Recuperative Care and Short-Term Post Hospitalization Housing

IEHP supports DHCS' proposal to develop a revised recuperative care model that integrates the levels of care offered under both recuperative care and short-term post-hospitalization housing. In alignment with DHCS' priorities, IEHP remains committed to ensuring uninterrupted access to these vital services for our members. We commend DHCS for its plan to transition federal authority for recuperative care from Section 1115 waiver authority to Medicaid managed care In Lieu of Services (ILOS) authority and to align the revised service with federal requirements. IEHP recommends explicit coordination mechanisms between these services and DMC-ODS institutions for mental disease (IMD) treatment to support step-down care for members completing residential SUD treatment who require transitional housing with clinical supports.

As DHCS advances this work, it will be important to ensure that managed care plans are actively engaged throughout the policy development process to support operational feasibility and long-term program success. Adequate implementation timelines will also be critical so plans can educate providers, update contractual arrangements, and implement necessary system changes to ensure a smooth transition that maintains uninterrupted member access to care. Additionally, to ensure program sustainability, it will be important that rates accurately reflect the operational implications associated with these program changes.

PATH Initiative

IEHP commends DHCS for its commitment to strengthening the capacity and infrastructure of on the ground partners, including CBOs, hospitals, county agencies, Tribes, and others, to effectively participate in the Medi-Cal delivery system as California implemented ECM, Community Supports, and Justice Involved reentry services under CalAIM. Although this one-time funding is set to sunset, the investments made through PATH will continue to play a pivotal role in supporting CalAIM service delivery moving forward.

Modification of Asset Test for Deemed SSI Populations

While IEHP recognizes the state's ongoing fiscal constraints and the rationale for reinstating an asset limit for certain populations as a cost containment measure, the elimination of the Medi-Cal asset test in 2024 represented a significant step toward reducing barriers to coverage for low-income seniors and persons with disabilities. The removal of the asset test had a positive impact on access to coverage, particularly for vulnerable populations who no longer had to spend down their savings to qualify for Medi-Cal coverage. Maintaining eligibility standards remains essential to ensuring individuals can access and retain coverage while preserving a basic level of financial security.

Global Payment Program

IEHP supports continuation of the Global Payment Program (GPP), which provides critical funding for public and district hospitals serving uninsured populations. Safety-net hospitals across the state such as Riverside University Health System and Arrowhead Regional Medical Center in the Inland Empire, provide disproportionate shares of uncompensated care, behavioral health crisis services, and

specialized tertiary care. IEHP requests that DHCS ensure that GPP funding formulas recognize regional variation in uninsured populations and uncompensated care burden, avoid methodologies that systematically disadvantage non-academic public systems or systems located in regions with lower commercial payer mix, and maintain predictable, multi-year funding commitments that support long-term capacity planning.

If DHCS implements an Equity Subpool within GPP, IEHP requests that performance metrics and qualifying activities reflect health equity priorities across diverse regions including rural, suburban, and exurban communities, recognize public systems for advancing language access, culturally responsive care, and community-based outreach in medically underserved areas, and provide technical assistance to smaller public systems so they can compete effectively for equity focused payments.

Data, Equity, and Regional Context

IEHP requests that DHCS publish Section 1115 evaluation results stratified by geographic region and health plan to ensure transparency, support region-specific quality improvement, and inform future waiver design based on geographic variation in outcomes. IEHP also urges DHCS to prioritize regions with high social vulnerability, rapid population growth, and evolving healthcare infrastructure. Additionally, IEHP recommends that the STCs formalize the role of managed care plans in program design and evaluation by establishing mechanisms for plan engagement in implementation planning, metric development, evaluation design and interpretation, and ongoing stakeholder feedback throughout the demonstration period.

IEHP truly appreciates this opportunity to submit comments on the waiver proposals, and we look forward to working with you and your teams to implement CalAIM. If you have any questions, please contact me directly at [redacted]

Sincerely,

[redacted]

Edward Juhn, MD, MBA, MPH
Chief Medical Officer
Inland Empire Health Plan

Orvin Hanson, Indian Health, Email received on March 12, 2026.

DHCS:

Attached are our comments concerning Traditional Healer and Natural Helpers including Statewide and Equitable Access, Reimbursement and Tribal Sovereignty, and Chiropractic Services and Uncompensated Care.

IHC and our consortium Tribes look forward to opening up the Traditional Healer and Natural Benefit beyond those with a SUD Diagnosis and working on simple and effective reimbursement process.

Respectfully Submitted:

Orvin Hanson
Chief Executive Officer
[redacted]
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Valley Center, CA 92082
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March 12, 2026

Subject: Tribal Comments on DHCS Notice of Intent to Submit Renewal of the CalAIM Section 1115 Demonstration

Dear Director Baass and Director Sadwith:

On behalf of Indian Health Council, Inc. (IHC), we submit the following comments in response to the Department of Health Care Services' (DHCS) February 10, 2026 Notice of Intent to Submit a Renewal of the CalAIM Section 1115 Demonstration.

Indian Health Council, Inc., is a Tribal organization as defined in 25 U.S.C.§ 5304(l) and Section 501(a)(5) of Title V (25 U.S.C. § 5381(a)(5)), whose member Tribes are the Inaja Band of Diegueno Mission Indians of the Inaja and Cosmit Reservation, California; the La Jolla Band of Luiseno Indians, California; the Los Coyotes Band of Cahuilla and Cupeno Indians, California; the Mesa Grande Band of Diegueno Mission Indians of the Mesa Grande Reservation, California; the Pala Band of Mission Indians; the Pauma Band of Luiseno Mission Indians of the Pauma and Yuima Reservation, California; the Rincon Band of Luiseno Mission Indians of the Rincon Reservation, California; the San Pasqual Band of Diegueno Mission Indians of California; and the Iipay Nation of Santa Ysabel, California, which have authorized Indian Health Council, Inc. (IHC), to compact on their behalf.

Traditional Healers and Natural Helpers:

While IHC currently operates within a county that participates in the Drug Medi Cal Organized Delivery System (DMC ODS), the existing structure of the Traditional Healer and Natural Helper benefit remains overly limited. Restricting eligibility to individuals with a substance use disorder (SUD) diagnosis and confining service delivery to DMC ODS unnecessarily constrains the full value of traditional healing practices.

Traditional healing is inherently holistic and supports wellness, prevention, chronic disease management, behavioral health integration, and cultural continuity. These services should not be restricted solely to SUD treatment.

Statewide and Equitable Access:

Even for Tribal programs currently included in DMC ODS, access remains uneven across the state. All Tribal communities deserve equitable access to culturally grounded services, regardless of county level behavioral health infrastructure.

DHCS should ensure statewide availability of Traditional Healer and Natural Helper services for all Tribal Health Programs.

Reimbursement Structure and Tribal Sovereignty:

The current county by county reimbursement approach places an unnecessary administrative burden on Tribal Health Programs and undermines Tribal sovereignty.

A centralized reimbursement mechanism—similar to Tribal Medicaid Administrative Activities or the CRIHB Options–Uncompensated Care model—would streamline implementation and promote consistent access statewide.

Chiropractic Services and Uncompensated Care:

We support DHCS's proposal to continue reimbursement for chiropractic services provided by Indian Health Service and Tribal facilities. However, uncompensated care under the 1115 waiver must not be limited solely to chiropractic services.
Any Medi Cal optional benefits that are reduced or eliminated under the Indian Health Service Memorandum of Agreement (IHS MOA) must remain eligible for reimbursement under the CRIHB Options–1115 Waiver uncompensated care program, including but not limited to dental, podiatry, audiology, and speech therapy services.

We urge DHCS to:

- Provide statewide authority for Traditional Healer and Natural Helper services;
- Allow Tribal Health Programs to offer these services regardless of county DMC ODS status; and
- Ensure that rural Tribal communities are not excluded from culturally essential care.
- Expand eligibility to all Medi Cal members receiving care at Indian Health Programs, regardless of diagnosis; and
- Create a streamlined reimbursement mechanism.

Conclusion:

IHC supports renewal of the CalAIM Section 1115 Demonstration and urges DHCS to ensure that Traditional Healer and Natural Helper services are equitably available, culturally responsive, and implemented in a manner that respects Tribal sovereignty.

[redacted]

Orvin Hanson, Chief Executive Officer

Cc: Robert Smith, Board Chairman

Ted Jackson, Marin Center for Independent Living, Email received March 12, 2026.

To Whom It May Concern,

Please find public comments in response to the proposed 1115 Waiver Renewal from Marin Center for Independent Living attached.

Thanks, Ted
--
Ted Jackson (he/him)
Chief Executive Officer
[redacted]
Marin Center for Independent Living
Matrix Parent at Marin CIL
710 Fourth Street San Rafael, CA 94901
[redacted]
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www.MatrixParents.org

MARIN CENTER FOR INDEPENDENT LIVING

MARIN CIL

March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

Submitted via email to 1115waiver@dhcs.ca.gov.

Re: Public Comments on CalAIM Section 1115 Demonstration Renewal Application

Dear Chief Deputy Director Sadwith,

I am writing to express the Marin Center for Independent Living's (MCIL) appreciation for the opportunity to comment on the Department of Health Care Services' (DHCS) Medicaid Section 1115 Demonstration Five-Year Renewal Request. These comments are offered in the spirit of strengthening Medi-Cal and improving access to Home and Community Based Services for older adults and people with disabilities as the state continues to advance the goals of CalAIM, strengthen community-based systems of care, and support the broader vision outlined in California's Master Plan for Aging.

Community-Based Adult Services (CBAS)
MCIL strongly supports the Department's proposal to transition the Community-Based Adult Services (CBAS) program to a permanent home- and community-based services (HCBS) benefit under 1915(i) state plan authority. This transition represents an important step toward strengthening the long-term sustainability of the program and ensuring continued access to this critical service.

As this transition moves forward, members have expressed interest in continued opportunities for stakeholder engagement to help inform implementation. For example, the Department may wish to consider establishing an advisory group or stakeholder forum focused on CBAS implementation. Such a structure could provide a venue for ongoing dialogue with consumers, providers, plans, and advocates as the Department works to expand access and ensure the benefit is implemented successfully statewide.

Modification of Asset Test for Deemed SSI Population
MCIL supports the proposal to modify the asset test for the deemed SSI population in alignment with the California 2025 Budget reinstatement of the asset test for other non-MAGI Medi-Cal populations. Aligning eligibility policies across populations will help maintain consistency within Medi-Cal and reduce administrative complexity for beneficiaries.

As this change is implemented, we encourage DHCS to ensure that all protections included in the State Plan Amendment are applied to the deemed SSI population as well. This includes holding individuals harmless for asset transfers made during the period when the asset limit was eliminated and requiring asset reporting only at the enrollee's first Medi-Cal renewal in 2027. These protections will help prevent unintended coverage disruptions for individuals with significant health and long-term care needs.

Employment Supports
We appreciate the Department's proposal to establish employment supports to assist Medi-Cal expansion adults in meeting new work and community engagement requirements under H.R. 1. As this new benefit is developed, it will be important to ensure equitable access across the state. Limiting availability to certain counties could create geographic disparities in access to the supports needed to maintain Medi-Cal coverage, particularly if individuals in some regions have access to employment assistance while others do not. Ensuring that employment supports are available statewide would help prevent these disparities from being built into the program from the outset and support consistent access to coverage for Medi-Cal members across California.

At the same time, while regional flexibility may be appropriate, it may be helpful for the Department to establish a core set of employment and pre-employment supports that would be available to all eligible Medi-Cal members. A baseline package of services (such as job readiness support, training opportunities, and assistance with maintaining employment) could help ensure a consistent level of support across counties while still allowing local programs to tailor services to community needs.

As the Department continues to refine the proposal, additional clarity regarding how access to these supports will be structured would also be helpful. If the Department is considering a waiver of reasonable promptness or other mechanisms that could limit participation, transparency around how those limits would operate would be important to ensure stakeholders understand how eligibility and access will be determined.

Finally, it will be important that employment supports are designed to be accessible, culturally competent, and responsive to the diverse needs of Medi-Cal beneficiaries. For example, older adults between the ages of 50 and 64 may face unique barriers in the labor market, including age discrimination and gaps in employment history that require different types of training or counseling. Tailoring services to reflect these

realities, as well as the needs of individuals with limited English proficiency or other barriers to employment, will be critical to ensuring the program is effective and equitable.

Recuperative Care
We support the Department's proposal to move the Recuperative Care community support to a more permanent authority while sunsetting the Post-Hospitalization Short Term Housing service. Ensuring that recuperative care remains available statewide will be critical for individuals who need short-term stabilization and recovery support following hospitalization.

Justice-Involved Initiative
MCIL supports renewal of the Justice-Involved Reentry Initiative. Extending Medi-Cal coverage for critical services during the reentry process can help promote health stability and improve outcomes for individuals returning to their communities. However, given the growing number of older adults and individuals with disabilities within incarcerated populations, we would encourage the Department to consider how HCBS can be incorporated into reentry planning and service delivery. Early connection to HCBS may help ensure that individuals with functional needs are able to safely transition back into their communities with appropriate supports in place.

Mandatory Medicare Advantage Alignment
We support the continued renewal of the Medicare Advantage alignment authority as an important step toward improving care integration for individuals dually eligible for Medicare and Medi-Cal. As this work continues, we look forward to collaborating with DHCS to ensure that integration efforts include strong consumer protections, person centered care models, and robust oversight and accountability.

Thank you again for the opportunity to provide comments on the CalAIM Demonstration renewal and for the Department's continued engagement with stakeholders throughout this process. MCIL looks forward to ongoing collaboration to strengthen Medi-Cal and ensure access to LTSS for older adults and people with disabilities across California.

Sincerely,

Ted Jackson
Chief Executive Officer
Marin Center for Independent Living

Nancy Behm, PATH, Email received March 12, 2026.

Hello,

Please see attached Public Comment from PATH regarding the CalAIM Renewal Application.

Thank you,

Nancy Behm, MPH
Pronouns: she/her/hers
CalAIM Project Director
[redacted]
Path Logo
Book time with me!
Note: My work schedule is Tuesday and Friday only, 9am-12:30pm, with ability to accommodate some
meetings on alternative days.

MAKING IT HOME

www.epath.org

DHCS CalAIM Section 1115 Demonstration Renewal Application: Comments

March 12, 2026

Tyler Sadwith
Director
Department of Health Care Services
1115waiver@dhcs.ca.gov

Subject: Feedback on the CalAIM Section 1115 Demonstration Renewal Application

Dear Director Sadwith:

Thank you for inviting stakeholders and service providers to share input on the CalAIM Section 1115 Demonstration Renewal Application. We appreciate the long-term historical and future efforts of DHCS to address health disparities through treating social determinants of health in the Whole Person Care (WPC), Health Homes, and CalAIM programs.

PATH is a homeless service provider operating in 4 regions (Los Angeles, Orange, San Diego, and Santa Clara Counties) across the state of California; at present, we are operating Enhanced Care Management (ECM) and housing-related Community Supports (CS) in three regions. We received TA assistance for financial sustainbility and all three regions were IPP and CITED awardees. We are committed to having ECM and CS as part of our menu of services available to individuals and families experiencing homelessness.

We are grateful for DHCS' continued commitment to improving health outcomes and quality and coordination of care for individuals who are unhoused, justice-involved, or previously homeless. Many of the members we served through Health Homes and CalAIM have faced complicated, ineffective, and, at times, inhumane experiences in prior programs or lack thereof. While the first four years of CalAIM have not been perfect, it has been a significant improvement, providing access to vital services and investing in the well-being of some of California's most vulnerable residents who would not be housed without them. We hope to see continued support and unrestricted offering of Recuperative Care and the Housing Trio to

Medi-Cal beneficiaries in 2027 and beyond with the health plans we are contracted with.

COMMENTS ON SECTION 3 - CALAIM DEMONSTRATION FIVE YEAR RENEWAL REQUEST

We are encouraged to see and support the inclusion of Employment Supports to help Medi-Cal beneficiaries maintain their coverage, care, and case management (and even recuperative care stay), and potentially enhance their quality of life. We believe it is imperative that the counties we operate in, with some of the highest incidents of homelessness in the state, opt-in to cover this benefit "to address barriers to employment, support sustained workforce participation, and promote economic stability among Medi-Cal members.".

Of the two categories of services, we see Pre-Employment Services being the most needed, but both are very valuable. We suggest that, in addition to "job readiness assessments, individualized employment planning, job placement assistance, and post-employment retention services", Employment Services also support a member's pre-employment costs like transportation to and from interviews or even their job once hired, interview clothes (as some donation centers may not carry the right attire or even sizes), appropriate footwear (like steel-toed boots for construction), training fees for a profession, and tools or resources such as paying for a speciality license or card (like a guard card or CDL).

COMMENTS ON SECTION 4 – INITIATIVES BEING DISCONTINUED OR TRANSITIONED UNDER CALAIM SECTION 1115 AUTHORITY

A vital program for addressing health disparities and saving healthcare costs is recuperative care. Before CalAIM and even WPC, PATH provided recuperative care, which remains a critical part of the medical and housing care continuum. Many members, particularly seniors and individuals with chronic health conditions, lack a safe discharge destination from a hospital or skilled nursing facility (SNF), especially when it comes to accessing available beds in SNFs or shelters. Recuperative care provides a safe space for recovery after hospitalization and can also prevent costly hospital admissions. Our PATH outreach teams utilize recuperative care for hospital avoidance often. For individuals living on the street, managing health conditions like diabetes or wound care is extremely difficult.

Recuperative care is a far more cost-effective option compared to hospital stays—with one month of care sometimes costing less than a single day of hospitalization. We are encouraged to see the preliminary findings that "recuperative care and short-term posthospitalization housing resulted in 29.2 and 10.6 percent reductions, respectively, in aggregate per member per month (PMPM) costs due to decreases in inpatient, outpatient, emergency department (ED), and long-term care costs." We

see recuperative care as an essential part of the housing and healthcare continuums - for cost-savings, but also stabilization, equity, and access to longer-term supports.

We recognize the need to reconsider the funding authority and structure of Recuperative Care and STPHH. We support DHCS' efforts to continue investing in recuperative care as a long-term, permanent option in the in-lieu-of services menu, and also have many concerns due to the impact on the viability of our program in San Diego County.

We are in alignment with NIMRC's concerns and recommendations surrounding the proposed funding authority changes that warrant the removal of coverage for "Room and Board". "Room and Board" is the majority of our rate of service for both Recuperative Care and STPHH. If payment for "Room and Board" is no longer an option, it seems highly unlikely that reimbursement rates will be sufficient to remain open. We, along with NIMRC, encourage DHCS to consider reimbursing Room and Board costs through state-funded wrap payments.

With the sunsetting of STPHH and the need to change or even enhance the services under Recuperative Care to not include "Room and Board", we ask DHCS to remain true to the heart and purpose of Recuperative Care - a safe place for someone experiencing homelessness to discharge quicker and rest after a potentially traumatic and unrestful hospitalization. We join NIMRC in requesting that DHCS utilize the existing NIMRC Models of Medical Respite Care as the foundation for the creation of tiers of recuperative care services, including honoring those models that do not have clinical staff as part of their team. Adding clinical staff to our team, even an LVN, including all that goes with it, is not a financial risk we are prepared to take in such an unsettling federal healthcare and housing funding landscape. Considering and adequately funding all four of the established Models of Medical Respite Care will help DHCS support best practices statewide, by using a familiar framework for determining a program's model, level of services and subsequent reimbursement rate. Each of the four models serve a critical role in the housing and healthcare continuum, as not all members will need to access all levels of those care models, and not all providers, including ourselves, can pivot to increase the intensity of their care model.

ADDITIONAL COMMENTS ON CALAIM ENHANCED CARE MANAGEMENT & COMMUNITY SUPPORTS

Lastly, we want to address a key challenge in ECM and CS services: the program's struggle to adequately address health disparities among the most vulnerable: the unhoused and unsheltered. Currently, ECM, Housing Transition Navigation and Housing Tenancy and Sustaining Services are tailored to those who can access and maintain a phone and are easier to serve. The existing payment structure—with

limited outreach funding, a focus on only successful contacts, and a lack of tiered payment based on acuity—forces organizations to prioritize quantity over quality to meet program expenses. In our organization, we have intentionally kept caseloads smaller to ensure high-quality care, but this makes covering program expenses difficult and program sustainability questionable. Many organizations serving unhoused individuals face similar challenges. These members—often the hardest to reach and maintain engagement—are more likely to require higher levels of care (hospital or Skilled Nursing Facility) and are frequently disenrolled due to lack of engagement, or not enrolled at all. We encourage DHCS to find ways to incentivize organizations to focus on these hard-to-reach members. To truly address health disparities and achieve equity, we must prioritize the experience of these individuals.

Thank you for your continued commitment to supporting our unhoused community members and paving a path to a more equitable future.

Sincerely,

Jennifer Hark Dietz
Chief Executive
Officer PATH

Nicette Short, Rady Children's Health, Email received March 12, 2026.

Please see the comments of Rady Children's Health in support of the CalAIM 1115 Demonstration waiver application.

Thank you.

-Nicette Short

1102 Q Street, Suite 130
Sacramento, California 95811
[redacted]

March 12, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith

Via email: 1115waiver@dhcs.ca.gov

RE: CalAIM Section 1115 Demonstration Renewal Application

Dear Mr. Sadwith,

On behalf of Rady Children's Health, we appreciate the opportunity to write in support of California's CalAIM 1115 Demonstration Renewal Application.

Rady Children's Health is a premier pediatric healthcare system in Southern California that unites the trusted expertise of Children's Hospital of Orange County and Rady Children's Hospital San Diego. With three hospitals, a growing network of primary and specialty care centers spanning six counties, and two of the region's Level 1 pediatric trauma centers, Rady Children's Health is a trusted partner for families seeking safe, high-quality care. **Rady Children's Health is pleased to strongly support the continuation of the highly effective Enhanced Care Management (ECM) Program, particularly in the pediatric population.**

RADY CHILDREN'S HEALTH ECM PROGRAM

Leveraging the DHCS-awarded CalAIM Incentive Payment Program (IPP) and CITED Round 2 grant funding, Rady Children's Hospital San Diego launched our program in October of 2022. Since the program's launch, Rady Children's ECM program has served over 1,200 members and currently supports over 700 patients, with more than 550 patients in San Diego County and more than 150 patients in Riverside County. Building on prior investment, effective January 1, 2026, DHCS awarded Rady Children's a CITED Round 4 grant to expand capacity through December 31, 2026. Expansion supports increasing capacity to 750 members in San Diego County and to 300 members in Riverside County in response to the growing demand.

Clinical Outcomes and Utilization Impact

Comparative pre- and post-enrollment utilization data demonstrate that ECM substantially reduces acute care utilization across the enrolled population. Among all active patients, emergency department (ED) visits per 1,000 members declined by 18%, and inpatient admissions per 1,000 members declined by 40% following ECM enrollment. The effect is

particularly pronounced among the behavioral health population, in which ED utilization fell by 22% and inpatient admissions fell by 58%, outcomes consistent with the program's whole person model and its emphasis on addressing upstream social drivers of health.

Current FY2026 quality improvement priorities include increasing Well Child Visit completion rates from a baseline of 45.7% to 60% which has been surpassed with a current performance of 67.2% completion rate (N = 705). These results reflect the program's structured implementation approach, in which evidence-based interventions are deployed with iterative quality improvement to sustain impact.

Program retention metrics further support efficacy: 84.9% of members remain enrolled beyond six months, and over 170 members have been continuously enrolled for more than one year. High retention indicates sustained member engagement and suggests that care management intensity is well-matched to acuity. ECM supports long term self-sustainability and leads or more stable, improved health outcomes

Addressing Social Drivers of Health

Among the over 550 members screened for Social Drivers of Health (SDoH), a majority (62.6%) screened positive for at least one unmet social need, underscoring the breadth of non-clinical barriers that ECM is designed to address:

- Food Insecurity (52.2%)
- Transportation Barriers (43.5%)
- Housing Instability (42.0%)

To systematically address these needs, ECM conducts a closed-loop referral process to ensure that all medical, behavioral, and community supports referrals are truly connected. Care coordination and improved communications with community partners helps to lessen administrative challenges and increase member awareness of, and connection to, resources. To date, 961 referrals have been documented for 328 unique patients (mean: 3 referrals per patient; range: 1 to 11). Of the 272 referrals (28.3%) closed, 63.6% resulted in services. The remaining 689 referrals (71.7%) are in progress; the anticipated resolution time for external community-based services is 6 to 9 months, reflecting the growing need for impacted services.

Population Served and Workforce Capacity

ECM serves Medi-Cal members with high-complexity needs. A majority of active patients (54.3%) are also enrolled in California Children's Services (CCS), and serious mental illness (SMI) is prevalent across counties served, affecting over 20% of patients in San Diego and over 50% in Riverside. Rooted in a whole-person model of care, the program addresses the full spectrum of a child's medical, developmental, behavioral, and social needs through integrated, multidisciplinary care coordination. The lead care manager (LCM) staffing model sustains a 1:45 LCM-to-patient ratio, enabling intensive longitudinal engagement. All LCMs are

trained in person-centered care, cultural humility, and motivational interviewing, consistent with workforce development standards for community-based care programs.

The multidisciplinary team, comprised of the member and their support system, physicians, nurses, social workers, community health workers, and patient care coordinators, brings linguistic diversity; including Spanish, Pashto, Dari, Arabic, American Sign Language, and Vietnamese and direct lived experience across member groups; including intellectual and developmental disabilities (IDD), serious mental illness, justice involvement, maternal and infant health, and refugee. The members and family are recognized as integral members of the care team, and their feedback plays a critical role in informing program interventions, the development of health promotion materials, and overall service improvement.

Support for Continued Investment

The Rady Children's Health ECM program represents a high-value, evidence-supported intervention within the California Medi-Cal managed care framework. Implemented using a whole-person model of care, the program applies structured practices to produce clinically meaningful outcomes for one of the state's most medically complex and socially vulnerable pediatric populations. Documented reductions in emergency and inpatient utilization, particularly among behavioral health populations, combined with strong member retention and systematic mitigation of social drivers, demonstrate that ECM delivers measurable value across clinical, social, and fiscal dimensions. ECM supports long term self-sustainability and leads to more stable, improved health outcomes, that can have long term effects extending beyond ECM enrollment. Sustained state funding and continued DHCS contractual support are essential to maintaining program infrastructure, scaling county-level capacity, and realizing the long-term fiscal savings attributable to reduced acute care utilization. Legislative and regulatory continuity of ECM aligns with California's CalAIM transformation goals and the state's broader commitment to health equity for high-need pediatric Medi-Cal beneficiaries.

Rady Children’s Health is pleased to support the State’s 1115 Waiver Renewal Application and continuing the ECM program. If you would like any additional information, please reach out to our Sacramento advocate, [redacted]

Sincerely,

[redacted]

Clara Evans
Vice President
Government Affairs

[redacted]

Vice President
Chief Advocacy & Public Policy Officer

Serena Brooks, United Indian Health Services, Inc, Email received on March 11, 2026.

Department of Health Care Services:

Please accept the attached comments regarding the renewal of CalAIM Section 1115 Demonstration from United Indian Health Services, Inc., a consortium of nine federally recognized Tribes in Northwestern California.

Respectfully,

Serena Brooks, PACE
Yurok, Karuk, Eel River, Pomo
Executive Assistant
UNITED INDIAN HEALTH SERVICES, INC.
Potawot Health Village
1600 Weeot Way, Arcata, CA 95521
[redacted]
Fax: (707) 825-6747

UNITED INDIAN HEALTH SERVICES, INC.
Healthy mind, body, and spirit for generations of our American Indian Community

March 10, 2026

Dear Director Baass and Director Sadwith:

On behalf of United Indian Health Services, a non-profit Tribal Health Program providing health care services on behalf of Indian Community Representatives and nine federally recognized tribes to eligible Indian Beneficiaries and eligible members of their households within Humboldt and Del Norte Counties in Northwestern California, we submit the following comments in response to the Department of Health Care Services' (DHCS) February 10, 2026 Notice of Intent to Submit a Renewal of the CalAIM Section 1115 Demonstration.

While we appreciate DHCS's efforts to renew CalAIM authorities, we must express serious concern regarding the continued exclusion of our Tribal Health Program from access to Traditional Healer and Natural Helper services due solely to our county's non-participation in the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Discriminatory Impact on Rural Tribal Health Programs

United Indian Health Services, Inc. is located in a rural area of California and is not served by a DMC-ODS county. As a result, DHCS's current structure **categorically excludes our program and our patients from accessing Traditional Healer and Natural Helper services**, despite explicit recognition that these services benefit AIAN communities.

This exclusion is not based on clinical need, program readiness, or Tribal eligibility. Instead, it is based solely on geographic location—a factor outside of Tribal control. As applied, this policy discriminates against rural Tribal Health Programs and perpetuates inequities between urban and rural Tribal communities.

Traditional Healing Is Not County-Dependent

Traditional Healer and Natural Helper services are rooted in Tribal culture, not county behavioral health systems. Conditioning access to these services on DMC-ODS participation elevates county infrastructure over Tribal sovereignty and creates an inequitable, two-tiered system of care for AIAN Medi-Cal beneficiaries.

Failure to Operationalize DHCS's Stated Flexibility

The Notice indicates DHCS seeks to "retain flexibility to cover these services for other conditions beyond SUD and for other delivery systems." However, without explicit statewide implementation, that flexibility remains theoretical and inaccessible to Tribal Health Programs like ours.

Traditional healing is inherently holistic and supports wellness, prevention, chronic disease management, behavioral health integration, and cultural continuity. These services should not be restricted solely to SUD treatment.

Centralized Reimbursement and Equity

Requiring Tribal Health Programs to rely on county participation creates fragmented implementation and entrenches inequities. DHCS should adopt a centralized reimbursement approach that allows Tribal Health Programs to directly access reimbursement for Traditional Healer and Natural Helper services, independent of county systems.

We urge DHCS to:

- Provide statewide authority for Traditional Healer and Natural Helper services;
- Allow Tribal Health Programs to offer these services regardless of county DMC-ODS status; and
- Ensure that rural Tribal communities are not excluded from culturally essential care.
- Expand eligibility to all Medi-Cal members receiving care at Indian Health Programs, regardless of diagnosis; and
- Create a streamlined reimbursement mechanism.

Conclusion

United Indian Health Services, Inc. urges DHCS to correct the discriminatory impact of the current waiver structure and ensure that rural Tribal Health Programs are not excluded from CalAIM benefits solely due to geography.

Equitable access to Traditional Healer and Natural Helper services is not optional—it is essential to fulfilling Medi-Cal's obligation to AI/AN communities and honoring government-to-government responsibilities.

Sincerely,

[redacted]

Elizabeth Lara O'Rourke
Chief Executive Officer
United Indian Health Services, Inc.

[redacted]

LaWanda Green
Chairperson, Board of Directors
United Indian Health Services, Inc.

David Kane, Western Center on Law & Poverty, Email received on March 11, 2026.

Good afternoon!

Please find attached comments from the Western Center on Law & Poverty for the Department's CalAIM Section 1115 Demonstration Renewal Application.

Thanks,

David
David Kane
Senior Attorney
[redacted] | www.wclp.org

WESTERN CENTER
ON LAW & POVERTY

www.wclp.org

March 10, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

VIA EMAIL: 1115waiver@dhcs.ca.gov

Re: Comments on CalAIM Section 1115 Renewal Application – Employment Supports

Dear Tyler Sadwith:

Western Center on Law & Poverty writes to offer comments on the Department of Health Care Services' (DHCS) proposed California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration waiver renewal application. While we appreciate DHCS including "Employment Supports" (Section 3.12) to help Medi-Cal adults satisfy new work reporting requirements, we strongly urge the Department to revise the supports so that they include **volunteer and educational services** that Californians need to keep their coverage.

The current "Employment Supports" are too narrow. They exclusively prioritize job readiness assessments and formal job placement assistance. This fails to account for the diverse realities of Medi-Cal members—many of whom cannot or choose not to participate in traditional labor markets, or who are pursuing alternative forms of community and economic engagement. In addition, traditional workforce participation is not universally accessible or desirable. Nor should it be a prerequisite to health care. As a result, the CalAIM 1115 demonstration must specify that Employment Supports can be fully used by individuals engaging in, or seeking to engage in, volunteer work and schooling. Just like work activities, educational pursuits and volunteer service are powerful social drivers of health, fostering community integration, personal development, and benefits to the public.[1]

Further, limiting "Employment Supports" strictly to formal employment excludes Californians without work authorization. California has proudly led the nation in

[1] UCLA Health, October 27, 2025, "Volunteering can improve cognitive health," available at https://www.uclahealth.org/news/article/volunteering-can-improve-cognitive-health.

dismantling discriminatory barriers to health care, culminating in the historic Health4All expansions that opened full-scope Medi-Cal to all income-eligible undocumented residents. This includes the estimated 700,000 to 1 million undocumented Californians who recently obtained health coverage on January 1, 2024.

But now, these exact same community members—who now access full-scope Medi-Cal—are systematically barred from the formal labor market by federal immigration laws. For these Californians, participating in community volunteer activities or advancing their education and skills training are primary, lawful avenues for engagement and for fulfilling Medi-Cal's new work reporting requirements. If CalAIM's "Employment Supports" are strictly tied to authorized W-2 or 1099 employment, DHCS will effectively lock undocumented and certain lawfully present Medi-Cal enrollees out of the waiver's crucial resources, contradicting the state's commitment to universal inclusion. For these reasons, we urge the Department to expand Section 3.12 to include volunteer services and academic enrollment.

Please add to "Section 3.12 – Employment Supports" services to help Medi-Cal members find and complete volunteer work, and find and enroll in academic programs. This may include services fully aligned with CalAIM's proposal:

- *Pre-Volunteer and Pre-Education Services*:
  - Helping members find and apply for volunteer opportunities and education programs, including access to listings, referrals to local programs, application assistance, interview coaching and more;
  - Education and training programs should include ones already in the CalAIM application (General Education Programs, vocational training, college degree programs), as well as all other education and training programs available in local communities;
  - Individual one-on-one coaching, counseling tutoring, mentoring, and supports.
- *Volunteer and Education Sustaining Services:* Supporting members who have secured volunteer service opportunities and education/training enrollments through individual one-on-one coaching, counseling, tutoring, mentoring, and linking to high quality childcare, transportation assistance, and any other supports that members need to maintain their volunteer service and education/training enrollment.

We urge DHCS to amend the "Employment Supports" proposal to explicitly guarantee that these supports are universally accessible for Medi-Cal beneficiaries pursuing **volunteer work and educational opportunities**. This necessary modification will align the waiver with California's commitment to racial and economic justice and ensure that all residents—regardless of immigration status—have the supports that they need to keep their Medi-Cal coverage.

Thank you for considering our suggestions. [redacted]

Sincerely,

[redacted]

David Kane
Western Center on Law & Poverty

Jay Calcagno, California Behavioral Health Association (CBHA), Email received on March 12, 2026.

Good afternoon,

On behalf of the California Behavioral Health Association (CBHA) and our diverse membership of behavioral health providers, please see attached our feedback for the CalAIM Section 1115 Demonstration Renewal Application. We appreciate the opportunity to provide this feedback which includes direct member concerns and recommendations for consideration. If there are any immediate questions from DHCS, CBHA's Policy Team is cc'd to provide support.

Thank you, and we look forward to the finalized application.

In Partnership,

Jay Calcagno (he/him)
Policy Analyst
California Behavioral Health Association (CBHA)
455 Capitol Mall, Suite 215, Sacramento, CA 95814
[redacted]
CBHA manages the California Access Coalition (CAC).
“CBHA provides advocacy and support for behavioral health safety net providers to be effective
in their mission to help their clients thrive.”

Sent via electronic transmission

March 12th, 2026

RE: Feedback for CalAIM Section 1115 Demonstration Renewal

Dear Department of Health Care Services (DHCS) Leadership,

On behalf of the California Behavioral Health Association (CBHA), we appreciate the opportunity to provide feedback on the renewal application for the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration. CBHA represents a diverse network of community-based behavioral health providers serving over two million Californians across the lifespan. Our association has been a partner in providing input as the CalAIM waiver was planned and implemented. We reiterate our continued commitment to ensuring the success of transforming Medi-Cal into a more accessible, equitable, and person-centered system of care while identifying opportunities to improve CalAIM.

We appreciate the dedication of the Governor, Legislature, and DHCS to CalAIM and the vision of continuous improvement for its implementation. While we recognize the significant fiscal and policy challenges imposed by the current federal and economic climate, we urge DHCS to protect uninterrupted, equitable access to care for the most vulnerable Californians. CalAIM is a generational opportunity to optimize and improve the delivery of behavioral health services at a systemic level for both Medi-Cal members and providers alike. Providers are an integral pillar of the Medi-Cal continuum and rely on transparent and collaborative relationships with government partners, including adequate reimbursement and supports, to deliver services effectively and with fidelity. In the spirit of this partnership, we respectfully request that DHCS consider our feedback on behalf of our members for the improvement of CalAIM.

Based on direct feedback from CBHA members, we would like to highlight the following areas of concern and potential solutions for consideration:

Payment Reform Implementation

Payment reform remains an ongoing challenge for providers that are facing an increasingly complex fiscal and policy landscape. In particular, our members have expressed concern regarding the transition from the fee-for-service model to value-based payments and its impact on their service delivery capacity. Providers depend on adequate reimbursement that covers the actual cost of service delivery and operational realities. Given the impending reduction of federal funding for Medi-Cal, concurrent state reforms including the Behavioral Health Services Act and BH-CONNECT, and rising operational

costs, it is essential for DHCS to commit to the timely, uniform implementation of payment reform.

In addition, providers have faced challenges with transparency and communication regarding implementation at the county level. Stakeholder engagement across counties with their provider networks remains inconsistent and contributes to concerns about adequate reimbursement and support for implementing payment reform. And unlike the counties which receive support and technical assistance via the California Mental Health Services Authority (CalMHSA), providers do not benefit from the same level of support and technical assistance. This remains highly problematic as providers *deliver* the direct services on behalf of the state and counties, yet are often the last in line for needed support. Without extensive provider engagement, payment reform will continue to carry the risk of uneven and fragmented implementation that contributes to unnecessary pain points and complexities that burden providers, and ultimately the communities they serve.

In order to support the fiscal sustainability of providers as payment reform unfolds, CBHA recommends that DHCS consider the following recommendations:

- **Clear Timelines for Implementation:** This should include clear expectations and accountability mechanisms for counties to follow as they implement payment reform amongst their respective provider networks. DHCS should provide anticipated milestones for counties to follow for each phase of implementation.

- **Best Practices for Stakeholder Engagement:** DHCS should provide information and model templates for counties to utilize in stakeholder engagement with providers and other community stakeholders. This should include information on rate development, documentation requirements, and strategies for refinement that are standardized across counties.

- **Standardized Documentation:** In addition to providing model templates on standardized documentation for counties, DHCS should reconvene the stakeholder workgroup on paperwork reduction. This workgroup is essential for providers to voice concerns about administrative burdens, identify related pain points in CalAIM implementation, and collaborate with the state and counties in identifying solutions. We recognize DHCS' historic commitment to reducing administrative burdens and encourage the continuation of this partnership.

- **Dedicated Support for Providers:** This should include dedicated state funding and a work group for providers based on the county model administered by CalMHSA. The infrastructure should faciliate programmatic support and technical assistance for providers as they identify blind spots and inform the development of best practices for implementation across systems.

Payment reform is positioned to dramatically restructure how behavioral health services are funded and delivered across systems. For providers, this is a critical moment that will determine the fiscal sustainability of delivering services and meeting the needs of as many

vulnerable Californians as possible. It is imperative that the state and counties engage providers as equal partners in identifying the challenges of implementation and collaboratively designing solutions to strengthen CalAIM.

Access to Care for Undocumented Californians

The new restrictions on federally funded benefits for undocumented immigrants under H.R. 1 and related executive orders threaten the well-being of undocumented Californians. Despite the new barriers to access to behavioral health services, there has been little communication on how future CalAIM improvements will address the needs of this populaton. There is no information on new or alternative funding streams to replace access to full-scope Medi-Cal. Without a backfill of reduced federal funds at the state level and cuts to emergency Medi-Cal rates, this will have adverse effects on providers who serve undocumented Californians. This includes:

- Increased burdens of uncompensated care for community clinics and hospitals.
- Reduced revenue for programs that service undocumented clients and are currently covered by full-scope Medi-Cal.
- Increased gaps in preventive and specialty care for undocumented clients, particularly those with behavioral health and chronic conditions which impact their quality of life.

The scaling back of Medi-Cal coverage for undocumented Californians due to federal restrictions and State Budget constraints will substantially increase barriers to access, financially strain providers, and increase overall health care costs. It is important for DHCS to consider strategies to address these shortfalls, including the leveraging of alternative funding streams, and mitigate the impact on undocumented Californians and the providers who serve them.

Addressing Barriers in Service Coordination

Current reimbursement models for behavioral health services, particularly for the administration of medication, present significant barriers to service coordination across systems. These concerns include:

- An emphasis on services delivered in clinic, pharmacy, or facility-based settings, which fails individuals who lack access to transportation, stable housing, or the ability to attend scheduled appointments.
- Inadequate coordination between community-based providers, facilities, and justice and correctional systems. Individuals who are treated in state hospitals, county jails, and state correctional facilities often lose access or experience delays in continuity of care upon reentry into the community. The institutional and policy barriers that prevent adequate coordination between systems of care pose a risk to the continued stability

and well-being of re-entering individuals.

- Restrictions on service delivery setting, particularly for medications used in substance use disorder (SUD) treatment, prevent qualified staff from treating individuals where they are. In addition, counties and systems of care lack the infrastructure to quickly and consistently deploy new medications, educate staff, and expand access to care in diverse settings. This poses a risk to individuals who may fall out of care and suffer from worsening behavioral health conditions.

Reducing barriers associated with service settings, cross-system coordination, and SUD treatment infrastructure is critical to supporting individuals with complex needs. In order to foster improvements in service coordiantion, CBHA recommends that DHCS consider the following recommendations:

- **Flexibility in Service Setting:** This includes equal priority and reimbursement for services delivered outside of clinic, pharmacy, and facility settings. Flexibility in service setting is a significant step toward enhancing access for Californians at heightened risk of behavioral health crisis including those experiencing instability in transportation, housing, or justice involvement.

- **Enhancing Cross-System Coordination:** DHCS should develop template protocols and training resources for providers, facilities, and justice system stakeholders to establish standardized pathways for seamless handoffs of individuals reentering the community.

- **Flexibility for Medication Administration:** DHCS should develop protocols for the flexible delivery and reimbursement of behavioral health medications, particularly long-acting injectable medications, based on provider qualifications rather than setting. In the long-term, this can include the implementation of a new Medi-Cal benefit for these medications that creates a structured, standardized pathway for administration, reimbursment, and scope of practice qualifications.

We hope these recommendations bolster the ongoing efforts to protect and expand access to behavioral health services for Medi-Cal members via the CalAIM 1115 Waiver. CBHA and our members stand ready to partner with DHCS to identify practical, person-centered solutions to mitigate the harm of funding reductions, adequately support providers, and preserve access to care. CalAIM must continue to serve *all* Californians regardless of the unprecedented changes to federal funding and policies. We appreciate the leadership demonstrated by DHCS during this challenging period and look forward to continued dialogue.

For more information about CBHA and the providers we represent, please feel free to follow up with myself at [redacted]

Best regards,

[redacted]

Le Ondra Clark Harvey, Ph.D.
Chief Executive Officer
California Behavioral Health Association

Fernando Lopez Rico, CityNet, Email received March 12, 2026.

Dear Tyler Sadwith,

Please see our response regarding the CalAIM Section 1115 Demonstration Renewal Application. The letter outlining our feedback and comments is attached for your review.

We appreciate the continued partnership and collaboration. Thank you.

Fernando Rico, MPA
CalAIM Program Manager
Sacramento County, Santa Barbara County, Orange County
[redacted]
CalAIM Hotline: (888)224-8102
[redacted]
Website: www.citynet.org

March 10, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Via email: CalAIMWaiver@dhcs.ca.gov

Re: CalAIM Section 1115 Demonstration Renewal Application

Dear Director Sadwith,

California's CalAIM Section 1115 renewal should protect and strengthen the housing continuum that Medi-Cal members rely on particularly Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Transitional Rent, and Enhanced Care Management. CityNet is a California based nonprofit organization that partners with local governments, behavioral health agencies, and Medi-Cal Managed Care Plans across multiple counties to provide housing navigation, intensive case management, and housing stabilization services for individuals experiencing homelessness. Through these partnerships, CityNet connects vulnerable individuals to housing and supportive services using collaborative and data driven approaches designed to improve long term stability and health outcomes.

Through our work coordinating services across several counties and working with multiple Managed Care Plans, CityNet has direct operational experience implementing Enhanced Care Management and housing related Community Supports under CalAIM. This experience highlights both the strengths of the program and the administrative challenges providers face when operational requirements vary across MCPs.

The draft renewal appropriately recognizes that Enhanced Care Management and 12 of the 15 Community Supports can continue under managed care authority and do not require renewal under the Section 1115 waiver. As CalAIM moves into its next phase, DHCS has an important opportunity to reduce administrative complexity and create greater statewide consistency in how these programs operate across Managed Care Plans.

The draft application shows that Community Supports and ECM have expanded significantly with more than 429,000 members receiving Community Supports and approximately 373,000 receiving ECM between January 2022 and March 2025. PATH funding also played a critical role in supporting provider staffing, billing systems, EHR capacity, and implementation infrastructure that enabled community-based providers to participate in CalAIM. As PATH sunsets, DHCS should consider how to maintain provider infrastructure and technical assistance so housing and ECM providers can continue delivering services effectively.

Reducing variation across Managed Care Plans represents one of the greatest opportunities to strengthen implementation. Providers operating across multiple plans often encounter different referral processes, authorization requirements, documentation standards, billing procedures, and audit expectations despite delivering the same Medi-Cal benefits. Establishing clearer statewide standards would significantly reduce administrative burden while improving efficiency and consistency.

DHCS should consider developing standardized ECM assessment domains and a consistent member-centered care plan framework aligned with existing DHCS ECM and Community Supports guidance. Providers working across multiple MCPs are often required to complete different assessment tools, care plan formats, and referral documentation even though program requirements are defined by DHCS. Standardizing these core elements would improve care coordination and allow providers to focus more time on supporting members rather than navigating duplicative administrative processes.

We also encourage DHCS to align Transitional Rent operationally with the housing trio and ECM. From a provider perspective, these services function as a housing continuum rather than separate programs. Members frequently move across navigation services, housing deposits, tenancy supports, and transitional rent based on their housing and clinical needs. Ensuring these services operate as a coordinated pathway will strengthen housing stability and improve outcomes for Medi-Cal members.

Finally, maintaining stable provider networks will be essential as CalAIM continues to mature. Reducing administrative variation, supporting provider infrastructure, and strengthening coordination across housing services will help ensure ECM and Community Supports continue improving health and housing outcomes for Medi-Cal members statewide.

Thank you for the opportunity to provide comments on these important waiver amendments and for DHCS's continued work to strengthen CalAIM and improve housing and health outcomes for Medi-Cal members.

Sincerely,

Brad Fieldhouse

Chief Executive Officer

Lisa James, Futures Without Violence, Email received March 12, 2026.

Thank you for the opportunity to comment and for all of your hard work on this! Comments are attached.

Sincerely, Lisa James
Lisa James
Vice President of Health
Futures Without Violence
[redacted]

Justin Miller, Health Care Integrated Services (HCIS), Email received March 12, 2026.

Dear DHCS Leadership and CalAIM Renewal Team:

Health Care Integrated Services (HCIS) respectfully submits this public comment in support of the CalAIM Section 1115 Demonstration five-year renewal application. As a community-based organization delivering school-based health services, mobile health outreach, and Medi- Cal enrollment assistance in some of Los Angeles County's most underserved communities, we have seen firsthand how CalAIM's framework of integrated, person-centered care transforms outcomes for the populations we serve.

HCIS operates in priority ZIP codes, including 90037, 90011, 90001, 90002, 90003, 90061, and 90059; areas characterized by significant health disparities, limited access to primary care, and high concentrations of uninsured and underinsured families. Our services include enhanced care management, medical screenings, vaccinations, behavioral health screening, family health fairs, case management, and professional development delivered through partnerships with school districts, universities, and county agencies.

With gratitude,

Justin C. Miller M.S.
President || HCIS
[redacted]
jcmiller@hciswellness.org
"The 'Anomaly' that heals disparities".

HEALTH CARE INTEGRATED SERVICES (HCIS)
Community-Based Health Services | School-Based Care | Mobile Health Outreach

March 3, 2026

California Department of Health Care Services
CalAIM 1115 Demonstration Renewal
1501 Capitol Avenue
Sacramento, CA 95814

RE: Public Comment on CalAIM Section 1115 Demonstration Five-Year Renewal Application

Dear DHCS Leadership and CalAIM Renewal Team:

Health Care Integrated Services (HCIS) respectfully submits this public comment in support of the CalAIM Section 1115 Demonstration five-year renewal application. As a community-based organization delivering school-based health services, mobile health outreach, and Medi-Cal enrollment assistance in some of Los Angeles County's most underserved communities, we have seen firsthand how CalAIM's framework of integrated, person-centered care transforms outcomes for the populations we serve.

HCIS operates in priority ZIP codes, including 90037, 90011, 90001, 90002, 90003, 90061, and 90059; areas characterized by significant health disparities, limited access to primary care, and high concentrations of uninsured and underinsured families. Our services include enhanced care management, medical screenings, vaccinations, behavioral health screening, family health fairs, case management, and professional development delivered through partnerships with school districts, universities, and county agencies.

Support for CalAIM's Core Principles

We strongly endorse the renewal's continued commitment to integrating physical, behavioral, and social services. This model aligns directly with HCIS's approach to whole-person care. Through our school-based programs, we routinely encounter children and families whose health needs span medical, behavioral, and social domains—needs that cannot be addressed through siloed systems. CalAIM's emphasis on breaking down these silos has been essential to our ability to connect families with comprehensive resources.

The Critical Role of Community-Based Organizations

As the renewal moves forward, we urge DHCS to continue strengthening the role of community-based organizations (CBOs) within the CalAIM framework. Organizations like HCIS serve as trusted access points in communities where institutional healthcare systems often face barriers to engagement. Our mobile medical units, deployed in partnership with Charles R. Drew University, bring preventive health screenings and care coordination directly to communities that traditional clinic models struggle to reach.

We recommend that the renewal application explicitly:

1. **Expand reimbursement pathways for CBO-delivered preventive and screening services** in non-traditional settings such as schools and community events, recognizing these as critical touchpoints for Medi-Cal members.

2. **Streamline administrative processes for CBOs partnering with Medi-Cal managed care plans**, including credentialing, contracting, and claims submission, which remain significant barriers to CBO participation.

3. **Invest in data-sharing infrastructure** that enables CBOs to coordinate effectively with managed care plans and county agencies. The recent release of the ASCMI Form 2.0 is a welcome step, and we encourage continued investment in electronic collection and transmission capabilities that include smaller community-based providers.

4. **Sustain and expand school-based health service models** as a recognized delivery mechanism within Medi-Cal, given the demonstrated effectiveness of reaching children and families where they already are.

Reducing Health Disparities in Underserved Communities

CalAIM's focus on reducing health disparities is particularly meaningful in the communities HCIS serves. The LA REPAIR Zone initiative and related grant-funded outreach have enabled us to target resources to ZIP codes with some of the county's highest rates of chronic disease, uninsurance, and poverty. We urge DHCS to ensure the renewal continues to prioritize equity-driven resource allocation and to consider mechanisms that direct managed care plan investments toward these highest-need areas.

Children's Behavioral Health Integration

As a CYBHI Scaling EBP/CDEP grantee, HCIS is actively working to expand evidence-based and community-defined behavioral health practices for children and youth. The CalAIM renewal presents an opportunity to further align the Children and Youth Behavioral Health Initiative with Medi-Cal service delivery, ensuring that school-based behavioral health screenings, early intervention services, and family support programs are fully integrated into the managed care continuum.

Conclusion

HCIS is proud to support the CalAIM Section 1115 Demonstration renewal. The principles embedded in CalAIM—whole-person care, equity, integration, and innovation beyond traditional care settings—reflect the values that guide our work every day in South Los Angeles and beyond. We look forward to continued partnership with DHCS as California advances this transformative vision for Medi-Cal.

Thank you for the opportunity to provide input. We welcome any follow-up questions or requests for additional information about our programs and their outcomes.

Respectfully submitted,

[redacted]

Justin Miller, President
Health Care Integrated Services (HCIS)
[redacted]

Brenda Ramirez, Heritage Health Network, Email received March 12, 2026.

Dear Director Baass and DHCS team,

On behalf of Heritage Health Network, please find attached our comments on California's renewal of the CalAIM Section 1115 Demonstration Waiver.

Thank you for the opportunity to provide input.

Brenda Ramirez | Senior Associate, Marketing & Communications Manager
[redacted]
F: (909) 966 4069

HERITAGE HEALTH NETWORK
2155 Chicago Ave. #201
Riverside, CA 92507
(866) 744-1231

Re: Comments on California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration Renewal Application

March 12, 2026

Michelle Baass, Director
California Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Director Baass:

Heritage Health Network (Heritage) appreciates the opportunity to comment on California's renewal of the CalAIM Section 1115 Demonstration Waiver.

California has built one of the most ambitious Medicaid delivery system transformations in the country. CalAIM's framework, including Enhanced Care Management (ECM), Community Supports, Population Health Management, and cross-sector accountability, reflects a clear understanding that health extends beyond clinical walls. The policy design is strong.The progress achieved since CalAIM launched in 2022 reflects significant collaboration between DHCS, managed care plans, counties, providers, and community partners.

The next phase of CalAIM presents an opportunity to further advance the goals outlined in the renewal proposal: strengthening early identification of member needs, reducing program complexity, and improving outcomes through coordinated whole-person care.

As CalAIM moves from initial implementation into long-term system operation, the central policy challenge shifts from launching programs to sustaining the infrastructure required to deliver them consistently across the state. The next phase must ensure that the infrastructure needed to sustain implementation, particularly the continuity systems that protect members and providers during eligibility churn, is fully capitalized and aligned with operational reality.

Heritage operates ECM across six counties, serving high-need Medi-Cal members through multidisciplinary, trauma-informed, and culturally responsive teams. While Enhanced Care Management will continue under managed care authority rather than Section 1115, the operational infrastructure required to deliver coordinated care remains dependent on stable financing, workforce capacity, and cross-system alignment.

From the field, we see that CalAIM's long-term durability depends on reinforcing three foundational layers:

- Coordination infrastructure
- Workforce infrastructure
- Sustainable financing infrastructure

From Fragmentation to Orchestration

CalAIM seeks to reduce fragmentation in members' lives. ECM and Community Supports build on what providers have long understood: individuals with complex medical, behavioral, and social needs require coordinated, cross-sector engagement rather than episodic transactions.

Technology enables this work, but true transformation depends on operational orchestration across managed care plans, counties, hospitals, correctional facilities, shelters, and community-based organizations. Structured local collaboratives that connect these partners function as backbone coordination infrastructure, resolving implementation barriers, aligning workflows, and protecting continuity of care.

This infrastructure becomes even more critical as federal eligibility policy increases the frequency of redeterminations and the risk of coverage gaps. Temporary loss of Medi-Cal coverage can disrupt ECM care plans, reset Community Supports referrals, and erode the trusted relationships that take months to build. Without cross-plan continuity mechanisms, administrative fragmentation undermines clinical progress.

As California expands the Justice-Involved Reentry Initiative and the 90-day pre-release benefit, sustained cross-system alignment will be essential. Eligibility continuity, warm handoffs, and data exchange cannot rely on informal coordination. They require supported infrastructure that spans correctional systems, managed care plans, and community providers.

Balancing Accountability with Operational Efficiency

Accountability and quality oversight are central to ECM. As implementation matures, maintaining accountability while reducing unnecessary administrative variation will be key.

For providers operating across multiple counties and managed care plans, variation in referral, authorization, documentation, and reentry workflows drives structural cost. This multi-plan inconsistency is not transitional friction. It is an enduring infrastructure burden.

Greater standardization of referral, authorization, and reentry processes, along with clear shared documentation expectations, would materially reduce administrative fragmentation and strengthen equitable access. A "no wrong door" system requires that care plans and Community Supports follow members across enrollment changes rather than reset with each plan assignment. Reducing cross-plan variation directly supports CalAIM's goal of reducing complexity and improving program efficiency.

Workforce as Foundational Infrastructure

Delivering ECM to high-acuity populations requires a resilient, well-supported workforce. Field-based care managers navigate the intersections of clinical complexity, housing instability, behavioral health needs, and social service systems. This work is relational and labor-intensive.

Workforce stabilization is system stabilization.

Investment in training, supervision, retention, and cross-sector team integration is foundational to CalAIM's success. Proposition 1 and the Behavioral Health Services Act appropriately recognize this need. Ensuring these investments translate into durable staffing capacity will determine whether the model remains viable amid administrative and enrollment volatility.

Sustainable Financing and Capital Alignment

ECM and Community Supports require substantial ongoing investment: multidisciplinary staffing, partner coordination, plan-specific workflow management, continuous quality oversight, and re-engagement support amid federal policy shifts.

Recent eligibility changes have introduced volatility into Medi-Cal enrollment, creating continuity risks that extend far beyond temporary loss of coverage.

ECM providers and community partners often act as trusted messengers supporting continuity of enrollment and care. However, outreach, re-engagement, and cross-plan coordination demand infrastructure and staffing not currently reflected in rate structures. Protecting continuity through churn will require explicit policy and financing alignment.

As the PATH initiative sunsets, the infrastructure investments that supported early implementation must transition to sustainable operational financing. Maintaining the backbone coordination capacity that enables ECM and Community Supports to function effectively will be critical to the program's long-term success.

Tracking ECM continuity rates through coverage redetermination cycles and measuring time to re-engagement after churn would provide actionable feedback on system stability. Community Reinvestment planning presents an opportunity to explicitly fund backbone coordination capacity, churn-response systems, shared data capabilities, and workforce stabilization. Without dedicated resources, the operational burden of continuity will fall unevenly on providers. These types of operational metrics could also strengthen the state's evaluation of CalAIM by helping demonstrate how continuity infrastructure contributes to improved outcomes and reduced high-cost utilization.

Policy ambition must be matched by sustainable capital alignment.

Conclusion

Across counties, providers, plans, and community partners remain deeply committed to CalAIM's success. The policy architecture is in place. The next phase of CalAIM will depend on ensuring that the infrastructure, workforce, and coordination systems required to deliver whole-person care are supported at the same scale as the policy ambition that created them.

Heritage Health Network remains committed to partnering with DHCS, managed care plans, counties, and community organizations to move CalAIM from successful implementation to long-term sustainability.

Respectfully,

Cameron M. Stewart
Chief Executive Officer
Heritage Health Network

HERITAGE HEALTH NETWORK

Teresa Yolotl Gomez, Indian Health Center of Santa Clara Valley, Email on March 12, 2026.

Attached you will find IHCSCV's comments on the CalAIM Section 1115 waiver.

Warmly,
--
Teresa Yolotl Gomez, Policy Analyst
Indian Health Center of Santa Clara Valley
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[redacted]
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Where everyone is welcome!

INDIAN HEALTH CENTER OF SANTA CLARA VALLEY

Medical • Dental • WIC/Nutrition • Counseling • Community Wellness & Outreach

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March 12, 2026

Subject: IHCSCV Comment on CalAIM Section 1115 Demonstration Renewal – Traditional Healer and Natural Helper Services

Dear Director and DHCS Leadership,

The Indian Health Center of Santa Clara Valley appreciates the opportunity to provide comments on the proposed renewal of the CalAIM Section 1115 Demonstration Waiver.

As an Urban Indian Organization (UIO), we provide culturally grounded health services to American Indian and Alaska Native (AI/AN) community members living in urban areas. We strongly support the inclusion of Traditional Healer and Natural Helper services within Medi-Cal, as these services reflect longstanding cultural practices that support healing, prevention, and community wellbeing. Based on early implementation experience, we offer the following observations for DHCS consideration.

Assessment Requirements
Current requirements for ASAM assessments can create administrative challenges for UIOs that are not structured to conduct these assessments internally. In practice, this requirement can delay access to Traditional Healer and Natural Helper services. We encourage DHCS to explore flexibility in assessment approaches that support timely access to culturally grounded care.

Eligibility Limitations
Eligibility for Traditional Healer and Natural Helper services is currently limited to individuals with a Substance Use Disorder diagnosis. Many community members seeking these services are experiencing mental health needs, trauma, or other wellness concerns that fall outside this diagnosis. Expanding eligibility to include broader behavioral health conditions would better align with the holistic nature of traditional healing practices and support prevention and early intervention.

Implementation Through Counties
UIOs are working closely with counties to establish contracting and reimbursement processes. Implementation timelines and requirements vary across counties, creating delays in service rollout and additional administrative burden for providers. Continued collaboration between DHCS, counties, and Indian health providers will be important to support consistent statewide implementation.

Traditional healing practices are an important component of culturally grounded care for AI/AN communities. We appreciate DHCS' efforts to recognize these services within Medi-Cal and look forward to continued partnership to ensure this benefit is accessible and effective for the communities it is intended to serve.

Sincerely,

[redacted]

Sonya Tetnowski
Chief Executive Officer
Indian Health Center of Santa Clara Valley

Nancy Eldred, NAMI California, Email received March 12, 2026.

The below public comment can be attributed to NAMI California regarding the CalAIM Section 1115 Demonstration Renewal Application—

Dear Director Sadwith:

On behalf of NAMI California, thank you for the opportunity to comment on California's CalAIM Section 1115 demonstration renewal application.

NAMI California supports DHCS's goals for the renewal, including strengthening the ability of DHCS, plans, and providers to identify and intervene early through whole-person care; improving quality and delivery-system transformation; and expanding access for high-need Medi-Cal populations. The application also reflects DHCS's extensive engagement with stakeholders, including community-based providers and organizations. That emphasis is important. Trusted community-based organizations play a critical role in helping Medi-Cal members engage in care, sustain recovery, and navigate complex behavioral health systems.

We urge DHCS to use this renewal to create clearer operational pathways for community-based behavioral health organizations to participate in Medi-Cal delivery systems when they are delivering functions that align with covered services.

1. Clarify the role of community-based organizations in delivering peer, recovery, family support, and linkage functions

The application's discussion of peer support services is especially important. DHCS describes peer support services as culturally competent services delivered by certified peer support specialists that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths, and that support linkages to community resources and educate members and families about conditions and recovery. That description closely aligns with the kinds of services community-based organizations like NAMI provide.

For example, NAMI's Peer-to-Peer / Persona a Persona program is described as a peer-led recovery education course for people living with serious mental illness, and NAMI Connection / Conexión is described as a peer-facilitated recovery support group in which participants learn coping strategies, offer mutual encouragement, and maintain wellness. Family-to-Family / De Familia a Familia is an evidence-based family education course for families, partners, and friends of individuals living with serious mental illness. These are exactly the kinds of trusted, community-based supports that can strengthen engagement, recovery, and continuity of care when tied to Medi-Cal pathways.

We therefore ask DHCS to clarify in the final renewal and subsequent implementation materials that community-based organizations may participate in Medi-Cal behavioral health delivery as providers, subcontractors, and partners for covered functions such as:

- peer recovery support,
- family education and psychoeducation,
- navigation and linkage,
- recovery-oriented groups and coaching,
- transition support and relapse-prevention support.

2. Clarify that family-facing supports and psychoeducation can be part of covered care pathways

NAMI also urges DHCS to recognize the importance of family-facing supports, especially for children, youth, transition-age youth, and adults with serious behavioral health needs.

California's broader behavioral health policy framework recognizes the value of multigenerational family engagement, education, support, navigation, and service referrals across systems. In practice, family education and psychoeducation often improve treatment engagement, reduce fragmentation, and help individuals remain connected to care. These functions should not be treated as outside the Medi-Cal transformation conversation simply because they do not always fit a traditional clinic model.

We ask DHCS to clarify that family education, psychoeducation, support, and navigation functions may be included where they are part of a covered service pathway and support engagement, care transitions, recovery, or continuity of care for eligible Medi-Cal members.

We recognize that not every NAMI signature program will fit neatly into Medi-Cal reimbursement. Broad public education programs are different from member-specific covered services. But peer support, recovery support, navigation, family-facing supports, and transition-related services often do fit the goals and structure of CalAIM and should have clearer pathways for participation.

In short, we ask DHCS to ensure that trusted community-based behavioral health organizations have a clearer place in Medi-Cal delivery systems when they provide covered, recovery-oriented, family supportive, and linkage-focused services that improve outcomes for Medi-Cal members.

Thank you for your consideration and for your ongoing work to strengthen Medi-Cal behavioral health services for Californians.

Beth Malinowski, SEIU California State Council, Email received March 12, 2026.

Dear Mr. Sadwith,
On behalf of SEIU California's 750,000 members and their families, please find attached important feedback to strengthen California's Section 1115 Demonstration Renewal Request. We appreciate the time you spent with SEIU CA, SEIU Local 2015, and SEIU Local 721 staff last week discussing the new BridgeCare Pilot initiative. The comments here build on that conversation.

If you or your team would like to discuss the feedback in the letter further, please do not hesitate to reach out.

Best,

Beth
Beth Malinowski, MPH
Government Affairs Advocate
SEIU California State Council
[redacted]

SEIU California

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March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Submitted via: 1115waiver@dhcs.ca.gov

Subject: Renewal of CalAIM Section 1115 Demonstration Renewal Request

Dear Mr. Sadwith,

On behalf of SEIU California's 750,000 members and their families, I am writing today with important feedback to strengthen California's Section 1115 Demonstration Renewal Request. As a union that proudly represents the diversity of California, including the workforce at the heart of Medi-Cal eligibility, health care delivery, and long-term care services, we deeply appreciate the challenges the Trump Administration and GOP-led Congress have brought to maintaining the health and well-being of Medi-Cal enrollees. We further understand the unique challenges that brings to negotiating our state's next Section 1115 Demonstration Waiver under the leadership of the current Centers for Medicare & Medicaid Services Administrator, Dr. Mehmet Oz, and the Secretary of Health and Human Services, Robert F. Kennedy Jr. As our focused comments below highlight, we, overall, appreciate the Department of Health Care Services' (DHCS) steady hand advocating for the health and well-being of Medi-Cal enrollees and the systems that provide their care. We also appreciate the bold advocacy and intent behind the two newly proposed BridgeCare and Employment Supports initiatives, however we ask for the Department's consideration of key changes to improve these initiative proposals for consumers, our dedicated health workforce, and counties during this turbulent time.

Renewing Authority

SEIU CA supports DHCS' primary goals to increase coordination and create a person-centered and equitable health system that works for all Californians. As DHCS seeks to build upon the success of the current CalAIM initiative, we specifically write in strong support of the **five-year**

renewal of the Global Payment Program (GPP) as a crucial component of the CalAIM Section 1115 demonstration renewal application. The financial stability GPP offers is critical support to further cement and incentivize the delivery of quality, value-based care at a time when the disruptive and destructive elements within H.R. 1 undermine the very stability of our safety net systems.

SEIU CA proudly represents over 25,000 health care workers and physicians-in-training across the public hospital and health systems, some of whom are facing layoffs and reduced hours, and resource restrictions in the early stages of H.R.1 implementation as public systems question their ability to stay financially afloat. Since 2005, California's 17 public hospital systems have leveraged participation in Medi-Cal 1115 waivers to catalyze significant delivery system transformation, resulting in improved quality and patient outcomes, greater efficiencies within our systems, and stronger care coordination for complex and high-risk patients. For over a decade, the GPP has been a key program in making this transformation possible by creating flexible funding strategies and strong financial incentives for public hospitals to address non emergent care needs in lower cost, and more appropriate primary and preventive care settings. SEIU CA believes the proposed GPP changes are appropriate and would sustain and accelerate essential gains as our public systems are forced to shoulder an influx of uninsured patients, while facing steep cuts to their primary payor source, Medi-Cal.

Request for New Authority

We appreciate DHCS' thoughtful intent in requesting authority for two new initiatives - BridgeCare Pilots and Employment Supports—and the spirit behind such advocacy in this current environment. However, we have concerns regarding implementation of both programs as they will require significant administrative, financial, and programmatic investments by counties and other eligible local jurisdictions.

BridgeCare Pilots Initiative
Representing over 500,000 long-term care workers, SEIU CA is deeply committed to supporting older adults aging in place. Across cultures, there is a widespread preference to remain in one's home and community. Research shows that doing so is good for one's health, prevents costly nursing home admissions, and reduces avoidable health care spending. However, we question the design and viability of the BridgeCare Pilots Initiative.

Specifically, we are not aware of a local entity (county or regional) that would have the required discretionary funding to opt in to the BridgeCare Pilot. The county workforce is expected to weather potentially unprecedented workloads as counties face highly challenging fiscal headwinds. Absent financial support to plan and initiate, we simply do not see how local entities will have the means or capacity to design and implement a new care program. Furthermore, we do not believe now is the time to ask local entities to invest dollars in new care programs by fronting the non-federal share of Medicaid funding; they are already being forced

to redouble current efforts to meet existing indigent care needs which will only grow due to the impact of H.R. 1.

Due to the narrow proposed eligibility criteria for participants, counties that are interested in implementing this initiative may not find a large enough universe of interested participants to make the program viable. We align with Justice in Aging in recommending broader eligibility criteria. Specifically, we urge DHCS to remove Medicare enrollment as an eligibility criterion for this benefit since there are near-eligible older adults who are not enrolled in Medicare. These individuals—disproportionately immigrants and women of color—would be left with no LTSS access. We also oppose limiting access to this initiative based on Medi-Cal Share of Cost enrollment. Eligibility in this initiative should be based solely on meeting financial and level of care criteria. Finally, with regard to financial criteria, we encourage a higher Federal Poverty Level (FPL) maximum of 250%; this aligns with other Medi-Cal eligibility thresholds, including MAC for pregnant persons and working SSI disabled persons.

At a time when our state battles federal policies that breed greater inequity, this initiative risks further compounding inequity. The mix of targeted services proposed for the "near duals" in this initiative is more expansive than what In-Home Supportive Services (IHSS) recipients receive today. Unless there is a parallel plan to increase services and supports to the IHSS population, this well-intentioned initiative risks further exacerbating existing health disparities. Similarly, if a "near dual" individual has a change in circumstance and becomes a "dual" individual, we would not want them to see a loss in services and supports.

Lastly, if this initiative is to move forward, DHCS must provide clear guidance to counties and other local jurisdictions to guarantee that their local effort is centered on the current public workforce and offer program participants a self-direction option for personal care services. At a minimum, this must include identifying opportunities to collaborate with in-region trained IHSS workforce. This also means working with county departments, including county health and human service agencies, to identify case managers, nursing, social service, and therapeutic staff that could best support this program. Participating localities should be encouraged to use this program as an opportunity for public sector recruitment and retention. If contracting for services is necessary, clear contracting guardrails—inclusive of wage and labor standards—must be required.

Employment Supports

We appreciate, and agree with, the Employment Supports initiative in concept. Given DHCS must implement H.R. 1's work requirements during this next waiver period, we support DHCS using this waiver as an opportunity to support training and employment for current, and future, Medi-Cal recipients. This move reinforces our shared goal—supported by labor and consumer advocates—of maintaining healthcare coverage for all eligible adults.

Similar to the BridgeCare Initiative, we have concerns with the readiness of counties and other county-based entities to implement this program without seed funding and clear guidelines. Both are necessary to ensure that employment supports translate into in-demand skills development and a viable pathway to meaningful, quality jobs. We recommend California use its trusted community partners—with current and past experience partnering with county government and their public sector unions—to provide the services needed to address barriers to employment, support sustained workforce participation, and promote economic stability among Medi-Cal members. One such partner is the Worker Education & Resource Center (WERC), which reports that about 23% of the total participants in their training programs receive Medi-Cal benefits. Done right, skills training and employment supports create a pathway to living-wage jobs while ensuring a diverse healthcare workforce rooted in the lived experiences of the community.

This could be particularly true for community health workers (CHW), peer support specialists, and other entry-level positions that require minimal, formal classroom instruction. These positions can be utilized to provide wraparound support to mental health clients, those managing chronic illnesses, or formerly-incarcerated individuals as they navigate complex health and social needs.

We encourage DHCS to consider this initiative as a distinct opportunity to strengthen the Medi-Cal workforce and health care ecosystem, bringing the investment full circle, such as by training IHSS providers, certified nursing assistants, and CHWs. In guidance to counties, we request that DHCS recommend that counties utilize this program as a pipeline to public employment. This will ensure a sustainable infrastructure directly linked to other county-run programs and core functions, including the work of county health and human services that are critical to historically underserved communities.

DHCS should describe how this initiative intersects with, and is differentiated from, Workforce Innovation and Opportunity Act (WIOA) funding and programs at the county and regional level. Coordination with local workforce development boards and America's Job Center of California (AJCCs) that provide no-cost job and training services should occur where appropriate. Similarly, where available, counties must be required to prioritize existing workforce partnerships with formal labor-management partnerships, such as The Education Fund, WERC, and the Center for Caregiver Advancement. Additionally, counties should be encouraged to seek new partnerships with nonprofit healthcare workforce training organizations, like FuturoHealth, and, where direct employment by the county is not available, the AlliedUp Cooperative should be utilized to connect the newly trained with high quality jobs in the private sector.

Transition Authority

We appreciate DHCS using other authority outside of Section 1115 to continue Enhanced Care Management (ECM) and 12 of the 15 Community Supports. As these services are transitioned, we recommend exploring the alignment of IHSS to see where there could be further

coordination, or at minimum, require a self-directed option for some of the Community Supports. We hope to engage with the Department further regarding the plan for transitioning services.

Sunset Authority

With the proposed sunsetting of three programs—Low-Income Pregnant Women, Providing Access and Transforming Health (PATH) Initiative, and Designated State Health Programs—we ask DHCS to give clear guidance about the transition process to minimize any negative consequences to individuals and employees.

As you continue your deliberations to submit the strongest possible 1115 Waiver Renewal application, we thank you in advance for considering our remarks. Please do not hesitate to contact me with any questions or if you need any additional information at [redacted]

Sincerely,

[redacted]

Beth Malinowski
Government Relations Advocate
SEIU California

CC: Michelle Baass, Director, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS

Shawn Smith, SYMBA Center, Email received on March 12, 2026.

To whom it may concern,

Please see attached public comments on 1115 Waiver for DHCS' consideration.

Best regards
--
Shawn R. Smith, PharmD
Chief Executive Officer
[redacted]

March 12, 2026

California Department of Health Care Services
Attn: Tyler Sadwith, State Medicaid Director
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

RE: Public Comment on the Transition of Recuperative Care from Section 1115 waiver

To the Department of Health Care Services (DHCS):

Thank you for allowing Symba Center to offer public comment regarding the announcement to transition recuperative care from the Section 1115 waiver to a Medicaid managed care In-Lieu-of-Services (ILOS) authority.

As the only National Institute for Medical Respite Care (NIMRC) certified recuperative care serving San Bernardino and Riverside Counties, Symba Center strongly believes the Recuperative Care Community Support is most appropriate for the Section 1115 waiver. However, we understand that by moving away from temporary waiver authority and into the established ILOS framework—whether it be the 1915(b) or 1915(i)—these vital services are "enshrined in federal Medicaid managed care regulations" and may position recuperative care as a more stable Medicaid option long-term.

We are also gravely concerned about the loss of reimbursement for room and board services, which is a core component of recuperative care. Symba strongly suggests that DHCS identify a funding alternative to reimburse room and board costs for recuperative care programs, which we've estimated to be $66-$92 per day, based on a sampling of providers.

Symba urges DHCS to reconsider implementing an LVN staffing requirement in favor of a model based on the NIMRC Certification program and competency-based training.

Lastly, as DHCS seeks to create a model for recuperative care that incorporates the levels of care offered under both recuperative care and STPHH—while sunsetting the latter as a separate Community Support—Symba requests that DHCS utilize the existing NIMRC Models of Medical Respite Care as the foundation for the creation of tiers of recuperative care services. Using these established Models of Care will provide a familiar framework for determining a program's model, level of services and subsequent reimbursement rate.

Through this transition process, Symba's objective is to maintain the integrity, efficacy, and accessibility of vital recuperative care services. We hope to prevent the loss of recuperative care beds, especially in rural and under-resourced communities. We appreciate DHCS' commitment to preserving recuperative care services for Medi-Cal members and that they remain uninterrupted while you pursue the most appropriate, sustainable authority for these essential programs.

We welcome the opportunity to discuss this further. Please reach out to me directly if you have any questions or would like to schedule a meeting.

Best regards,

[redacted]

Shawn R. Smith, PharmD
Chief Executive Officer
Symba Center
[redacted]

Casey Reinholtz, Soul Housing, March 12, 2026.

Hello,

Please find attached Soul Housing's public comment for acceptance.

Best,

Casey Reinholtz
Chief Executive Officer
Soul Housing
WWW.SOULHOUSING.ORG

SOUL Housing Recuperative Care
Socially Oriented United Living, Inc.
7226 S. Figueroa St, Los Angeles, CA 90003

March 12, 2026

California Department of Health Care Services
Attn: Tyler Sadwith, State Medicaid Director
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Re: CalAIM Section 1115 Demonstration Waiver

Dear Tyler –

SOUL Housing appreciates the opportunity to submit comments regarding the proposed transition of Recuperative Care services from the Section 1115 Demonstration Waiver to a Medi-Cal managed care In-Lieu-of-Services (ILOS) authority.

As one of the California's larger Recuperative Care providers serving individuals with complex medical, behavioral health, and social needs who are experiencing homelessness, SOUL Housing supports the state's continued commitment to strengthening integrated care models through CalAIM. Recuperative Care programs have become an essential component of California's care continuum, enabling hospitals, managed care plans, and community-based providers to safely discharge medically vulnerable individuals who require continued recovery support but do not meet criteria for inpatient hospitalization.

Across California, more than one hundred Recuperative Care providers now operate as part of this evolving system of care. SOUL Housing provides recuperative care to approximately 500 individuals daily. As the State transitions these services to a long-term Medicaid authority, the operational viability of these programs must be preserved.

Preserving the Recuperative Care Model

Recuperative Care programs provide structured post-hospital recovery services for individuals who are medically stable but too vulnerable to recover safely on the streets or in traditional shelter settings.

These programs typically include:
- Health monitoring and basic medical support
- Medication management and education
- Care coordination and discharge follow-up
- Behavioral health engagement
- Connection to primary care providers
- Coordination with housing navigation and tenancy services

Research has shown that, by providing a safe recovery environment and coordinated care, Recuperative Care programs help reduce avoidable hospital readmissions and emergency department utilization while supporting

stabilization for individuals experiencing homelessness.[1] At the same time, H.R. 1 will increase the number of uninsured individuals requiring safety-net services across California, placing additional pressure on the very programs DHCS hopes to sustain.

Protecting Funding for Room and Board

A safe and stable environment for recovery is foundational to the Recuperative Care model. Without a place where individuals can rest and heal following hospitalization, the clinical and supportive services delivered in Recuperative Care cannot be effectively provided.

As DHCS transitions Recuperative Care from the Section 1115 waiver authority to an ILOS framework, we encourage the Department to identify sustainable funding mechanisms that support the room and board component of these programs.

Recuperative Care providers across California expanded beds, facilities, and staffing capacity in response to the State's CalAIM vision and encouragement to build a robust recovery network. Removing reimbursement for room and board would create significant financial challenges for SOUL Housing as well as Recuperative Care providers across the state and will jeopardize the stability of this network. Without sustainable support for the room and board component, hospitals will lose access to medically appropriate discharge options, thereby increasing emergency department boarding, inpatient length of stay, and avoidable readmissions.

We respectfully ask that DHCS identify a sustainable funding mechanism for room and board as a priority in the design of the ILOS framework. As DHCS continues developing long-term reimbursement structures under a managed care authority, consideration of tiered Recuperative Care service levels reflecting participant acuity may help ensure that reimbursement appropriately aligns with the intensity of services required.

Clinical Staffing Requirements

Recuperative Care providers are committed to delivering high-quality services for medically complex populations. However, proposed clinical staffing requirements, such as mandatory onsite Licensed Vocational Nurse staffing, may introduce significant financial and workforce challenges for many community-based providers.

California's Recuperative Care network includes programs operating in diverse environments, including rural and under-resourced communities where healthcare workforce shortages are common. Prescriptive statewide staffing mandates may inadvertently reduce provider participation or limit the number of available Recuperative Care beds.

As DHCS considers long-term program standards, clinical expectations aligned with participant acuity levels may provide a balanced approach that maintains high standards of care while preserving access to Recuperative Care programs across diverse communities throughout California.

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[1] Donald Shepard and Alix Shetler, "Medical Respite for People Experiencing Homelessness: Financial Impacts with Alternative Levels of Medicaid Coverage," *Health Services Research* 54, no. 1 (2019): 164–174. https://pubmed.ncbi.nlm.nih.gov/29805141/
National Health Foundation / Commonwealth Fund (2021): https://www.commonwealthfund.org/publications/case-study/2021/aug/how-medical-respite-care-program-offers-pathway-health-housing
Center for Health Care Strategies, "Medical Respite Care," September 2025: https://www.chcs.org/resource/medical-respite-care/
Lachaud et al., "Medical Respite as an Intervention for Reducing Acute Healthcare Utilization," *Health & Social Care in the Community* 29 (2021): https://tibhospice.org/media/attachments/2025/09/17/literature-review-medical-respite-as-an-intervention-on-utilization.pdf

We also encourage DHCS to utilize the established Recuperative Care certification guidelines developed by the National Institute for Medical Respite Care as a framework for defining appropriate clinical standards and program competencies for Recuperative Care providers.

Conclusion

Recuperative Care programs serve as a critical bridge between hospital care, housing stability, and ongoing healthcare engagement for individuals experiencing homelessness. As DHCS finalizes the transition of these services into a managed care authority, we respectfully encourage the Department to ensure that financing structures, clinical requirements, and program design preserve the sustainability of these programs so they can continue serving California's most vulnerable residents.

SOUL Housing appreciates the opportunity to provide comments and looks forward to continued collaboration with DHCS to strengthen California's integrated systems of care. Providers operating at scale within the Recuperative Care system can offer valuable operational insight as DHCS continues refining implementation.

Best,

Casey Reinholtz
CEO
Soul Housing

Nanette Star, California Consortium for Urban Indian Health, Email received March 12, 2026.

Dear DHCS CalAIM Team,

Please find attached a comment letter from the California Consortium for Urban Indian Health (CCUIH) regarding the proposed renewal of California's CalAIM Section 1115 Demonstration.

We appreciate the opportunity to provide input and look forward to continued engagement as the waiver renewal moves forward.

Please feel free to reach out if any additional information would be helpful.

Best regards,

Nanette Star

Director of Policy

California Consortium for Urban Indian Health

California Consortium for Urban Indian Health

CCUIH Strengthening The Organizations That Strengthen Our Communities

March 11, 2026

Subject: Comment on CalAIM Section 1115 Demonstration Renewal – Traditional Healer and Natural Helper Implementation

Dear Director and DHCS Leadership,

The California Consortium for Urban Indian Health (CCUIH) respectfully submits the following comments regarding the proposed renewal of the CalAIM Section 1115 Demonstration Waiver.

CCUIH is a statewide consortium representing ten Urban Indian Organizations (UIOs) that are part of the Indian Health System delivery network serving American Indian and Alaska Native (AI/AN) communities across California. UIOs are federally authorized providers under Title V of the Indian Health Care Improvement Act and play a critical role in delivering culturally grounded care to urban AI/AN communities.

We appreciate DHCS' continued commitment to culturally responsive care, including the inclusion of **Traditional Healer and Natural Helper services** within Medi-Cal. This benefit represents an important step toward recognizing culturally grounded approaches to wellness and healing for AI/AN communities.

As the state evaluates the renewal of the CalAIM Section 1115 demonstration, CCUIH offers several observations based on early implementation experience among Urban Indian Organizations.

Administrative and Clinical Barriers to Access

UIOs report that the current requirement for ASAM assessments creates significant administrative burden and delays access to services. Many UIOs and Tribal Health Programs are not structured to conduct ASAM assessments internally, resulting in additional coordination requirements before individuals can access culturally grounded care. This process can delay services and may discourage participation before care begins.

We encourage DHCS to evaluate whether alternative documentation pathways or culturally appropriate assessment models could support access to Traditional Healer and Natural Helper services while maintaining program integrity.

Eligibility Limited to Substance Use Disorder Diagnoses

Current reimbursement structures limit eligibility for Traditional Healer and Natural Helper services to individuals with a Substance Use Disorder diagnosis. UIOs have observed that many community members who would benefit from these services present with mental health needs, trauma, or other behavioral health concerns that fall outside the current eligibility criteria.

Traditional healing practices are often centered on prevention, balance, and holistic wellness. Expanding eligibility to include broader behavioral health conditions could better align the benefit with its intended purpose and with CalAIM's whole-person care framework.

County-Based Reimbursement Structure

UIOs and counties are currently navigating new contracting and reimbursement arrangements, which vary significantly across counties. This structure has created uneven implementation timelines and additional administrative workload for providers.

We encourage DHCS to evaluate whether the current county-based model is the most efficient pathway for delivering this benefit and whether alternative reimbursement structures or administrative support mechanisms could support more consistent statewide implementation.

Administrative Burden and Implementation Costs

Over the past year, providers, counties, and state partners have dedicated significant time to troubleshooting implementation challenges. For smaller providers, including UIOs, these administrative layers can create disproportionate burdens relative to available staffing and infrastructure.

An evaluation of the administrative costs associated with implementation may help identify opportunities to streamline processes and improve access for communities that this benefit was designed to serve.

CCUIH remains committed to working collaboratively with DHCS, Tribal partners, and counties to ensure that Traditional Healer and Natural Helper services are implemented in a way that supports culturally grounded care for AI/AN communities across California.

We appreciate the opportunity to provide input and look forward to continued engagement as the CalAIM waiver renewal moves forward.

Sincerely,

[redacted]

Jennifer Ruiz, MBA
Executive Director
California Consortium for Urban Indian Health

Nikki Figueroa, Chief Probation Officers of California (CPOC), Email received March 12, 2026.

Hello,

Please find attached comments on behalf of the Chief Probation Officers of California (CPOC) regarding the CalAIM Section 1115 Demonstration Renewal Application.

Thank you,

Nikki Figueroa
Policy Analyst
Chief Probation Officers of California (CPOC)
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T 916.447.2762

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CHIEF PROBATION OFFICERS
OF CALIFORNIA

March 12, 2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

RE: Public Comment for the Medicaid Section 1115 Demonstration Five-Year Renewal Request: Continuing CalAIM Demonstration

Dear Tyler Sadwith:

The Chief Probation Officers of California (CPOC) is an association of all 58 counties with a shared identity as law enforcement leaders. We are committed to a research-based approach to public safety that promotes positive behavior change. Our leadership guides policy and practice in the areas of prevention, community-based corrections, secure detention for youth and direct human services. Our goal is to prevent crime and delinquency, reduce recidivism, restore victims, and promote healthy families and communities. We proudly serve our Counties and Courts.

After reviewing the proposed CalAIM 1115 Waiver, CPOC has developed comments and recommendations for the California Department of Health Care Services (DHCS) to consider during the finalization of the waiver. CPOC appreciates the opportunity to inform DHCS about the CalAIM justice involved policies and recognizes the DHCS for continuing to authorize the CalAIM program.

Listed below are CPOC's concerns and recommendations related to the 1115 demonstration waiver:

- Specific Recognition for Probation as a Core Partner in the Implementation
    - Concerns:
        - The role of Probation in the delivery of services to ADULT JI clients is not clearly defined in the CalAIM Justice Involve reentry initiative.
        - There is no formalized role for probation in the adult implementation process. Probation plays a key role in the successful reentry of individuals being released from State Prison and/or County Jail and this role needs to be codified in the policy framework.
    - Recommendations:
        - DHCS provides clarification in the role of Probation in the delivery of service to ADULT clients in the CalAIM justice involved reentry initiative that does not conflict with completion of the work as outlined by court orders. CalAIM services should not interfere with court ordered responses that probation is responsible for addressing.
        - DHCS to add language highlighting the importance of including Probation into the local frameworks.

- Short-Term Stays in Secure Juvenile Facilities
    - Concerns:
        - It is challenging to deliver pre-release services for youth in a secure juvenile facility who may be released in the first 48 to 72 hours.
        - There is a notable percentage of youth with a shorter than 30-day length of stay in secure juvenile detention facilities and there are high expectations placed on probation departments to provide services to this population.
            - The CalAIM policy states that it applies to every individual booked into custody and meeting the eligibility requirements for pre-release services, regardless of the length of stay in the detention facility.
        - CalAIM JI reentry services for pre-adjudicated juvenile populations being detained in the facility for less than 72 hours, are not included in the policy or reimbursements, which represent a portion of youth detained in secure juvenile facilities.
    - Recommendations:
        - DHCS to clarify the expectations for individuals who are in facilities for 72 hours or less.

- Individuals Released from a Secure Juvenile Facility ages 21-25

- Concerns:
    - Waiver continues to reference youth up to age 21, which may be related to the EPSDT age limitation, however there are youth in the secure juvenile facilities up to age 25 (and technically can be older than 25 at time of release).
    - The guidance addresses "youth" being released from a secure juvenile facility but also references the age of 21 in the document.
- Recommendations:
    - Update the language in the waiver to ensure individuals aged 21-25 being released from a secure juvenile facility are "youth" as defined in the waiver and guidance expectations.
    - Clarify if an individual is released after the age of 25, if they fall under the youth justice-involved category or adult
    - DHCS to clarify the EPSDT and CHIP requirements for the individuals under 21 years of age (in relation to the JI requirements for individuals 25 years and younger).

- Sunset of PATH funding
    - Concerns:
        - Current waiver language indicates that the grant funding has served its intended purpose to build capacity yet there are still counties that have applied for Round 4 funds (which are set to expire 12/31/2026) that have not received funding.
        - No current status of whether Round 4 funds will be distributed.
        - PATH funds were intended for capacity building within the counties, however approximately 90% of counties have not launched prerelease services and therefore there is no real understanding of the continued needs of counties as they truly implement the CalAIM requirements.
        - There is still significant infrastructure work to be done and PATH funds have supported these efforts. These monumental changes within the system take time and while the money has been identified, received (PATH JI Rounds 1-3), and is being utilized; more time is needed to use these PATH funds while the intended uses for these funds are being realized.
        - Lack of clarity on how funding and infrastructure needs are to be addressed after PATH ends.
        - Counties will need on-going funding to support processes that have been implemented until at least there is a point where the Medi-Cal billing process has been fully realized in all counties so that there is a true understanding of cost vs. reimbursement for the CalAIM requirements.
    - Recommendations:

        - Continue PATH funding for counties who have already received these funds.
        - DHCS to award the fourth round of PATH funding to Probation and Sheriff's Office by 6/30/2026 to allow for continuation of readiness efforts.
        - DHCS to provide an extension for probation departments and Sheriff's Offices to expend the grant funds.
        - Identify a new funding stream to support the on-going efforts of county correctional facilities to implement the CalAIM requirements.
        - Provide specifics for long-term sustainability implementation funding and administrative support beyond 12/31/26.
        - Define a post-PATH plan for counties that clarifies funding, staffing, and roles between MCPs.

- Foster Youth
    - Concern:
        - Former foster youth (18-26) are eligible by default but the guidance does not address those foster youth who are currently detained in adult institutions (county jails and state prisons).
    - Recommendation:
        - Clarify guidance on the identification of former foster youth in facilities.

- Loss of Support Programs
    - Concern:
        - Removal of PATH (Providing Access and Transforming Heath), DSHP (Designated State Health Programs), and HRSN (Health-Related Social Needs) funding may weaken reentry outcomes by reducing workforce coordination and basic needs support. This raises concerns about whether there is enough support to maintain a successful reentry program.
    - Recommendation:
        - Replace lost Supports by providing funding for workforce, data systems, and basic needs (housing, food, transportation).

- Medi-Cal Billing Waiver
    - Concerns:
        - Probation Departments have been providing services within facilities and supported reentry for years and have developed local systems and fiscal resources to provide these services.
        - The current CalAIM requirements can be disruptive to current processes in some jurisdictions and in some cases are limiting or

eliminating current providers of service for our justice involved population.
        - CalAIM requirements can be a hindrance to providing person-specific services.
    - Recommendation:
        - DHCS to request the ability for county facilities to apply for a waiver to be an Exempt from Licensure Clinic and billing for Medi-Cal services if the CalAIM services are being provided and funded using an alternative funding stream.

- Current Impacts of CalAIM on Counties
    - Concerns:
        - Limited number of secure county juvenile detention facilities received conditional approval and launch pre-release services, and these counties are still working through implementation concerns (e.g. Medi-Cal billing)
        - Counties are still working though readiness for all expectations even if the facility is already "live" with unknown impacts on facilities after going "live".
        - MOUs/agreements are still outstanding even in "live" counties, and this process feels rushed for the remaining counties working to "go live."
    - Recommendations:
        - Identify implementation impact to counties that have gone live with service delivery.
        - Consider extending the deadline into 2027 for some counties who require additional support to "go live."

- Medi-Cal Immigration Policies
    - Concerns:
        - Medi-Cal immigration policies are primarily impacting individuals 19 years and older, and limits pre-release services for long-term commitments in a youth correctional facility for those 19 years or older if undocumented.
        - A potential conflict exists between federal direction to restrict Medi-Caid eligibility for undocumented individuals and the state's intent to expand Medi-Cal access to the incarcerated population.
            - It is unclear if this conflict creates risks (either to departments or individuals applying for Medi-Cal) as departments invest more time in trying to secure Medi-Cal enrollment.

        - Fewer individuals may choose to enroll in Medi-Cal due to immigration concerns, which could impact a department's ability to maximize revenue opportunities.
    - Recommendation:
        - DHCS to update immigration policies and expectations for CalAIM implementation

- DHCS Requested Budget Increases
    - Concerns:
        - Forensic health care cost increases exceeding annual rate increases outpace the proposed DHCS budget increases of 4.72% per year.
        - The requested budget increases (4.72%) jeopardizes the sustainability of the pre-release services if the Probation Departments are unable to cover the costs.
        - Low volume of juveniles in the youth correction facilities results in lower revenues, and the recurring costs to administer the forensic health services increases annually at a rate higher than the DHCS budget (4.72% increase per year).
        - Administrative costs to sustain the pre-release services and administrative oversights (including the billing service) is burdened by the low volume of juveniles being detained.
    - Recommendation:
        - DHCS to consider an enhancement to the proposed budget increases commensurate with the increased cost for the required services.

While the following concerns and recommendations are not explicitly addressed in the Section 1115 Demonstration Five-Year Renewal Request, they continue to be implementation issues we believe necessary to flag for your consideration in the event they require that the federal waiver renewal application be modified in order for the state to address:

- Existing CalAIM JI Policy & Operations Guide
    - Concerns:
        - There has been no updated written guidance since October 2023.
        - While updates have been disseminated in various ways, they are difficult to locate and to determine which is the latest guidance.
        - While questions have been answered and guidance revised verbally or in ancillary written communications, primary source documents contain old or outdated information requiring the need to seek clarification on topics already addressed.

        - There are significant differences between adult and juvenile systems, including between adult and youth institutions.
            - Guidance is often too generic and does not address differences, creating room for misinterpretation and the need for further clarification.
    - Recommendations:
        - DHCS to release updated guidance for correctional agencies, including administrative reporting requirements (CalAIM JI Policy and Operations Guidance).
        - DHCS to provide facility-specific guidance which addresses operational challenges unique to juvenile settings.

- Data
    - Concerns:
        - Data sharing for juveniles is impacted by the state and federal laws related to privacy, juvenile records sealing and expungement rules pertaining to the youth's history.
        - Sharing data in a health exchange does not have the necessary controls to remove certain information currently contained in local criminal justice systems and Probation Department case management systems, which are constructed to expunge various records per state record sealing laws.
        - Data-sharing complications may require technology improvements
            - Lack of standardization for what is collected, who accesses the data, and how the data is maintained by external organizations and users of health information exchanges (i.e. youth's criminal history may be expunged by the courts).
            - Lack of guidance on what is required to be collected, shared and/or reported. Data information exchange is crucial to the success of not only CalAIM but justice outcomes. Data protocols should reflect both systems data needs.

    - Recommendations:
        - Outline what is mutually required between systems and encourage conflicts to be resolved in a way that takes into account court orders. Data sharing should be specific to what is needed in order to implement CalAIM, determine Medi-Cal eligibility and not exceed what is needed for those purposes unless mutually agreed upon and in compliance with state confidentiality laws.
        - Data requirements must be sensitive to the differences between juvenile and adult data-sharing.

- Audits and Controls Processes
    - Concerns:
        - Utilization reporting for Probation Departments has not been defined by the DHCS in the Policy and Operations Guide issued in October 2023, and limited guidance has been released by the DHCS.
        - Utilization reporting for pre-release services is dependent primarily on the encounter reporting and claiming for Medi-Cal reimbursements. Probation Departments and the reentry partners complete non-billable actions that pertain to the pre-release services and warm handoffs into community service providers. Examples include pre-trial services, adult probation services, court appearances, and other case management services provided by the Probation Department.
    - Recommendations:
        - DHCS to define utilization reporting and provide specific guidance in the updated Policy Guide that should be limited to activity billed to Medi-Cal.
        - DHCS to provide specific Technical Assistance for county correctional facilities should a regulatory audit be expected.

- Counties Without a Secure Juvenile Facility
    - Concerns:
        - CalAIM JI policy excludes the eighteen (18) counties that do not operate a secure juvenile detention facility.
        - The DHCS Readiness Assessment (RA), Operations and Policy Guide, and supporting guidance have not addressed the specific needs for the Probation Departments in these 18 counties.
    - Recommendations:
        - Update the regulatory guidance to address counties without a juvenile detention facility and include expectations for MCPs in these jurisdictions.

- Medi-Cal Eligibility
    - Concerns:
        - Medi-Cal eligibility is the cornerstone of the reimbursements and program sustainability for Probation Departments and poses one of the most significant challenges.
        - Probation Departments require a system that quickly addresses situations where an individual's eligibility status is 'suspended' and needs to be activated prior to release from the detention facility.
    - Recommendations:

        - DHCS to publish the Medi-Cal benefits guidelines for correctional agencies and behavioral health agencies. The guidelines would address the authorizations, modifiers, sign-off and approval of billable records.
        - DHCS to revise standard Medi-Cal rules to be reflective of secure detention settings and recognize that embedded staffing in detention facilities is different.
        - DHCS to remove authorization requirements for correctional facilities rendering pre-release services. The authorizations include pharmaceuticals and pre-release services performed in the detention facility.

- Medi-Cal Billing
    - Concerns:
        - Probation Departments have no history of Medi-Cal services billing and there is a significant learning curve and ramp up process for the billing requirements and processes.
        - Development of techniques and standard operating procedures to bill for Medi-Cal services averages 2-3 years, and the Probation Departments are likely to experience a higher pattern of claim denials and missed reporting of service encounters during this ramp-up period.
    - Recommendations:
        - DHCS to monitor and assess the patterns of claim denials
        - DHCS to remove financial penalties to correctional facilities for claims submitted 6-12 months after the date of service and extend the one-year timely filing period to eighteen (18) months.

- Memorandum of Understanding (MOU) Development Between MCPs and Secure Juvenile Facilities
    - Concerns:
        - Intermittent engagement in certain counties with MCPs and county partners to develop the MOU.
        - Intermittent engagement in certain counties with MCPs and county partners to identify and recruit CBOs with experience with justice involved individuals as ECMs.
        - The process seems rushed and needs more focus on providing individuals with quality services that meet the specific needs of the JI population.
        - The number of Enhanced Care Management (ECM) providers available to support justice-involved referrals is currently insufficient, which negatively impacts continuity of care.
    - Recommendations:

- Require MCPs to engage with correctional facilities to identify existing community providers that have experience with the JI population.
- Define measurements for adherence to state guidance for both government and non-government entities electing to be an ECM providing services either inside a facility and/or upon reentry.

We respectfully submit these comments to the Department of Health Care Services. Should you have any questions, I can be reached at [redacted]

Respectfully,

[redacted]

Karen A. Pank
Executive Director

Yasmin Guerra, Ventura County Probation Agency, Email received March 11, 2026.

Good afternoon,

Attached please find VCPA's public comments to DHCS CalAIM Section 1115 Demonstration Waiver.

Kind regards,

Yasmin Guerra
Program Administrator II-CalAIM, Juvenile Facilities
[redacted]
4333 Vineyard Avenue Oxnard, CA 93036 L#8000
[redacted]
probation.venturacounty.gov
joinprobation.venturacounty.gov

COUNTY OF VENTURA
PROBATION AGENCY

March 11, 2026

Yasmin Guerra
Program Administrator II-CalAIM, Juvenile Facilities
Ventura County Probation Agency
800 S. Victoria Ave.
Ventura, CA 93003

Re: Public Comment for the Medicaid Section 1115 Demonstration Five-Year Renewal Request: Continuing CalAIM Demonstration

The Ventura County Probation Agency (VCPA) is preparing to launch the CalAIM pre-release services on April 1, 2026. After reviewing the proposed CalAIM 1115 Waiver, the VCPA team has developed comments and recommendations for the California Department of Health Care Services (DHCS) to consider during the finalization of the waiver. VCPA appreciates the opportunity to provide input to DHCS regarding the CalAIM justice-involved policies and commends the DHCS for continuing to authorize and support the CalAIM program.

Listed below are the comments and recommendations from VCPA related to the 1115 demonstration waiver:

Comments & Recommendations:

1) Medi-Cal eligibility is referenced throughout the 1115 waiver and the challenges associated with new enrollment, activation, and assignment into the health plans are recommended for inclusion. The sustainability of the justice-involved program is dependent on VCPA's ability to receive timely completion of applications and assignments into the managed care system to enable the referrals for enhanced care management. It is recommended that DHCS include a section pertaining to the risks and opportunities being experienced by the justice-involved reentry program.

2) The proposed budget between 2027 and 2031 reflects a 4.7% increase year-over-year, and the health care costs in the detention facility increase at a significantly higher rate. VCPA recommends additional funding be added, including an incentive amount for the Probation Departments during the initial twenty-four (24) months of operating pre-release services. VCPA and other Probation Departments are ramping up operations and developing new operational protocols to support implementation. The Medi-Cal incentive funds will be used to offset the increased costs associated with delivering services to youth in the detention facilities.

3) Revenue cycle management within the Medi-Cal fee-for-service reimbursement system represents a new responsibility for Probation Departments. Under the CalAIM JI program, Probation Departments are being positioned similarly to community clinics and

hospitals. As a result, the regulatory requirements associated with delivering Medi-Cal services introduce new compliance standards, including medical necessity criteria, service and pharmaceutical authorizations, claims submission for reimbursement, and navigating denial and appeal processes.

VCPA recommends allowing correctional agencies the option to extend the timely filing requirement from twelve (12) months to eighteen (18) months. Additionally, VCPA recommends waiving timely filing penalties that begin after the sixth month and increase over time.

4) DHCS has released information regarding billing Medi-Cal for pre-release services and references a limited set of "Y" codes. However, the scope of reimbursable codes for pre-release services may extend beyond these codes when member entitlements are taken into account. VCPA recommends that DHCS issue specific Medi-Cal billing guidance for correctional facilities that clearly limits the number of billable codes and defines the covered services that may be provided within the detention facilities.

   Additionally, there are operational challenges associated with Medi-Cal billing that should be considered for inclusion in the 1115 waiver. VCPA also recommends emphasizing Probation Departments' reliance on Medi-Cal reimbursement to sustain the delivery of pre-release services within the detention setting.

5) The number of Enhanced Care Management (ECM) providers in Ventura County available to support justice-involved referrals is currently insufficient, which negatively impacts continuity of care. While the waiver references investments in the ECM system, it should be expanded to include a statement regarding health plans' continued efforts to increase the number of JI providers. Therefore, VCPA recommends adding language to the waiver that acknowledges the current deficiencies in provider networks and outlines expectations for health plans to expand the availability of ECM providers serving the JI population.

6) The role of adult probation services in the CalAIM program, including services provided to pre-trial populations within the criminal justice system, should be incorporated into the 1115 waiver. Probation Departments oversee juvenile detention facilities and administer post-release services for adults transitioning from county jails and state prisons. While the CalAIM justice-involved pre-release services are primarily focused on detention facilities, Probation Departments also provide case management and reentry support services to both adults and youths in the community. VCPA recommends that DHCS amend the proposed waiver to reflect the full scope of services provided by Probation Departments and to highlight the importance of coordinated reentry efforts between the Offices of the Sheriff and Probation Departments.

COUNTY OF VENTURA
PROBATION AGENCY

Thank you for your consideration of VCPA's comments on the proposed 1115 CalAIM waiver. We appreciate the opportunity to provide feedback and look forward to continued collaboration with DHCS.

Regards,

[redacted]

Yasmin Guerra
Program Administrator II-CalAIM, Juvenile Facilities

Mark VanHolle, MISI Community Solutions, Email received March 12, 2026.

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith

Dear Director and DHCS Leadership:

On behalf of MISI Community Solutions, thank you for the opportunity to submit comments regarding the CalAIM Section 1115 Demonstration Renewal Application.

MISI strongly supports renewal of the CalAIM demonstration and the State's continued advancement of a more integrated, person-centered Medi-Cal delivery system. We recognize the considerable complexity involved in balancing federal requirements, budget neutrality standards, program consolidation, and operational realities across a statewide managed care environment. We also acknowledge the significant implementation role carried by Medi-Cal managed care plans in operationalizing Community Supports at scale.

From our vantage point as a community-based provider participating in this ecosystem, we respectfully offer the following observations and recommendations.

1. Support for Renewal and Whole-Person Care Continuity

MISI supports renewal of the Section 1115 demonstration and the continued refinement of CalAIM's whole-person framework. Aligning physical health, behavioral health, and health-related social needs remains essential for members with complex medical and social circumstances.

We appreciate DHCS' preliminary findings indicating meaningful cost reductions associated with recuperative care and short-term post-hospitalization housing. Preserving services that promote safe recovery outside of high-cost institutional settings is not only clinically responsible, but fiscally aligned with the program's long-term sustainability objectives.

2. Preservation of the Recuperative Care and Post-Hospitalization Continuum

We support DHCS' stated intent to maintain the full continuum of care currently delivered through recuperative care and short-term post-hospitalization housing.

As consolidation into a unified recuperative-care model is contemplated, we respectfully request clear operational guidance addressing:

a. Preservation of existing levels of care and core service components within the
b. consolidated structure;

c. Continuity of eligibility standards sufficient to prevent unintended access narrowing;
d. Protection of members actively receiving services at the time of transition; and
e. Advance clarification of billing mechanics, documentation expectations, and clinical criteria.

In practice, these services often function as sequenced stabilization supports. Preserving that practical continuum will be essential to maintaining their effectiveness.

3. Authority Transition and Implementation Precision

We recognize DHCS' intent to transition recuperative care from Section 1115 authority to Medicaid managed-care ILOS authority or another appropriate federal pathway, while ensuring coverage remains uninterrupted.

Authority transitions of this magnitude require operational precision. To safeguard continuity and provider readiness, we respectfully request advance guidance addressing:

a. Treatment of room-and-board related components under the post-1115 structure, given federal coverage constraints;
b. Statewide standardization of MCP contract amendments to reduce regional variability;
c. Alignment of authorization criteria and utilization-management expectations across plans;
d. Advance clarification of claims submission and reimbursement procedures; and
e. Rate adequacy sufficient to sustain compliant, high-quality community-based providers.

Clarity in these areas will promote stability, reduce administrative friction, and support consistent member access across counties and plans.

4. Sustaining Ecosystem Infrastructure

The renewal application appropriately highlights the role of PATH and related implementation supports in building the Community Supports ecosystem. The measurable efficiencies and early outcomes reflected in the State's analysis are the result of coordinated efforts among DHCS, MCPs, community-based providers, and ecosystem partners who facilitated readiness, collaboration, and technical alignment.

As waiver authorities evolve, we respectfully encourage continued emphasis on:

a. Provider readiness and cross-sector coordination;
b. Consistency in MCP expectations and contract administration;
c. Standardized referral pathways and communication protocols; and

d. Support for intermediary and collaborative entities that strengthen field-level alignment.

The sustainability of CalAIM depends not only on policy design, but on continued ecosystem coherence.

5. Member Protection During Transition

Members served through recuperative and post-hospitalization services are often medically fragile and housing-insecure. Transitional ambiguity can have immediate real-world consequences.

We respectfully urge incorporation of explicit safeguards including:

a. Protection against abrupt service discontinuation during authority shifts;
b. Clear grandfathering provisions for members mid-course in recovery; and
c. Communication timelines sufficient for discharge planning teams, MCPs, and providers to adjust responsibly.

Member continuity should remain the guiding principle throughout implementation.

6. Practical Field Perspective

While MISI does not have access to statewide utilization analytics, our direct service experience consistently demonstrates the stabilizing value of recuperative and posthospitalization supports.

We have observed numerous cases in which members discharged from acute settings were able to recover safely in structured environments that facilitated medication adherence, follow-up care coordination, and transition planning toward longer-term housing and support. Without these services, many of these individuals would face unsafe discharge conditions or avoidable return to higher-acuity settings.

These field-level observations reinforce the importance of maintaining a stable, predictable framework for these supports within the Medi-Cal program.

7. Conclusion

MISI Community Solutions supports the CalAIM Section 1115 renewal and the continued evolution of a coordinated, whole-person Medi-Cal system.

We respectfully encourage DHCS and CMS to ensure that:

a. The authority transition for recuperative care is executed with clarity and operational readiness;
b. The full stabilization continuum is preserved;

c. Reimbursement structures remain sufficient to sustain quality providers;
d. Ecosystem coordination infrastructure remains strong; and
e. Member continuity remains paramount throughout implementation.

We appreciate DHCS' leadership in advancing this nationally significant reform effort and stand ready to continue partnering constructively in the next phase of CalAIM's development.

Respectfully submitted,

Logo Mark VonHolle | Director of CalAIM
MISI Community Solutions
[redacted]www.myisi.net
101 Creekside Ridge Ct., Suite 215, Roseville, CA 95678

Jason Bloome, Connections, Email received March 9, 2026.

Hello DHCS,

We are a CS Provider for the CalAIM Assisted Living Facility Transitions (ALFT) for Health Net and Kaiser and were highlighted in the California Health Care Foundation CalAIM Community Hub article. We currently have enrolled 1,300 authorized members with 80% (1040) for SNF Transition which saves the state approximately $2,500/month. The annual Medi-Cal cost savings is approximately: $25 million dollars (1040 x 2500 x 12) and we are growing at about 100 new authorizations each month. SNF Diversion also saves the state money for less utilization for LTSS SNF, hospital or emergency room stays. We think this CS shows solid evidence for the success of CalAIM in saving state and federal dollars. We would be happy to provide more details about this CS at your request.

Kind regards,

Jason
--
Jason Bloome
CEO
Connections - Care Home Consultants
[redacted]
www.connectionscarehomeconsultants.com

Jennifer Alley, MSA, Email received on March 13, 2026.

Good evening,
Attached are the MSA's comments to the CalAIm Waiver Renewal Application.

Please let me know if you have any questions or issues with the attachment.

Thank you for your consideration,

Jen

Jennifer Alley
MSA
Executive Director

Multipurpose Senior Services
Program Site Association

March 12, 2026

Tyler Sadwith
Chief Deputy Director and State Medicaid Director
DHCS

Via Email: 1115waiver@dhcs.ca,gov

Re: ***CalAIM Section 1115 Demonstration Renewal Application***

Dear Mr. Sadwith:

The MSSP Site Association (MSA) represents Multipurpose Senior Services Program (MSSP) providers in California who after a thorough assessment determine what an individual requires to remain safely in their homes through the coordination of medical care, transportation, meals, personal care assistance, and minor home repairs.

We appreciate the opportunity to provide comments on the State's CalAIM renewal application.

Our MSSP sites have decades of experience providing Long-Term Services and Supports (LTSS) to Medi-Cal eligible individuals over age 60 and over, who qualify for nursing home placement. We believe extending this type of care through the proposed BridgeCare Pilot for "near duals" with health and functional needs could decrease emergency department use, hospitalization risk, and eventual Medi-Cal spend-down. While we support this concept, we have the following concerns and questions regarding the proposed BridgeCare Pilot:

Workforce and Resource Capacity
As providers, we are acutely aware of the current shortage of services and workforce available to meet the needs of the Medi-Cal population. Hiring and retaining qualified staff is a constant struggle and research predicts a workforce shortage as the aging population continues to grow[1]. We are concerned that this expansion may reduce resources available to the existing LTSS population, potentially impacting those who currently rely on these services.

Programmatic Clarifications

Additional information is needed to fully evaluate the risks and benefits of the new program:

- Cost Sharing: How will cost sharing be implemented? How will increased care costs impact on the ability of new duals to afford to remain in the community?

[1] CHCF

- Participation and Eligibility: Will there be a cap on the number of participants? What are the eligibility criteria for selecting participants, and is the program limited to those with a Medi-Cal share of cost:

- Administration and Funding: Which local entities will provide care, and who will oversee the provision of care? How will counties fund the program, how will reimbursement be managed, and when would savings be identified?

Thank you for the opportunity to provide feedback. We look forward to continuing this discussion and welcome the opportunity to meet to discuss these points further.

Sincerely,

[redacted]

Jennifer Alley
Executive Director
MSA

Kimberly Lewis, National Health Law Program, Email received on March 12, 2026.

Hi Tyler -

Please accept these comments on the CalAIM Renewal Waiver application on behalf of the National Health Law Program.

All the best,

Kim
--
Kim Lewis (*she/her/hers*)
Director of California Policy
Practice Area Managing Director
National Health Law Program
3701 Wilshire Blvd, Suite #315
Los Angeles, CA 90010
[redacted]
healthlaw.org

March 12, 2026

Tyler Sadwith,
State Medicaid Director
Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Sent via email to 1115Waiver@dhcs.ca.gov

Re: Comments on Renewal of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration

Dear Tyler,

Please accept these comments on behalf of the National Health Law Program in response to the California Department of Health Care Services (DHCS) request for a five-year renewal of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration, which is set to expire on December 31, 2026.

Overview of 1115 Waiver Authority.

For the Secretary to approve a project pursuant to § 1115, the project must:

- be an "experimental, pilot or demonstration" project;
- be likely to promote the objectives of the Medicaid Act;
- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.

Discussing each of these limitations a bit further:

First, the state must propose to conduct an "experimental, pilot, or demonstration" project. This demands a "novel

approach" to program administration. *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved.

Second, the project must promote the Medicaid Act's objectives. Congress has made clear that the purpose of Medicaid is to enable states "to furnish[] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1; 1396d(a) (defining "medical assistance" as provision of, or payment for, specified health care and services). Thus, the "central objective" of the Medicaid Act is "to provide medical assistance." *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting "promoting health" as an independent objective because the Medicaid Act is "designed … to address not health generally but the provision of care to needy populations" through a health insurance program).

Third, the Secretary can only waive provisions set forth in section 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in sections 1396b-1396w-5. *See* Social Security Act, § 1115(a)(1)). Once the Secretary has acted under section 1115(a)(1) to waive compliance with designated provisions in section 1396a, section 1115(a)(2) provides that the costs of "such project" are "regarded as expenditures under the State plan" and, thus, paid for under the same statutory formula that applies for a state's expenditures under its State plan. *Id.* § 1115(a)(2). Section 1115(a)(2) does not create an independent "expenditure authority" for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a or to rewrite the provisions in section 1396a or any other provision outside of section 1396a. To the contrary, it is a "clean-up" provision that merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1).

Fourth, section 1115 allows approvals only "to the extent and for the period necessary" to carry out the experiment. *Id.* § 1115(a); *see also id.* §§ 1115(e)(2), (f)(6) (limiting the extension of "state-wide, comprehensive demonstration projects" to one initial extension of up to 3 years (5 years, for a waiver involving Medicare-Medicaid eligible individuals) and one subsequent extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers).[1] Congress did not enact section 1115 to permit the Secretary to make long-term policy changes.

[1] In 2017, a CMS Informational Bulletin announced the intent "[w]here possible, . . . [to] approve the extension of *routine, successful, non-complex*" Section 1115(a) waivers for a period up to 10 years. Ctr. for Medicaid & CHIP Servs., CMS, CMCS Informational Bulletin 3 (Nov. 6, 2017) (emphasis added). The Bulletin should be disregarded because it conflicts with, among other things, section 1115's limitation of approvals to experimental, pilot, or demonstration projects (not for "routine" projects) and only for the period necessary to carry out the experiment (not to maintain a successful experiment as an ongoing policy).

Comments on the Specific Elements in the Waiver Application.

Section 3.1 - Reentry Services for Justice-Involved Populations 90-Days Pre-Release

NHeLP supports DHCS's renewal and continued implementation of the targeted Medi-Cal services for justice-involved individuals for up to 90 days prior to release from carceral settings. Continuing this effort as part of a waiver demonstration request is the only current legal mechanism to achieve this. Justice-involved individuals have significant behavioral and physical health needs and are much more likely to have disabilities and chronic conditions, including serious mental illnesses and substance use disorders (SUD). Post-incarceration, the health of justice-involved individuals can worsen if they lack access to needed medications and community-based providers to initiate or continue their care after release. The provision of select Medi-Cal services in jails and prisons prior to discharge will help address the structural challenges justice-involved individuals face when navigating the health care and social services systems that can function as a driver on health outcomes post-incarceration.

As required under California state law, all California counties with correctional facilities and all the state prison sites are mandated to implement pre-release Medi-Cal services by October 1, 2026. Currently, all the state prison sites and 34 facilities in 12 California counties have implemented these services. According to the Renewal Request, as of September 30, 2025, more than 35,000 Medi-Cal members have been identified as eligible for pre-release services; an estimated 64,500 services were delivered to eligible individuals; and 14,086 justice-involved individuals received 94,450 prescriptions for the 90-day pre-release period and medications upon release. Many justice-involved individuals were able to receive DME items upon release and were enrolled in ECM, where they were able to receive community-based services and support for their transition back into their communities. This data is based on the facilities that have started implementing these services.

There are still numerous county correctional facility sites that need to go-live to comply with the October 1, 2026 mandate. It is essential that reentry services are renewed to prevent any interruption during the demonstration implementation process of these services into county correctional facilities. Any interruption during implementation will hinder access for justice-involved individuals that need these life-saving health care services and given the slow rollout currently under the initial demonstration waiver period, additional time will likely be needed. In conjunction with the renewal process, we encourage DHCS to continue monitoring the implementation process to ensure that county correctional facilities are equipped with the necessary processes needed to provide pre-release Medi-Cal services, as well as ensure Medi-Cal coverage is in place upon release, to all eligible justice-involved individuals.

We also support DHCS request to continue providing Medi-Cal services up to 90 days post-release. As explained in the renewal request, providers and correctional facilities need sufficient time to arrange services and connections before an individual's release date.

Transitioning out of incarceration can be an overwhelming experience for many individuals and providing pre-release services and building key relationships between the individual and their provider before they are released is crucial to sustaining and stabilizing the individual's health. Cutting the time frame to less than 90 days may hinder that individual's health stability.

As for the implementation of H.R. 1 work requirements, we support DHCS using the Justice-Involved Reentry Initiative to ensure that individuals who are currently incarcerated or being released from incarceration are exempted or excluded from complying with work requirements, as federally required. We also support and encourage DHCS to use ex parte data sources wherever possible to determine and verify that incarcerated and formerly incarcerated individuals are excluded or exempted from work requirements. We agree with DHCS that to make an ex parte determination for work requirements, the State can use data gathered from the implementation of the Justice-Involved Reentry Initiative, which includes information regarding incarceration status and release date; and information identifying medical or behavioral health conditions that establish exemption from work requirements, such as a SUD, mental health condition, and other chronic conditions – in compliance with federal law. If possible, we encourage DHCS to automate these determinations to make the process easier for the State and individuals having to comply with these requirements and ensure that individuals who qualify for exemptions under multiple categories are able to take advantage of that overlap. Overall, NHeLP supports DHCS in seeking renewal and continued implementation of the Justice-Involved Reentry Initiative and encourages it to continue to implement policies that will support a smooth transition for individuals being released from incarceration back into their communities.

Section 3.2 - DMC-ODS: Waiver of the IMD Exclusion for SUD Services

NHeLP opposes yet another renewal of the IMD waiver for beneficiaries with SUD. As DHCS states in the proposal, California first received approval to waive the IMD exclusion back in 2015.[2] The waiver was later renewed in 2020 and in 2021. As explained above, section 1115 waivers must propose to conduct an experiment, pilot, or demonstration, and the State must put forward a hypothesis to be tested throughout the demonstration period. We fail to see how a renewal of the IMD waiver for beneficiaries with SUD proposes an experiment, pilot, or demonstration different from what California has already tested since 2015. In addition, section 1115 proposals are approved only for the period of time necessary to carry out the experiment. If DHCS believes additional time is needed to test the program, the department must outline the specific reasons why 11 years have not been enough for the experiment and support its conclusion with data from the demonstration. The department fails to do as such in the proposal available for public comment.

We are concerned that California (like other states) is seeking approval to use federal funding in ways not authorized in federal law and is using 1115 authority to sidestep congressional authority in perpetuity. This concern is heightened by the fact that Congress has established (first for a temporary period and subsequently on a permanent basis) a

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state plan option for states seeking to use federal Medicaid funds for coverage of residents of IMDs with SUDs.[3] Rather than request section 1115 authority to waive the IMD exclusion in perpetuity, we urge DHCS to consider submitting a SPA pursuant to Section 1915(I) of the Social Security Act. Under Section 1915(I), Congress clearly established a pathway for states to maintain funding for residential SUD treatment by using state plan authority while abiding by the following requirements: 1) the State must make efforts to fund, at appropriate levels, community-based services; 2) the State must implement and utilize appropriate placement criteria and assessment tools that ensure patients remain at residential facilities no longer than medically necessary and are transitioned to outpatient services as soon as feasible; 3) the State must continuously assess availability of SUD providers and medications for SUD at all levels of care and in all regions to ensure access to the whole continuum of SUD care. These guardrails are essential to guarantee that the increased use and availability of IMDs for SUD treatment is not happening at the expense of more effective community-based services and that beneficiaries can always access care in the least restrictive setting necessary.

We commend DHCS for already implementing many such efforts aimed at ensuring that individuals with SUD are only accessing treatment at IMDs when that level of care is needed for their condition, but we strongly believe it is time for the State to follow federal Medicaid law by moving IMD services to the State Plan. As DHCS acknowledges, California already received approval to provide other DMC-ODS services through State Plan authority after an initial period of demonstration through section 1115. If the State wants to continue using federal funds for IMD stays for beneficiaries with SUD, it must equally do so after receiving State Plan approval.

Section 3.3 - County Option to Cover Select Outpatient SUD Services

While we urge DHCS to ensure all DMC-ODS services remain available, we strongly encourage DHCS to move away from the approach of allowing counties to opt-in to providing certain SUD services. It is time for the State to require coverage of all DMC-ODS services in all counties; there is no reason to continue waiving statewideness.

We commend DHCS for working closely with smaller rural counties to establish partnerships that support availability of services in hard to reach places. DHCS should continue allowing counties to join forces to increase access to new SUD services in those places, but this should not depend solely on the willingness of the county to participate. DMC-ODS services are evidence-based and have been shown to reduce the burdens associated with SUD, including overdose deaths. Therefore, we urge DHCS to move towards statewide coverage of the services through the state plan.

Rather than moving away from waiving statewideness, DHCS is proposing to allow DMC counties to opt in to cover care coordination, recovery services, withdrawal management, and partial hospitalization services. This proposal is certainly better than the status quo; nonetheless, it will not go far enough to address remaining gaps in counties not yet

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participating in the DMC-ODS program. As an alternative to requiring all counties to provide all DMC-ODS services, we urge DHCS to consider requiring coverage of those four services on a statewide basis, and allow counties to cover the rest of the DMC-ODS services on an optional basis. Since those services are already in the State Plan, California would simply need to withhold submission of the 1915(b) waiver that makes the services optional for counties.

We have particular concerns about DHCS's proposal to seek new authority for DMC counties to opt-in to cover Mobile Crisis services. To begin, we note that under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of the Medicaid Act, counties have a legal obligation to cover all Medi-Cal coverable services, including Mobile Crisis services, when necessary to correct or ameliorate a mental health or SUD condition of a beneficiary under the age of 21. This mandate applies regardless of whether the State requires statewide coverage of the benefit and regardless of whether the county elects to cover an optional benefit. Thus, the opt-in proposal must be understood to apply only to the Mobile Crisis benefit for adults age 21 and older.

Currently, the Medi-Cal Mobile Crisis Benefit for adults provides critical, timely, and coordinated behavioral health crisis support throughout the state. Since its establishment, mobile crisis teams have successfully diverted adults experiencing behavioral health crises from emergency departments and law enforcement involvement. Mobile crisis teams have contributed to a significant reduction in arrests and involuntary psychiatric holds under Welfare and Institutions Code 5150, both of which can be traumatic and have lasting negative impacts on individuals and their families. Mobile crisis teams are now an integral component of local communities' efforts to address homelessness, and SUD.

As part of the continuum of care for SUD, coverage of mobile crisis services as a DMC and DMC-ODS benefit is also an important component of California's efforts to fight the opioid overdose epidemic. The overall efforts to divert individuals with SUD away from criminal justice settings and connect them to care have resulted in reductions in deaths associated with opioid overdoses throughout the State. Cutting access to mobile crisis services by allowing DMC counties to stop covering it as a Medi-Cal benefit will result in increased use of law enforcement to respond to overdoses and opioid use crises. In turn, increased interactions with law enforcement will lead to a decrease in the number of individuals with SUD seeking medical care, putting at risk the improvements achieved in the last few years.

While this benefit was established to serve the Medi-Cal population, mobile crisis teams are structured to respond regardless of insurance status. In practice, these teams serve not only individuals enrolled in the Medi-Cal program, but also those served through commercial insurance or those who lack insurance. While the state and FFP currently cover the full costs of the Medi-Cal mobile crisis encounters, counties are already subsidizing the costs of mobile crisis encounters for those who are uninsured or those with commercial insurance coverage.

Over the course of the last few years, both State and County investments have been made to build out the infrastructure, workforce, and systems coordination necessary to deliver this

benefit effectively and meet its stringent federal and state requirements. Scaling back coverage of this benefit would risk undermining these investments and lead to gaps in access to crisis services and lead to negative outcomes for individuals with behavioral health crisis needs.

NHeLP further notes that the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act both prohibit disability-based discrimination that excludes people with behavioral health needs from receiving needed services. These laws are designed to ensure disabled people are not denied care and that they receive needed care in the least restrictive setting, in their home and community-based settings, rather than be segregated in institutions. Eliminating mobile crisis services will result in more frequent and unnecessary institutionalization of people with behavioral health conditions.

Section 3.4 - Recovery Incentives

NHeLP strongly supports DHCS's proposal to seek a renewal of its demonstration program related to contingency management for stimulant use disorders. This intervention has been proven effective in addressing stimulant use disorders, particularly in the absence of FDA-approved medications to treat this condition. In addition, California's initiative has been successful, as demonstrated by the levels of intake and satisfaction among beneficiaries participating in the program. To the extent possible, we urge DHCS to extend the availability of these services to DMC counties. Individuals in rural areas who struggle to access key SUD services because of lack of availability may particularly benefit from these interventions given the heightened need. Therefore, just as DHCS is proposing to make certain outpatient DMC-ODS services available to DMC counties, it should likewise make the Recovery Incentives program available for other counties wishing to participate.

Section 3.5 - Traditional Healers and Natural Helpers

We also similarly support the proposal to renew the demonstration program related to traditional healers and natural helpers. These interventions aim to incorporate the particular needs of Native American populations across California, who are disproportionately impacted by the substance misuse crisis. Given that this demonstration was approved in late 2024, the State has not had significant opportunity to test its effect; therefore, the initiative should be maintained. As with the Recovery Incentives program, we urge DHCS to extend the availability of these services to DMC counties given the needs of tribal communities in rural areas.

Section 3.6 - Coverage for Out-of-State Former Foster Care Youth

NHeLP strongly supports DHCS's proposal to renew Medi-Cal coverage for out-of-state former foster youth who turned age 18 before January 1, 2023 through this Section 1115 demonstration. Young people who have been involved in child welfare have complex health needs, due in part to their compounding experiences with trauma. Without Medi-Cal coverage, many of these youth may not otherwise have access to the health care they need—especially when they lack family support and/or are geographically separated from

their previous support systems. We appreciate that DHCS is proposing to continue to support this underserved population until age 26 through this waiver authority.

Section 3.7 - Chiropractic Services from IHS and Tribal Facilities

NHeLP also supports the proposal to renew coverage of chiropractic services rendered by tribal providers. For some pain patients, chiropractic treatment represents an important alternative to opioid-based therapy. As such, expanding availability and coverage of these services is yet another tool California has to address the opioid overdose crisis. While we hope the legislature will soon reconsider Medi-Cal coverage of chiropractic services more broadly, DHCS should renew coverage under CalAIM for populations hard hit by the epidemic, such as Native American populations.

Section 3.8 - Modification of Assets Test for Deemed Supplemental Security Income

While we do not support the reinstatement of the asset test for any individuals in the non-MAGI Medi-Cal populations, in applying this change to the Deemed SSI Population, DHCS must ensure all current protections apply. This includes disregarding any transfer of assets through 2026, and requiring asset reporting on the same timelines set out in current guidance. DHCS must update guidance to capture this population, given all of the current materials are aimed at the non-MAGI populations for whom the asset test was reinstated in 2026. DHCS should also develop a messaging plan immediately so that the Deemed SSI population has notice of this change and adequate time to prepare as needed.

Section 3.9 - Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan.

We support the planned renewal of aligning a dually eligible member's Medicaid plan with their MA Plan choice if the MA plan has an affiliated Medicaid plan. DHCS should continue to enforce safeguards for beneficiaries, including through education about their options to enroll in original Medicare or to change their MA plan. DHCS should also continue to ensure care that reflects individual needs and preferences, and rigorous oversight of plans.

Section 3.10 - Managed Care Authority to Limit Plan choice of Certain Counties - No comment

Section 3.11 - Global Payment Program

The GPP is an important program that has created financial incentives to shift uninsured services from the emergency department to primary and preventative care settings. The proposed renewal of the GPP would create even greater incentives and opportunities to provide preventive and primary care and manage chronic conditions for uninsured patients. The GPP renewal would add services that expand the program's focus on prevention, chronic disease management, and behavioral health and incentivize investment in system transformations to improve health, wellness, and chronic disease management; and developing and implementing system-wide efforts that reduce harmful practices.

The renewal of the GPP is especially critical at a time when public hospitals and health care systems are facing steep cuts to their funding in the Medi-Cal program and expect to see an influx of uninsured patients over the next few years due to the passage of H.R. 1. One question that this proposal does not answer is how DHCS plans to utilize this GPP to address the needs of a growing number of Californians who will lose coverage through Medi-Cal or Covered California and will present at these public hospitals and health systems, even sicker given they will not be able to obtain or afford preventive services or chronic disease management.

Section 3.12 - Employment Supports

We strongly support DHCS's proposal to add Employment Supports as a Medi-Cal covered benefit under this Section 1115 Demonstration. We believe that it will provide a critical bridge to employment and community engagement for Medi-Cal members who may be at risk of losing their Medi-Cal coverage due to impending work requirements. We offer the following feedback to further strengthen this critical benefit.

First, we appreciate DHCS's proposal to include both Pre-Employment Services and Employment Sustaining Services under this benefit. However, we think the components of these services should be expanded to more effectively meet the needs of Medi-Cal beneficiaries. Specifically, while we appreciate the inclusion of services to help individuals find and apply for jobs and educational programs, we also think it is important to include supports to help individuals find and participate in community service and work programs—which are two additional ways an individual can satisfy the work requirements mandated by H.R. 1. *See* 42 U.S.C. § 1396a(xx)(2). Additionally, under Employment Sustaining Services, we suggest adding education about workers' rights, including those related to having a safe workplace, fair compensation, and anti-discrimination (including rights to request disability accommodations). Further, we suggest expanding "Sustaining Services" to not just employment, but to services related to maintaining enrollment in education programs, such as student advising, financial assistance opportunities and loan advising, education on student rights, and/or linkages to existing services at the educational institution or in the community that provide the same. Last, we also suggest ensuring supports to individuals who lose employment—either through this benefit or otherwise—to ensure such individuals do not fall through the cracks.

Second, we encourage DHCS to prioritize community-based organizations as Employment Support providers and as a primary source of referrals, much like it has done with Enhanced Care Management and Community Supports. Utilizing existing expertise and community ties will serve to enhance the quality of the benefit and reach a broader population who may otherwise be unaware of the benefit.

Third, we seek clarification about the scope of eligibility for Employment Supports. In its proposal, DHCS states that this benefit would be available to "Medi-Cal members in the expansion group who have not been found exempt from or compliant with work and community engagement requirements" (p. 43). To be clear, this benefit should be available

to all Medi-Cal beneficiaries who are subject to work requirements, regardless of whether or not they are currently in compliance. Otherwise, many individuals who could benefit from Sustaining Services to *maintain* compliance with work requirements could be ineligible for the benefit.

Fourth, we seek further information about the Department's efforts to ensure beneficiaries' activities through Employment Supports are connected to the counties. Another critical component of work requirements is the *reporting* requirement to verify compliance. Establishing pathways to ensure partners providing such supports are built into counties' ability to access this data at application and renewal is a critical piece to streamline case processing and optimize the success of this benefit.

Finally, we are concerned that DHCS's proposal limits Employment Supports to Medi-Cal beneficiaries who live in counties that opt to provide the benefit. Instead, we urge the Department to consider making this benefit available statewide. Impacted beneficiaries across California must comply with work requirements and they do not have the choice whether to opt-out. Yet, the proposed county opt-in model, which relies on counties' ability and willingness to provide the non-federal share, risks creating a patchwork of participation across the State. With critical Medi-Cal coverage on the line, we strongly urge DHCS to consider an alternative model that would make Employment Supports available statewide to beneficiaries subject to work requirements and accessible to counties of varying sizes and resources. An individual's zip code should not determine whether or not they have access to the supports they need to maintain Medi-Cal coverage that they cannot opt out of. A statewide approach would avoid geographic inequities, better promote consistency, and help protect more Californians from impending work requirements.

Section 3.13 - Bridgecare Pilots

We strongly support the goal of expanding home and community-based services (HCBS), and caregiver supports to older adults with Medicare who have significant health needs and incomes above Medi-Cal eligibility limits.

However, we have several reservations about the design of BridgeCare as proposed, including: (1) the optional nature of the pilot; (2) the eligibility criteria, including capping eligibility at 220 percent of the federal poverty level; 3) the service package; 4) the interaction with existing HCBS programs; 5) cost sharing; and 6) due process protections for participants.

Optional nature of pilot

Because BridgeCare is designed as a county opt-in pilot with no dedicated state funding, we are concerned that county participation will be low. Rural counties — which already contend with fewer providers, weaker infrastructure, and greater geographic barriers — are particularly unlikely to opt in, especially given cuts to funding as a result of both federal and state laws. Moreover, as we have seen from the implementation of Community Supports, HCBS-related supports have not been offered or utilized in significant numbers. Community or Home Transition Services, the Community Support most analogous to BridgeCare's

goals, is not offered by almost 40% of managed care plan and county combinations, including 14 plans that discontinued the benefit as of January 1, 2026.[4] In the most recent data reporting period (Q2 2025), only 0.18% of all Community Supports beneficiaries received this service. Utilization of other HCBS-related Community Supports follows a similar pattern. Nursing Facility Transition/Diversion to Assisted Living Facilities accounted for just 1.2% of Community Supports utilization in Q2 2025. And while Personal Care and Homemaker Services are available in nearly all plans, they represented only 2.6% of Community Supports utilization in the same period.[5]

DHCS frames BridgeCare as a cost-saving measure that prevents expensive institutional care and delays/avoids Medi-Cal enrollment. But these savings accrue broadly—to the Medicare program, to Medi-Cal, and to the health system as a whole—while the costs of participation fall on individual counties. As a result, individual counties do not have sufficient incentive to bear the upfront costs. DHCS should consider state-level financing mechanisms or mandatory participation with state funding support to ensure the program is viable for counties.

Eligibility Criteria

The requirement that participants "require the level of care that is typically provided in a skilled nursing facility" needs further definition. The concept paper does not specify an assessment tool, who will conduct assessments, what training assessors will receive, or how the level-of-care standard will be defined. Given the service package contemplated, and the target population, which aligns with both the In Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS) programs, we recommend reviewing the criteria for eligibility for these programs and building from existing assessment tools.[6] We also recommend that DHCS extend the income eligibility threshold to 400% of the Federal Poverty Level. The proposed ceiling of 220% FPL excludes a significant population of older adults who have functional needs that meet or approach skilled nursing facility level of care, but whose incomes are too high for Medi-Cal and too low to afford private long-term care services. These individuals face the same risk of impoverishment and institutionalization that BridgeCare is designed to prevent — and without intervention, many will eventually

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[4] Cal. Dep't Health Care Servs., *Community Supports Elections (by MCP and County) Updated December 2025*, https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf (last visited March 6, 2026).

[5] Cal. Dep't Health Care Servs., *ECM and Community Supports Quarterly Implementation Report*, https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117?item=6 (last visited March 6, 2026).

[6] Cal. Dep't of Aging, Eligibility and Service Authorization (last visited March 6, 2026) https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Forms_and_Instructions/Eligibility_and_Service_Authorization/; Cal. Dep't of Soc. Svcs., In Home Supportive Services Program, (last visited March 6, 2026), https://www.cdss.ca.gov/in-home-supportive-services.

spend down to Medi-Cal eligibility, at which point the state bears the substantially higher cost of institutional or other Medi-Cal HCBS services.[7]

Service Package

We are supportive of the proposed service package but recommend DHCS provide further specific parameters for each benefit. If the BridgeCare pilot leaves the service package loosely defined, there will be significant variation between counties. Defining each service allows participants to understand what services they are entitled to receive, and how those services will be delivered. Likewise, community-based providers and counties need to understand what is expected to build appropriate capacity, hire and train staff, and negotiate reimbursement rates. We also recommend that DHCS consider requiring "Communication: Device and Translation/Interpretation" as a mandatory service. Almost 40% of adults over sixty speak a language other than English.[8] Studies demonstrate that Limited-English proficient (LEP) older adults have significantly worse health outcomes.[9] Eliminating language barriers is critical for effective communication with healthcare providers and leads to informed decision-making and better quality of care.[10]

Transitioning to and from existing HCBS programs

The proposal does not discuss how transitions from the BridgeCare pilot to existing HCBS, including the IHSS program, the Assisted Living Waiver, the Home and Community-Based Alternatives Waiver, the Multipurpose Senior Services Program Waiver, and CBAS will occur. For individuals who may transition between income levels and program eligibility,

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[7] Cal. Dep't Health Care Servs., Office of Medicare Innovation and Integration Prepared by ATI Advisory, Profile *of Older Californians: Medicare Beneficiaries Near Income Eligibility for Medi-Cal* (July 2023),

https://www.dhcs.ca.gov/services/Documents/OMII-Chartbook-3-Near-Medi-Cal-Income-Eligible.pdf (27% of California Medicare beneficiaries have one or more disability).

[8] California Health Care Foundation, *California's Older Adults and Adults with Disabilities Almanac — 2024 Edition* (November 15, 2024), https://www.chcf.org/wp-content/uploads/2024/11/OlderAdultsAlmanac2024.pdf.

[9] Ninez A. Ponce, Ron D. Hays, William E. Cunningham, Journal of General Internal Medicine, *Linguistic Disparities in Health Care Access and Health Status Among Older Adult* (July 2006), https://link.springer.com/article/10.1111/j.1525-1497.2006.00491.x.

[10] Hilal Al Shamsi, Abdullah G Almutairi, Sulaiman Al Mashrafi, Talib Al Kalbani, Oman Medical Journal, *Implications of Language Barriers for Healthcare: A Systematic Review* (April 2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7201401/#:~:text=We%20found%20that%20language%20barriers,both%20medical%20providers%20and%20patients.

seamless coordination is essential. DHCS should address how BridgeCare participants who become eligible for Medi-Cal will transition to appropriate services without disruption.

Cost Sharing

The concept paper provides no detail on the cost-sharing structure, analysis of affordability, or hardship exemption process. We recommend that any cost sharing be de minimis, given, as DHCS acknowledges, that the proposal is aimed at individuals who "lack[s] resources for adequate care." In addition, cost sharing must be designed to avoid creating a financial barrier that defeats the program's purpose and must include a process for waiving cost sharing based on hardship.

Due Process

The concept paper describes eligibility criteria that involve multiple determinations: whether the individual "require[s] the level of care that is typically provided in a skilled nursing facility," whether they have "countable income between 138 and 220 percent FPL," and whether they have "countable assets within Medi-Cal asset limits." Each of these determinations is a potential point of error or exclusion.

The proposal is silent on what due process protections will be afforded to individuals who are determined ineligible, whose services are reduced or terminated, or who are placed on a waitlist. Given BridgeCare will be authorized through Section 1115 Medicaid authority and uses federal Medicaid matching funds, beneficiaries are entitled to due process protections, and DHCS should provide participating counties with a grievance, appeal, and fair hearing framework that they must follow.

Reporting

Finally, we recommend that DHCS publish transparent reporting on which counties opt in, their enrollment numbers versus eligible populations in the county, waitlist data, services offered, length of time in the program, and grievance and appeal numbers, disaggregated by race, ethnicity, language, and disability status, to enable independent assessment of whether the pilot is achieving equitable access to services.

Section 4.

Community Based Adult Services

We support the plan to transition the CBAS program to a permanent state plan service using the 1915(i) authority. Making CBAS available statewide will improve access to HCBS for older adults and people with disabilities, and we urge DHCS to ensure network adequacy to meet the need for this benefit. We also appreciate DHCS' commitment to a smooth transition for current beneficiaries.

Recuperative Care and Short-Term Post Hospitalization Housing

We appreciate DHCS's commitment to preserving the continuum of care that is currently being provided under the Recuperative Care and Short-Term Post Hospitalization Housing (STPHH) Community Supports. However, we have questions and concerns about how DHCS's proposal—which would eliminate the room and board components of these benefits, merge them into one benefit, and transfer authority from Section 1115 waiver authority to Medicaid In Lieu of Service (ILOS) authority—will be structured and implemented to meet the needs of Medi-Cal beneficiaries.

First and foremost, we strongly support renewing these Community Supports and preserving as much of the currently covered services as possible. While we understand that federal decisions with respect to coverage of room and board services are outside of DHCS's control, we encourage the Department to retain all other components of the benefits. Additionally, should CMS' position on room and board services under Section 1115 or other waiver authority change in the future, we encourage DHCS to revisit adding back in this critical component.

Second, while we are open to DHCS's proposal to combine Recuperative Care and STPHH into one benefit (to be called Recuperative Care), we need additional information to provide substantive feedback. Specifically, especially in light of the removal of room and board, what services will be provided under the new benefit? How does DHCS intend to combine these benefits in practice (e.g., will there be multiple tiers based on need)? What will the eligibility criteria be for this new benefit, considering that the criteria for the two current benefits are different? NHeLP would oppose any narrowing of eligibility for the service. As DHCS emphasized in its Proposal, these two Community Supports have been successful at meeting the needs of Medi-Cal beneficiaries—reducing inpatient, outpatient, emergency department, and long-term care utilization. What steps is DHCS taking to preserve and monitor this success?

Finally, we urge DHCS to consider offering Recuperative Care (and other Community Supports) through the State Plan, rather than ILOS authority. Services can only be provided as ILOS if they could otherwise be covered as HCBS waiver or State Plan services. *See* 42 C.F.R. § 438.16(b). Thus, with the removal of the room and board component, Recuperative Care can now be covered through the State Plan. Adding this benefit to the State Plan would offer several advantages to Medi-Cal beneficiaries and the State. Under this approach, Recuperative Care would be uniformly available to all beneficiaries across the State, rather than only available when a managed care plan (MCP) opts to provide it. Currently, take-up of Community Supports has been limited and uneven––driven in part by variability in requirements or lack of clarity in requirements across MCPs. Changes to the Recuperative Care/STPHH benefit may further fuel this confusion. By adding this service to the State Plan, DHCS could do more to ensure that beneficiaries are aware of this service and have access to it when they need it. For this reason, NHeLP also believes that covering the service under the State Plan is preferable to covering it through a 1915(c) waiver, since covering the service through the State Plan will ensure that it is uniformly available throughout the State.

PATH Initiative - No comment.

Designated Health Program (DSHP) - No comment.

Low-Income Pregnant Women - No comment.

We look forward to our continuing work with the Department to effectively and equitably implement CalAIM, including any 1115 renewal, if approved.

Please contact me ([redacted]) if you have any questions about these comments or would like to meet to discuss them further.

Sincerely,

[redacted]

Kim Lewis
Director of California Policy
National Health Law Program

Sarah Nelson, 18 Reasons, Email received March 12, 2026.

Please see attached.

Thank you,
Sarah
--
Sarah Nelson (she/her)
[redacted]
Executive Director, 18 Reasons
Click here to make a donation in support of our free community programs
18 Reasons empowers our community with the confidence and creativity needed to buy, cook, and eat good food every day.

To: 1115waiver@dhcs.ca.gov
Subject Line: CalAIM Section 1115 Waiver – Public Comment

Dear California Department of Health Care Services,

Thank you for the opportunity to provide public comment on the *CalAIM Section 1115 Waiver Renewal*. I am writing to urge DHCS to remove arbitrary limits on Medically Tailored Meal (MTM) prescriptions and instead empower clinicians to determine the medically necessary duration of MTM services. I also urge DHCS to separate meals from groceries, as these two benefits serve different purposes and audiences. Finally, I ask DHCS to increase rate guidance for MTM, which is extremely low, and was actually lowered in December, causing plans to decrease their rates.

Currently, MTM services are capped at 12 weeks, with extensions considered on a case-by-case basis. While appropriate for short-term acute needs, this limit is not sufficient for patients with chronic nutrition-sensitive conditions, for whom longer-term nutritional therapy is evidence-based and essential to achieve meaningful health outcomes.

Examples include:

- **Type 2 diabetes mellitus:** Studies show that medically tailored diets can reverse diabetes and reduce HbA1c when sustained for months to years, not just 12 weeks (Lean et al., *Lancet*, 2018).
- **Pediatric obesity:** Effective interventions for children require at least 6–12 months of structured nutrition support alongside family engagement (Katz et al., *Pediatrics*, 2020).
- **Congestive heart failure & chronic kidney disease:** Diet modification with MTM reduces hospitalizations and improves outcomes over long-term periods (AHA/ACC Heart Failure Guidelines, 2022; KDIGO Nutrition Guidelines, 2020).

The duration and "dosage" of MTM services should be determined by the prescribing clinician, who best understands the patient's health status and goals. Arbitrary time limits risk interrupting care, limiting effectiveness, and exacerbating health inequities.

Recommendations:

1. Separate meals from groceries as two different benefits with different purposes and policies
2. Eliminate hard limits (e.g., 12 weeks) on MTM prescriptions in CalAIM.

3. Increase rates: the most recent DCHS rate guidance lowered rates for MTM services, despite the well-documented rising costs of food. We recommend increasing the rate guidance to start at $100 a week for food.
4. Authorize MTM services for the duration clinicians determine is medically necessary to manage chronic conditions or achieve clinical goals.
5. Clarify in CalAIM documentation that MTM can be both a short-term support post-hospitalization and a long-term therapeutic intervention.
6. Enforce health plan compliance with DHCS policies; policies are unevenly applied by health plans
7. Remove the burden of medical documentation from food providers for community-based or community-driven referrals: one of DHCS's objectives is to increase community-driven referrals;

Providing clinicians and food providers with more flexibility will allow California to fully realize the vision of the "food as medicine" movement, improving health outcomes, preventing costly hospitalizations, and supporting equity in nutrition-sensitive care.

Thank you for your consideration of this comment.

Sincerely,
Sarah Nelson
18 Reasons

References:

- Lean MEJ et al., *Primary Care-Led Weight Management for Remission of Type 2 Diabetes (DiRECT)*, *Lancet*, 2018;391:541-551.
- Katz DL et al., *Pediatric Obesity Prevention and Treatment Guidelines*, *Pediatrics*, 2020;145:e20193592.
- Heidenreich PA et al., *2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure*, *Circulation*, 2022;145:e895–e1032.
- Kidney Disease: Improving Global Outcomes (KDIGO) Clinical Practice Guideline for Nutrition in CKD, 2020.

Kate Ross, California Association of Health Plans, Email received on March 12, 2026.

Hello,

The plans appreciate and support DHCS's efforts to renew the CalAIM Section 1115 Waiver Demonstration. This feedback is intended to build on our progress and strengthen the delivery of services to Medi-Cal members across California. The plans recommend DHCS align the use of "continuity of care" in the 1115 waiver renewal application with the regulatory definition in APL 22-032. The plans also request guardrails for Community Supports to ensure program integrity and sustainability as well as plan flexibilities to address inappropriate utilization. Lastly, the plans request clarification on the rate and provider contract implications the recuperative care waiver authority change will have and request for DHCS to ensure that room and board remains a core component of the benefit.

Please let us know if you have questions or concerns.

Thank you,
Kate

Kate Ross
California Association of Health Plans
[redacted]
www.calhealthplans.org

Page #	Section/Subsection	Current Language	Comment/Recommended Change	Reason for the Change	Reviewers Name/Title/Organization	Date
N/A	N/A	N/A	The plan appreciates DHCS requesting the renewal of CalAIM, especially ECM and nearly all the Community Supports.	N/A	CAHP	3/12/2026
27	Section 3.1 – Reentry Services for Justice-Involved Populations 90-Days Pre-Release	"Improve access to services prior to release to improve transitions and continuity of care into the community upon release"	The plan recommends DHCS align with the broader concept of care continuity as described in page 58, rather than invoking the formal Continuity of Care construct to avoid regulatory confusion . "Continuity of Care" has a specific regulatory definition under APL 22-032 and is intended to allow certain members to temporarily continue care with out-of-network community providers when transitioning between delivery systems. It is not designed to support the continuation of services provided in a carceral setting. The Reentry initiative does not appear to intend for members to continue receiving services from correctional providers post-release.	Clarification	CAHP	3/12/2026
27	Section 3.1 – Reentry Services for Justice-Involved Populations 90-Days Pre-Release	"Improve connections between correctional systems and community-based service providers upon release to address physical and behavioral health care needs"	Stronger expectations are needed for individuals released from incarceration with significant and complex medical needs, including those leaving via compassionate release or with total care requirements (e.g., bedridden, paraplegic). In many cases referred to plans, the Plan Liaisons receive very short notice (sometimes only 5–8 days) to secure an accepting Skilled Nursing Facility (SNF). This timeframe is insufficient and is further complicated by limited access to medical records, the inability to conduct in-person clinical evaluations, and the fact that the member is often not yet active in AEVS at the time of referral. Meaningful care transitions for these members require earlier notification, more complete clinical information, and the ability to assess the individual prior to release.	Added Insights	CAHP	3/12/2026
35	Section 3.6 – Coverage for out of state former foster care youth	Section 3.6 – Coverage for out of state former foster care youth	The plan requests additional guidance which will be necessary to address coverage for former foster youth residing out of state up to age 26. As seen during the foster youth transition in some counties, plans enrolled new members who were actively receiving care from providers located far outside California, including Alaska, Montana, and New York. Clear expectations will be needed to address network access, care transitions, and continuity considerations in these circumstances.	Added Insights	CAHP	3/12/2026
42	Section 3.12 – Employment Supports	To further support expansion adults in obtaining or maintaining employment, and in alignment with CMS' priority of connecting adult expansion members to employment support services, California proposes to include Employment Supports as a Medi-Cal covered benefit under this Section 1115 Demonstration.	The plan requests clarification regarding whether the proposed new Employment Supports benefit will be administered by MCPs or whether it is being proposed as a county-operated program with direct state funding provided to participating counties. As drafted, the language is unclear on which entity would be responsible for the proposed benefit.	Clarification	CAHP	3/12/2026
41–44	Section 3.12 - Employment Supports	N/A	The plan supports the concept of employment supports to help members obtain/sustain minimum employment for Medi-Cal coverage, as well as targeting the adult expansion population to be the focus of this pilot. To be most effective, the initiative would need solid coordination of referrals from MCPs to counties. DHCS should seek feedback to inform furture gudiance that sets expectations for: Coordination between MCPs and county/other agency (via MOU or other tools) to define the counties that may be part of pilot/s, and an expected timeline for implementation.	Clarification	CAHP	3/12/2026
44–47	Section 3.13 - BridgeCare Pilots	N/A	The plan request that DHCS consider the following as Discretionary Services available to this population (the list below are the Community Supports that prevent skilled nursing facility stays): -Assisted Living Facility Transitions -Environmental Accessibility Adaptations -All Housing-Related Community Supports	Clarification	CAHP	3/12/2026
48	Section 4 - Recuperative Care and Short-Term Post Hospitalization Housing	"…reductions, respectively, in aggregate PMPM costs due to decreases in inpatient, outpatient, ED, and long-term care costs."	The Plan requests DHCS' clarification on whether services delivered through Street Medicine programs are included within the "outpatient" category for purposes of this analysis.	Clarification	CAHP	3/12/2026
48–49	Section 4-Recuperative Care & Short-Term Post-Hospitalization Housing	N/A	Moving recuperative care under a different authority may lead to removal of the room and board component of recuperative care. Without secured payment for the room and board component, the core purpose of recuperative care is removed and members will either remain in the hospital or be discharged without secured shelter. This will impact a very vulnerable population as hospital discharge planners will lose the ability to safely discharge an unhoused Member from the hospital. The plan recommends DHCS ensure that room and board remains a core component of recuperative care and that services are not interrupted for Medi-Cal members.	Added Insights	CAHP	3/12/2026

48-49	Section 4 - Recuperative Care and Short-Term Post Hospitalization Housing	As Medicaid policy does not permit the coverage of room and board outside of 1115 authority, California will pursue modifications, as necessary, to cover recuperative care in alignment with federal requirements.	The plan requests clarification on how the room and board component will be excluded under the new authority and how this change will affect plan rates and contracts. The plan also requests that health plans be included in the development of these policies to ensure operational feasibility and alignment with program requirements as the proposed changes will impact how the refined service is operationalized.	Added Insights	CAHP	3/12/2026
48-49	Section 4 – Recuperative Care and Short Term Post Hospitalization Housing	DHCS seeks to create a model for recuperative care that incorporates the levels of care offered under both recuperative care and short-term hospitalization housing..."	Will forthcoming guidance require Recuperative Care facilities to be Community Care-Licensed in order to directly support Members with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)?	Clarification	CAHP	3/12/2026
48-49	Section 4 – Recuperative Care and Short Term Post Hospitalization Housing	General	The Plan requests DHCS more tightly align eligibility criteria for Short-Term Post-Hospitalization Housing (STPHH) as it becomes folded into a single, integrated recuperative care model. Specifically, eligibility should prioritize individuals transitioning directly from acute care settings, rather than relying on the broader recuperative care eligibility framework. This distinction is critical. Plans need DHCS to tighten recuperative care's eligibility criteria and ensure it is similar to STPHH or there is a significant risk for discontinuing recuperative care altogether due to cost ineffectiveness.	Added Insights	CAHP	3/12/2026
51	Section 4 – CBAS	Section 4 – CBAS	The plan requests DHCS clarify if the transition from the 1115 demonstration to 1915(i) authority includes CBAS Emergency Remote Services? CBAS is a facility-based benefit that provides skilled nursing, social services, therapies, personal care, nutrition, care coordination, and transportation. Emergency Remote Services, by contrast, are not facility-based, do not deliver any of the core CBAS services, and appear duplicative of Enhanced Care Management (ECM) and other Community Supports already available under the CalAIM program.	Clarification	CAHP	3/12/2026
58-59	Section 5 - Reentry Services for Justice-Involved Populations 90-Days Pre-Release	The JI Screening Portal, intended as a communication and documentation tool, has presented usability challenges, requiring manual data entry and improvements to better support cross-system coordination. Changes are underway to address some of the challenges identified by the counties.	The intent of the JI initiative is to ensure continuity of care for individuals upon release from incarceration, including activation of Medi-Cal coverage and access to necessary medications. However, upon release, ECM providers frequently encounter instances in which a member's Medi-Cal eligibility appears to remain on hold, as though the individual is still incarcerated. The Plan understands that one contributing factor may be changes to release dates, which can complicate timely updates to eligibility systems. This issue has delayed essential care for justice-impacted members and created administrative burdens for ECM providers. The plan commends DHCS for its commitment to cross-system coordination and requests DHCS' assistance in reviewing the JI portal to ensure it is properly interfacing with DPSS systems.	The reason for this change is that improper Medi-Cal eligibility status—specifically, eligibility appearing as inactive due to individuals being incorrectly listed as still incarcerated is causing delays in member care.	CAHP	3/12/2026
60	Section 5 – Managed Care Plan Transition	"Maintain or improve overall access to and continuity of care."	"Continuity of Care" has a specific regulatory meaning under APL 22-032 and is intended to allow certain members to temporarily continue care with out-of-network providers. The language should clarify that Continuity of Care protections apply only to select services and circumstances as defined in the APL, rather than implying broad applicability across all services.	Edit Needed	CAHP	3/12/2026
Page 63	Section 6 - Table 2. Evaluation Hypotheses	"Employment Supports will support continuity of care"	The phrase should be revised to "care continuity" to avoid confusion with the formal Continuity of Care regulatory protections defined in the APL.	Edit Needed	CAHP	3/12/2026
page 65	Section 6, Table 2. Evaluation Hypotheses	"Continuity of care from incarceration to community"	The phrase should be revised to "care continuity" to avoid confusion with the formal Continuity of Care regulatory protections defined in the APL.	Edit Needed	CAHP	3/12/2026
N/A	N/A	General	The Plan requests that DHCS publish level-of-care definitions, minimum service components, and rate-setting parameters, plus compliance pathways for room/board separation as services shift from 1115 to ILOS. The Plan requests DHCS to provide a CBAS transition glidepath (authorizations, medical necessity criteria under 1915(i), grievance/appeal routing). Employment Sevices: The role of MCPs is unclear. The Plan requests that DHCS Define MCP responsibilities (referral vs contracting vs documentation), data elements required for WCE adjudication, provider payment model/IGT flow, and program KPIs (e.g., participation, placement, retention) with reporting back to MCPs.	N/A	CAHP	3/12/2026
N/A	N/A	General	The Traditional Healer and Natural Helper benefit remains an essential component of CalAIM, particularly for Tribal communities working to strengthen culturally grounded approaches to health and wellness. Over the past two years, much of the focus has been on Tribal Health Programs opting into the benefit and establishing the internal processes needed to navigate, operationalize, and sustain it effectively. This implementation period has largely centered on capacity-building, education, and infrastructure development rather than measurable service outcomes. Because of this, additional time is needed to fully understand the benefit's true impact, ensure consistent utilization, and support Tribal Health Programs in maturing their workflows. The plan requests the consideration to extend the time frame to allow the state and Tribal partners to gather meaningful data, assess long-term effects, and continue refining the benefit in a way that honors cultural practices and supports whole-person care.	N/A	CAHP	3/12/2026

N/A	N/A	General	The plan recommends an explicit focus on targeting high-risk members to drive Community Supports (CS) outcomes and long-term sustainability. Why targeting matters: A relatively small subset of high-risk members accounts for a disproportionate share of CS utilization and overall medical spend, particularly for housing-related and long-duration supports. Broad, untargeted availability of CS can dilute impact and increases the risk of low substitution value, duplication with state plan benefits, and escalating costs. Prioritizing CS for members most likely to substitute for acute, institutional, or long-term care better aligns with DHCS expectations around medical appropriateness, cost-effectiveness, and sustainability.	Added Insights	CAHP	3/12/2026
N/A	N/A	General-Community Supports	For program sustainability beyond 2026, Community Supports must be clinically targeted, time-limited where appropriate, operationally feasible, and there must be regulatory alignment. At a high level, we recommend the following: -Guardrails for Program Integrity and Sustainability: As enrollment and utilization continue to grow, clear guardrails and MCP flexibilities to address inappropriate utilization and cost escalation must be in place. -Regulatory Alignment: Align DMHCS and DHCS oversight. Ongoing DMHC review of CS appeals and regulatory friction when CS are interpreted as "benefits" rather than targeted in-lieu-of services must be addressed. -MCP Authority and Flexibility: Authorize MCP flexibility for sustainability and proper utilization. Allow MCPs to limit the scope of services based on clinical appropriateness and program effectiveness.	Community Supports Recommendations	CAHP	3/12/2026
N/A	N/A	General-Community Supports/Home modifications	The plan notes that the cost of needed home modifications frequently goes above $7,500, requiring use of an exception process that is administratively burdensome and costly. The plan recommends DHCS provide additional guidance that specifies the type and scope of services covered under this CS so that there is less of an expectation from referring parties/members that they will automatically be put into an exception process. (i.e. ramps and vertical lifts are often requested, and these are never within the $7500 maximum)	Community Supports Recommendations	CAHP	3/12/2026
N/A	N/A	General-Community Supports/Medically tailored meals	The Policy Guide revisions added oversight requirements for MCPs related to dietary/nutritional value of food provided, etc that go well beyond MCP determination of member eligibility for the service, which added administrative burden. Policy Guide suggests that eligible conditions are highly expansive, with very little room for MCPs to to focus on specific diagnoses or conditions ("nutrition-sensitive conditions" terminology leaves a lot of gray area). The plan requests clearer guidance on nutrition-sensitive conditions or criteria that would target those that would most benefit from the service, to increase likelihood of positive outcomes.	Community Supports Recommendations	CAHP	3/12/2026
N/A	N/A	Community Supports-Asthma remediation	Complexity for the MCPs and providers due to new policy re asthma remediation (voluntary CS) and asthma preventive services (benefit) under the CHW benefit. The plan recommends DHCS make this CS a benefit to avoid the piecemeal nature of services that impacts not only administrative burden for MCPs and Providers, but also over-complicates access to care for members.	Community Supports-Asthma remediation	CAHP	3/12/2026
N/A	N/A	General	Minimum-Necessary Guardrails: The plan recommends DHCS reiterate that data exchanges under CalAIM and DxF/AB 133 must be scoped to the permitted purpose and to the minimum necessary data needed to accomplish that purpose (including avoiding blanket "full file" requests absent clear authority and purpose-specific justification).	Member Privacy protections	CAHP	3/12/2026
N/A	N/A	General	Standardized Data Exchange Specifications for High-Risk Use Cases: For Justice-Involved Reentry and SUD-related workflows, the plan recommends DHCS provide clear, consistent specifications for the data elements required, the permitted recipients, and expected safeguards to reduce variability and prevent inconsistent interpretation across counties and partners.	Clarification-Required data elements for high-risk use cases	CAHP	3/12/2026
N/A	N/A	General	Partner Governance Expectations: Where new partner types are involved (e.g., Traditional Healers/Natural Helpers, Employment Supports, BridgeCare Pilots), the plan recommends DHCS clarify governance expectations for secure handling, role clarity, and appropriate agreements to ensure member data is protected consistently.	Member data protections	CAHP	3/12/2026
N/A	N/A	General	Operational Clarity on Required vs. Optional Sharing: DHCS should clearly delineate what data sharing is mandatory for participation or compliance versus what is optional or locally determined, including how plans should respond to partner requests for data that exceed the minimum necessary.	Clarification-Required vs. optional data sharing	CAHP	3/12/2026

Mark Humowiecki, National Center for Complex Health and Social Needs, Email received on March 12, 2026.

Please see our comments, both attached as PDF and copied below in the email. Thank you for the opportunity to submit our reflections.

Respectfully submitted,

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PUBLIC COMMENT
California Advancing and Innovating Medi-Cal (CalAIM)
Section 1115 Demonstration Five-Year Renewal Application
Submitted to: California Department of Health Care Services (DHCS)
Email: 1115Waiver@dhcs.ca.gov
Subject: CalAIM Section 1115 & 1915(b) Waivers
Date: March 12, 2026
Submitted by: Jim Hickman, Principal & Chief Catalyzer, Hickman Strategies LLC | Mark Humowiecki, JD, General Counsel & Senior Director, National Center for Complex Health and Social Needs, Camden Coalition
Capacity: Hickman Strategies LLC: CalAIM Subject Matter Expert | Principal CalAIM Advisor & National Center Advisor, Camden Coalition | Camden Coalition: Approved PATH Technical Assistance Vendor; PATH CPI Facilitator, Merced, Southeast, and Coastal Regions
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INTRODUCTION AND STATEMENT OF INTEREST
Hickman Strategies LLC and the Camden Coalition submit these comments jointly in strong support of the CalAIM Section 1115 demonstration five-year renewal and to offer specific recommendations grounded in more than three decades of healthcare transformation leadership and more than two decades of national complex care implementation.

This submission reflects the combined institutional standing of both co-submitters. Jim Hickman brings direct field experience as a CalAIM Subject Matter Expert and serves as Principal CalAIM Advisor and National Center Advisor with the Camden Coalition — where, in our capacity as PATH Collaborative Planning and Implementation (CPI) facilitator for the Merced, Southeast, and Coastal regions, we have facilitated structured cross-sector collaboration across multiple California counties since November 2022. The Camden Coalition is a nationally recognized leader in complex care, an approved PATH Technical Assistance Marketplace vendor, and the organizational home of the Ecosystems of Care framework and Ecosystem Assessment Tool, which has been adopted by PCG as the reporting framework for PATH CPI facilitators in 2026. Camden Coalition also organizes an annual national complex care conference, which was held in Sacramento in 2022 and will take place in Oakland in the fall, that helps inform our perspectives on CalAIM implementation and complex care policy and practice nationally. Kathleen Noonan, Camden Coalition CEO, also serves as a member of the University of California Board of Regents' Health Services Committee. Our combined experience — locally, nationally, and most importantly in California — informs the recommendations throughout this comment. As both CPI facilitator and co-submitter of this public comment, we acknowledge a dual role: we are implementation partners to DHCS and California's counties, and we are also stakeholders with a direct interest in the renewal's design. We have made every effort to ensure our recommendations reflect what California's Medicaid members need — not what is administratively convenient for any implementation partner, including ourselves. This submission also draws on the August 2025 Comprehensive Recommendations Memorandum submitted by Jim Hickman [redacted] in response to the DHCS Medi-Cal Transformation Concept Paper.

CalAIM represents the most ambitious whole-person care transformation in California Medicaid history. The renewal before us is not simply an administrative continuation — it is a strategic inflection point. H.R. 1, enacted July 4, 2025, places up to $30 billion annually in federal Medicaid funding at risk for California and, according to DHCS estimates, could result in up to 3.4 million Californians losing Medi-Cal coverage. [DHCS, California Health Care Foundation (October 2025); Governor Newsom (June 27, 2025)] The question is not whether to renew CalAIM, but how to build the renewal period into a platform for durable, equitable transformation that can withstand this challenging federal funding environment.

In the interest of full transparency, the co-submitters disclose the following relationships separately. [redacted]

[redacted] Readers should note that Recommendation 2.2 — which proposes that MCPs fund shared technical assistance and cross-sector convening infrastructure as a permissible managed care administrative expense — describes a category of services Camden currently provides under PATH and in other states. Camden has a direct institutional interest in the continuation of backbone coordination funding beyond the DSHP authority period. As both implementation partner and public commenter, Camden Coalition acknowledges this dual role and affirms that its recommendations reflect independent analysis of what is required for effective cross-sector systems to improve whole-person health for Medicaid members with complex biopsychosocial needs — not what is favorable to its own implementation contracts. The recommendations in this comment reflect the independent professional judgment of both co-submitters, grounded in combined field experience and submitted because they reflect what California's Medicaid members need from this renewal. Readers should weigh these disclosures and judge accordingly.

CORE THESIS: Technology enables — but relationships transform. The renewal period must invest deliberately in the infrastructure that sustains cross-sector relationships and collaboration as it does in data systems and clinical protocols. The Camden Coalition's Ecosystems of Care framework — grounded in more than two decades of building infrastructure for communities serving people with complex needs — is the governing design principle: coordination across stakeholders, sustained by dedicated investment in backbone infrastructure, is what makes whole-person care operationally real.

DHCS RENEWAL STRATEGY: The decision to embed ECM and twelve Community Supports in permanent managed care authorities — rather than renewing them exclusively as 1115 demonstration programs — is the most consequential structural choice in this renewal. These programs are not experiments. They are the operational infrastructure of whole-person Medi-Cal. Our recommendations address what it takes for permanent authority to mean permanent access: at scale, for every eligible member, through a provider network that is both accountable and intact.

SECTION 1: BROAD SUPPORT FOR CORE CALAIM CONTINUATION

We strongly support DHCS's renewal request for the following authorities, which form the foundation of California's whole-person care transformation:

- Enhanced Care Management (ECM) for high-need, high-cost populations
- Community Supports (including the two 1115-authorized services: Housing Transition Navigation Services and Housing Tenancy and Sustaining Services)
- In Lieu of Services (ILOS) framework for the remaining twelve Community Supports under 42 CFR Section 438.3(e)(2)

- Pre-release and post-release Medi-Cal services for justice-involved populations
- Global Payment Program for Public Health Care Systems
- Delivery system authorities through the 1915(b) waiver (managed care, specialty mental health, DMC-ODS, dental managed care)
- BH-CONNECT authority for behavioral health continuum services

The evidence base supporting these initiatives is now substantial. Community Supports have moved from pilot to statewide mandate. ECM operates as a statewide benefit across all 58 counties, though the California Legislative Analyst's Office (LAO) has documented significant variation in provider network depth and utilization rates across plans and counties — a reality the renewal evaluation framework should address. [LAO Report 5003, 2025] The evaluation design approved by CMS confirms a rigorous framework for measuring what works. We urge DHCS to ensure the renewal application communicates this evidence base with specificity, as CMS will face questions from federal policymakers about the return on California's investment.

EVIDENCE: CalAIM's HRSN Community Supports Protocol (CMS-approved January 2025) establishes the authorization infrastructure, data exchange requirements, and evaluation framework that position California to demonstrate impact at scale. This is foundational — the renewal protects it.

SECTION 2: PATH INFRASTRUCTURE — DOCUMENTING WHAT WE BUILT, PROTECTING WHAT IT PRODUCED

The Providing Access and Transforming Health (PATH) initiative — authorized under DSHP funding now ending — created collaboration infrastructure that CalAIM's clinical programs depend upon but cannot replace on their own. We have facilitated PATH CPI meetings across multiple California counties and can speak with specificity about what PATH produced.

The UCLA and RAND independent evaluation of PATH — required by the 1115 demonstration and currently underway — has documented very substantial capacity building: significant increases in the number of ECM and Community Supports users, contracted providers, and broad adoption of CalAIM programs across counties. [UCLA/RAND CalAIM PATH Evaluation, 2025-2026] This is the government's own evaluation confirming the infrastructure value we document below. Our recommendation for structured PATH transition documentation is a direct response to that finding: what the evaluation confirms was built should not be allowed to dissipate without a record of what it produced and how it can be sustained and evolved.

QUESTION: What did PATH produce, and what is at risk when it sunsets at the end of the current waiver?

EVIDENCE: PATH funded cross-sector convening, shared data infrastructure, and collaborative planning capacity that allowed counties to transition WPC pilots into ECM and Community Supports at scale. The EDIE digital safety net deployment connecting multiple hospitals — identifying thousands of shared patients — exemplifies the kind of system connecting infrastructure PATH enabled. PATH's CPI facilitation created county level tables where managed care plans, CBOs, behavioral health agencies, housing departments, and justice partners could develop shared workflows, not just data agreements.

RECOMMENDATION: DHCS should use the renewal period to document the PATH infrastructure investment in measurable terms — counties convened, shared patients identified, cross-sector workflows formalized, ECM ramp-up rates in counties with strong CPI infrastructure, ECM enrollment, and other measures that show uptake versus those without. This documentation serves two purposes: it demonstrates CalAIM ROI to CMS and it creates a baseline of the current connective tissue within regional ecosystems while facilitating efforts to sustain and grow that infrastructure using alternative financing (MCP-funded TA, community-sustained convening, philanthropic bridging).

The Camden Coalition has facilitated PATH Collaborative Planning and Implementation convenings across the Merced, Southeast, and Coastal regions since November 2022. In that time, we observed county ecosystems move from parallel organizational siloes to coordinated cross-sector collaborators — and we have observed what happens when the scaffolding of facilitation is removed without a successor infrastructure in place. The documentation requirement in Recommendation 2.1 is not a theoretical proposal. It reflects what Camden has seen built — the trusted relationships, shared data practices, and cross-sector accountability structures that take months and years to construct — and what we have seen become fragile when grant cycles end without a transition plan. California has built something real under PATH. This recommendation is about ensuring the renewal period captures what was built, so that it can be sustained.

For example, in early 2023, the Merced Community Action Agency (Merced CAA) began attending Merced CPI meetings. After participating in CPI presentations and discussions, Merced CAA developed a stronger understanding of the CalAIM opportunity and the long term value it could create for both the organization and the populations it serves. Through the CPI, Merced CAA was connected with the managed care plan, CCAH, and ultimately enrolled as both an Enhanced Care Management (ECM) provider and a Community Supports Housing Trio provider. They worked closely with CCAH to align on service capacity and received an IPP grant to purchase additional space to support program growth. Merced CAA then became a leader within the Merced CPI, helping coach other community-based organizations on the opportunity and the steps needed to be successful. According to the latest implementation report, Merced now has among the highest penetration rates for services among individuals experiencing homelessness, and the highest among counties that did not previously participate in Whole Person Care.

While Merced CAA, other housing providers, and CCAH deserve the credit for this success, the CPI table served as a catalyst to activate and support this community of providers.

Recommendation 2.1: Establish a PATH Transition Documentation Requirement

We recommend DHCS establish a structured documentation requirement in the renewal application that captures: (1) county-level ECM and Community Supports ramp-up rates correlated with PATH CPI participation; (2) cross-sector agreements and workflows formalized under PATH; and (3) data infrastructure investments that will persist post-PATH. This record serves federal accountability and informs the design of successor collaboration infrastructure.

Recommendation 2.2: Create a Managed Care Collaboration Infrastructure Mechanism

With DSHP authority unavailable for PATH renewal, the collaboration infrastructure it funded must find a new home. We recommend DHCS explore whether the renewal STCs can authorize MCPs to fund shared technical assistance and cross-sector convening as a permissible managed care administrative expense. The Camden Coalition's Ecosystems of Care framework — the intellectual foundation of PATH CPI facilitation — defines backbone coordination explicitly as a sustainability domain, not overhead: infrastructure that requires dedicated investment like any other infrastructure if it is to survive funding transitions. [Camden Coalition, Ecosystems of Care Framework; Camden Coalition Ecosystem Assessment Tool, 2024] The policy rationale for the renewal is straightforward: collaboration infrastructure that enables better ECM and Community Supports performance is a legitimate managed care investment. California's MCPs are well-positioned to sustain CPI-style tables in the counties where they operate.

DHCS DATA + FIELD CONFIRMATION: DHCS has identified a concrete, verifiable measure of backbone infrastructure progress: the percentage of cross-sector partners who text or call each other directly when issues arise — without routing through a convener. In DHCS's own webinar data, 47% of partners communicate through formal channels only; just 22% have reached the level of direct peer to peer communication that signals real collaboration infrastructure. [DHCS, "The Fierce Urgency of Community Partnerships," 2025] In our capacity as PATH CPI facilitators, we observe this same pattern across county tables. The Camden Coalition's Ecosystem Assessment Tool — which formalizes the Ecosystems of Care framework — places this measure within its 'teaming and collaboration' domain: backbone infrastructure can enable progress that is visible to MCPs, investors, and county leadership, and that precedes every coordinated outcome on a shared dashboard. Moving from 22% to 50% direct-contact relationships is not a soft goal. It is a governance milestone. Trust is infrastructure — and unlike data systems, it cannot be reconstructed quickly if it sunsets now. We cannot afford to rebuild it during a coverage crisis. Technology enables the identification of who needs to be reached. Relationships determine whether they get there. The PATH Transition Documentation Requirement in Rec 2.1 should establish this DHCS-measured baseline as a required

metric — and the renewal STCs should make it a reportable standard going forward. [Camden Coalition Ecosystem Assessment Tool, 2024; Hickman, CalAIM Field Notes SE-06, February 2026]

SECTION 3: COMMUNITY SUPPORTS DATA INFRASTRUCTURE — ORCHESTRATION AS THE CORE STRATEGY

DHCS has framed the next phase of CalAIM as a deliberate shift from infrastructure-building (2022-2026) to utilization, quality, and performance — what the renewal application describes as the maturation of Community Supports from demonstration to embedded managed care benefit. [DHCS CalAIM Concept Paper, July 2025] We endorse this framing entirely, and our recommendations in this section are designed to operationalize it.

The California Budget & Policy Center has documented that Community Supports has already reached approximately 430,000 Californians. [California Budget & Policy Center, 2026] That number is a foundation to build on — and it makes the utilization gap more, not less, urgent to close. Field observation across our CPI facilitation engagements in multiple California counties, corroborated by the LAO's 2025 analysis, suggests that ECM enrollment of eligible members remains substantially below what the program's design would support. [LAO Report 5003, 2025] 430,000 members reached is a real achievement. The architecture capable of reaching the full eligible population is what the renewal period must invest in.

And the stakes of that investment have never been higher. Under H.R. 1, every member whose Medi-Cal coverage lapses is an ECM care plan that dies. A Community Supports referral that resets. A trusted relationship that took months to build, severed by an administrative gap that policy alone did not close. The data infrastructure recommendations in this section are not technical upgrades — they are the mechanisms by which 430,000 becomes one million, and by which coverage continuity becomes a system property rather than a provider-by-provider aspiration.

The CMS-approved HRSN Community Supports Protocol (Attachment X, January 2025) establishes specific data exchange requirements: Member Information Sharing Guidance, Authorization Status Files, Provider Transmission Files, and Data Exchange Framework integration. These requirements are the right architecture. The challenge is the gap between what the Protocol requires and what is actually flowing between MCPs and CBOs on the ground.

QUESTION: Why is data exchange between MCPs and Community Supports providers still inconsistent four years into CalAIM implementation?

EVIDENCE: Our field facilitation across multiple counties reveals a consistent pattern: the standards exist, but the implementation supports — technical assistance, standardized integration pathways, and workflow training — has not kept pace with the mandate. Community Supports providers, particularly smaller CBOs, face documentation burdens that consume capacity that should be directed toward member services. MCPs, operating across multiple counties with different CBO ecosystems, lack standardized integration pathways that would allow technology platforms to connect consistently. The result is that Community Supports authorizations happen, but the closed-loop referral data that would allow MCPs to improve targeting and CBOs to demonstrate impact is incomplete.

RECOMMENDATION: The renewal period is the opportunity to establish orchestration as the governing framework: connecting the systems that exist rather than mandating new ones, building shared integration standards that allow any certified Community Supports platform to connect to any MCP, and investing in the CBO data readiness that makes participation sustainable.

Recommendation 3.1: Establish a Community Supports Data Readiness Fund

We recommend DHCS include in the renewal application a request for authorization of a Community Supports Data Readiness Fund — analogous to the data exchange investments authorized in other state 1115 demonstrations — that provides CBOs with the technical assistance and infrastructure support needed to meet HRSN Protocol requirements. A $10-20M fund administered through DHCS or a qualified intermediary would create a significant return on investment through improved closed-loop referral rates and more accurate Community Supports outcome data.

Recommendation 3.2: Extend HRSN Data Standards to All ILOS Community Supports

The approved Protocol applies specifically to the two 1115-authorized Community Supports. We recommend DHCS use the renewal period to establish equivalent data exchange standards for all twelve ILOS Community Supports. Consistent standards across the full menu will enable statewide learning, reduce the MCP compliance burden (one standard, not thirteen), and create the data infrastructure needed for the evaluation design to capture Community Supports impact at scale.

ORCHESTRATION PRINCIPLE: The goal is not more data systems — it's connecting the ones we have. A single authorization-to-outcome data thread from MCP referral through CBO delivery to health outcome is more valuable than twelve separate reporting streams. This is the Camden Coalition's Ecosystems of Care principle in practice: coordination infrastructure, not digitization, is what closes the gap between authorization and outcome.

SECTION 3.5: RECUPERATIVE CARE AND THE ROOM-AND-BOARD TRANSITION

RISK

The renewal application confirms that Short-Term Post-Hospitalization Housing (STPH) will be discontinued as a standalone Community Support and incorporated into an expanded Recuperative Care model under ILOS managed care authority, effective January 1, 2027. [DHCS CalAIM 1115 Renewal Application, 2026] We support the move to a more durable managed care authority.

We raise one implementation concern that warrants attention before the renewal is finalized: federal ILOS rules under 42 CFR Section 438.3(e)(2) prohibit reimbursement for room and board. The current STPH benefit includes a housing cost component that the ILOS-based Recuperative Care model may not be able to fully replicate. We recommend DHCS conduct a gap analysis — before final submission to CMS — of the difference between what STPH currently covers for post-hospitalization housing and what an ILOS-authorized Recuperative Care model can cover under the room-and-board prohibition. If a gap exists, we urge DHCS to identify a companion state plan mechanism or supplemental state funding that preserves the member-facing service. Structural authority improvements should not produce functional service reductions for members most in need of stable post-hospital housing.

SECTION 4: EMPLOYMENT SUPPORTS — IMPLEMENTATION ARCHITECTURE FOR MEMBER SUCCESS

The Employment Supports request is the most strategically significant new initiative in the renewal application. We strongly support DHCS's decision to establish a proactive member success framework for employment services. A critical legal and strategic point: H.R. 1's work requirements — effective January 1, 2027 — are a federal statutory mandate that cannot be waived under Section 1115 authority. [Health Management Associates, December 2025; KFF, July 2025] California's Employment Supports request is therefore not an alternative to work requirements; it is the infrastructure for implementing them in a way that protects coverage for members who are eligible or who qualify for an exemption. We offer the following implementation architecture recommendations.

QUESTION: What determines whether Employment Supports becomes a genuine member success pathway versus a bureaucratic compliance exercise?

EVIDENCE: The evidence from states that have implemented community engagement requirements — including Arkansas, Georgia, and Michigan — indicates that outcomes are strongly shaped by implementation architecture. States where MCPs, CBOs, workforce agencies, and county eligibility systems operated in coordinated workflows achieved substantially higher engagement rates; states where systems operated independently saw

substantially higher disenrollment rates, even among members who were technically eligible. [Urban Institute, Medicaid Work Requirements Research, 2019-2023; KFF State Medicaid Community Engagement Requirements Analysis] The difference was not member motivation or eligibility — it was system design.

RECOMMENDATION: Employment Supports must be designed from the start as an integrated workflow, not a standalone benefit. The critical design decisions are: (1) how Employment Supports providers connect to ECM care plans; (2) what data flows between workforce agencies and MCPs; (3) how exemption processes are operationalized to be accessible, not just technically available; and (4) how the system prevents coverage loss for members who are engaged but face barriers the system hasn't yet resolved.

Recommendation 4.1: Support County Readiness and Establish a Statewide Exemption Floor

The renewal application describes Employment Supports as a voluntary initiative for counties or county-based entities — a design we support as consistent with California's county administered service architecture. [DHCS CalAIM 1115 Renewal Application, 2026] We recommend DHCS supplement the county opt-in design with two elements: (1) a County Employment Supports Readiness Initiative — targeted technical assistance and planning support for counties that wish to participate but face infrastructure barriers, ensuring that the program's benefits are accessible to members regardless of which county they live in; and (2) a set of statewide floor requirements, applicable in all 58 counties regardless of Employment Supports participation, specifically around proactive outreach and screening for work requirement exemptions.

The county opt-in architecture is sound — and it makes the exemption floor more important, not less. Where counties choose not to participate, eligible members still carry the risk of a work requirement. The statewide exemption screening requirement is what ensures that risk does not fall unevenly on the members least equipped to navigate it alone.

Recommendation 4.2: Invest in Proactive Exemption Processing — In All Counties

The exemption categories in H.R. 1 are broad — caregiving responsibilities, disability, housing instability, among others. The implementation risk is that members who qualify for exemptions lose coverage because the exemption process is difficult to navigate — and DHCS's own implementation planning makes this risk concrete: of the approximately 2.8 million new adult group members expected to require manual verification when automated ex parte checks fail, DHCS estimates that up to 50% could lose coverage from administrative burden alone — not because they are ineligible, but because the system cannot reach them in time. [DHCS All-Comer Webinar, Tyler Sadwith, 2026; Hickman, CalAIM Field Notes SE- 06, February 2026] This risk exists whether or not a county has opted into Employment Supports. We recommend DHCS establish, in the renewal STCs, a requirement that MCPs proactively screen members for exemption eligibility and

document that screening before any coverage action related to work requirement non-participation, statewide and without exception. The alternative is coverage loss at scale for people the program is designed to serve.

Recommendation 4.3: Build a Community-Based Workforce Partnership Infrastructure in Opt-In Counties

In counties that opt into Employment Supports, DHCS should establish a certification pathway for CBOs — particularly those already providing Community Supports — to deliver Employment Supports services. Organizations already trusted by Medi-Cal members for housing, food, and transportation support are natural employment support partners. We also recommend that MCP referral protocols in opt-in counties connect Employment Supports to ECM care plans for members enrolled in both, ensuring employment goals are a documented element of the member's ECM assessment rather than a parallel compliance track. Camden Coalition has long included employment as a core domain of care planning for even those individuals with the most complex needs.

SECTION 5: BRIDGECARE PILOTS — THE INSTITUTIONAL DIVERSION CASE

We strongly support the BridgeCare Pilots request and recommend DHCS frame this initiative in the renewal application with specific emphasis on institutional diversion and total cost of care reduction. In the current federal environment, HCBS investments are most likely to secure CMS approval when framed as alternatives to more expensive institutional placement — not primarily as quality-of-life or social determinants investments.

QUESTION: What is the strongest framing for BridgeCare that will resonate with the current CMS posture?

EVIDENCE: The CMS Independence at Home Demonstration documented $3,500 per member per year in savings through reduced readmissions for older adults receiving homebased primary care. [CMS Independence at Home Demonstration Evaluation, Avalere Health, 2023] The PACE program — which BridgeCare draws from — has 30+ years of evidence showing that comprehensive home and community-based services delay or prevent nursing facility placement. [Ghosh et al., Health Affairs, 2015; CMS PACE Evaluation Reports] California's Medi-Cal nursing facility costs average more than $114,000 per member per year— more than $312 per day — according to Justice in Aging. [Justice in Aging, cited in CalMatters, June 2025] A BridgeCare investment of $200/month per member is cost-effective against even a modest reduction in nursing facility days.

RECOMMENDATION: Position BridgeCare explicitly as an institutional diversion strategy in the renewal application narrative. Quantify the avoided institutional cost. Establish

evaluation metrics that measure nursing facility placement rates, readmission rates, and total cost of care — not just process measures. This framing is both accurate and strategically aligned with a CMS that prioritizes value and cost containment.

Recommendation 5.1: Establish BridgeCare-ECM Integration for Complex Older Adults

We recommend the BridgeCare pilot design require coordination protocols with ECM for dually eligible members. Older adults with complex health needs who qualify for both BridgeCare and ECM represent the highest-cost cohort — and the greatest opportunity for total cost of care reduction. Integrating BridgeCare home modification, personal care, and respite services with ECM care coordination will generate the outcome data that supports statewide expansion.

Recommendation 5.2: Include Caregiver Support as a BridgeCare Core Component

The evidence is clear that caregiver burnout is a primary driver of nursing facility placement for older adults with complex needs. We recommend BridgeCare include structured caregiver support — respite care, navigation, training — as a core component alongside member-directed services. This is consistent with the CalAIM dyadic services model for children's care and extends the same logic to older adult care.

SECTION 6: REENTRY SERVICES — ALL-COUNTY READINESS AND THE IT INFRASTRUCTURE GAP

The all-county mandate for pre-release Medi-Cal services by October 2026 is a significant implementation challenge for counties that are just beginning this work. As a CPI facilitator working across counties at different stages of CalAIM readiness, we offer targeted recommendations for the renewal period.

Early evaluation of the Justice-Involved Reentry Initiative — including RAND's analysis of focal counties — documents strong early results: approximately 35,000 individuals identified as eligible and 64,500 pre-release services delivered in the program's first year of operation, with evidence of improved care transitions and growing cross-system coordination among corrections, behavioral health, and community providers. [RAND CalAIM Evaluation, 2025; DHCS CalAIM Evaluation Highlights] These results confirm the strong foundation described in the renewal application — and they also underscore the infrastructure investment required. This level of cross-system coordination was not spontaneous; it was built through PATH-funded capacity development that is now sunsetting. The renewal must account for what replaces it.

QUESTION: What implementation barriers are preventing counties from achieving the all-county pre-release mandate?

EVIDENCE: Field observations across multiple counties identify three consistent barriers: (1) data matching — connecting CDCR and county jail identifiers to Medicaid records requires IT investment that many counties have not yet made; (2) warm handoff infrastructure — the relationship between pre-release planners and community-based providers who receive individuals post-release requires active development, not just referral protocols; and (3) MCP-corrections agency partnership formalization — the data sharing agreements and care coordination workflows between MCPs and corrections settings are at varying levels of development across counties.

RECOMMENDATION: The renewal application should include explicit performance metrics for the all-county rollout: percentage of eligible individuals receiving pre-release assessments, Medi-Cal enrollment rates at release, 30-day and 90-day healthcare engagement post-release. The RAND evaluation focal counties provide a learning laboratory — the STCs should establish a mechanism for rapid learning dissemination to the remaining counties.

Recommendation 6.1: Authorize Reinvestment Funds for Warm Handoff Infrastructure

STC 9.11's reinvestment requirement — that new FFP generated from previously-state-funded carceral services be reinvested in community-based capacity — is a powerful mechanism. We recommend DHCS explicitly expand the allowable reinvestment categories to include warm handoff infrastructure: CHW pre-release outreach, CHW peer support in the 30 days post-release, and the technology investments that enable data continuity between corrections settings and community providers.

Recommendation 6.2: Establish a Cross-County Learning Collaborative for Justice Services

Given the wide variation in county readiness for reentry services, we recommend DHCS establish — or authorize MCPs to fund — a structured learning collaborative for justice-involved population implementation. Counties that have achieved strong pre-release service infrastructure can accelerate learning in counties still developing capacity. This is a PATH CPI-style model applied to a specific population, and it is exactly the kind of infrastructure that the renewal period should invest in. The governing principle is the same one that applies across CalAIM's implementation challenge: data systems can identify who is eligible, but only coordinated, trusted cross-sector relationships can ensure those individuals are actually reached, enrolled, and served — across county boundaries, across coverage gaps, and across the corrections-to-community transition that defines this population's experience. A learning collaborative can facilitate broader adoption of emerging best practices from leading counties and also serve as a sandbox in which to identify and create tools and resources to solve
common problems across the state.

SECTION 7: FEDERAL RISK MITIGATION — BUILDING RESILIENCE INTO THE RENEWAL STRUCTURE

The renewal application will be negotiated against the backdrop of H.R. 1 Medicaid provisions that represent the most significant federal threat to California's Medi-Cal system in a generation. The DSHP approval letter documents a Total DSHP Cap of $1.29 billion — funding now at risk. California's county associations have quantified the downstream fiscal impact: the combined annual cost to California counties from H.R. 1 is projected at $6 billion to $9.5 billion — comprising $2B-$5.5B in indigent care costs for residents losing Medi-Cal, $3.4 billion in public hospital revenue losses from State Directed Payment reductions, and nearly $600 million in county workforce costs to administer the new eligibility requirements alone. [CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis, February 2026] DHCS's own Medicaid Director has provided phased coverage loss projections: up to 233,000 losing coverage by June 2027, up to 1 million by January 2028, and up to 1.4 million at full implementation. [DHCS All-Comer Webinar, Tyler Sadwith, 2026] Note: the Introduction references the pre-enactment DHCS estimate of up to 3.4 million — a figure reflecting a broader scenario range developed before H.R. 1's final provisions were known; Sadwith's phased projections reflect DHCS's post-enactment operational planning. Both are DHCS sources; the range between them documents the genuine uncertainty California's planning must accommodate. These are not projections from advocacy organizations. They are the state's own estimates and the counties' own fiscal analysis. The renewal must be built to withstand them.

We name these numbers not to frame this renewal as a defensive exercise, but because clarity about what is at stake is what makes the possibilist case compelling. CalAIM's infrastructure— the ECM care relationships, the Community Supports networks, the cross-sector coordination tables built through PATH — is precisely what California needs most right now. A renewal designed with resilience is not a retreat from ambition. It is the architecture that allows the program to do more, for more people, under more pressure than it was originally designed to face. The six months between now and January 1, 2027 are the most consequential implementation window in CalAIM's history. What we resource before that window closes determines what thrives beyond it.

California's Medicaid financing faces pressure on three simultaneous fronts — not two. H.R. 1 directly targets health care-related provider taxes, phasing the maximum allowable rate from 6% to 3.5% beginning in federal fiscal year 2028. The MCO tax — made permanent by Proposition 35 but requiring federal reapproval — faces the same prohibition. And now the Trump Administration has moved to its second target: the intergovernmental transfer (IGT) and certified public expenditure (CPE) mechanisms that constitute the third leg of California's Medicaid financing structure. The Administration has solicited stakeholder feedback, due March 30, 2026, on how to prevent 'fraud, waste, and abuse' related to IGTs — a framing that mirrors the political strategy used to build the case for provider tax restrictions before H.R. 1. California's DSHP itself operated through CPE

methodology under Attachment Z of the CMS approval letter. That mechanism is now under active federal scrutiny. [Schubel, Health Affairs Forefront, March 9, 2026] We offer three structural recommendations for building resilience into the renewal design.

Recommendation 7.1: Build Budget Neutrality on Conservative Federal Scenarios

Budget neutrality methodology is the primary federal lever for limiting state demonstration expenditures. We recommend DHCS develop the renewal's budget neutrality demonstration on a range of federal scenarios — including partial FMAP reduction and work requirement implementation costs — to ensure California does not face mid-demonstration renegotiation. A renewal built on optimistic assumptions about federal policy continuity creates structural fragility.

Recommendation 7.2: Establish Evaluation Design as a Federal Advocacy Asset

The CalAIM Evaluation Design approved by CMS in early 2026 is not just an accountability mechanism — it is a federal advocacy asset. We recommend DHCS design the renewal-period evaluation with explicit attention to metrics that speak to the current federal priorities: cost containment, employment outcomes, reduction of unnecessary institutional utilization, and efficient use of Medicaid dollars. When California demonstrates that CalAIM saves more than it costs, that data protects the program.

Recommendation 7.3: Create a Multi-Payer Sustainability Pathway

California's MCO tax — made permanent under state law by Proposition 35 in November 2024 — generates approximately $8-10 billion in gross revenue annually and has been a critical non-federal financing tool for Medi-Cal. [LAO Ballot Analysis, Initiative 2023-024; LAO Report 4992, 2025] However, H.R. 1 prohibits states from charging substantially higher tax rates on Medicaid enrollment than on commercial enrollment — a prohibition that directly targets California's rate structure. CMS finalized a rule codifying this restriction on January 29, 2026. The path to federal reapproval of the MCO tax under the new rules is uncertain. At the same time, the Trump Administration is now targeting the IGT and CPE mechanisms — the third leg of California's Medicaid financing structure — with a stakeholder comment deadline of March 30, 2026. All three non-federal financing legs face simultaneous federal pressure. The renewal must name this convergence explicitly and authorize DHCS to pursue alternative financing architecture. We recommend four specific pathways:

- Authorize and direct MCPs to designate backbone coordination infrastructure — cross-sector convening capacity, coverage continuity outreach, and cross-boundary data governance — as named investments in their Q3 2026 community reinvestment plans, which require MCPs to reinvest 5-7.5% of net profits in community health infrastructure. This window closes when plans are filed; what is not named will not be funded for the following three years — precisely the period when H.R. 1's first wave lands. Note: H.R. 1's

$3.4 billion in State Directed Payment losses to public hospitals puts MCP profitability under direct pressure; plans that report operating losses owe nothing under current requirements. Moving before Q3 2026 is not optional — it is time-bounded. [Hickman, CalAIM Field Notes SE-06, February 2026]

- Align CalAIM's evaluation and community health investment criteria with CalPERS's Total Portfolio Approach, which goes live July 1, 2026 — creating a formal pathway for community health infrastructure to be recognized as a legitimate investment category within CalPERS's portfolio. [CalPERS Board Investment Committee, November 2025; CalPERS Total Portfolio Approach Framework] California's I-Bank provides loan guarantees of up to $5M for smaller projects and $5-30M for community infrastructure through its Climate Catalyst and CDLAC programs; COIN, administered by the California Department of Insurance, connects insurers to community development investment pipeline. [California IBank Program Guidelines; COIN Program Overview, CA Dept. of Insurance] These instruments are available now. They require a creditworthy county-level governance entity to receive and deploy capital across funding streams — exactly the backbone infrastructure the renewal period should authorize and resource.

- Pursue Social Impact Bond structures for reentry services and Community Supports — particularly recuperative care, housing navigation, and employment transition supports — where the total cost of care savings are documentable and the payer ecosystem is sufficiently organized to support a multi-year payment model.

- Urge DHCS to formally respond to the Trump Administration's March 30, 2026 IGT/CPE stakeholder comment solicitation and include in the renewal application an explicit defense of California's CPE methodology — documented in Attachment Z of the CMS DSHP approval letter — as a transparent, CMS-approved financing mechanism with a verifiable non-federal share. The Health Affairs analysis published March 9, 2026 is correct: local government financing mechanisms are the third leg of the Medicaid financing stool, and protecting them requires building a public record before restrictions are proposed — not after. [Schubel, Health Affairs Forefront, March 9, 2026]

SECTION 8: WORKFORCE, ECM SUSTAINABILITY, AND PROVIDER NETWORK ACCOUNTABILITY

CalAIM's clinical ambitions depend on a workforce California has not yet fully built, and a CBO provider network navigating simultaneous pressure from two directions. ECM Lead Care Managers, Community Health Workers, and peer support specialists are the human infrastructure of whole-person care. The renewal period must invest in sustaining this workforce — and must address two structural vulnerabilities that field observation and publicly available documentation place squarely before this renewal.

The scale of new workforce burden is quantified. California's county associations estimate that H.R. 1's new eligibility requirements alone will impose nearly $600 million in new county workforce costs — just to administer six-month renewals, work requirement verification, and increased eligibility foot traffic. [CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis, February 2026] The county eligibility workers carrying that burden are the same workforce whose relationship with CBOs determines whether ECM care plans survive coverage churn, whether Community Supports referrals are rebuilt after a gap, and whether the 50% of members who fail automated ex parte checks are reached before they disappear from the system. Workforce investment and coverage continuity are the same question at the county level.

The workforce challenge is not only quantitative — it is qualitative. ECM Lead Care Managers are being asked to navigate one of the most complex care coordination roles in Medicaid: managing caseloads that frequently include members with co-occurring behavioral health conditions, housing instability, and chronic disease, often without the clinical supervision infrastructure that would exist in a traditional health system setting. California has not yet established statewide competency standards for ECM LCMs, nor has it built a consistent training and supervision framework that travels with the role across the diverse organizational settings — CBOs, health plans, FQHCs — where ECM is delivered. The renewal period is the appropriate vehicle to establish that infrastructure: not as a compliance burden, but as a professional foundation that makes retention possible and quality measurable.

The CBO provider network faces pressure from two directions simultaneously — and both require a response in this renewal. The first is federal scrutiny: CMS has intensified program integrity oversight on Community Supports providers, CBOs, and the expansion of social and health-related services through Medicaid at a national level — an environment documented across multiple state Medicaid programs and reflected in recent CMS correspondence to states. DHCS and California's MCPs must demonstrate rigorous provider enrollment and oversight. Strong oversight and broad access are not competing goals — they are reinforcing ones, and the design of oversight mechanisms will determine which of those outcomes is achieved. The second is market austerity: the California Legislative Analyst's Office has documented significant variation in ECM enrollment rates and Community Supports utilization across managed care plans [LAO Report 5003, 2025] — a pattern corroborated by field observation across CalAIM implementation counties and provider stakeholder communications, indicating that some MCPs are taking an austerity-focused approach to ECM and Community Supports network investment — pausing provider contracting and reducing administrative investment in these programs — even as DHCS's renewal strategy treats them as permanent managed care responsibilities. These two dynamics together constitute the most pressing implementation risk in the renewal period, and they require a public record response.

- Establish ECM workforce retention metrics as a statewide performance measure — tracking not just enrollment but Lead Care Manager caseload, turnover rates, and compensation benchmarks

- Establish statewide ECM Lead Care Manager competency standards within the renewal STCs — defining core knowledge domains, required training, minimum supervision ratios, and a continuing education framework — and authorize MCPs to fund LCM training and professional development as a managed care administrative expense, consistent with the workforce investment rationale that already applies to CHW professional development

- Authorize MCPs to fund CHW professional development and technology support as a managed care administrative expense within the renewal STCs

- Establish a CHW career pathway framework within the renewal, building on the Song-Brown workforce investment model (currently authorized through DSHP at $310.6M in DSHP-eligible expenditures) and plan now for the funding cliff when DSHP authority ends December 31, 2026, as Song-Brown continuation will depend on state appropriations alone

- Require ECM contracting standards that ensure CBO ECM providers are compensated on a schedule that does not require unreimbursed bridge financing — CBOs are currently absorbing 60 to 90 days of unreimbursed costs as an invisible subsidy to the Medi-Cal transformation — a pattern consistent with national findings on Medicaid managed care payment timing and widely reported by California CBO provider networks — an unsustainable practice that erodes organizational capacity over time [Hickman, Mason, and Cantor, California Health Report, February 2026; consistent with MACPAC findings on Medicaid payment adequacy for community-based providers]

- Establish a graduated program integrity framework for ECM and Community Supports providers that leads with technical assistance and corrective action plans — not network termination — as the first-line response to compliance concerns; distinguish oversight standards for smaller, community-embedded CBOs from those applicable to larger healthcare entities; and require public reporting on provider network stability metrics so access erosion is visible and addressable

- Establish minimum MCP performance standards for ECM enrollment rates and Community Supports utilization in the renewal STCs — specific, measurable, and enforceable — with public quarterly reporting and a remediation pathway for MCPs below threshold. This is where the governing principle becomes an accountability standard: without contractual performance expectations, the program can have every data system it needs and still fail the members it was built to serve. Technology enables the coordination. Relationships — between MCPs, CBOs, counties, and members — transform it into outcomes. Both require sustained investment, and the renewal STCs are where that investment becomes a requirement rather than a recommendation.

CONCLUSION: A RENEWAL BUILT FOR WHAT COMES NEXT

California stands at an extraordinary moment. The CalAIM renewal we are commenting on today is the bridge between what we built and what we can sustain — and between a relatively favorable federal environment and a more challenging one. The recommendations in this comment are designed to strengthen that bridge: to document what CalAIM has produced, to address the implementation gaps that field experience reveals, and to build structures that can withstand federal policy uncertainty.

We are possibilists about CalAIM's future. The evidence that whole-person care, addressed through coordinated ECM, Community Supports, and cross-sector collaboration, reduces total cost of care and improves health outcomes is now substantial. California's renewal application can put that evidence in federal hands in a form that protects the program.

We look forward to DHCS's continued partnership in making this renewal the foundation for the next phase of California's Medi-Cal transformation. The Camden Coalition's two decades of complex care implementation and Hickman Strategies' field experience across California's CalAIM counties arrive at the same conclusion: the infrastructure that connects systems and the relationships that make those connections real are not soft investments. They are the mechanism by which policy becomes outcomes for people with the most complex needs. Both require sustained investment — and this renewal is where that investment becomes a requirement rather than an aspiration.

Respectfully submitted,

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This public comment reflects the independent professional analysis of both co-submitters: more than three decades of healthcare transformation experience (Hickman Strategies LLC) and more than two decades of national complex care implementation (Camden Coalition). It draws on publicly available CalAIM documentation, field experience

facilitating PATH CPI implementation in multiple California counties, and the August 2025 Comprehensive Recommendations Memorandum submitted in response to the DHCS Medi-Cal Transformation Concept Paper.

Key sources: DHCS via Transform Health (October 2025) | California Health Care Foundation (October 2025) | Governor Newsom (June 27, 2025) | LAO Reports 5003 and 4992 | KFF (July 2025) | HMA (December 2025) | CHCS (December 2025) | CMS DSHP Approval Letter Attachment Y (December 12, 2024) | Hickman, Mason, Cantor, California Health Report (February 2026) | UCLA/RAND CalAIM Evaluation (2025-2026) | DHCS CalAIM 1115 Renewal Application (2026) | 42 CFR Section 438.3(e)(2) | CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis (February 2026) | DHCS All-Comer Webinar, Tyler Sadwith (2026) | California Budget & Policy Center (2026) | Schubel, Health Affairs Forefront: 'Local Governments Play An Important Role In Medicaid Financing' (March 9, 2026) | Convergence Community Hubs Field Scan (January 2026) | Hickman, CalAIM Field Notes SE-06 (February 2026)

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PUBLIC COMMENT

California Advancing and Innovating Medi-Cal (CalAIM)

Section 1115 Demonstration Five-Year Renewal Application

Submitted to:	California Department of Health Care Services (DHCS)
Email:	1115Waiver@dhcs.ca.gov
Subject:	CalAIM Section 1115 & 1915(b) Waivers
Date:	March 12, 2026
Submitted by:	Jim Hickman, Principal & Chief Catalyzer, Hickman Strategies LLC | Mark Humowiecki, JD, General Counsel & Senior Director, National Center for Complex Health and Social Needs, Camden Coalition I
Capacity:	Hickman Strategies LLC: CalAIM Subject Matter Expert | Principal CalAIM Advisor & National Center Advisor, Camden Coalition | Camden Coalition: Approved PATH Technical Assistance Vendor; PATH CPI Facilitator, Merced, Southeast, and Coastal Regions
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Introduction and Statement of Interest

Hickman Strategies LLC and the Camden Coalition submit these comments jointly in strong support of the CalAIM Section 1115 demonstration five-year renewal and to offer specific recommendations grounded in more than three decades of healthcare transformation leadership and more than two decades of national complex care implementation.

This submission reflects the combined institutional standing of both co-submitters. Jim Hickman brings direct field experience as a CalAIM Subject Matter Expert and serves as Principal CalAIM Advisor and National Center Advisor with the Camden Coalition — where, in our capacity as PATH Collaborative Planning and Implementation (CPI) facilitator for the Merced, Southeast, and Coastal regions, we have facilitated structured cross-sector collaboration across multiple California counties since November 2022. The Camden Coalition is a nationally recognized leader in complex care, an approved PATH Technical Assistance Marketplace vendor, and the organizational home of the Ecosystems of Care framework and Ecosystem Assessment Tool, which has been adopted by PCG as the reporting framework for PATH CPI facilitators in 2026. Camden Coalition also organizes an annual national complex care conference, which was held in Sacramento in 2022 and will take place in Oakland in the fall, that helps inform our perspectives on CalAIM implementation and complex care policy and practice nationally. Kathleen Noonan,

Camden Coalition CEO, also serves as a member of the University of California Board of Regents' Health Services Committee. Our combined experience – locally, nationally, and most importantly in California – informs the recommendations throughout this comment. As both CPI facilitator and co-submitter of this public comment, we acknowledge a dual role: we are implementation partners to DHCS and California's counties, and we are also stakeholders with a direct interest in the renewal's design. We have made every effort to ensure our recommendations reflect what California's Medicaid members need — not what is administratively convenient for any implementation partner, including ourselves. This submission also draws on the August 2025 Comprehensive Recommendations Memorandum submitted by Jim Hickman [redacted] in response to the DHCS Medi-Cal Transformation Concept Paper.

CalAIM represents the most ambitious whole-person care transformation in California Medicaid history. The renewal before us is not simply an administrative continuation — it is a strategic inflection point. H.R. 1, enacted July 4, 2025, places up to $30 billion annually in federal Medicaid funding at risk for California and, according to DHCS estimates, could result in up to 3.4 million Californians losing Medi-Cal coverage. [DHCS, California Health Care Foundation (October 2025); Governor Newsom (June 27, 2025)] The question is not whether to renew CalAIM, but how to build the renewal period into a platform for durable, equitable transformation that can withstand this challenging federal funding environment.

[redacted]

CORE THESIS

Technology enables — but relationships transform. The renewal period must invest deliberately in the infrastructure that sustains cross-sector relationships and collaboration as it does in data systems and clinical protocols. The Camden Coalition's Ecosystems of Care framework — grounded in more than two decades of building infrastructure for communities serving people with complex needs — is the governing design principle: coordination across

stakeholders, sustained by dedicated investment in backbone infrastructure, is what makes whole-person care operationally real.

DHCS RENEWAL STRATEGY

The decision to embed ECM and twelve Community Supports in permanent managed care authorities — rather than renewing them exclusively as 1115 demonstration programs — is the most consequential structural choice in this renewal. These programs are not experiments. They are the operational infrastructure of whole-person Medi-Cal. Our recommendations address what it takes for permanent authority to mean permanent access: at scale, for every eligible member, through a provider network that is both accountable and intact.

Section 1: Broad Support for Core CalAIM Continuation

We strongly support DHCS's renewal request for the following authorities, which form the foundation of California's whole-person care transformation:

- Enhanced Care Management (ECM) for high-need, high-cost populations
- Community Supports (including the two 1115-authorized services: Housing Transition Navigation Services and Housing Tenancy and Sustaining Services)
- In Lieu of Services (ILOS) framework for the remaining twelve Community Supports under 42 CFR § 438.3(e)(2)
- Pre-release and post-release Medi-Cal services for justice-involved populations
- Global Payment Program for Public Health Care Systems
- Delivery system authorities through the 1915(b) waiver (managed care, specialty mental health, DMC-ODS, dental managed care)
- BH-CONNECT authority for behavioral health continuum services

The evidence base supporting these initiatives is now substantial. Community Supports have moved from pilot to statewide mandate. ECM operates as a statewide benefit across all 58 counties, though the California Legislative Analyst's Office (LAO) has documented significant variation in provider network depth and utilization rates across plans and counties — a reality the renewal evaluation framework should address. [LAO Report 5003, 2025] The evaluation design approved by CMS confirms a rigorous framework for measuring what works. We urge DHCS to ensure the renewal application communicates this evidence base with specificity, as CMS will face questions from federal policymakers about the return on California's investment.

EVIDENCE

CalAIM's HRSN Community Supports Protocol (CMS-approved January 2025) establishes the authorization infrastructure, data exchange requirements, and evaluation framework that position California to demonstrate impact at scale. This is foundational — the renewal protects it.

Section 2: PATH Infrastructure — Documenting What We Built, Protecting What It Produced

The Providing Access and Transforming Health (PATH) initiative — authorized under DSHP funding now ending — created collaboration infrastructure that CalAIM's clinical programs depend upon but cannot replace on their own. We have facilitated PATH CPI meetings across multiple California counties and can speak with specificity about what PATH produced.

The UCLA and RAND independent evaluation of PATH — required by the 1115 demonstration and currently underway — has documented very substantial capacity building: significant increases in the number of ECM and Community Supports users, contracted providers, and broad adoption of CalAIM programs across counties. [UCLA/RAND CalAIM PATH Evaluation, 2025–2026] This is the government's own evaluation confirming the infrastructure value we document below. Our recommendation for structured PATH transition documentation is a direct response to that finding: what the evaluation confirms was built should not be allowed to dissipate without a record of what it produced and how it can be sustained and evolved.

QUESTION	What did PATH produce, and what is at risk when it sunsets at the end of the current waiver?
EVIDENCE	PATH funded cross-sector convening, shared data infrastructure, and collaborative planning capacity that allowed counties to transition WPC pilots into ECM and Community Supports at scale. The EDIE digital safety net deployment connecting multiple hospitals — identifying thousands of shared patients — exemplifies the kind of system-connecting infrastructure PATH enabled. PATH's CPI facilitation created county-level tables where managed care plans, CBOs, behavioral health agencies, housing departments, and justice partners could develop shared workflows, not just data agreements.
RECOMMENDATION	DHCS should use the renewal period to document the PATH infrastructure investment in measurable terms — counties convened, shared patients identified, cross-sector workflows formalized, ECM ramp-up rates in counties with strong CPI infrastructure, ECM enrollment, and other measures that show uptake versus those without. This documentation serves two purposes: it demonstrates CalAIM ROI to CMS and it creates a baseline of the current connective tissue within regional ecosystems while facilitating efforts to sustain and grow that infrastructure using alternative financing (MCP-funded TA, community-sustained convening, philanthropic bridging).

The Camden Coalition has facilitated PATH Collaborative Planning and Implementation convenings across the Merced, Southeast, and Coastal regions since November 2022. In that time, we observed county ecosystems move from parallel organizational siloes to coordinated cross-sector collaborators — and we have observed what happens when the scaffolding of facilitation is removed without a successor infrastructure in place. The documentation requirement in Recommendation 2.1 is not a theoretical proposal. It reflects what Camden has seen built — the trusted relationships, shared data practices, and cross-sector accountability structures that take months and years to construct — and what we have seen become fragile when grant cycles end without a transition plan. California has built something real under PATH. This recommendation is about ensuring the renewal period captures what was built, so that it can be sustained.

For example, in early 2023, the Merced Community Action Agency (Merced CAA) began attending Merced CPI meetings. After participating in CPI presentations and discussions, Merced CAA developed a stronger understanding of the CalAIM opportunity and the long-term

value it could create for both the organization and the populations it serves. Through the CPI, Merced CAA was connected with the managed care plan, CCAH, and ultimately enrolled as both an Enhanced Care Management (ECM) provider and a Community Supports Housing Trio provider. They worked closely with CCAH to align on service capacity and received an IPP grant to purchase additional space to support program growth. Merced CAA then became a leader within the Merced CPI, helping coach other community-based organizations on the opportunity and the steps needed to be successful. According to the latest implementation report, Merced now has among the highest penetration rates for services among individuals experiencing homelessness, and the highest among counties that did not previously participate in Whole Person Care. While Merced CAA, other housing providers, and CCAH deserve the credit for this success, the CPI table served as a catalyst to activate and support this community of providers.

Recommendation 2.1: Establish a PATH Transition Documentation Requirement

We recommend DHCS establish a structured documentation requirement in the renewal application that captures: (1) county-level ECM and Community Supports ramp-up rates correlated with PATH CPI participation; (2) cross-sector agreements and workflows formalized under PATH; and (3) data infrastructure investments that will persist post-PATH. This record serves federal accountability and informs the design of successor collaboration infrastructure.

Recommendation 2.2: Create a Managed Care Collaboration Infrastructure Mechanism

With DSHP authority unavailable for PATH renewal, the collaboration infrastructure it funded must find a new home. We recommend DHCS explore whether the renewal STCs can authorize MCPs to fund shared technical assistance and cross-sector convening as a permissible managed care administrative expense. The Camden Coalition's Ecosystems of Care framework — the intellectual foundation of PATH CPI facilitation — defines backbone coordination explicitly as a sustainability domain, not overhead: infrastructure that requires dedicated investment like any other infrastructure if it is to survive funding transitions. [Camden Coalition, Ecosystems of Care Framework; Camden Coalition Ecosystem Assessment Tool, 2024] The policy rationale for the renewal is straightforward: collaboration infrastructure that enables better ECM and Community Supports performance is a legitimate managed care investment. California's MCPs are well-positioned to sustain CPI-style tables in the counties where they operate.

DHCS DATA + FIELD CONFIRMATION

DHCS has identified a concrete, verifiable measure of backbone infrastructure progress: the percentage of cross-sector partners who text or call each other directly when issues arise — without routing through a convener. In DHCS's own webinar data, 47% of partners communicate through formal channels only; just 22% have reached the level of direct peer to peer communication that signals real collaboration infrastructure. [DHCS, "The Fierce Urgency of Community Partnerships," 2025] In our capacity as PATH CPI facilitators, we observe this same pattern across county tables. The Camden Coalition's Ecosystem Assessment Tool — which formalizes the Ecosystems of Care framework — places this measure within its 'teaming and collaboration' domain: backbone infrastructure can enable progress that is visible to MCPs, investors, and county leadership, and that precedes every coordinated outcome on a shared dashboard. Moving from 22% to 50% direct-contact relationships is not a soft goal. It is a governance milestone. Trust is infrastructure — and unlike data systems, it cannot be reconstructed quickly if it sunsets now. We

	cannot afford to rebuild it during a coverage crisis. Technology enables the identification of who needs to be reached. Relationships determine whether they get there. The PATH Transition Documentation Requirement in Rec 2.1 should establish this DHCS-measured baseline as a required metric — and the renewal STCs should make it a reportable standard going forward. [Camden Coalition Ecosystem Assessment Tool, 2024; Hickman, CalAIM Field Notes SE-06, February 2026]

Section 3: Community Supports Data Infrastructure — Orchestration as the Core Strategy

DHCS has framed the next phase of CalAIM as a deliberate shift from infrastructure-building (2022–2026) to utilization, quality, and performance — what the renewal application describes as the maturation of Community Supports from demonstration to embedded managed care benefit. [DHCS CalAIM Concept Paper, July 2025] We endorse this framing entirely, and our recommendations in this section are designed to operationalize it.

The California Budget & Policy Center has documented that Community Supports has already reached approximately 430,000 Californians. [California Budget & Policy Center, 2026] That number is a foundation to build on — and it makes the utilization gap more, not less, urgent to close. Field observation across our CPI facilitation engagements in multiple California counties, corroborated by the LAO's 2025 analysis, suggests that ECM enrollment of eligible members remains substantially below what the program's design would support. [LAO Report 5003, 2025] 430,000 members reached is a real achievement. The architecture capable of reaching the full eligible population is what the renewal period must invest in.

And the stakes of that investment have never been higher. Under H.R. 1, every member whose Medi-Cal coverage lapses is an ECM care plan that dies. A Community Supports referral that resets. A trusted relationship that took months to build, severed by an administrative gap that policy alone did not close. The data infrastructure recommendations in this section are not technical upgrades — they are the mechanisms by which 430,000 becomes one million, and by which coverage continuity becomes a system property rather than a provider-by-provider aspiration.

The CMS-approved HRSN Community Supports Protocol (Attachment X, January 2025) establishes specific data exchange requirements: Member Information Sharing Guidance, Authorization Status Files, Provider Transmission Files, and Data Exchange Framework integration. These requirements are the right architecture. The challenge is the gap between what the Protocol requires and what is actually flowing between MCPs and CBOs on the ground.

QUESTION	Why is data exchange between MCPs and Community Supports providers still inconsistent four years into CalAIM implementation?
EVIDENCE	Our field facilitation across multiple counties reveals a consistent pattern: the standards exist, but the implementation supports technical assistance, standardized integration pathways, and workflow training has not kept pace with the mandate. Community Supports providers, particularly smaller CBOs, face documentation burdens that consume capacity that should be directed toward

	member services. MCPs, operating across multiple counties with different CBO ecosystems, lack standardized integration pathways that would allow technology platforms to connect consistently. The result is that Community Supports authorizations happen, but the closed-loop referral data that would allow MCPs to improve targeting and CBOs to demonstrate impact is incomplete.
RECOMMENDATION	The renewal period is the opportunity to establish orchestration as the governing framework: connecting the systems that exist rather than mandating new ones, building shared integration standards that allow any certified Community Supports platform to connect to any MCP, and investing in the CBO data readiness that makes participation sustainable.

Recommendation 3.1: Establish a Community Supports Data Readiness Fund

We recommend DHCS include in the renewal application a request for authorization of a Community Supports Data Readiness Fund — analogous to the data exchange investments authorized in other state 1115 demonstrations — that provides CBOs with the technical assistance and infrastructure support needed to meet HRSN Protocol requirements. A $10–20M fund administered through DHCS or a qualified intermediary would create a significant return on investment through improved closed-loop referral rates and more accurate Community Supports outcome data.

Recommendation 3.2: Extend HRSN Data Standards to All ILOS Community Supports

The approved Protocol applies specifically to the two 1115-authorized Community Supports. We recommend DHCS use the renewal period to establish equivalent data exchange standards for all twelve ILOS Community Supports. Consistent standards across the full menu will enable statewide learning, reduce the MCP compliance burden (one standard, not thirteen), and create the data infrastructure needed for the evaluation design to capture Community Supports impact at scale.

ORCHESTRATION PRINCIPLE	*The goal is not more data systems — it's connecting the ones we have. A single authorization-to-outcome data thread from MCP referral through CBO delivery to health outcome is more valuable than twelve separate reporting streams. This is the Camden Coalition's Ecosystems of Care principle in practice: coordination infrastructure, not digitization, is what closes the gap between authorization and outcome.*

Section 3.5: Recuperative Care and the Room-and-Board Transition Risk

The renewal application confirms that Short-Term Post-Hospitalization Housing (STPH) will be discontinued as a standalone Community Support and incorporated into an expanded Recuperative Care model under ILOS managed care authority, effective January 1, 2027. [DHCS CalAIM 1115 Renewal Application, 2026] We support the move to a more durable managed care authority.

We raise one implementation concern that warrants attention before the renewal is finalized: federal ILOS rules under 42 CFR § 438.3(e)(2) prohibit reimbursement for room and board. The current STPH benefit includes a housing cost component that the ILOS-based Recuperative Care model may not be able to fully replicate. We recommend DHCS conduct a gap analysis — before final submission to CMS — of the difference between what STPH currently covers for post-hospitalization housing and what an ILOS-authorized Recuperative Care model can cover under the room-and-board prohibition. If a gap exists, we urge DHCS to identify a companion state plan mechanism or supplemental state funding that preserves the member-facing service. Structural authority improvements should not produce functional service reductions for members most in need of stable post-hospital housing.

Section 4: Employment Supports — Implementation Architecture for Member Success

The Employment Supports request is the most strategically significant new initiative in the renewal application. We strongly support DHCS's decision to establish a proactive member success framework for employment services. A critical legal and strategic point: H.R. 1's work requirements — effective January 1, 2027 — are a federal statutory mandate that cannot be waived under Section 1115 authority. [Health Management Associates, December 2025; KFF, July 2025] California's Employment Supports request is therefore not an alternative to work requirements; it is the infrastructure for implementing them in a way that protects coverage for members who are eligible or who qualify for an exemption. We offer the following implementation architecture recommendations.

QUESTION	What determines whether Employment Supports becomes a genuine member success pathway versus a bureaucratic compliance exercise?
EVIDENCE	The evidence from states that have implemented community engagement requirements — including Arkansas, Georgia, and Michigan — indicates that outcomes are strongly shaped by implementation architecture. States where MCPs, CBOs, workforce agencies, and county eligibility systems operated in coordinated workflows achieved substantially higher engagement rates; states where systems operated independently saw substantially higher disenrollment rates, even among members who were technically eligible. [Urban Institute, Medicaid Work Requirements Research, 2019–2023; KFF State Medicaid Community Engagement Requirements Analysis] The difference was not member motivation or eligibility — it was system design.
RECOMMENDATION	Employment Supports must be designed from the start as an integrated workflow, not a standalone benefit. The critical design decisions are: (1) how Employment Supports providers connect to ECM care plans; (2) what data flows between workforce agencies and MCPs; (3) how exemption processes are operationalized to be accessible, not just technically available; and (4) how the system prevents coverage loss for members who are engaged but face barriers the system hasn't yet resolved.

Recommendation 4.1: Support County Readiness and Establish a Statewide Exemption Floor

The renewal application describes Employment Supports as a voluntary initiative for counties or county-based entities — a design we support as consistent with California's county-administered service architecture. [DHCS CalAIM 1115 Renewal Application, 2026] We recommend DHCS supplement the county opt-in design with two elements: (1) a County Employment Supports Readiness Initiative — targeted technical assistance and planning support for counties that wish to participate but face infrastructure barriers, ensuring that the program's benefits are accessible to members regardless of which county they live in; and (2) a set of statewide floor requirements, applicable in all 58 counties regardless of Employment Supports participation, specifically around proactive outreach and screening for work requirement exemptions.

The county opt-in architecture is sound — and it makes the exemption floor more important, not less. Where counties choose not to participate, eligible members still carry the risk of a work requirement. The statewide exemption screening requirement is what ensures that risk does not fall unevenly on the members least equipped to navigate it alone.

Recommendation 4.2: Invest in Proactive Exemption Processing — In All Counties

The exemption categories in H.R. 1 are broad — caregiving responsibilities, disability, housing instability, among others. The implementation risk is that members who qualify for exemptions lose coverage because the exemption process is difficult to navigate — and DHCS's own implementation planning makes this risk concrete: of the approximately 2.8 million new adult group members expected to require manual verification when automated ex parte checks fail, DHCS estimates that up to 50% could lose coverage from administrative burden alone — not because they are ineligible, but because the system cannot reach them in time. [DHCS All-Comer Webinar, Tyler Sadwith, 2026; Hickman, CalAIM Field Notes SE-06, February 2026] This risk exists whether or not a county has opted into Employment Supports. We recommend DHCS establish, in the renewal STCs, a requirement that MCPs proactively screen members for exemption eligibility and document that screening before any coverage action related to work requirement non-participation, statewide and without exception. The alternative is coverage loss at scale for people the program is designed to serve.

Recommendation 4.3: Build a Community-Based Workforce Partnership Infrastructure in Opt-In Counties

In counties that opt into Employment Supports, DHCS should establish a certification pathway for CBOs — particularly those already providing Community Supports — to deliver Employment Supports services. Organizations already trusted by Medi-Cal members for housing, food, and transportation support are natural employment support partners. We also recommend that MCP referral protocols in opt-in counties connect Employment Supports to ECM care plans for members enrolled in both, ensuring employment goals are a documented element of the member's ECM assessment rather than a parallel compliance track. Camden Coalition has long included employment as a core domain of care planning for even those individuals with the most complex needs.

Section 5: BridgeCare Pilots — The Institutional Diversion Case

We strongly support the BridgeCare Pilots request and recommend DHCS frame this initiative in the renewal application with specific emphasis on institutional diversion and total cost of care reduction. In the current federal environment, HCBS investments are most likely to secure CMS approval when framed as alternatives to more expensive institutional placement — not primarily as quality-of-life or social determinants investments.

QUESTION	What is the strongest framing for BridgeCare that will resonate with the current CMS posture?
EVIDENCE	The CMS Independence at Home Demonstration documented $3,500 per member per year in savings through reduced readmissions for older adults receiving home-based primary care. [CMS Independence at Home Demonstration Evaluation, Avalere Health, 2023] The PACE program — which BridgeCare draws from — has 30+ years of evidence showing that comprehensive home and community-based services delay or prevent nursing facility placement. [Ghosh et al., Health Affairs, 2015; CMS PACE Evaluation Reports] California's Medi-Cal nursing facility costs average more than $114,000 per member per year — more than $312 per day — according to Justice in Aging. [Justice in Aging, cited in CalMatters, June 2025] A BridgeCare investment of $200/month per member is cost-effective against even a modest reduction in nursing facility days.
RECOMMENDATION	Position BridgeCare explicitly as an institutional diversion strategy in the renewal application narrative. Quantify the avoided institutional cost. Establish evaluation metrics that measure nursing facility placement rates, readmission rates, and total cost of care — not just process measures. This framing is both accurate and strategically aligned with a CMS that prioritize value and cost containment.

Recommendation 5.1: Establish BridgeCare-ECM Integration for Complex Older Adults

We recommend the BridgeCare pilot design require coordination protocols with ECM for dually eligible members. Older adults with complex health needs who qualify for both BridgeCare and ECM represent the highest-cost cohort — and the greatest opportunity for total cost of care reduction. Integrating BridgeCare home modification, personal care, and respite services with ECM care coordination will generate the outcome data that supports statewide expansion.

Recommendation 5.2: Include Caregiver Support as a BridgeCare Core Component

The evidence is clear that caregiver burnout is a primary driver of nursing facility placement for older adults with complex needs. We recommend BridgeCare include structured caregiver support — respite care, navigation, training — as a core component alongside member-directed services. This is consistent with the CalAIM dyadic services model for children's care and extends the same logic to older adult care.

Section 6: Reentry Services — All-County Readiness and the IT Infrastructure Gap

The all-county mandate for pre-release Medi-Cal services by October 2026 is a significant implementation challenge for counties that are just beginning this work. As a CPI facilitator working across counties at different stages of CalAIM readiness, we offer targeted recommendations for the renewal period.

Early evaluation of the Justice-Involved Reentry Initiative — including RAND's analysis of focal counties — documents strong early results: approximately 35,000 individuals identified as eligible and 64,500 pre-release services delivered in the program's first year of operation, with evidence of improved care transitions and growing cross-system coordination among corrections, behavioral health, and community providers. [RAND CalAIM Evaluation, 2025; DHCS CalAIM Evaluation Highlights] These results confirm the strong foundation described in the renewal application — and they also underscore the infrastructure investment required. This level of cross-system coordination was not spontaneous; it was built through PATH-funded capacity development that is now sunsetting. The renewal must account for what replaces it.

QUESTION	What implementation barriers are preventing counties from achieving the all-county pre-release mandate?
EVIDENCE	Field observations across multiple counties identify three consistent barriers: (1) data matching — connecting CDCR and county jail identifiers to Medicaid records requires IT investment that many counties have not yet made; (2) warm handoff infrastructure — the relationship between pre-release planners and community-based providers who receive individuals post-release requires active development, not just referral protocols; and (3) MCP-corrections agency partnership formalization — the data sharing agreements and care coordination workflows between MCPs and corrections settings are at varying levels of development across counties.
RECOMMENDATION	The renewal application should include explicit performance metrics for the all-county rollout: percentage of eligible individuals receiving pre-release assessments, Medi-Cal enrollment rates at release, 30-day and 90-day healthcare engagement post-release. The RAND evaluation focal counties provide a learning laboratory — the STCs should establish a mechanism for rapid learning dissemination to the remaining counties.

Recommendation 6.1: Authorize Reinvestment Funds for Warm Handoff Infrastructure

STC 9.11's reinvestment requirement — that new FFP generated from previously-state-funded carceral services be reinvested in community-based capacity — is a powerful mechanism. We recommend DHCS explicitly expand the allowable reinvestment categories to include warm handoff infrastructure: CHW pre-release outreach, CHW peer support in the 30 days post-release, and the technology investments that enable data continuity between corrections settings and community providers.

Recommendation 6.2: Establish a Cross-County Learning Collaborative for Justice Services

Given the wide variation in county readiness for reentry services, we recommend DHCS establish — or authorize MCPs to fund — a structured learning collaborative for justice-involved population implementation. Counties that have achieved strong pre-release service infrastructure can accelerate learning in counties still developing capacity. This is a PATH CPI-style model applied to a specific population, and it is exactly the kind of infrastructure that the renewal period should invest in. The governing principle is the same one that applies across CalAIM's implementation challenge: data systems can identify who is eligible, but only coordinated, trusted cross-sector relationships can ensure those individuals are actually reached, enrolled, and served — across county boundaries, across coverage gaps, and across the corrections-to-community transition that defines this population's experience. A learning collaborative can facilitate broader adoption of emerging best practices from leading counties and also serve as a sandbox in which to identify and create tools and resources to solve common problems across the state.

Section 7: Federal Risk Mitigation — Building Resilience Into the Renewal Structure

The renewal application will be negotiated against the backdrop of H.R. 1 Medicaid provisions that represent the most significant federal threat to California's Medi-Cal system in a generation. The DSHP approval letter documents a Total DSHP Cap of $1.29 billion — funding now at risk. California's county associations have quantified the downstream fiscal impact: the combined annual cost to California counties from H.R. 1 is projected at $6 billion to $9.5 billion — comprising $2B–$5.5B in indigent care costs for residents losing Medi-Cal, $3.4 billion in public hospital revenue losses from State Directed Payment reductions, and nearly $600 million in county workforce costs to administer the new eligibility requirements alone. [CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis, February 2026] DHCS's own Medicaid Director has provided phased coverage loss projections: up to 233,000 losing coverage by June 2027, up to 1 million by January 2028, and up to 1.4 million at full implementation. [DHCS All-Comer Webinar, Tyler Sadwith, 2026] Note: the Introduction references the pre-enactment DHCS estimate of up to 3.4 million — a figure reflecting a broader scenario range developed before H.R. 1's final provisions were known; Sadwith's phased projections reflect DHCS's post-enactment operational planning. Both are DHCS sources; the range between them documents the genuine uncertainty California's planning must accommodate. These are not projections from advocacy organizations. They are the state's own estimates and the counties' own fiscal analysis. The renewal must be built to withstand them.

We name these numbers not to frame this renewal as a defensive exercise, but because clarity about what is at stake is what makes the possibilist case compelling. CalAIM's infrastructure — the ECM care relationships, the Community Supports networks, the cross-sector coordination tables built through PATH — is precisely what California needs most right now. A renewal designed with resilience is not a retreat from ambition. It is the architecture that allows the program to do more, for more people, under more pressure than it was originally designed to face. The six months between now and January 1, 2027 are the most consequential implementation window in CalAIM's history. What we resource before that window closes determines what thrives beyond it.

California's Medicaid financing faces pressure on three simultaneous fronts — not two. H.R. 1 directly targets health care-related provider taxes, phasing the maximum allowable rate from 6% to 3.5% beginning in federal fiscal year 2028. The MCO tax — made permanent by Proposition 35 but requiring federal reapproval — faces the same prohibition. And now the Trump Administration has moved to its second target: the intergovernmental transfer (IGT) and certified public expenditure (CPE) mechanisms that constitute the third leg of California's Medicaid financing structure. The Administration has solicited stakeholder feedback, due March 30, 2026, on how to prevent 'fraud, waste, and abuse' related to IGTs — a framing that mirrors the political strategy used to build the case for provider tax restrictions before H.R. 1. California's DSHP itself operated through CPE methodology under Attachment Z of the CMS approval letter. That mechanism is now under active federal scrutiny. [Schubel, Health Affairs Forefront, March 9, 2026] We offer three structural recommendations for building resilience into the renewal design.

Recommendation 7.1: Build Budget Neutrality on Conservative Federal Scenarios

Budget neutrality methodology is the primary federal lever for limiting state demonstration expenditures. We recommend DHCS develop the renewal's budget neutrality demonstration on a range of federal scenarios — including partial FMAP reduction and work requirement implementation costs — to ensure California does not face mid-demonstration renegotiation. A renewal built on optimistic assumptions about federal policy continuity creates structural fragility.

Recommendation 7.2: Establish Evaluation Design as a Federal Advocacy Asset

The CalAIM Evaluation Design approved by CMS in early 2026 is not just an accountability mechanism — it is a federal advocacy asset. We recommend DHCS design the renewal-period evaluation with explicit attention to metrics that speak to the current federal priorities: cost containment, employment outcomes, reduction of unnecessary institutional utilization, and efficient use of Medicaid dollars. When California demonstrates that CalAIM saves more than it costs, that data protects the program.

Recommendation 7.3: Create a Multi-Payer Sustainability Pathway

California's MCO tax — made permanent under state law by Proposition 35 in November 2024 — generates approximately $8–10 billion in gross revenue annually and has been a critical non-federal financing tool for Medi-Cal. [LAO Ballot Analysis, Initiative 2023-024; LAO Report 4992, 2025] However, H.R. 1 prohibits states from charging substantially higher tax rates on Medicaid enrollment than on commercial enrollment — a prohibition that directly targets California's rate structure. CMS finalized a rule codifying this restriction on January 29, 2026. The path to federal reapproval of the MCO tax under the new rules is uncertain. At the same time, the Trump Administration is now targeting the IGT and CPE mechanisms — the third leg of California's Medicaid financing structure — with a stakeholder comment deadline of March 30, 2026. All three non-federal financing legs face simultaneous federal pressure. The renewal must name this convergence explicitly and authorize DHCS to pursue alternative financing architecture. We recommend four specific pathways:

- Authorize and direct MCPs to designate backbone coordination infrastructure — cross-sector convening capacity, coverage continuity outreach, and cross-boundary data governance — as named investments in their Q3 2026 community reinvestment plans,

which require MCPs to reinvest 5–7.5% of net profits in community health infrastructure. This window closes when plans are filed; what is not named will not be funded for the following three years — precisely the period when H.R. 1's first wave lands. Note: H.R. 1's $3.4 billion in State Directed Payment losses to public hospitals puts MCP profitability under direct pressure; plans that report operating losses owe nothing under current requirements. Moving before Q3 2026 is not optional — it is time-bounded. [Hickman, CalAIM Field Notes SE-06, February 2026]

- Align CalAIM's evaluation and community health investment criteria with CalPERS's Total Portfolio Approach, which goes live July 1, 2026 — creating a formal pathway for community health infrastructure to be recognized as a legitimate investment category within CalPERS's portfolio. [CalPERS Board Investment Committee, November 2025; CalPERS Total Portfolio Approach Framework] California's I-Bank provides loan guarantees of up to $5M for smaller projects and $5–30M for community infrastructure through its Climate Catalyst and CDLAC programs; COIN, administered by the California Department of Insurance, connects insurers to community development investment pipeline. [California IBank Program Guidelines; COIN Program Overview, CA Dept. of Insurance] These instruments are available now. They require a creditworthy county-level governance entity to receive and deploy capital across funding streams — exactly the backbone infrastructure the renewal period should authorize and resource.
- Pursue Social Impact Bond structures for reentry services and Community Supports — particularly recuperative care, housing navigation, and employment transition supports — where the total cost of care savings are documentable and the payer ecosystem is sufficiently organized to support a multi-year payment model.
- Urge DHCS to formally respond to the Trump Administration's March 30, 2026 IGT/CPE stakeholder comment solicitation and include in the renewal application an explicit defense of California's CPE methodology — documented in Attachment Z of the CMS DSHP approval letter — as a transparent, CMS-approved financing mechanism with a verifiable non-federal share. The Health Affairs analysis published March 9, 2026 is correct: local government financing mechanisms are the third leg of the Medicaid financing stool, and protecting them requires building a public record before restrictions are proposed — not after. [Schubel, Health Affairs Forefront, March 9, 2026]

Section 8: Workforce, ECM Sustainability, and Provider Network Accountability

CalAIM's clinical ambitions depend on a workforce California has not yet fully built, and a CBO provider network navigating simultaneous pressure from two directions. ECM Lead Care Managers, Community Health Workers, and peer support specialists are the human infrastructure of whole-person care. The renewal period must invest in sustaining this workforce — and must address two structural vulnerabilities that field observation and publicly available documentation place squarely before this renewal.

The scale of new workforce burden is quantified. California's county associations estimate that H.R. 1's new eligibility requirements alone will impose nearly $600 million in new county workforce costs — just to administer six-month renewals, work requirement verification, and increased eligibility foot traffic. [CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis, February 2026] The county eligibility workers carrying that burden are the same workforce whose relationship with CBOs determines whether ECM care plans survive coverage churn, whether Community

Supports referrals are rebuilt after a gap, and whether the 50% of members who fail automated ex parte checks are reached before they disappear from the system. Workforce investment and coverage continuity are the same question at the county level.

The workforce challenge is not only quantitative — it is qualitative. ECM Lead Care Managers are being asked to navigate one of the most complex care coordination roles in Medicaid: managing caseloads that frequently include members with co-occurring behavioral health conditions, housing instability, and chronic disease, often without the clinical supervision infrastructure that would exist in a traditional health system setting. California has not yet established statewide competency standards for ECM LCMs, nor has it built a consistent training and supervision framework that travels with the role across the diverse organizational settings — CBOs, health plans, FQHCs — where ECM is delivered. The renewal period is the appropriate vehicle to establish that infrastructure: not as a compliance burden, but as a professional foundation that makes retention possible and quality measurable.

The CBO provider network faces pressure from two directions simultaneously — and both require a response in this renewal. The first is federal scrutiny: CMS has intensified program integrity oversight on Community Supports providers, CBOs, and the expansion of social and health-related services through Medicaid at a national level — an environment documented across multiple state Medicaid programs and reflected in recent CMS correspondence to states. DHCS and California's MCPs must demonstrate rigorous provider enrollment and oversight. Strong oversight and broad access are not competing goals — they are reinforcing ones, and the design of oversight mechanisms will determine which of those outcomes is achieved. The second is market austerity: the California Legislative Analyst's Office has documented significant variation in ECM enrollment rates and Community Supports utilization across managed care plans [LAO Report 5003, 2025] — a pattern corroborated by field observation across CalAIM implementation counties and provider stakeholder communications, indicating that some MCPs are taking an austerity-focused approach to ECM and Community Supports network investment — pausing provider contracting and reducing administrative investment in these programs — even as DHCS's renewal strategy treats them as permanent managed care responsibilities. These two dynamics together constitute the most pressing implementation risk in the renewal period, and they require a public record response.

- Establish ECM workforce retention metrics as a statewide performance measure — tracking not just enrollment but Lead Care Manager caseload, turnover rates, and compensation benchmarks
- Establish statewide ECM Lead Care Manager competency standards within the renewal STCs — defining core knowledge domains, required training, minimum supervision ratios, and a continuing education framework — and authorize MCPs to fund LCM training and professional development as a managed care administrative expense, consistent with the workforce investment rationale that already applies to CHW professional development
- Authorize MCPs to fund CHW professional development and technology support as a managed care administrative expense within the renewal STCs
- Establish a CHW career pathway framework within the renewal, building on the Song-Brown workforce investment model (currently authorized through DSHP at $310.6M in DSHP-eligible expenditures) and plan now for the funding cliff when DSHP authority ends December 31, 2026, as Song-Brown continuation will depend on state appropriations alone

- Require ECM contracting standards that ensure CBO ECM providers are compensated on a schedule that does not require unreimbursed bridge financing — CBOs are currently absorbing 60 to 90 days of unreimbursed costs as an invisible subsidy to the Medi-Cal transformation — a pattern consistent with national findings on Medicaid managed care payment timing and widely reported by California CBO provider networks — an unsustainable practice that erodes organizational capacity over time [Hickman, Mason, and Cantor, California Health Report, February 2026; consistent with MACPAC findings on Medicaid payment adequacy for community-based providers]
- Establish a graduated program integrity framework for ECM and Community Supports providers that leads with technical assistance and corrective action plans — not network termination — as the first-line response to compliance concerns; distinguish oversight standards for smaller, community-embedded CBOs from those applicable to larger healthcare entities; and require public reporting on provider network stability metrics so access erosion is visible and addressable
- Establish minimum MCP performance standards for ECM enrollment rates and Community Supports utilization in the renewal STCs — specific, measurable, and enforceable — with public quarterly reporting and a remediation pathway for MCPs below threshold. This is where the governing principle becomes an accountability standard: without contractual performance expectations, the program can have every data system it needs and still fail the members it was built to serve. Technology enables the coordination. Relationships — between MCPs, CBOs, counties, and members — transform it into outcomes. Both require sustained investment, and the renewal STCs are where that investment becomes a requirement rather than a recommendation.

Conclusion: A Renewal Built for What Comes Next

California stands at an extraordinary moment. The CalAIM renewal we are commenting on today is the bridge between what we built and what we can sustain — and between a relatively favorable federal environment and a more challenging one. The recommendations in this comment are designed to strengthen that bridge: to document what CalAIM has produced, to address the implementation gaps that field experience reveals, and to build structures that can withstand federal policy uncertainty.

We are possibilists about CalAIM's future. The evidence that whole-person care, addressed through coordinated ECM, Community Supports, and cross-sector collaboration, reduces total cost of care and improves health outcomes is now substantial. California's renewal application has the opportunity to put that evidence in federal hands in a form that protects the program.

We look forward to DHCS's continued partnership in making this renewal the foundation for the next phase of California's Medi-Cal transformation. The Camden Coalition's two decades of complex care implementation and Hickman Strategies' field experience across California's CalAIM counties arrive at the same conclusion: the infrastructure that connects systems and the relationships that make those connections real are not soft investments. They are the mechanism by which policy becomes outcomes for people with the most complex needs. Both require sustained investment — and this renewal is where that investment becomes a requirement rather than an aspiration.

Respectfully submitted,

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This public comment reflects the independent professional analysis of both co-submitters: more than three decades of healthcare transformation experience (Hickman Strategies LLC) and more than two decades of national complex care implementation (Camden Coalition).

It draws on publicly available CalAIM documentation, field experience facilitating PATH CPI implementation in multiple California counties,
and the August 2025 Comprehensive Recommendations Memorandum submitted in response to the DHCS Medi-Cal Transformation Concept Paper.

Key sources: DHCS via Transform Health (October 2025) | California Health Care Foundation (October 2025) | Governor Newsom (June 27, 2025) | LAO Reports 5003 and 4992 | KFF (July 2025)
HMA (December 2025) | CHCS (December 2025) | CMS DSHP Approval Letter Attachment Y (December 12, 2024) | Hickman, Mason, Cantor, California Health Report (February 2026)
UCLA/RAND CalAIM Evaluation (2025–2026) | DHCS CalAIM 1115 Renewal Application (2026) | 42 CFR § 438.3(e)(2)
CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis (February 2026) | DHCS All-Comer Webinar, Tyler Sadwith (2026) | California Budget & Policy Center (2026)
Schubel, Health Affairs Forefront: 'Local Governments Play An Important Role In Medicaid Financing' (March 9, 2026) | Convergence Community Hubs Field Scan (January 2026) | Hickman, CalAIM Field Notes SE-06 (February 2026)

Jim Hickman, Hickman Strategies, Email received on March 12, 2026.

PUBLIC COMMENT
California Advancing and Innovating Medi-Cal (CalAIM)
Section 1115 Demonstration Five-Year Renewal Application
Submitted to: California Department of Health Care Services (DHCS)
Email: 1115Waiver@dhcs.ca.gov
Subject: CalAIM Section 1115 & 1915(b) Waivers
Date: March 12, 2026
Submitted by: Jim Hickman, Principal & Chief Catalyzer, Hickman Strategies LLC | Mark Humowiecki, JD, General Counsel & Senior Director, National Center for Complex Health and Social Needs, Camden Coalition
Capacity: Hickman Strategies LLC: CalAIM Subject Matter Expert | Principal CalAIM Advisor & National Center Advisor, Camden Coalition | Camden Coalition: Approved PATH Technical Assistance Vendor; PATH CPI Facilitator, Merced, Southeast, and Coastal Regions
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INTRODUCTION AND STATEMENT OF INTEREST
Hickman Strategies LLC and the Camden Coalition submit these comments jointly in strong support of the CalAIM Section 1115 demonstration five-year renewal and to offer specific recommendations grounded in more than three decades of healthcare transformation leadership and more than two decades of national complex care implementation.

This submission reflects the combined institutional standing of both co-submitters. Jim Hickman brings direct field experience as a CalAIM Subject Matter Expert and serves as Principal CalAIM Advisor and National Center Advisor with the Camden Coalition — where, in our capacity as PATH Collaborative Planning and Implementation (CPI) facilitator for the Merced, Southeast, and Coastal regions, we have facilitated structured cross-sector collaboration across multiple California counties since November 2022. The Camden Coalition is a nationally recognized leader in complex care, an approved PATH Technical Assistance Marketplace vendor, and the organizational home of the Ecosystems of Care framework and Ecosystem Assessment Tool, which has been adopted by PCG as the reporting framework for PATH CPI facilitators in 2026. Camden Coalition also organizes an annual national complex care conference, which was held in Sacramento in 2022 and will take place in Oakland in the fall, that helps inform our perspectives on CalAIM implementation and complex care policy and practice nationally. Kathleen Noonan, Camden Coalition CEO, also serves as a member of the University of California Board of Regents' Health Services Committee. Our combined experience — locally, nationally, and most importantly in California — informs the recommendations throughout this comment. As both CPI facilitator and co-submitter of this public comment, we acknowledge a dual role: we are implementation partners to DHCS and California's counties, and we are also

stakeholders with a direct interest in the renewal's design. We have made every effort to ensure our recommendations reflect what California's Medicaid members need — not what is administratively convenient for any implementation partner, including ourselves. This submission also draws on the August 2025 Comprehensive Recommendations Memorandum submitted by Jim [redacted] in response to the DHCS Medi-Cal Transformation Concept Paper.

CalAIM represents the most ambitious whole-person care transformation in California Medicaid history. The renewal before us is not simply an administrative continuation — it is a strategic inflection point. H.R. 1, enacted July 4, 2025, places up to $30 billion annually in federal Medicaid funding at risk for California and, according to DHCS estimates, could result in up to 3.4 million Californians losing Medi-Cal coverage. [DHCS, California Health Care Foundation (October 2025); Governor Newsom (June 27, 2025)] The question is not whether to renew CalAIM, but how to build the renewal period into a platform for durable, equitable transformation that can withstand this challenging federal funding environment.

CORE THESIS: Technology enables — but relationships transform. The renewal period must invest deliberately in the infrastructure that sustains cross-sector relationships and

collaboration as it does in data systems and clinical protocols. The Camden Coalition's Ecosystems of Care framework — grounded in more than two decades of building infrastructure for communities serving people with complex needs — is the governing design principle: coordination across stakeholders, sustained by dedicated investment in backbone infrastructure, is what makes whole-person care operationally real.

DHCS RENEWAL STRATEGY: The decision to embed ECM and twelve Community Supports in permanent managed care authorities — rather than renewing them exclusively as 1115 demonstration programs — is the most consequential structural choice in this renewal. These programs are not experiments. They are the operational infrastructure of whole-person Medi-Cal. Our recommendations address what it takes for permanent authority to mean permanent access: at scale, for every eligible member, through a provider network that is both accountable and intact.

SECTION 1: BROAD SUPPORT FOR CORE CALAIM CONTINUATION

We strongly support DHCS's renewal request for the following authorities, which form the foundation of California's whole-person care transformation:

- Enhanced Care Management (ECM) for high-need, high-cost populations
- Community Supports (including the two 1115-authorized services: Housing Transition Navigation Services and Housing Tenancy and Sustaining Services)
- In Lieu of Services (ILOS) framework for the remaining twelve Community Supports under 42 CFR Section 438.3(e)(2)
- Pre-release and post-release Medi-Cal services for justice-involved populations
- Global Payment Program for Public Health Care Systems
- Delivery system authorities through the 1915(b) waiver (managed care, specialty mental health, DMC-ODS, dental managed care)
- BH-CONNECT authority for behavioral health continuum services

The evidence base supporting these initiatives is now substantial. Community Supports have moved from pilot to statewide mandate. ECM operates as a statewide benefit across all 58 counties, though the California Legislative Analyst's Office (LAO) has documented significant variation in provider network depth and utilization rates across plans and counties — a reality the renewal evaluation framework should address. [LAO Report 5003, 2025] The evaluation design approved by CMS confirms a rigorous framework for measuring what works. We urge DHCS to ensure the renewal application communicates this evidence base with specificity, as CMS will face questions from federal policymakers about the return on California's investment.

EVIDENCE: CalAIM's HRSN Community Supports Protocol (CMS-approved January 2025) establishes the authorization infrastructure, data exchange requirements, and evaluation

framework that position California to demonstrate impact at scale. This is foundational — the renewal protects it.

SECTION 2: PATH INFRASTRUCTURE — DOCUMENTING WHAT WE BUILT, PROTECTING WHAT IT PRODUCED

The Providing Access and Transforming Health (PATH) initiative — authorized under DSHP funding now ending — created collaboration infrastructure that CalAIM's clinical programs depend upon but cannot replace on their own. We have facilitated PATH CPI meetings across multiple California counties and can speak with specificity about what PATH produced.

The UCLA and RAND independent evaluation of PATH — required by the 1115 demonstration and currently underway — has documented very substantial capacity building: significant increases in the number of ECM and Community Supports users, contracted providers, and broad adoption of CalAIM programs across counties. [UCLA/RAND CalAIM PATH Evaluation, 2025-2026] This is the government's own evaluation confirming the infrastructure value we document below. Our recommendation for structured PATH transition documentation is a direct response to that finding: what the evaluation confirms was built should not be allowed to dissipate without a record of what it produced and how it can be sustained and evolved.

QUESTION: What did PATH produce, and what is at risk when it sunsets at the end of the current waiver?

EVIDENCE: PATH funded cross-sector convening, shared data infrastructure, and collaborative planning capacity that allowed counties to transition WPC pilots into ECM and Community Supports at scale. The EDIE digital safety net deployment connecting multiple hospitals — identifying thousands of shared patients — exemplifies the kind of system connecting infrastructure PATH enabled. PATH's CPI facilitation created county level tables where managed care plans, CBOs, behavioral health agencies, housing departments, and justice partners could develop shared workflows, not just data agreements.

RECOMMENDATION: DHCS should use the renewal period to document the PATH infrastructure investment in measurable terms — counties convened, shared patients identified, cross-sector workflows formalized, ECM ramp-up rates in counties with strong CPI infrastructure, ECM enrollment, and other measures that show uptake versus those without. This documentation serves two purposes: it demonstrates CalAIM ROI to CMS and it creates a baseline of the current connective tissue within regional ecosystems while facilitating efforts to sustain and grow that infrastructure using alternative financing (MCP-funded TA, community-sustained convening, philanthropic bridging).

The Camden Coalition has facilitated PATH Collaborative Planning and Implementation convenings across the Merced, Southeast, and Coastal regions since November 2022. In that time, we observed county ecosystems move from parallel organizational siloes to coordinated cross-sector collaborators — and we have observed what happens when the scaffolding of facilitation is removed without a successor infrastructure in place. The documentation requirement in Recommendation 2.1 is not a theoretical proposal. It reflects what Camden has seen built — the trusted relationships, shared data practices, and cross-sector accountability structures that take months and years to construct — and what we have seen become fragile when grant cycles end without a transition plan. California has built something real under PATH. This recommendation is about ensuring the renewal period captures what was built, so that it can be sustained.

For example, in early 2023, the Merced Community Action Agency (Merced CAA) began attending Merced CPI meetings. After participating in CPI presentations and discussions, Merced CAA developed a stronger understanding of the CalAIM opportunity and the long term value it could create for both the organization and the populations it serves. Through the CPI, Merced CAA was connected with the managed care plan, CCAH, and ultimately enrolled as both an Enhanced Care Management (ECM) provider and a Community Supports Housing Trio provider. They worked closely with CCAH to align on service capacity and received an IPP grant to purchase additional space to support program growth. Merced CAA then became a leader within the Merced CPI, helping coach other community-based organizations on the opportunity and the steps needed to be successful. According to the latest implementation report, Merced now has among the highest penetration rates for services among individuals experiencing homelessness, and the highest among counties that did not previously participate in Whole Person Care. While Merced CAA, other housing providers, and CCAH deserve the credit for this success, the CPI table served as a catalyst to activate and support this community of providers.

Recommendation 2.1: Establish a PATH Transition Documentation Requirement

We recommend DHCS establish a structured documentation requirement in the renewal application that captures: (1) county-level ECM and Community Supports ramp-up rates correlated with PATH CPI participation; (2) cross-sector agreements and workflows formalized under PATH; and (3) data infrastructure investments that will persist post-PATH. This record serves federal accountability and informs the design of successor collaboration infrastructure.

Recommendation 2.2: Create a Managed Care Collaboration Infrastructure Mechanism

With DSHP authority unavailable for PATH renewal, the collaboration infrastructure it funded must find a new home. We recommend DHCS explore whether the renewal STCs can authorize MCPs to fund shared technical assistance and cross-sector convening as a permissible managed care administrative expense. The Camden Coalition's Ecosystems of

Care framework — the intellectual foundation of PATH CPI facilitation — defines backbone coordination explicitly as a sustainability domain, not overhead: infrastructure that requires dedicated investment like any other infrastructure if it is to survive funding transitions. [Camden Coalition, Ecosystems of Care Framework; Camden Coalition Ecosystem Assessment Tool, 2024] The policy rationale for the renewal is straightforward: collaboration infrastructure that enables better ECM and Community Supports performance is a legitimate managed care investment. California's MCPs are well-positioned to sustain CPI-style tables in the counties where they operate.

DHCS DATA + FIELD CONFIRMATION: DHCS has identified a concrete, verifiable measure of backbone infrastructure progress: the percentage of cross-sector partners who text or call each other directly when issues arise — without routing through a convener. In DHCS's own webinar data, 47% of partners communicate through formal channels only; just 22% have reached the level of direct peer to peer communication that signals real collaboration infrastructure. [DHCS, "The Fierce Urgency of Community Partnerships," 2025] In our capacity as PATH CPI facilitators, we observe this same pattern across county tables. The Camden Coalition's Ecosystem Assessment Tool — which formalizes the Ecosystems of Care framework — places this measure within its 'teaming and collaboration' domain: backbone infrastructure can enable progress that is visible to MCPs, investors, and county leadership, and that precedes every coordinated outcome on a shared dashboard. Moving from 22% to 50% direct-contact relationships is not a soft goal. It is a governance milestone. Trust is infrastructure — and unlike data systems, it cannot be reconstructed quickly if it sunsets now. We cannot afford to rebuild it during a coverage crisis. Technology enables the identification of who needs to be reached. Relationships determine whether they get there. The PATH Transition Documentation Requirement in Rec 2.1 should establish this DHCS-measured baseline as a required metric — and the renewal STCs should make it a reportable standard going forward. [Camden Coalition Ecosystem Assessment Tool, 2024; Hickman, CalAIM Field Notes SE-06, February 2026]

SECTION 3: COMMUNITY SUPPORTS DATA INFRASTRUCTURE — ORCHESTRATION AS THE CORE STRATEGY

DHCS has framed the next phase of CalAIM as a deliberate shift from infrastructure-building (2022-2026) to utilization, quality, and performance — what the renewal application describes as the maturation of Community Supports from demonstration to embedded managed care benefit. [DHCS CalAIM Concept Paper, July 2025] We endorse this framing entirely, and our recommendations in this section are designed to operationalize it.

The California Budget & Policy Center has documented that Community Supports has already reached approximately 430,000 Californians. [California Budget & Policy Center,

2026] That number is a foundation to build on — and it makes the utilization gap more, not less, urgent to close. Field observation across our CPI facilitation engagements in multiple California counties, corroborated by the LAO's 2025 analysis, suggests that ECM enrollment of eligible members remains substantially below what the program's design would support. [LAO Report 5003, 2025] 430,000 members reached is a real achievement. The architecture capable of reaching the full eligible population is what the renewal period must invest in.

And the stakes of that investment have never been higher. Under H.R. 1, every member whose Medi-Cal coverage lapses is an ECM care plan that dies. A Community Supports referral that resets. A trusted relationship that took months to build, severed by an administrative gap that policy alone did not close. The data infrastructure recommendations in this section are not technical upgrades — they are the mechanisms by which 430,000 becomes one million, and by which coverage continuity becomes a system property rather than a provider-by-provider aspiration.

The CMS-approved HRSN Community Supports Protocol (Attachment X, January 2025) establishes specific data exchange requirements: Member Information Sharing Guidance, Authorization Status Files, Provider Transmission Files, and Data Exchange Framework integration. These requirements are the right architecture. The challenge is the gap between what the Protocol requires and what is actually flowing between MCPs and CBOs on the ground.

QUESTION: Why is data exchange between MCPs and Community Supports providers still inconsistent four years into CalAIM implementation?

EVIDENCE: Our field facilitation across multiple counties reveals a consistent pattern: the standards exist, but the implementation supports — technical assistance, standardized integration pathways, and workflow training — has not kept pace with the mandate. Community Supports providers, particularly smaller CBOs, face documentation burdens that consume capacity that should be directed toward member services. MCPs, operating across multiple counties with different CBO ecosystems, lack standardized integration pathways that would allow technology platforms to connect consistently. The result is that Community Supports authorizations happen, but the closed-loop referral data that would allow MCPs to improve targeting and CBOs to demonstrate impact is incomplete.

RECOMMENDATION: The renewal period is the opportunity to establish orchestration as the governing framework: connecting the systems that exist rather than mandating new ones, building shared integration standards that allow any certified Community Supports platform to connect to any MCP, and investing in the CBO data readiness that makes participation sustainable.

Recommendation 3.1: Establish a Community Supports Data Readiness Fund

We recommend DHCS include in the renewal application a request for authorization of a Community Supports Data Readiness Fund — analogous to the data exchange investments authorized in other state 1115 demonstrations — that provides CBOs with the technical assistance and infrastructure support needed to meet HRSN Protocol requirements. A $10-20M fund administered through DHCS or a qualified intermediary would create a significant return on investment through improved closed-loop referral rates and more accurate Community Supports outcome data.

Recommendation 3.2: Extend HRSN Data Standards to All ILOS Community Supports

The approved Protocol applies specifically to the two 1115-authorized Community Supports. We recommend DHCS use the renewal period to establish equivalent data exchange standards for all twelve ILOS Community Supports. Consistent standards across the full menu will enable statewide learning, reduce the MCP compliance burden (one standard, not thirteen), and create the data infrastructure needed for the evaluation design to capture Community Supports impact at scale.

ORCHESTRATION PRINCIPLE: The goal is not more data systems — it's connecting the ones we have. A single authorization-to-outcome data thread from MCP referral through CBO delivery to health outcome is more valuable than twelve separate reporting streams. This is the Camden Coalition's Ecosystems of Care principle in practice: coordination infrastructure, not digitization, is what closes the gap between authorization and outcome.

SECTION 3.5: RECUPERATIVE CARE AND THE ROOM-AND-BOARD TRANSITION RISK

The renewal application confirms that Short-Term Post-Hospitalization Housing (STPH) will be discontinued as a standalone Community Support and incorporated into an expanded Recuperative Care model under ILOS managed care authority, effective January 1, 2027. [DHCS CalAIM 1115 Renewal Application, 2026] We support the move to a more durable managed care authority.

We raise one implementation concern that warrants attention before the renewal is finalized: federal ILOS rules under 42 CFR Section 438.3(e)(2) prohibit reimbursement for room and board. The current STPH benefit includes a housing cost component that the ILOS-based Recuperative Care model may not be able to fully replicate. We recommend DHCS conduct a gap analysis — before final submission to CMS — of the difference between what STPH currently covers for post-hospitalization housing and what an ILOS-authorized Recuperative Care model can cover under the room-and-board prohibition. If a gap exists, we urge DHCS to identify a companion state plan mechanism or supplemental state funding that preserves the member-facing service. Structural authority

improvements should not produce functional service reductions for members most in need of stable post-hospital housing.

SECTION 4: EMPLOYMENT SUPPORTS — IMPLEMENTATION ARCHITECTURE FOR MEMBER SUCCESS

The Employment Supports request is the most strategically significant new initiative in the renewal application. We strongly support DHCS's decision to establish a proactive member success framework for employment services. A critical legal and strategic point: H.R. 1's work requirements — effective January 1, 2027 — are a federal statutory mandate that cannot be waived under Section 1115 authority. [Health Management Associates, December 2025; KFF, July 2025] California's Employment Supports request is therefore not an alternative to work requirements; it is the infrastructure for implementing them in a way that protects coverage for members who are eligible or who qualify for an exemption. We offer the following implementation architecture recommendations.

QUESTION: What determines whether Employment Supports becomes a genuine member success pathway versus a bureaucratic compliance exercise?

EVIDENCE: The evidence from states that have implemented community engagement requirements — including Arkansas, Georgia, and Michigan — indicates that outcomes are strongly shaped by implementation architecture. States where MCPs, CBOs, workforce agencies, and county eligibility systems operated in coordinated workflows achieved substantially higher engagement rates; states where systems operated independently saw substantially higher disenrollment rates, even among members who were technically eligible. [Urban Institute, Medicaid Work Requirements Research, 2019-2023; KFF State Medicaid Community Engagement Requirements Analysis] The difference was not member motivation or eligibility — it was system design.

RECOMMENDATION: Employment Supports must be designed from the start as an integrated workflow, not a standalone benefit. The critical design decisions are: (1) how Employment Supports providers connect to ECM care plans; (2) what data flows between workforce agencies and MCPs; (3) how exemption processes are operationalized to be accessible, not just technically available; and (4) how the system prevents coverage loss for members who are engaged but face barriers the system hasn't yet resolved.

Recommendation 4.1: Support County Readiness and Establish a Statewide Exemption Floor
The renewal application describes Employment Supports as a voluntary initiative for counties or county-based entities — a design we support as consistent with California's county administered service architecture. [DHCS CalAIM 1115 Renewal Application, 2026] We recommend DHCS supplement the county opt-in design with two elements: (1) a

County Employment Supports Readiness Initiative — targeted technical assistance and planning support for counties that wish to participate but face infrastructure barriers, ensuring that the program's benefits are accessible to members regardless of which county they live in; and (2) a set of statewide floor requirements, applicable in all 58 counties regardless of Employment Supports participation, specifically around proactive outreach and screening for work requirement exemptions.

The county opt-in architecture is sound — and it makes the exemption floor more important, not less. Where counties choose not to participate, eligible members still carry the risk of a work requirement. The statewide exemption screening requirement is what ensures that risk does not fall unevenly on the members least equipped to navigate it alone.

Recommendation 4.2: Invest in Proactive Exemption Processing — In All Counties

The exemption categories in H.R. 1 are broad — caregiving responsibilities, disability, housing instability, among others. The implementation risk is that members who qualify for exemptions lose coverage because the exemption process is difficult to navigate — and DHCS's own implementation planning makes this risk concrete: of the approximately 2.8 million new adult group members expected to require manual verification when automated ex parte checks fail, DHCS estimates that up to 50% could lose coverage from administrative burden alone — not because they are ineligible, but because the system cannot reach them in time. [DHCS All-Comer Webinar, Tyler Sadwith, 2026; Hickman, CalAIM Field Notes SE- 06, February 2026] This risk exists whether or not a county has opted into Employment Supports. We recommend DHCS establish, in the renewal STCs, a requirement that MCPs proactively screen members for exemption eligibility and document that screening before any coverage action related to work requirement non-participation, statewide and without exception. The alternative is coverage loss at scale for people the program is designed to serve.

Recommendation 4.3: Build a Community-Based Workforce Partnership Infrastructure in Opt-In Counties

In counties that opt into Employment Supports, DHCS should establish a certification pathway for CBOs — particularly those already providing Community Supports — to deliver Employment Supports services. Organizations already trusted by Medi-Cal members for housing, food, and transportation support are natural employment support partners. We also recommend that MCP referral protocols in opt-in counties connect Employment Supports to ECM care plans for members enrolled in both, ensuring employment goals are a documented element of the member's ECM assessment rather than a parallel compliance track. Camden Coalition has long included employment as a core domain of care planning for even those individuals with the most complex needs.

SECTION 5: BRIDGECARE PILOTS — THE INSTITUTIONAL DIVERSION CASE

We strongly support the BridgeCare Pilots request and recommend DHCS frame this initiative in the renewal application with specific emphasis on institutional diversion and total cost of care reduction. In the current federal environment, HCBS investments are most likely to secure CMS approval when framed as alternatives to more expensive institutional placement — not primarily as quality-of-life or social determinants investments.

QUESTION: What is the strongest framing for BridgeCare that will resonate with the current CMS posture?

EVIDENCE: The CMS Independence at Home Demonstration documented $3,500 per member per year in savings through reduced readmissions for older adults receiving homebased primary care. [CMS Independence at Home Demonstration Evaluation, Avalere Health, 2023] The PACE program — which BridgeCare draws from — has 30+ years of evidence showing that comprehensive home and community-based services delay or prevent nursing facility placement. [Ghosh et al., Health Affairs, 2015; CMS PACE Evaluation Reports] California's Medi-Cal nursing facility costs average more than $114,000 per member per year— more than $312 per day — according to Justice in Aging. [Justice in Aging, cited in CalMatters, June 2025] A BridgeCare investment of $200/month per member is cost-effective against even a modest reduction in nursing facility days.

RECOMMENDATION: Position BridgeCare explicitly as an institutional diversion strategy in the renewal application narrative. Quantify the avoided institutional cost. Establish evaluation metrics that measure nursing facility placement rates, readmission rates, and total cost of care — not just process measures. This framing is both accurate and strategically aligned with a CMS that prioritizes value and cost containment.

Recommendation 5.1: Establish BridgeCare-ECM Integration for Complex Older Adults

We recommend the BridgeCare pilot design require coordination protocols with ECM for dually eligible members. Older adults with complex health needs who qualify for both BridgeCare and ECM represent the highest-cost cohort — and the greatest opportunity for total cost of care reduction. Integrating BridgeCare home modification, personal care, and respite services with ECM care coordination will generate the outcome data that supports statewide expansion.

Recommendation 5.2: Include Caregiver Support as a BridgeCare Core Component

The evidence is clear that caregiver burnout is a primary driver of nursing facility placement for older adults with complex needs. We recommend BridgeCare include structured caregiver support — respite care, navigation, training — as a core component alongside

member-directed services. This is consistent with the CalAIM dyadic services model for children's care and extends the same logic to older adult care.

SECTION 6: REENTRY SERVICES — ALL-COUNTY READINESS AND THE IT INFRASTRUCTURE GAP

The all-county mandate for pre-release Medi-Cal services by October 2026 is a significant implementation challenge for counties that are just beginning this work. As a CPI facilitator working across counties at different stages of CalAIM readiness, we offer targeted recommendations for the renewal period.

Early evaluation of the Justice-Involved Reentry Initiative — including RAND's analysis of focal counties — documents strong early results: approximately 35,000 individuals identified as eligible and 64,500 pre-release services delivered in the program's first year of operation, with evidence of improved care transitions and growing cross-system coordination among corrections, behavioral health, and community providers. [RAND CalAIM Evaluation, 2025; DHCS CalAIM Evaluation Highlights] These results confirm the strong foundation described in the renewal application — and they also underscore the infrastructure investment required. This level of cross-system coordination was not spontaneous; it was built through PATH-funded capacity development that is now sunsetting. The renewal must account for what replaces it.

QUESTION: What implementation barriers are preventing counties from achieving the all-county pre-release mandate?

EVIDENCE: Field observations across multiple counties identify three consistent barriers: (1) data matching — connecting CDCR and county jail identifiers to Medicaid records requires IT investment that many counties have not yet made; (2) warm handoff infrastructure — the relationship between pre-release planners and community-based providers who receive individuals post-release requires active development, not just referral protocols; and (3) MCP-corrections agency partnership formalization — the data sharing agreements and care coordination workflows between MCPs and corrections settings are at varying levels of development across counties.

RECOMMENDATION: The renewal application should include explicit performance metrics for the all-county rollout: percentage of eligible individuals receiving pre-release assessments, Medi-Cal enrollment rates at release, 30-day and 90-day healthcare engagement post-release. The RAND evaluation focal counties provide a learning laboratory — the STCs should establish a mechanism for rapid learning dissemination to the remaining counties.

Recommendation 6.1: Authorize Reinvestment Funds for Warm Handoff Infrastructure

STC 9.11's reinvestment requirement — that new FFP generated from previously-state-funded carceral services be reinvested in community-based capacity — is a powerful mechanism. We recommend DHCS explicitly expand the allowable reinvestment categories to include warm handoff infrastructure: CHW pre-release outreach, CHW peer support in the 30 days post-release, and the technology investments that enable data continuity between corrections settings and community providers.

Recommendation 6.2: Establish a Cross-County Learning Collaborative for Justice Services

Given the wide variation in county readiness for reentry services, we recommend DHCS establish — or authorize MCPs to fund — a structured learning collaborative for justice-involved population implementation. Counties that have achieved strong pre-release service infrastructure can accelerate learning in counties still developing capacity. This is a PATH CPI-style model applied to a specific population, and it is exactly the kind of infrastructure that the renewal period should invest in. The governing principle is the same one that applies across CalAIM's implementation challenge: data systems can identify who is eligible, but only coordinated, trusted cross-sector relationships can ensure those individuals are actually reached, enrolled, and served — across county boundaries, across coverage gaps, and across the corrections-to-community transition that defines this population's experience. A learning collaborative can facilitate broader adoption of emerging best practices from leading counties and also serve as a sandbox in which to identify and create tools and resources to solve
common problems across the state.

SECTION 7: FEDERAL RISK MITIGATION — BUILDING RESILIENCE INTO THE RENEWAL STRUCTURE

The renewal application will be negotiated against the backdrop of H.R. 1 Medicaid provisions that represent the most significant federal threat to California's Medi-Cal system in a generation. The DSHP approval letter documents a Total DSHP Cap of $1.29 billion — funding now at risk. California's county associations have quantified the downstream fiscal impact: the combined annual cost to California counties from H.R. 1 is projected at $6 billion to $9.5 billion — comprising $2B-$5.5B in indigent care costs for residents losing Medi-Cal, $3.4 billion in public hospital revenue losses from State Directed Payment reductions, and nearly $600 million in county workforce costs to administer the new eligibility requirements alone. [CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis, February 2026] DHCS's own Medicaid Director has provided phased coverage loss projections: up to 233,000 losing coverage by June 2027, up to 1 million by January 2028, and up to 1.4 million at full implementation. [DHCS All-Comer Webinar, Tyler Sadwith, 2026] Note: the Introduction references the pre-enactment DHCS estimate of up to 3.4 million — a figure reflecting a broader scenario range developed before H.R. 1's

final provisions were known; Sadwith's phased projections reflect DHCS's post-enactment operational planning. Both are DHCS sources; the range between them documents the genuine uncertainty California's planning must accommodate. These are not projections from advocacy organizations. They are the state's own estimates and the counties' own fiscal analysis. The renewal must be built to withstand them.

We name these numbers not to frame this renewal as a defensive exercise, but because clarity about what is at stake is what makes the possibilist case compelling. CalAIM's infrastructure— the ECM care relationships, the Community Supports networks, the cross-sector coordination tables built through PATH — is precisely what California needs most right now. A renewal designed with resilience is not a retreat from ambition. It is the architecture that allows the program to do more, for more people, under more pressure than it was originally designed to face. The six months between now and January 1, 2027 are the most consequential implementation window in CalAIM's history. What we resource before that window closes determines what thrives beyond it.

California's Medicaid financing faces pressure on three simultaneous fronts — not two. H.R. 1 directly targets health care-related provider taxes, phasing the maximum allowable rate from 6% to 3.5% beginning in federal fiscal year 2028. The MCO tax — made permanent by Proposition 35 but requiring federal reapproval — faces the same prohibition. And now the Trump Administration has moved to its second target: the intergovernmental transfer (IGT) and certified public expenditure (CPE) mechanisms that constitute the third leg of California's Medicaid financing structure. The Administration has solicited stakeholder feedback, due March 30, 2026, on how to prevent 'fraud, waste, and abuse' related to IGTs — a framing that mirrors the political strategy used to build the case for provider tax restrictions before H.R. 1. California's DSHP itself operated through CPE methodology under Attachment Z of the CMS approval letter. That mechanism is now under active federal scrutiny. [Schubel, Health Affairs Forefront, March 9, 2026] We offer three structural recommendations for building resilience into the renewal design.

Recommendation 7.1: Build Budget Neutrality on Conservative Federal Scenarios

Budget neutrality methodology is the primary federal lever for limiting state demonstration expenditures. We recommend DHCS develop the renewal's budget neutrality demonstration on a range of federal scenarios — including partial FMAP reduction and work requirement implementation costs — to ensure California does not face mid-demonstration renegotiation. A renewal built on optimistic assumptions about federal policy continuity creates structural fragility.

Recommendation 7.2: Establish Evaluation Design as a Federal Advocacy Asset

The CalAIM Evaluation Design approved by CMS in early 2026 is not just an accountability mechanism — it is a federal advocacy asset. We recommend DHCS design the renewal-period evaluation with explicit attention to metrics that speak to the current federal

priorities: cost containment, employment outcomes, reduction of unnecessary institutional utilization, and efficient use of Medicaid dollars. When California demonstrates that CalAIM saves more than it costs, that data protects the program.

Recommendation 7.3: Create a Multi-Payer Sustainability Pathway

California's MCO tax — made permanent under state law by Proposition 35 in November 2024 — generates approximately $8-10 billion in gross revenue annually and has been a critical non-federal financing tool for Medi-Cal. [LAO Ballot Analysis, Initiative 2023-024; LAO Report 4992, 2025] However, H.R. 1 prohibits states from charging substantially higher tax rates on Medicaid enrollment than on commercial enrollment — a prohibition that directly targets California's rate structure. CMS finalized a rule codifying this restriction on January 29, 2026. The path to federal reapproval of the MCO tax under the new rules is uncertain. At the same time, the Trump Administration is now targeting the IGT and CPE mechanisms — the third leg of California's Medicaid financing structure — with a stakeholder comment deadline of March 30, 2026. All three non-federal financing legs face simultaneous federal pressure. The renewal must name this convergence explicitly and authorize DHCS to pursue alternative financing architecture. We recommend four specific pathways:

- Authorize and direct MCPs to designate backbone coordination infrastructure — cross-sector convening capacity, coverage continuity outreach, and cross-boundary data governance — as named investments in their Q3 2026 community reinvestment plans, which require MCPs to reinvest 5-7.5% of net profits in community health infrastructure. This window closes when plans are filed; what is not named will not be funded for the following three years — precisely the period when H.R. 1's first wave lands. Note: H.R. 1's $3.4 billion in State Directed Payment losses to public hospitals puts MCP profitability under direct pressure; plans that report operating losses owe nothing under current requirements. Moving before Q3 2026 is not optional — it is time-bounded. [Hickman, CalAIM Field Notes SE-06, February 2026]

- Align CalAIM's evaluation and community health investment criteria with CalPERS's Total Portfolio Approach, which goes live July 1, 2026 — creating a formal pathway for community health infrastructure to be recognized as a legitimate investment category within CalPERS's portfolio. [CalPERS Board Investment Committee, November 2025; CalPERS Total Portfolio Approach Framework] California's I-Bank provides loan guarantees of up to $5M for smaller projects and $5-30M for community infrastructure through its Climate Catalyst and CDLAC programs; COIN, administered by the California Department of Insurance, connects insurers to community development investment pipeline. [California IBank Program Guidelines; COIN Program Overview, CA Dept. of Insurance] These instruments are available now. They require a creditworthy county-level governance entity to receive and deploy capital across funding streams — exactly the backbone infrastructure the renewal period should authorize and resource.

- Pursue Social Impact Bond structures for reentry services and Community Supports — particularly recuperative care, housing navigation, and employment transition supports — where the total cost of care savings are documentable and the payer ecosystem is sufficiently organized to support a multi-year payment model.

- Urge DHCS to formally respond to the Trump Administration's March 30, 2026 IGT/CPE stakeholder comment solicitation and include in the renewal application an explicit defense of California's CPE methodology — documented in Attachment Z of the CMS DSHP approval letter — as a transparent, CMS-approved financing mechanism with a verifiable non-federal share. The Health Affairs analysis published March 9, 2026 is correct: local government financing mechanisms are the third leg of the Medicaid financing stool, and protecting them requires building a public record before restrictions are proposed — not after. [Schubel, Health Affairs Forefront, March 9, 2026]

SECTION 8: WORKFORCE, ECM SUSTAINABILITY, AND PROVIDER NETWORK ACCOUNTABILITY

CalAIM's clinical ambitions depend on a workforce California has not yet fully built, and a CBO provider network navigating simultaneous pressure from two directions. ECM Lead Care Managers, Community Health Workers, and peer support specialists are the human infrastructure of whole-person care. The renewal period must invest in sustaining this workforce — and must address two structural vulnerabilities that field observation and publicly available documentation place squarely before this renewal.

The scale of new workforce burden is quantified. California's county associations estimate that H.R. 1's new eligibility requirements alone will impose nearly $600 million in new county workforce costs — just to administer six-month renewals, work requirement verification, and increased eligibility foot traffic. [CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis, February 2026] The county eligibility workers carrying that burden are the same workforce whose relationship with CBOs determines whether ECM care plans survive coverage churn, whether Community Supports referrals are rebuilt after a gap, and whether the 50% of members who fail automated ex parte checks are reached before they disappear from the system. Workforce investment and coverage continuity are the same question at the county level.

The workforce challenge is not only quantitative — it is qualitative. ECM Lead Care Managers are being asked to navigate one of the most complex care coordination roles in Medicaid: managing caseloads that frequently include members with co-occurring behavioral health conditions, housing instability, and chronic disease, often without the clinical supervision infrastructure that would exist in a traditional health system setting. California has not yet established statewide competency standards for ECM LCMs, nor has it built a consistent training and supervision framework that travels with the role across

the diverse organizational settings — CBOs, health plans, FQHCs — where ECM is delivered. The renewal period is the appropriate vehicle to establish that infrastructure: not as a compliance burden, but as a professional foundation that makes retention possible and quality measurable.

The CBO provider network faces pressure from two directions simultaneously — and both require a response in this renewal. The first is federal scrutiny: CMS has intensified program integrity oversight on Community Supports providers, CBOs, and the expansion of social and health-related services through Medicaid at a national level — an environment documented across multiple state Medicaid programs and reflected in recent CMS correspondence to states. DHCS and California's MCPs must demonstrate rigorous provider enrollment and oversight. Strong oversight and broad access are not competing goals — they are reinforcing ones, and the design of oversight mechanisms will determine which of those outcomes is achieved. The second is market austerity: the California Legislative Analyst's Office has documented significant variation in ECM enrollment rates and Community Supports utilization across managed care plans [LAO Report 5003, 2025] — a pattern corroborated by field observation across CalAIM implementation counties and provider stakeholder communications, indicating that some MCPs are taking an austerity-focused approach to ECM and Community Supports network investment — pausing provider contracting and reducing administrative investment in these programs — even as DHCS's renewal strategy treats them as permanent managed care responsibilities. These two dynamics together constitute the most pressing implementation risk in the renewal period, and they require a public record response.

- Establish ECM workforce retention metrics as a statewide performance measure — tracking not just enrollment but Lead Care Manager caseload, turnover rates, and compensation benchmarks

- Establish statewide ECM Lead Care Manager competency standards within the renewal STCs — defining core knowledge domains, required training, minimum supervision ratios, and a continuing education framework — and authorize MCPs to fund LCM training and professional development as a managed care administrative expense, consistent with the workforce investment rationale that already applies to CHW professional development

- Authorize MCPs to fund CHW professional development and technology support as a managed care administrative expense within the renewal STCs

- Establish a CHW career pathway framework within the renewal, building on the Song-Brown workforce investment model (currently authorized through DSHP at $310.6M in DSHP-eligible expenditures) and plan now for the funding cliff when DSHP authority ends December 31, 2026, as Song-Brown continuation will depend on state appropriations alone

- Require ECM contracting standards that ensure CBO ECM providers are compensated on a schedule that does not require unreimbursed bridge financing — CBOs are currently absorbing 60 to 90 days of unreimbursed costs as an invisible subsidy to the Medi-Cal transformation — a pattern consistent with national findings on Medicaid managed care payment timing and widely reported by California CBO provider networks — an unsustainable practice that erodes organizational capacity over time [Hickman, Mason, and Cantor, California Health Report, February 2026; consistent with MACPAC findings on Medicaid payment adequacy for community-based providers]

- Establish a graduated program integrity framework for ECM and Community Supports providers that leads with technical assistance and corrective action plans — not network termination — as the first-line response to compliance concerns; distinguish oversight standards for smaller, community-embedded CBOs from those applicable to larger healthcare entities; and require public reporting on provider network stability metrics so access erosion is visible and addressable

- Establish minimum MCP performance standards for ECM enrollment rates and Community Supports utilization in the renewal STCs — specific, measurable, and enforceable — with public quarterly reporting and a remediation pathway for MCPs below threshold. This is where the governing principle becomes an accountability standard: without contractual performance expectations, the program can have every data system it needs and still fail the members it was built to serve. Technology enables the coordination. Relationships — between MCPs, CBOs, counties, and members — transform it into outcomes. Both require sustained investment, and the renewal STCs are where that investment becomes a requirement rather than a recommendation.

CONCLUSION: A RENEWAL BUILT FOR WHAT COMES NEXT

California stands at an extraordinary moment. The CalAIM renewal we are commenting on today is the bridge between what we built and what we can sustain — and between a relatively favorable federal environment and a more challenging one. The recommendations in this comment are designed to strengthen that bridge: to document what CalAIM has produced, to address the implementation gaps that field experience reveals, and to build structures that can withstand federal policy uncertainty.

We are possibilists about CalAIM's future. The evidence that whole-person care, addressed through coordinated ECM, Community Supports, and cross-sector collaboration, reduces total cost of care and improves health outcomes is now substantial. California's renewal application can put that evidence in federal hands in a form that protects the program.

We look forward to DHCS's continued partnership in making this renewal the foundation for the next phase of California's Medi-Cal transformation. The Camden Coalition's two decades of complex care implementation and Hickman Strategies' field experience across California's CalAIM counties arrive at the same conclusion: the infrastructure that connects systems and the relationships that make those connections real are not soft investments. They are the mechanism by which policy becomes outcomes for people with the most complex needs. Both require sustained investment — and this renewal is where that investment becomes a requirement rather than an aspiration.

Respectfully submitted,

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This public comment reflects the independent professional analysis of both co-submitters: more than three decades of healthcare transformation experience (Hickman Strategies LLC) and more than two decades of national complex care implementation (Camden Coalition). It draws on publicly available CalAIM documentation, field experience facilitating PATH CPI implementation in multiple California counties, and the August 2025 Comprehensive Recommendations Memorandum submitted in response to the DHCS Medi-Cal Transformation Concept Paper.

Key sources: DHCS via Transform Health (October 2025) | California Health Care Foundation (October 2025) | Governor Newsom (June 27, 2025) | LAO Reports 5003 and 4992 | KFF (July 2025) | HMA (December 2025) | CHCS (December 2025) | CMS DSHP Approval Letter Attachment Y (December 12, 2024) | Hickman, Mason, Cantor, California Health Report (February 2026) | UCLA/RAND CalAIM Evaluation (2025-2026) | DHCS CalAIM 1115 Renewal Application (2026) | 42 CFR Section 438.3(e)(2) | CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis (February 2026) | DHCS All-Comer Webinar, Tyler Sadwith (2026) | California Budget & Policy Center (2026) | Schubel, Health Affairs Forefront: 'Local Governments Play An Important Role In Medicaid Financing' (March 9, 2026) | Convergence Community Hubs Field Scan (January 2026) | Hickman, CalAIM Field Notes SE-06 (February 2026)

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PUBLIC COMMENT

California Advancing and Innovating Medi-Cal (CalAIM)

Section 1115 Demonstration Five-Year Renewal Application

Submitted to:	California Department of Health Care Services (DHCS)
Email:	1115Waiver@dhcs.ca.gov
Subject:	CalAIM Section 1115 & 1915(b) Waivers
Date:	March 12, 2026
Submitted by:	Jim Hickman, Principal & Chief Catalyzer, Hickman Strategies LLC | Mark Humowiecki, JD, General Counsel & Senior Director, National Center for Complex Health and Social Needs, Camden Coalition I
Capacity:	Hickman Strategies LLC: CalAIM Subject Matter Expert | Principal CalAIM Advisor & National Center Advisor, Camden Coalition | Camden Coalition: Approved PATH Technical Assistance Vendor; PATH CPI Facilitator, Merced, Southeast, and Coastal Regions
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Introduction and Statement of Interest

Hickman Strategies LLC and the Camden Coalition submit these comments jointly in strong support of the CalAIM Section 1115 demonstration five-year renewal and to offer specific recommendations grounded in more than three decades of healthcare transformation leadership and more than two decades of national complex care implementation.

This submission reflects the combined institutional standing of both co-submitters. Jim Hickman brings direct field experience as a CalAIM Subject Matter Expert and serves as Principal CalAIM Advisor and National Center Advisor with the Camden Coalition — where, in our capacity as PATH Collaborative Planning and Implementation (CPI) facilitator for the Merced, Southeast, and Coastal regions, we have facilitated structured cross-sector collaboration across multiple California counties since November 2022. The Camden Coalition is a nationally recognized leader in complex care, an approved PATH Technical Assistance Marketplace vendor, and the organizational home of the Ecosystems of Care framework and Ecosystem Assessment Tool, which has been adopted by PCG as the reporting framework for PATH CPI facilitators in 2026. Camden Coalition also organizes an annual national complex care conference, which was held in Sacramento in 2022 and will take place in Oakland in the fall, that helps inform our perspectives on CalAIM implementation and complex care policy and practice nationally. Kathleen Noonan,

Camden Coalition CEO, also serves as a member of the University of California Board of Regents' Health Services Committee. Our combined experience – locally, nationally, and most importantly in California – informs the recommendations throughout this comment. As both CPI facilitator and co-submitter of this public comment, we acknowledge a dual role: we are implementation partners to DHCS and California's counties, and we are also stakeholders with a direct interest in the renewal's design. We have made every effort to ensure our recommendations reflect what California's Medicaid members need — not what is administratively convenient for any implementation partner, including ourselves. This submission also draws on the August 2025 Comprehensive Recommendations Memorandum submitted by Jim Hickman [redacted] in response to the DHCS Medi-Cal Transformation Concept Paper.

CalAIM represents the most ambitious whole-person care transformation in California Medicaid history. The renewal before us is not simply an administrative continuation — it is a strategic inflection point. H.R. 1, enacted July 4, 2025, places up to $30 billion annually in federal Medicaid funding at risk for California and, according to DHCS estimates, could result in up to 3.4 million Californians losing Medi-Cal coverage. [DHCS, California Health Care Foundation (October 2025); Governor Newsom (June 27, 2025)] The question is not whether to renew CalAIM, but how to build the renewal period into a platform for durable, equitable transformation that can withstand this challenging federal funding environment.

[redacted]

CORE THESIS

Technology enables — but relationships transform. The renewal period must invest deliberately in the infrastructure that sustains cross-sector relationships and collaboration as it does in data systems and clinical protocols. The Camden Coalition's Ecosystems of Care framework — grounded in more than two decades of building infrastructure for communities serving people with complex needs — is the governing design principle: coordination across

stakeholders, sustained by dedicated investment in backbone infrastructure, is what makes whole-person care operationally real.

DHCS RENEWAL STRATEGY

The decision to embed ECM and twelve Community Supports in permanent managed care authorities — rather than renewing them exclusively as 1115 demonstration programs — is the most consequential structural choice in this renewal. These programs are not experiments. They are the operational infrastructure of whole-person Medi-Cal. Our recommendations address what it takes for permanent authority to mean permanent access: at scale, for every eligible member, through a provider network that is both accountable and intact.

Section 1: Broad Support for Core CalAIM Continuation

We strongly support DHCS's renewal request for the following authorities, which form the foundation of California's whole-person care transformation:

- Enhanced Care Management (ECM) for high-need, high-cost populations
- Community Supports (including the two 1115-authorized services: Housing Transition Navigation Services and Housing Tenancy and Sustaining Services)
- In Lieu of Services (ILOS) framework for the remaining twelve Community Supports under 42 CFR § 438.3(e)(2)
- Pre-release and post-release Medi-Cal services for justice-involved populations
- Global Payment Program for Public Health Care Systems
- Delivery system authorities through the 1915(b) waiver (managed care, specialty mental health, DMC-ODS, dental managed care)
- BH-CONNECT authority for behavioral health continuum services

The evidence base supporting these initiatives is now substantial. Community Supports have moved from pilot to statewide mandate. ECM operates as a statewide benefit across all 58 counties, though the California Legislative Analyst's Office (LAO) has documented significant variation in provider network depth and utilization rates across plans and counties — a reality the renewal evaluation framework should address. [LAO Report 5003, 2025] The evaluation design approved by CMS confirms a rigorous framework for measuring what works. We urge DHCS to ensure the renewal application communicates this evidence base with specificity, as CMS will face questions from federal policymakers about the return on California's investment.

EVIDENCE

CalAIM's HRSN Community Supports Protocol (CMS-approved January 2025) establishes the authorization infrastructure, data exchange requirements, and evaluation framework that position California to demonstrate impact at scale. This is foundational — the renewal protects it.

Section 2: PATH Infrastructure — Documenting What We Built, Protecting What It Produced

The Providing Access and Transforming Health (PATH) initiative — authorized under DSHP funding now ending — created collaboration infrastructure that CalAIM's clinical programs depend upon but cannot replace on their own. We have facilitated PATH CPI meetings across multiple California counties and can speak with specificity about what PATH produced.

The UCLA and RAND independent evaluation of PATH — required by the 1115 demonstration and currently underway — has documented very substantial capacity building: significant increases in the number of ECM and Community Supports users, contracted providers, and broad adoption of CalAIM programs across counties. [UCLA/RAND CalAIM PATH Evaluation, 2025–2026] This is the government's own evaluation confirming the infrastructure value we document below. Our recommendation for structured PATH transition documentation is a direct response to that finding: what the evaluation confirms was built should not be allowed to dissipate without a record of what it produced and how it can be sustained and evolved.

QUESTION	What did PATH produce, and what is at risk when it sunsets at the end of the current waiver?
EVIDENCE	PATH funded cross-sector convening, shared data infrastructure, and collaborative planning capacity that allowed counties to transition WPC pilots into ECM and Community Supports at scale. The EDIE digital safety net deployment connecting multiple hospitals — identifying thousands of shared patients — exemplifies the kind of system-connecting infrastructure PATH enabled. PATH's CPI facilitation created county-level tables where managed care plans, CBOs, behavioral health agencies, housing departments, and justice partners could develop shared workflows, not just data agreements.
RECOMMENDATION	DHCS should use the renewal period to document the PATH infrastructure investment in measurable terms — counties convened, shared patients identified, cross-sector workflows formalized, ECM ramp-up rates in counties with strong CPI infrastructure, ECM enrollment, and other measures that show uptake versus those without. This documentation serves two purposes: it demonstrates CalAIM ROI to CMS and it creates a baseline of the current connective tissue within regional ecosystems while facilitating efforts to sustain and grow that infrastructure using alternative financing (MCP-funded TA, community-sustained convening, philanthropic bridging).

The Camden Coalition has facilitated PATH Collaborative Planning and Implementation convenings across the Merced, Southeast, and Coastal regions since November 2022. In that time, we observed county ecosystems move from parallel organizational siloes to coordinated cross-sector collaborators — and we have observed what happens when the scaffolding of facilitation is removed without a successor infrastructure in place. The documentation requirement in Recommendation 2.1 is not a theoretical proposal. It reflects what Camden has seen built — the trusted relationships, shared data practices, and cross-sector accountability structures that take months and years to construct — and what we have seen become fragile when grant cycles end without a transition plan. California has built something real under PATH. This recommendation is about ensuring the renewal period captures what was built, so that it can be sustained.

For example, in early 2023, the Merced Community Action Agency (Merced CAA) began attending Merced CPI meetings. After participating in CPI presentations and discussions, Merced CAA developed a stronger understanding of the CalAIM opportunity and the long-term

value it could create for both the organization and the populations it serves. Through the CPI, Merced CAA was connected with the managed care plan, CCAH, and ultimately enrolled as both an Enhanced Care Management (ECM) provider and a Community Supports Housing Trio provider. They worked closely with CCAH to align on service capacity and received an IPP grant to purchase additional space to support program growth. Merced CAA then became a leader within the Merced CPI, helping coach other community-based organizations on the opportunity and the steps needed to be successful. According to the latest implementation report, Merced now has among the highest penetration rates for services among individuals experiencing homelessness, and the highest among counties that did not previously participate in Whole Person Care. While Merced CAA, other housing providers, and CCAH deserve the credit for this success, the CPI table served as a catalyst to activate and support this community of providers.

Recommendation 2.1: Establish a PATH Transition Documentation Requirement

We recommend DHCS establish a structured documentation requirement in the renewal application that captures: (1) county-level ECM and Community Supports ramp-up rates correlated with PATH CPI participation; (2) cross-sector agreements and workflows formalized under PATH; and (3) data infrastructure investments that will persist post-PATH. This record serves federal accountability and informs the design of successor collaboration infrastructure.

Recommendation 2.2: Create a Managed Care Collaboration Infrastructure Mechanism

With DSHP authority unavailable for PATH renewal, the collaboration infrastructure it funded must find a new home. We recommend DHCS explore whether the renewal STCs can authorize MCPs to fund shared technical assistance and cross-sector convening as a permissible managed care administrative expense. The Camden Coalition's Ecosystems of Care framework — the intellectual foundation of PATH CPI facilitation — defines backbone coordination explicitly as a sustainability domain, not overhead: infrastructure that requires dedicated investment like any other infrastructure if it is to survive funding transitions. [Camden Coalition, Ecosystems of Care Framework; Camden Coalition Ecosystem Assessment Tool, 2024] The policy rationale for the renewal is straightforward: collaboration infrastructure that enables better ECM and Community Supports performance is a legitimate managed care investment. California's MCPs are well-positioned to sustain CPI-style tables in the counties where they operate.

DHCS DATA + FIELD CONFIRMATION

DHCS has identified a concrete, verifiable measure of backbone infrastructure progress: the percentage of cross-sector partners who text or call each other directly when issues arise — without routing through a convener. In DHCS's own webinar data, 47% of partners communicate through formal channels only; just 22% have reached the level of direct peer to peer communication that signals real collaboration infrastructure. [DHCS, "The Fierce Urgency of Community Partnerships," 2025] In our capacity as PATH CPI facilitators, we observe this same pattern across county tables. The Camden Coalition's Ecosystem Assessment Tool — which formalizes the Ecosystems of Care framework — places this measure within its 'teaming and collaboration' domain: backbone infrastructure can enable progress that is visible to MCPs, investors, and county leadership, and that precedes every coordinated outcome on a shared dashboard. Moving from 22% to 50% direct-contact relationships is not a soft goal. It is a governance milestone. Trust is infrastructure — and unlike data systems, it cannot be reconstructed quickly if it sunsets now. We

	cannot afford to rebuild it during a coverage crisis. Technology enables the identification of who needs to be reached. Relationships determine whether they get there. The PATH Transition Documentation Requirement in Rec 2.1 should establish this DHCS-measured baseline as a required metric — and the renewal STCs should make it a reportable standard going forward. [Camden Coalition Ecosystem Assessment Tool, 2024; Hickman, CalAIM Field Notes SE-06, February 2026]

Section 3: Community Supports Data Infrastructure — Orchestration as the Core Strategy

DHCS has framed the next phase of CalAIM as a deliberate shift from infrastructure-building (2022–2026) to utilization, quality, and performance — what the renewal application describes as the maturation of Community Supports from demonstration to embedded managed care benefit. [DHCS CalAIM Concept Paper, July 2025] We endorse this framing entirely, and our recommendations in this section are designed to operationalize it.

The California Budget & Policy Center has documented that Community Supports has already reached approximately 430,000 Californians. [California Budget & Policy Center, 2026] That number is a foundation to build on — and it makes the utilization gap more, not less, urgent to close. Field observation across our CPI facilitation engagements in multiple California counties, corroborated by the LAO's 2025 analysis, suggests that ECM enrollment of eligible members remains substantially below what the program's design would support. [LAO Report 5003, 2025] 430,000 members reached is a real achievement. The architecture capable of reaching the full eligible population is what the renewal period must invest in.

And the stakes of that investment have never been higher. Under H.R. 1, every member whose Medi-Cal coverage lapses is an ECM care plan that dies. A Community Supports referral that resets. A trusted relationship that took months to build, severed by an administrative gap that policy alone did not close. The data infrastructure recommendations in this section are not technical upgrades — they are the mechanisms by which 430,000 becomes one million, and by which coverage continuity becomes a system property rather than a provider-by-provider aspiration.

The CMS-approved HRSN Community Supports Protocol (Attachment X, January 2025) establishes specific data exchange requirements: Member Information Sharing Guidance, Authorization Status Files, Provider Transmission Files, and Data Exchange Framework integration. These requirements are the right architecture. The challenge is the gap between what the Protocol requires and what is actually flowing between MCPs and CBOs on the ground.

QUESTION	Why is data exchange between MCPs and Community Supports providers still inconsistent four years into CalAIM implementation?
EVIDENCE	Our field facilitation across multiple counties reveals a consistent pattern: the standards exist, but the implementation supports technical assistance, standardized integration pathways, and workflow training has not kept pace with the mandate. Community Supports providers, particularly smaller CBOs, face documentation burdens that consume capacity that should be directed toward

	member services. MCPs, operating across multiple counties with different CBO ecosystems, lack standardized integration pathways that would allow technology platforms to connect consistently. The result is that Community Supports authorizations happen, but the closed-loop referral data that would allow MCPs to improve targeting and CBOs to demonstrate impact is incomplete.
RECOMMENDATION	The renewal period is the opportunity to establish orchestration as the governing framework: connecting the systems that exist rather than mandating new ones, building shared integration standards that allow any certified Community Supports platform to connect to any MCP, and investing in the CBO data readiness that makes participation sustainable.

Recommendation 3.1: Establish a Community Supports Data Readiness Fund

We recommend DHCS include in the renewal application a request for authorization of a Community Supports Data Readiness Fund — analogous to the data exchange investments authorized in other state 1115 demonstrations — that provides CBOs with the technical assistance and infrastructure support needed to meet HRSN Protocol requirements. A $10–20M fund administered through DHCS or a qualified intermediary would create a significant return on investment through improved closed-loop referral rates and more accurate Community Supports outcome data.

Recommendation 3.2: Extend HRSN Data Standards to All ILOS Community Supports

The approved Protocol applies specifically to the two 1115-authorized Community Supports. We recommend DHCS use the renewal period to establish equivalent data exchange standards for all twelve ILOS Community Supports. Consistent standards across the full menu will enable statewide learning, reduce the MCP compliance burden (one standard, not thirteen), and create the data infrastructure needed for the evaluation design to capture Community Supports impact at scale.

ORCHESTRATION PRINCIPLE	*The goal is not more data systems — it's connecting the ones we have. A single authorization-to-outcome data thread from MCP referral through CBO delivery to health outcome is more valuable than twelve separate reporting streams. This is the Camden Coalition's Ecosystems of Care principle in practice: coordination infrastructure, not digitization, is what closes the gap between authorization and outcome.*

Section 3.5: Recuperative Care and the Room-and-Board Transition Risk

The renewal application confirms that Short-Term Post-Hospitalization Housing (STPH) will be discontinued as a standalone Community Support and incorporated into an expanded Recuperative Care model under ILOS managed care authority, effective January 1, 2027. [DHCS CalAIM 1115 Renewal Application, 2026] We support the move to a more durable managed care authority.

We raise one implementation concern that warrants attention before the renewal is finalized: federal ILOS rules under 42 CFR § 438.3(e)(2) prohibit reimbursement for room and board. The current STPH benefit includes a housing cost component that the ILOS-based Recuperative Care model may not be able to fully replicate. We recommend DHCS conduct a gap analysis — before final submission to CMS — of the difference between what STPH currently covers for post-hospitalization housing and what an ILOS-authorized Recuperative Care model can cover under the room-and-board prohibition. If a gap exists, we urge DHCS to identify a companion state plan mechanism or supplemental state funding that preserves the member-facing service. Structural authority improvements should not produce functional service reductions for members most in need of stable post-hospital housing.

Section 4: Employment Supports — Implementation Architecture for Member Success

The Employment Supports request is the most strategically significant new initiative in the renewal application. We strongly support DHCS's decision to establish a proactive member success framework for employment services. A critical legal and strategic point: H.R. 1's work requirements — effective January 1, 2027 — are a federal statutory mandate that cannot be waived under Section 1115 authority. [Health Management Associates, December 2025; KFF, July 2025] California's Employment Supports request is therefore not an alternative to work requirements; it is the infrastructure for implementing them in a way that protects coverage for members who are eligible or who qualify for an exemption. We offer the following implementation architecture recommendations.

QUESTION	What determines whether Employment Supports becomes a genuine member success pathway versus a bureaucratic compliance exercise?
EVIDENCE	The evidence from states that have implemented community engagement requirements — including Arkansas, Georgia, and Michigan — indicates that outcomes are strongly shaped by implementation architecture. States where MCPs, CBOs, workforce agencies, and county eligibility systems operated in coordinated workflows achieved substantially higher engagement rates; states where systems operated independently saw substantially higher disenrollment rates, even among members who were technically eligible. [Urban Institute, Medicaid Work Requirements Research, 2019–2023; KFF State Medicaid Community Engagement Requirements Analysis] The difference was not member motivation or eligibility — it was system design.
RECOMMENDATION	Employment Supports must be designed from the start as an integrated workflow, not a standalone benefit. The critical design decisions are: (1) how Employment Supports providers connect to ECM care plans; (2) what data flows between workforce agencies and MCPs; (3) how exemption processes are operationalized to be accessible, not just technically available; and (4) how the system prevents coverage loss for members who are engaged but face barriers the system hasn't yet resolved.

Recommendation 4.1: Support County Readiness and Establish a Statewide Exemption Floor

The renewal application describes Employment Supports as a voluntary initiative for counties or county-based entities — a design we support as consistent with California's county-administered service architecture. [DHCS CalAIM 1115 Renewal Application, 2026] We recommend DHCS supplement the county opt-in design with two elements: (1) a County Employment Supports Readiness Initiative — targeted technical assistance and planning support for counties that wish to participate but face infrastructure barriers, ensuring that the program's benefits are accessible to members regardless of which county they live in; and (2) a set of statewide floor requirements, applicable in all 58 counties regardless of Employment Supports participation, specifically around proactive outreach and screening for work requirement exemptions.

The county opt-in architecture is sound — and it makes the exemption floor more important, not less. Where counties choose not to participate, eligible members still carry the risk of a work requirement. The statewide exemption screening requirement is what ensures that risk does not fall unevenly on the members least equipped to navigate it alone.

Recommendation 4.2: Invest in Proactive Exemption Processing — In All Counties

The exemption categories in H.R. 1 are broad — caregiving responsibilities, disability, housing instability, among others. The implementation risk is that members who qualify for exemptions lose coverage because the exemption process is difficult to navigate — and DHCS's own implementation planning makes this risk concrete: of the approximately 2.8 million new adult group members expected to require manual verification when automated ex parte checks fail, DHCS estimates that up to 50% could lose coverage from administrative burden alone — not because they are ineligible, but because the system cannot reach them in time. [DHCS All-Comer Webinar, Tyler Sadwith, 2026; Hickman, CalAIM Field Notes SE-06, February 2026] This risk exists whether or not a county has opted into Employment Supports. We recommend DHCS establish, in the renewal STCs, a requirement that MCPs proactively screen members for exemption eligibility and document that screening before any coverage action related to work requirement non-participation, statewide and without exception. The alternative is coverage loss at scale for people the program is designed to serve.

Recommendation 4.3: Build a Community-Based Workforce Partnership Infrastructure in Opt-In Counties

In counties that opt into Employment Supports, DHCS should establish a certification pathway for CBOs — particularly those already providing Community Supports — to deliver Employment Supports services. Organizations already trusted by Medi-Cal members for housing, food, and transportation support are natural employment support partners. We also recommend that MCP referral protocols in opt-in counties connect Employment Supports to ECM care plans for members enrolled in both, ensuring employment goals are a documented element of the member's ECM assessment rather than a parallel compliance track. Camden Coalition has long included employment as a core domain of care planning for even those individuals with the most complex needs.

Section 5: BridgeCare Pilots — The Institutional Diversion Case

We strongly support the BridgeCare Pilots request and recommend DHCS frame this initiative in the renewal application with specific emphasis on institutional diversion and total cost of care reduction. In the current federal environment, HCBS investments are most likely to secure CMS approval when framed as alternatives to more expensive institutional placement — not primarily as quality-of-life or social determinants investments.

QUESTION	What is the strongest framing for BridgeCare that will resonate with the current CMS posture?
EVIDENCE	The CMS Independence at Home Demonstration documented $3,500 per member per year in savings through reduced readmissions for older adults receiving home-based primary care. [CMS Independence at Home Demonstration Evaluation, Avalere Health, 2023] The PACE program — which BridgeCare draws from — has 30+ years of evidence showing that comprehensive home and community-based services delay or prevent nursing facility placement. [Ghosh et al., Health Affairs, 2015; CMS PACE Evaluation Reports] California's Medi-Cal nursing facility costs average more than $114,000 per member per year — more than $312 per day — according to Justice in Aging. [Justice in Aging, cited in CalMatters, June 2025] A BridgeCare investment of $200/month per member is cost-effective against even a modest reduction in nursing facility days.
RECOMMENDATION	Position BridgeCare explicitly as an institutional diversion strategy in the renewal application narrative. Quantify the avoided institutional cost. Establish evaluation metrics that measure nursing facility placement rates, readmission rates, and total cost of care — not just process measures. This framing is both accurate and strategically aligned with a CMS that prioritize value and cost containment.

Recommendation 5.1: Establish BridgeCare-ECM Integration for Complex Older Adults

We recommend the BridgeCare pilot design require coordination protocols with ECM for dually eligible members. Older adults with complex health needs who qualify for both BridgeCare and ECM represent the highest-cost cohort — and the greatest opportunity for total cost of care reduction. Integrating BridgeCare home modification, personal care, and respite services with ECM care coordination will generate the outcome data that supports statewide expansion.

Recommendation 5.2: Include Caregiver Support as a BridgeCare Core Component

The evidence is clear that caregiver burnout is a primary driver of nursing facility placement for older adults with complex needs. We recommend BridgeCare include structured caregiver support — respite care, navigation, training — as a core component alongside member-directed services. This is consistent with the CalAIM dyadic services model for children's care and extends the same logic to older adult care.

Section 6: Reentry Services — All-County Readiness and the IT Infrastructure Gap

The all-county mandate for pre-release Medi-Cal services by October 2026 is a significant implementation challenge for counties that are just beginning this work. As a CPI facilitator working across counties at different stages of CalAIM readiness, we offer targeted recommendations for the renewal period.

Early evaluation of the Justice-Involved Reentry Initiative — including RAND's analysis of focal counties — documents strong early results: approximately 35,000 individuals identified as eligible and 64,500 pre-release services delivered in the program's first year of operation, with evidence of improved care transitions and growing cross-system coordination among corrections, behavioral health, and community providers. [RAND CalAIM Evaluation, 2025; DHCS CalAIM Evaluation Highlights] These results confirm the strong foundation described in the renewal application — and they also underscore the infrastructure investment required. This level of cross-system coordination was not spontaneous; it was built through PATH-funded capacity development that is now sunsetting. The renewal must account for what replaces it.

QUESTION	What implementation barriers are preventing counties from achieving the all-county pre-release mandate?
EVIDENCE	Field observations across multiple counties identify three consistent barriers: (1) data matching — connecting CDCR and county jail identifiers to Medicaid records requires IT investment that many counties have not yet made; (2) warm handoff infrastructure — the relationship between pre-release planners and community-based providers who receive individuals post-release requires active development, not just referral protocols; and (3) MCP-corrections agency partnership formalization — the data sharing agreements and care coordination workflows between MCPs and corrections settings are at varying levels of development across counties.
RECOMMENDATION	The renewal application should include explicit performance metrics for the all-county rollout: percentage of eligible individuals receiving pre-release assessments, Medi-Cal enrollment rates at release, 30-day and 90-day healthcare engagement post-release. The RAND evaluation focal counties provide a learning laboratory — the STCs should establish a mechanism for rapid learning dissemination to the remaining counties.

Recommendation 6.1: Authorize Reinvestment Funds for Warm Handoff Infrastructure

STC 9.11's reinvestment requirement — that new FFP generated from previously-state-funded carceral services be reinvested in community-based capacity — is a powerful mechanism. We recommend DHCS explicitly expand the allowable reinvestment categories to include warm handoff infrastructure: CHW pre-release outreach, CHW peer support in the 30 days post-release, and the technology investments that enable data continuity between corrections settings and community providers.

Recommendation 6.2: Establish a Cross-County Learning Collaborative for Justice Services

Given the wide variation in county readiness for reentry services, we recommend DHCS establish — or authorize MCPs to fund — a structured learning collaborative for justice-involved population implementation. Counties that have achieved strong pre-release service infrastructure can accelerate learning in counties still developing capacity. This is a PATH CPI-style model applied to a specific population, and it is exactly the kind of infrastructure that the renewal period should invest in. The governing principle is the same one that applies across CalAIM's implementation challenge: data systems can identify who is eligible, but only coordinated, trusted cross-sector relationships can ensure those individuals are actually reached, enrolled, and served — across county boundaries, across coverage gaps, and across the corrections-to-community transition that defines this population's experience. A learning collaborative can facilitate broader adoption of emerging best practices from leading counties and also serve as a sandbox in which to identify and create tools and resources to solve common problems across the state.

Section 7: Federal Risk Mitigation — Building Resilience Into the Renewal Structure

The renewal application will be negotiated against the backdrop of H.R. 1 Medicaid provisions that represent the most significant federal threat to California's Medi-Cal system in a generation. The DSHP approval letter documents a Total DSHP Cap of $1.29 billion — funding now at risk. California's county associations have quantified the downstream fiscal impact: the combined annual cost to California counties from H.R. 1 is projected at $6 billion to $9.5 billion — comprising $2B–$5.5B in indigent care costs for residents losing Medi-Cal, $3.4 billion in public hospital revenue losses from State Directed Payment reductions, and nearly $600 million in county workforce costs to administer the new eligibility requirements alone. [CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis, February 2026] DHCS's own Medicaid Director has provided phased coverage loss projections: up to 233,000 losing coverage by June 2027, up to 1 million by January 2028, and up to 1.4 million at full implementation. [DHCS All-Comer Webinar, Tyler Sadwith, 2026] Note: the Introduction references the pre-enactment DHCS estimate of up to 3.4 million — a figure reflecting a broader scenario range developed before H.R. 1's final provisions were known; Sadwith's phased projections reflect DHCS's post-enactment operational planning. Both are DHCS sources; the range between them documents the genuine uncertainty California's planning must accommodate. These are not projections from advocacy organizations. They are the state's own estimates and the counties' own fiscal analysis. The renewal must be built to withstand them.

We name these numbers not to frame this renewal as a defensive exercise, but because clarity about what is at stake is what makes the possibilist case compelling. CalAIM's infrastructure — the ECM care relationships, the Community Supports networks, the cross-sector coordination tables built through PATH — is precisely what California needs most right now. A renewal designed with resilience is not a retreat from ambition. It is the architecture that allows the program to do more, for more people, under more pressure than it was originally designed to face. The six months between now and January 1, 2027 are the most consequential implementation window in CalAIM's history. What we resource before that window closes determines what thrives beyond it.

California's Medicaid financing faces pressure on three simultaneous fronts — not two. H.R. 1 directly targets health care-related provider taxes, phasing the maximum allowable rate from 6% to 3.5% beginning in federal fiscal year 2028. The MCO tax — made permanent by Proposition 35 but requiring federal reapproval — faces the same prohibition. And now the Trump Administration has moved to its second target: the intergovernmental transfer (IGT) and certified public expenditure (CPE) mechanisms that constitute the third leg of California's Medicaid financing structure. The Administration has solicited stakeholder feedback, due March 30, 2026, on how to prevent 'fraud, waste, and abuse' related to IGTs — a framing that mirrors the political strategy used to build the case for provider tax restrictions before H.R. 1. California's DSHP itself operated through CPE methodology under Attachment Z of the CMS approval letter. That mechanism is now under active federal scrutiny. [Schubel, Health Affairs Forefront, March 9, 2026] We offer three structural recommendations for building resilience into the renewal design.

Recommendation 7.1: Build Budget Neutrality on Conservative Federal Scenarios

Budget neutrality methodology is the primary federal lever for limiting state demonstration expenditures. We recommend DHCS develop the renewal's budget neutrality demonstration on a range of federal scenarios — including partial FMAP reduction and work requirement implementation costs — to ensure California does not face mid-demonstration renegotiation. A renewal built on optimistic assumptions about federal policy continuity creates structural fragility.

Recommendation 7.2: Establish Evaluation Design as a Federal Advocacy Asset

The CalAIM Evaluation Design approved by CMS in early 2026 is not just an accountability mechanism — it is a federal advocacy asset. We recommend DHCS design the renewal-period evaluation with explicit attention to metrics that speak to the current federal priorities: cost containment, employment outcomes, reduction of unnecessary institutional utilization, and efficient use of Medicaid dollars. When California demonstrates that CalAIM saves more than it costs, that data protects the program.

Recommendation 7.3: Create a Multi-Payer Sustainability Pathway

California's MCO tax — made permanent under state law by Proposition 35 in November 2024 — generates approximately $8–10 billion in gross revenue annually and has been a critical non-federal financing tool for Medi-Cal. [LAO Ballot Analysis, Initiative 2023-024; LAO Report 4992, 2025] However, H.R. 1 prohibits states from charging substantially higher tax rates on Medicaid enrollment than on commercial enrollment — a prohibition that directly targets California's rate structure. CMS finalized a rule codifying this restriction on January 29, 2026. The path to federal reapproval of the MCO tax under the new rules is uncertain. At the same time, the Trump Administration is now targeting the IGT and CPE mechanisms — the third leg of California's Medicaid financing structure — with a stakeholder comment deadline of March 30, 2026. All three non-federal financing legs face simultaneous federal pressure. The renewal must name this convergence explicitly and authorize DHCS to pursue alternative financing architecture. We recommend four specific pathways:

- Authorize and direct MCPs to designate backbone coordination infrastructure — cross-sector convening capacity, coverage continuity outreach, and cross-boundary data governance — as named investments in their Q3 2026 community reinvestment plans,

which require MCPs to reinvest 5–7.5% of net profits in community health infrastructure. This window closes when plans are filed; what is not named will not be funded for the following three years — precisely the period when H.R. 1's first wave lands. Note: H.R. 1's $3.4 billion in State Directed Payment losses to public hospitals puts MCP profitability under direct pressure; plans that report operating losses owe nothing under current requirements. Moving before Q3 2026 is not optional — it is time-bounded. [Hickman, CalAIM Field Notes SE-06, February 2026]

- Align CalAIM's evaluation and community health investment criteria with CalPERS's Total Portfolio Approach, which goes live July 1, 2026 — creating a formal pathway for community health infrastructure to be recognized as a legitimate investment category within CalPERS's portfolio. [CalPERS Board Investment Committee, November 2025; CalPERS Total Portfolio Approach Framework] California's I-Bank provides loan guarantees of up to $5M for smaller projects and $5–30M for community infrastructure through its Climate Catalyst and CDLAC programs; COIN, administered by the California Department of Insurance, connects insurers to community development investment pipeline. [California IBank Program Guidelines; COIN Program Overview, CA Dept. of Insurance] These instruments are available now. They require a creditworthy county-level governance entity to receive and deploy capital across funding streams — exactly the backbone infrastructure the renewal period should authorize and resource.
- Pursue Social Impact Bond structures for reentry services and Community Supports — particularly recuperative care, housing navigation, and employment transition supports — where the total cost of care savings are documentable and the payer ecosystem is sufficiently organized to support a multi-year payment model.
- Urge DHCS to formally respond to the Trump Administration's March 30, 2026 IGT/CPE stakeholder comment solicitation and include in the renewal application an explicit defense of California's CPE methodology — documented in Attachment Z of the CMS DSHP approval letter — as a transparent, CMS-approved financing mechanism with a verifiable non-federal share. The Health Affairs analysis published March 9, 2026 is correct: local government financing mechanisms are the third leg of the Medicaid financing stool, and protecting them requires building a public record before restrictions are proposed — not after. [Schubel, Health Affairs Forefront, March 9, 2026]

Section 8: Workforce, ECM Sustainability, and Provider Network Accountability

CalAIM's clinical ambitions depend on a workforce California has not yet fully built, and a CBO provider network navigating simultaneous pressure from two directions. ECM Lead Care Managers, Community Health Workers, and peer support specialists are the human infrastructure of whole-person care. The renewal period must invest in sustaining this workforce — and must address two structural vulnerabilities that field observation and publicly available documentation place squarely before this renewal.

The scale of new workforce burden is quantified. California's county associations estimate that H.R. 1's new eligibility requirements alone will impose nearly $600 million in new county workforce costs — just to administer six-month renewals, work requirement verification, and increased eligibility foot traffic. [CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis, February 2026] The county eligibility workers carrying that burden are the same workforce whose relationship with CBOs determines whether ECM care plans survive coverage churn, whether Community

Supports referrals are rebuilt after a gap, and whether the 50% of members who fail automated ex parte checks are reached before they disappear from the system. Workforce investment and coverage continuity are the same question at the county level.

The workforce challenge is not only quantitative — it is qualitative. ECM Lead Care Managers are being asked to navigate one of the most complex care coordination roles in Medicaid: managing caseloads that frequently include members with co-occurring behavioral health conditions, housing instability, and chronic disease, often without the clinical supervision infrastructure that would exist in a traditional health system setting. California has not yet established statewide competency standards for ECM LCMs, nor has it built a consistent training and supervision framework that travels with the role across the diverse organizational settings — CBOs, health plans, FQHCs — where ECM is delivered. The renewal period is the appropriate vehicle to establish that infrastructure: not as a compliance burden, but as a professional foundation that makes retention possible and quality measurable.

The CBO provider network faces pressure from two directions simultaneously — and both require a response in this renewal. The first is federal scrutiny: CMS has intensified program integrity oversight on Community Supports providers, CBOs, and the expansion of social and health-related services through Medicaid at a national level — an environment documented across multiple state Medicaid programs and reflected in recent CMS correspondence to states. DHCS and California's MCPs must demonstrate rigorous provider enrollment and oversight. Strong oversight and broad access are not competing goals — they are reinforcing ones, and the design of oversight mechanisms will determine which of those outcomes is achieved. The second is market austerity: the California Legislative Analyst's Office has documented significant variation in ECM enrollment rates and Community Supports utilization across managed care plans [LAO Report 5003, 2025] — a pattern corroborated by field observation across CalAIM implementation counties and provider stakeholder communications, indicating that some MCPs are taking an austerity-focused approach to ECM and Community Supports network investment — pausing provider contracting and reducing administrative investment in these programs — even as DHCS's renewal strategy treats them as permanent managed care responsibilities. These two dynamics together constitute the most pressing implementation risk in the renewal period, and they require a public record response.

- Establish ECM workforce retention metrics as a statewide performance measure — tracking not just enrollment but Lead Care Manager caseload, turnover rates, and compensation benchmarks
- Establish statewide ECM Lead Care Manager competency standards within the renewal STCs — defining core knowledge domains, required training, minimum supervision ratios, and a continuing education framework — and authorize MCPs to fund LCM training and professional development as a managed care administrative expense, consistent with the workforce investment rationale that already applies to CHW professional development
- Authorize MCPs to fund CHW professional development and technology support as a managed care administrative expense within the renewal STCs
- Establish a CHW career pathway framework within the renewal, building on the Song-Brown workforce investment model (currently authorized through DSHP at $310.6M in DSHP-eligible expenditures) and plan now for the funding cliff when DSHP authority ends December 31, 2026, as Song-Brown continuation will depend on state appropriations alone

- Require ECM contracting standards that ensure CBO ECM providers are compensated on a schedule that does not require unreimbursed bridge financing — CBOs are currently absorbing 60 to 90 days of unreimbursed costs as an invisible subsidy to the Medi-Cal transformation — a pattern consistent with national findings on Medicaid managed care payment timing and widely reported by California CBO provider networks — an unsustainable practice that erodes organizational capacity over time [Hickman, Mason, and Cantor, California Health Report, February 2026; consistent with MACPAC findings on Medicaid payment adequacy for community-based providers]
- Establish a graduated program integrity framework for ECM and Community Supports providers that leads with technical assistance and corrective action plans — not network termination — as the first-line response to compliance concerns; distinguish oversight standards for smaller, community-embedded CBOs from those applicable to larger healthcare entities; and require public reporting on provider network stability metrics so access erosion is visible and addressable
- Establish minimum MCP performance standards for ECM enrollment rates and Community Supports utilization in the renewal STCs — specific, measurable, and enforceable — with public quarterly reporting and a remediation pathway for MCPs below threshold. This is where the governing principle becomes an accountability standard: without contractual performance expectations, the program can have every data system it needs and still fail the members it was built to serve. Technology enables the coordination. Relationships — between MCPs, CBOs, counties, and members — transform it into outcomes. Both require sustained investment, and the renewal STCs are where that investment becomes a requirement rather than a recommendation.

Conclusion: A Renewal Built for What Comes Next

California stands at an extraordinary moment. The CalAIM renewal we are commenting on today is the bridge between what we built and what we can sustain — and between a relatively favorable federal environment and a more challenging one. The recommendations in this comment are designed to strengthen that bridge: to document what CalAIM has produced, to address the implementation gaps that field experience reveals, and to build structures that can withstand federal policy uncertainty.

We are possibilists about CalAIM's future. The evidence that whole-person care, addressed through coordinated ECM, Community Supports, and cross-sector collaboration, reduces total cost of care and improves health outcomes is now substantial. California's renewal application has the opportunity to put that evidence in federal hands in a form that protects the program.

We look forward to DHCS's continued partnership in making this renewal the foundation for the next phase of California's Medi-Cal transformation. The Camden Coalition's two decades of complex care implementation and Hickman Strategies' field experience across California's CalAIM counties arrive at the same conclusion: the infrastructure that connects systems and the relationships that make those connections real are not soft investments. They are the mechanism by which policy becomes outcomes for people with the most complex needs. Both require sustained investment — and this renewal is where that investment becomes a requirement rather than an aspiration.

Respectfully submitted,

Jim Hickman
Principal & Chief Catalyzer, Hickman Strategies LLC
Principal CalAIM Advisor & National Center Advisor, Camden Coalition
Venture Partner, Suncoast Ventures
[redacted] | www.HickmanStrategies.com

Mark Humowiecki, JD
General Counsel & Senior Director, National Center for Complex Health and Social Needs, Camden Coalition
Approved PATH Technical Assistance Marketplace Vendor
[redacted] | www.camdenhealth.org

This public comment reflects the independent professional analysis of both co-submitters: more than three decades of healthcare transformation experience (Hickman Strategies LLC) and more than two decades of national complex care implementation (Camden Coalition).

It draws on publicly available CalAIM documentation, field experience facilitating PATH CPI implementation in multiple California counties,
and the August 2025 Comprehensive Recommendations Memorandum submitted in response to the DHCS Medi-Cal Transformation Concept Paper.

Key sources: DHCS via Transform Health (October 2025) | California Health Care Foundation (October 2025) | Governor Newsom (June 27, 2025) | LAO Reports 5003 and 4992 | KFF (July 2025)
HMA (December 2025) | CHCS (December 2025) | CMS DSHP Approval Letter Attachment Y (December 12, 2024) | Hickman, Mason, Cantor, California Health Report (February 2026)
UCLA/RAND CalAIM Evaluation (2025–2026) | DHCS CalAIM 1115 Renewal Application (2026) | 42 CFR § 438.3(e)(2)
CSAC/CWDA/CAPH/CHEAC Joint Fiscal Impact Analysis (February 2026) | DHCS All-Comer Webinar, Tyler Sadwith (2026) | California Budget & Policy Center (2026)
Schubel, Health Affairs Forefront: 'Local Governments Play An Important Role In Medicaid Financing' (March 9, 2026) | Convergence Community Hubs Field Scan (January 2026) | Hickman, CalAIM Field Notes SE-06 (February 2026)

Natalie Aguilera, Native American Health Center, Email received on March 13, 2026.

Dear DHCS Leadership,

Please see attached comment letter re: CalAIM Section 1115.

Thank you,

Natalie Aguilera, MPA
Chief Executive Officer
Native American Health Center, Inc. I 2920 International Blvd., Third Floor, Oakland, CA 94601
([redacted] | 8 www.nativehealth.org

March 11, 2026

Subject: Comment on CalAIM Section 1115 Demonstration Renewal – Traditional Healer and Natural Helper Services

Dear Director and DHCS Leadership,

Native American Health Center, Inc. (NAHC) appreciates the opportunity to provide comments on the proposed renewal of the CalAIM Section 1115 Demonstration Waiver.

As an Urban Indian Organization (UIO), we provide culturally grounded health services to American Indian and Alaska Native (AI/AN) community members living in urban areas. We strongly support the inclusion of Traditional Healer and Natural Helper services within Medi-Cal, as these services reflect longstanding cultural practices that support healing, prevention, and community wellbeing. Based on early implementation experience, we offer the following observations for DHCS consideration.

Assessment Requirements
Current requirements for ASAM assessments can create administrative challenges for UIOs that are not structured to conduct these assessments internally. In practice, this requirement can delay access to Traditional Healer and Natural Helper services. We encourage DHCS to explore flexibility in assessment approaches that support timely access to culturally grounded care.

Eligibility Limitations
Eligibility for Traditional Healer and Natural Helper services is currently limited to individuals with a Substance Use Disorder diagnosis. Many community members seeking these services are experiencing mental health needs, trauma, or other wellness concerns that fall outside this diagnosis. Expanding eligibility to include broader behavioral health conditions would better align with the holistic nature of traditional healing practices and support prevention and early intervention.

Implementation Through Counties
UIOs are working closely with counties to establish contracting and reimbursement processes. Implementation timelines and requirements vary across counties, creating delays in service rollout and additional administrative burden for providers. Continued collaboration between DHCS, counties, and Indian health providers will be important to support consistent statewide implementation.

Traditional healing practices are an important component of culturally grounded care for AI/AN communities. We appreciate DHCS' efforts to recognize these services within Medi-Cal and look forward to continued partnership to ensure this benefit is accessible and effective for the communities it intends to serve.

Sincerely,

[redacted]

Natalie Aguilera
Chief Executive Officer
Native American Health Center, Inc.

CERTIFICATE *of* SIGNATURE

[redacted]

DOCUMENT COMPLETED BY ALL PARTIES ON
12 MAR 2026 18:24:30
UTC

SIGNER	TIMESTAMP	SIGNATURE
NATALIE AGUILERA [redacted]	SENT 11 MAR 2026 17:20:18 VIEWED 12 MAR 2026 18:24:07 SIGNED 12 MAR 2026 18:24:30	[redacted] IP ADDRESS 12.199.5.49 LOCATION OAKLAND, UNITED STATES

RECIPIENT VERIFICATION

EMAIL VERIFIED
12 MAR 2026 18:24:07

Trent Murphy, California Association of Alcohol and Drug Program Executives, Email received on March 13, 2026.

Good morning,

Attached is CAADPE's comments on the waiver renewal. Please reach out if you have any questions. Thank you

Best,
Trent
Trent Murphy
Analyst
California Association of Alcohol and Drug Program Executives
[redacted]

CAADPE
CALIFORNIA ASSOCIATION OF
ALCOHOL AND DRUG PROGRAM EXECUTIVES

3/11/2026

Department of Health Care Services
Director's Office
Attention: Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

RE: **Comments on the CalAIM Section 1115 Demonstration Waiver Renewal**

Dear Director Sadwith & CalAIM Waiver Renewal Team,

On behalf of the California Association of Alcohol and Drug Program Executives (CAADPE), we appreciate the opportunity to provide comments on the renewal of the Section 1115 demonstration waiver supporting the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

CAADPE represents a statewide network of substance use disorder (SUD) treatment providers delivering prevention, treatment, and recovery services across California. Our members operate community-based outpatient programs, residential treatment facilities, and recovery support services serving Medi-Cal beneficiaries across the state. We greatly appreciate the leadership of DHCS in advancing the CalAIM vision of a more integrated, person-centered Medi-Cal system.

We want to begin by recognizing several important and positive components of the waiver renewal proposal. Medi-Cal is a cornerstone of California's health care system, providing coverage to one in three Californians and more than half of the state's children, creating a powerful opportunity to improve health outcomes and advance equity.

CalAIM has introduced transformative reforms that better integrate physical health, behavioral health, and social services, including initiatives such as Enhanced Care Management, Community Supports addressing social drivers of health, and the PATH initiative supporting provider capacity and system transformation.

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(916) 329-7409 caadpe@caadpe.org

These efforts have helped move Medi-Cal toward a population health approach that emphasizes prevention, coordination, and whole-person care.

From the perspective of the SUD treatment system, we also strongly support several elements of CalAIM that expand evidence-based treatment and recovery supports. These include the continued integration of the Drug Medi-Cal Organized Delivery System, the introduction of peer support specialist services, and the implementation of contingency management as a Medi-Cal benefit, which represents a significant advancement in addressing stimulant use disorder.

These initiatives reflect California's leadership in expanding access to evidence-based behavioral health care.

We also appreciate the waiver's continued focus on improving outcomes for justice-involved individuals reentering the community, recognizing the importance of stabilizing health prior to release and ensuring continuity of coverage and care.

These reforms are critical for individuals with substance use disorders, who face heightened risks of overdose and relapse following release from incarceration.

While we strongly support the direction of the waiver renewal overall, we would like to highlight several considerations that we believe are important to maintaining continuity of care and strengthening treatment access.

Preserving the 90-Day In-Reach Engagement Period

CAADPE strongly recommends maintaining the 90-day in-reach engagement period rather than reducing it to 30 days. Providers across the state consistently report that early engagement with individuals prior to release from incarceration is essential for initiating treatment, building trust, and coordinating successful transitions to community-based care.

Individuals leaving correctional settings often present with complex behavioral health needs, including co-occurring mental health and substance use disorders. Meaningful engagement frequently requires time to conduct assessments, initiate treatment planning, connect individuals to community providers, and ensure continuity of medications and services following release. A reduction to 30 days could significantly limit providers' ability to carry out this work and could undermine the success of the state's reentry and overdose prevention efforts.

Maintaining the 90-day window would better support stabilization, continuity of care, and improved outcomes for justice-involved Medi-Cal beneficiaries.

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CAADPE
CALIFORNIA ASSOCIATION OF
ALCOHOL AND DRUG PROGRAM EXECUTIVES

Supporting Access to FDA-Approved Medications for Addiction Treatment

CAADPE also supports policies that ensure access to the full range of FDA-approved medications for addiction treatment, including long-acting formulations when clinically appropriate. Medication-assisted treatment is a cornerstone of evidence-based care for opioid and alcohol use disorders, and clinicians must have the flexibility to select the treatment approach that best meets the needs of each individual patient.

Policies that maintain broad access to these medications across treatment settings help improve retention in treatment, reduce overdose risk, and support long-term recovery outcomes.

Ensuring Adequate Reimbursement for Psychiatric and Medication Management Services

Finally, we encourage DHCS to continue evaluating reimbursement policies to ensure that psychiatric evaluation and medication management services are adequately supported within substance use disorder treatment settings. Many individuals receiving residential treatment require ongoing clinical oversight and medication management for co-occurring conditions, and reimbursement structures should ensure that providers can deliver these services effectively.

CAADPE appreciates the collaborative approach DHCS has taken in developing and implementing CalAIM and looks forward to continuing to work with the department to strengthen California's behavioral health system. We support the overall goals of the waiver renewal and welcome continued dialogue on how to ensure these reforms translate into improved access, continuity of care, and better outcomes for Medi-Cal beneficiaries.

Thank you for the opportunity to provide comments.

Sincerely,

Robb Layne
Executive Director

1017 L Street, #PMB 648, Sacramento, CA 95814
(916) 329-7409 caadpe@caadpe.org

Ryan Witz, DHLF, Email received on March 13, 2026.

Good morning, I wanted to also send this letter to you all as well. Apologies for not copying the general mailbox.

Thanks,
Ryan

DISTRICT HOSPITAL
LEADERSHIP FORUM

March 12, 2026

Michelle Baass, Director
Department of Health Care Services (DHCS)
1501 Capitol Ave
Sacramento, CA 95814

Re: DHLF Comments on Proposed CalAIM Section 1115 Demonstration Five-Year Renewal Request – Support for DPH GPP Extension and Request to Explore an Optional DMPH GPP

Dear Director Baass:

The District Hospital Leadership Forum (DHLF), on behalf of California's 33 district and municipal hospitals, appreciates the opportunity to comment on the Department of Health Care Services' (DHCS) proposed CalAIM Section 1115 demonstration renewal. DHLF supports DHCS' overall renewal direction and the Department's continued focus on strengthening Medi-Cal and California's safety net.

District and municipal hospitals (DMPHs) are independent local governments responsible for providing for the healthcare needs of their communities, including uninsured and Medi-Cal populations. More than two-thirds of these hospitals are rural and eighteen have Critical Access Hospital (CAH) designations. As independent public hospitals, many DMPHs operate without the scale, capital access, and system support available to large health systems, while still maintaining 24/7 readiness and essential service lines for their communities.

DHLF writes to express support for DHCS' proposal to continue and evolve the public hospital Global Payment Program (GPP) funds. DHLF also encourages DHCS to include in the waiver request authority that would allow for a voluntary pathway for eligible Medi-Cal Disproportionate Share Hospital (DSH) district hospitals to repurpose those funds and participate in a comparable value-based GPP model, if feasible and approvable by the Centers for Medicare & Medicaid Services (CMS).

Support: DHCS' request to extend and evolve the Designated Public Hospital (DPH) GPP

DHLF strongly supports DHCS' request to continue the GPP for DPH systems and echoes DHCS' case for why the program remains essential to maintain access and sustain the safety net.

DHLF also supports DHCS' rationale that GPP aligns financial incentives with modern care patterns by encouraging a shift from avoidable emergency department and inpatient utilization toward non-DSH eligible services that promote prevention, primary care, chronic disease management, and other outpatient services that improve outcomes and reduce costs. For these reasons, we further support DHCS seeking to add additional allowable services eligible under GPP and incentivizing provider investments in system transformation.

DHLF further supports continuation of GPP because the program's evaluation[1] results reflect meaningful progress toward its core aims. DHCS' interim evaluation findings indicate that participating public health care systems have made progress toward improving care delivery and quality. Reported results include improvements in selected preventive and screening measures for populations served by GPP participants relative to a comparison group, along with increased use of non-DSH eligible outpatient services, and continued movement toward strengthened data systems and reporting.

These findings support the case for continuing GPP and for exploring similar value-based approaches where appropriate to sustain access and support community-based services.

Request: Explore an optional District Hospital GPP pathway for eligible Medi-Cal DSH DMPHs

In addition to supporting the DPH GPP extension, DHLF respectfully requests that DHCS explore and, if feasible, include authority to develop an optional "district hospital GPP" pathway for eligible Medi-Cal DSH district and municipal hospitals. Many DMPHs provide essential safety-net services in rural and underserved communities. They serve as the "front door" to health care for their regions, and in many communities the safety net is not only the hospital, but also the emergency department and central hub for primary care, specialty clinics, behavioral health coordination, and post-acute transitions.

Rural and independent public hospitals operate under structural realities that make traditional financing approaches especially challenging:

- High fixed costs and low volume: Rural hospitals must maintain 24/7 readiness and core service lines even with lower patient volumes, limiting the ability to spread overhead costs.

- Workforce shortages: Recruitment and retention challenges can increase reliance on contracted labor and create service line vulnerability.

- Distance and limited alternatives: When outpatient access is constrained, patients may default to higher-cost settings (ED/inpatient) or forgo care entirely.

- Limited system support: Independent public hospitals often lack system-level capital, IT infrastructure, and administrative capacity to absorb significant new reporting burden or downside risk without commensurate funding.

Traditional DSH accounting and payment methodologies do not always align with today's delivery system, where hospitals and their community partners increasingly rely on outpatient care, prevention, care management, and other interventions that can reduce avoidable utilization in high-cost settings and improve outcomes.

[1] Evaluation of California's Global Payment Program

DHLF believes DHCS' stated policy rationale for continuing GPP for public hospitals also applies to many district hospitals. Sustainable safety-net financing can preserve access, modernize incentives toward prevention and outpatient care, and provide appropriate flexibility to support high-value services that meet community needs. With an appropriate design, district hospitals that choose to participate could pursue similar outcomes to those observed in the public hospital GPP, while reflecting the rural and independent public hospital realities.

DHLF, along with its interested and eligible member hospitals, would welcome the opportunity to partner with DHCS over the coming months to assess feasibility and, if viable, develop district hospital GPP concept for CMS consideration. This work could use the public hospital GPP as a framework for the key design decisions; while ensuring the district hospital pathway is separately designed and funded so it aligns with the unique circumstances of district hospitals.

At a minimum, DHLF proposes a collaborative process with DHCS to explore the following:

- Program scope and participation: Eligibility criteria for district hospitals and any minimum participation thresholds or other participation parameters.

- Funding and allocations: How participating district hospitals' DSH funds would inform pool sizing and hospital-level allocations; and how to ensure compliance with applicable federal limits and financing requirements.

- Allowable services and methodology: Allowable services and populations; a value-based points/threshold methodology and funding risks; and appropriate flexibilities and considerations to support prevention, outpatient care, and care management unique to district hospitals and their systems.

- Operational mechanics and reporting: Timing, cash flow and IGT mechanics (as applicable), reporting and documentation standards, and evaluation requirements that are scalable for district hospitals.

Critically, consistent with DHCS requirements and final decisions by CMS, participating district hospitals should retain the ability to evaluate final program terms, including funding sufficiency, risk exposure, reporting and validation requirements, and administrative feasibility, and to decline participation if the requirements become too rigorous, risky, or otherwise not workable.

To support that approach, DHLF encourages DHCS to incorporate clear participation protections and "off ramps," including the ability for hospitals to opt out prior to final participation commitments, and to reassess participation if program terms change materially during development and approval.

Conclusion

DHLF appreciates DHCS' leadership and supports the proposed CalAIM Section 1115 demonstration renewal, including DHCS' request to continue and evolve the public hospital GPP.

We respectfully request that DHCS also explore an optional district hospital GPP pathway for eligible Medi-Cal DSH district hospitals, grounded in the same value-based rationale DHCS has articulated for public hospitals and informed by the public hospital GPP evaluation evidence.

DHLF and interested district hospitals stand ready to partner with DHCS in the coming months to further develop and assess a district hospital GPP concept, recognizing that participation would remain voluntary and contingent on final program terms.

Sincerely,

Ryan Witz
Executive Director
District Hospital Leadership Forum

Cc:
Tyler Sadwidth, Medicaid Director
Lindy Harrington, Assistant Medicaid Director
Rafael Davtian, Deputy Director, Health Care Financing

Ken Hazlewood, Pit River Health Service, Inc, Email received March 14, 2026.

I am not Native, but have been working in Indian Country since 2017. I have been working with SUD patients and co-occuring since 2001. When starting working at a Native clinic in the Frontier lands of California, Siskiyou, Shasta, Lassen and Modoc I realized how traditional treatment did not work with my clients. The standard 12-step and cognitive therapy was falling on deaf ears. Red Roads and White Bison was used and was more effective. Our clinics researched how the Certified counselors and Licensed staff could do better, but found the best care was from with-in the Tribes themselves. The traditional practices that were shared amongst themselves out performed the standard care that may have worked in Los Angeles or San Francisco non tribal population. The catch was getting reimbursed, now we have a path to provide care that works and the funding must continue to serve the native population.

PLEASE CONTINUE THE REIMBURSMENT FOR NATURAL HELPERS AND TRADITIONAL HEALERS. Native American lives depend on us to give them care that works.

Ken Hazlewood LMFT
Ken Hazlewood
Director of Behavioral Health
Pit River Health Service, Inc.
[redacted]

Amy Carta, County of Santa Clara Health System, Email received Monday 16, 2026.

Dear Mr. Sadwith,

The County of Santa Clara Health System strongly supports Department of Health Care Services' proposal to request a five-year renewal of the CalAIM Section 1115 demonstration renewal application, including Reentry Services for the Justice Involved, Institutions for Mental Diseases Waiver Exclusion, Optional Substance Use Disorder Services, Global Payment Program and the newly proposed County option related to Employment Supports and BridgeCare Pilot.

The attached comments outline the reasons for our Health System's support and provide a few recommendations for the Department's consideration as it works to advance CalAIM and the health of the communities we serve.

Healthy regards,

Amy Carta
Director, Government Affairs, Public Relations and Special Projects
County of Santa Clara Health System
[redacted]

County of Santa Clara Health System Administration
777 Turner Drive, Suite 320
San Jose, CA 95128

COUNTY OF SANTA CLARA
Health System

March 12, 2026

Tyler Sadwith
Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Submitted via: 1115waiver@dhcs.ca.gov

Subject: Support for Proposed 1115 Demonstration Renewal

Dear Mr. Sadwith,

On behalf of the County of Santa Clara Health System, I am writing in strong support of the Department of Health Care Services' (DHCS) proposal to request a five-year renewal of the CalAIM Section 1115 demonstration renewal application, including Reentry Services for the Justice Involved (JI), Institutions for Mental Diseases (IMD) Waiver Exclusion, Optional Substance Use Disorder Services, Global Payment Program (GPP), Managed Care Authority, and the newly proposed County option related to Employment Supports and BridgeCare Pilot.

Reentry Services for the Justice Involved

The County of Santa Clara Health System values our strong partnership with the Department of Health Care Services (DHCS) in piloting Reentry Services for the Justice Involved (JI) population. As one of the first counties to launch JI pilot, our Health System worked closely with DHCS throughout the early implementation period. We appreciate the Department's collaborative, learning-oriented approach, its willingness to streamline processes, and its adoption of several of the County's recommendations.

Since October of 2024, our Health System has seen well over 10,000 portal entries for qualified Medi-Cal enrollees, resulting in more than 325,000 days of program coverage for eligible enrollees. During this time, we have provided medications to more than 1,300 enrollees upon release, completed over 750 care plans, and facilitated more than 350 warm hand-offs to community-based partners upon release. These services are essential to ensuring a coordinated transition from incarceration to the community, reducing gaps in care, and supporting continuity of care for individuals with significant medical, behavioral health, and social needs.

The County of Santa Clara Health System strongly supports the continuation of Reentry Services for the JI population in the upcoming Section 1115 Demonstration. Extending

these services will strengthen reentry pathways, improve health outcomes, and enhance connections to community supports and healthcare providers at a critical moment in individuals' lives. We look forward to continuing our collaboration with DHCS to address concerns that arise as we continue implementation.

Institutions for Mental Diseases (IMD) Exclusion Waiver

The County of Santa Clara Health System supports the continuation of the IMD Exclusion Waiver to allow for an important component of care for a small portion of our County residents. Having the ability to provide this level of care, when appropriate, and receive Medi-Cal reimbursement for that care supports the County's ability to offer a full continuum of care to patients in need.

Santa Clara will be the third county in California to fully implement the IMD Exclusion Waiver element of the Section 1115 Demonstration and looks forward to its continuation. Our Health System also looks forward to partnering with DHCS on implementation, including development of the necessary claims processing, to ensure smooth implementation for additional counties.

Optional Substance Use Disorder Services

The County of Santa Clara Health System supports continuing optional Substance Use Disorders (SUD) services, including Contingency Management. Contingency Management has been a successful behavior-based tool for providers within the County system to support individuals in achieving their goals around wellness and recovery. We have seen successes with program completions and see the value of continued support for people in our community who are suffering from SUD and are not fully engaged in other levels of care.

Global Payment Program (GPP)

Since its launch in 2015, GPP has been a critical program in supporting the County of Santa Clara Health System's ability to provide value-based care to uninsured patients and the financial stability to maintain these services. A renewal of GPP would build on this foundation by strengthening incentives for providing preventive and primary care as well as improving chronic disease management for uninsured patients, supporting ongoing change and the delivery of value-based care. This evolution is especially important for our Health System, as we are the predominant provider of care to Medi-Cal and uninsured patients living in Santa Clara County. Ensuring access to preventative care, even as patients cycle on and off of Medi-Cal coverage due to challenges in navigating new eligibility requirements, remains central to improving long-term health outcomes.

Since 2005, California's public hospital systems have leveraged participation in Medi-Cal 1115 Waivers to catalyze significant delivery system transformation, resulting in improved quality and patient outcomes, greater efficiencies within our systems, and stronger care coordination efforts for complex and high-risk patients. GPP has been a key program in making this transformation possible by creating strong financial

incentives for our System to shift uninsured services from hospital emergency departments to primary and preventive care settings. GPP supports these efforts by converting Medicaid Disproportionate Share Hospital funding, which is traditionally limited to reimbursement for more costly, hospital-based and emergency settings to a more flexible, value-based funding methodology that incentivizes low-cost, high-value services.

GPP supported our County Health System in delivering essential preventive services—such as cancer screenings, depression screenings, and diabetes management—to uninsured and underinsured patients. Among reported GPP patients in Calendar Year (CY) 2024, 80.2% completed breast cancer screening, 75.5% completed cervical cancer screening, and 68.8% completed colorectal cancer screening. These results exceed the 90th percentile performance of Managed Medi-Cal patients and demonstrate our Health System's commitment to high-quality care that improves health outcomes through early detection and timely intervention.

Our County Health System supports the changes proposed for GPP in the proposed Section 1115 Demonstration renewal, which would further evolve the GPP program by strengthening the focus on preventive care and chronic disease management and adding risk to earning GPP funding in ways that further incentivize preventive care and system transformation.

For over a decade, the GPP has allowed public hospital systems like the County of Santa Clara's to build a solid foundation for change and provided our uninsured patients with greater access to primary and specialty care. A renewal of the program would sustain these changes and allow us to further strengthen our delivery system transformation efforts. It is also especially critical at a time when we are facing steep cuts to our funding due to changes to the Medi-Cal program called for under federal law through H.R. 1 and expect to see an influx of uninsured patients over the next few years.

BridgeCare and Employment Supports Pilots

The County of Santa Clara Health System finds the two new pilots for BridgeCare and Employment Supports to be creative and intriguing proposals that would, if implemented, support our community in maintaining coverage and health by adding layers of support which could reach more people. Helping those who are near dual eligibility in maintaining their health and ability to stay at home (rather than a Skilled Nursing Facility or hospital) is an important goal.

In response to DHCS's request for input, our Health System recommends making the full list of BridgeCare services optional, to allow counties to opt-in and best align their communities needs with services provided by or within the county. Moreover, given the dramatic reductions in funding that counties and county health systems are facing as a result of H.R. 1, identifying a source for the non-federal share will be a significant challenge. Allowing counties to opt-in to a full list of optional services rather than requiring a core set (which goes beyond services counties currently provide) with

additional options could create a path forward that could be more easily taken. We strongly urge the service sets to be combined into a full set of optional services.

With regard to the Employment Supports proposal, our County supports including a county option to invest in pre-employment and employment sustaining services to address barriers to employment, support sustained workforce participation, and promote economic stability among Medi-Cal members subject to work requirements who cannot be determined exempt or compliant. Our County also recommends making the full list of Employment Support Services optional, to allow counties to opt-in and select between the service options to best meet community need and target limited resources.

For all of the reasons stated above, **we strongly support the renewal of the Section 1115 Demonstration Waiver, including GPP, through December 31, 2031.**

Thank you for your consideration of the points set forth in this comment letter, as well as your continued partnership with our County to serve California's Medi-Cal and uninsured patients and support the health care safety net.

Sincerely,

Paul E. Lorenz
Chief Executive Officer
County of Santa Clara Health System and
Santa Clara Valley Healthcare

Cc: Michelle Baass, Director, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS

Jack Cheng, Chinatown Service Center - Community Health Clinic, Email received on March 16, 2026.

Dear DHCS CalAIM Waiver Team,

Please find attached a comment letter from Chinatown Service Center regarding the proposed BridgeCare pilot included in the CalAIM Section 1115 Demonstration Waiver renewal.

Chinatown Service Center operates a federally qualified health center and a Program of All-Inclusive Care for the Elderly (PACE) program serving Medi-Cal beneficiaries across Los Angeles County. We appreciate the opportunity to share our perspective as DHCS continues refining the design of the BridgeCare pilots.

Thank you for your leadership and for considering our comments.

Jack Cheng, JD, CHC, CHPC | Chief Operations Officer
Chinatown Service Center - Community Health Clinic
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Los Angeles, CA 90012
[redacted]
Fax: 213-680-9427
[redacted]

華埠服務中心
Chinatown Service Center

www.cscla.org

March 16, 2026

Department of Health Care Services
CalAIM Section 1115
Demonstration Waiver Renewal
State of California

Subject: Public Comment on BridgeCare Pilot Design within the CalAIM Section 1115 Waiver

Dear DHCS Leadership,

Chinatown Service Center (CSC) appreciates the opportunity to provide comments regarding the BridgeCare pilots proposed under the CalAIM Section 1115 Demonstration Waiver. CSC operates a federally qualified health center and a Program of All-Inclusive Care for the Elderly (PACE) program serving diverse Medi-Cal beneficiaries across Los Angeles County, including many older adults with complex medical, behavioral health, and social needs.

CSC supports efforts to strengthen coordination between health care providers, community-based organizations, and long-term services and supports for Medi-Cal members. The BridgeCare concept reflects an important step toward improving care integration for individuals with complex needs, particularly older adults who often require both medical services and community-based supports to remain healthy and independent in their communities. As DHCS continues refining the design of the BridgeCare pilots, CSC respectfully offers several considerations based on our experience serving aging Medi-Cal populations.

First, programs serving older adults should have a strong role in the development and implementation of BridgeCare pilots. PACE organizations operate fully integrated care models that coordinate primary care, specialty care, behavioral health services, long-term services and supports, and social services for high-risk older adults. This experience can provide valuable insight into how BridgeCare models can effectively coordinate services across health systems and community providers.

Second, pilot design should ensure alignment with existing integrated care models, including PACE. PACE programs already serve many Medi-Cal beneficiaries who require the types of coordinated services envisioned under BridgeCare. Clear alignment will help prevent duplication of services while strengthening collaboration between providers serving older adults.

Third, community health centers and community-based providers should be included as partners in BridgeCare implementation. Federally qualified health centers and organizations like CSC often serve as trusted entry points to care for multilingual and underserved populations. Their participation will help ensure that BridgeCare pilots effectively reach high-need communities.

CSC welcomes continued engagement with DHCS as these pilots develop. Our organization would welcome opportunities to share operational experience serving Medi-Cal older adults and to support the development of models that strengthen coordinated care across the health and social service systems.

Thank you for your leadership and for considering these comments.

Sincerely,

[redacted]

Jack Cheng, JD, CHC, CHPC
Chief Operations Officer
Chinatown Service Center

Adam Dorsey, California Hospital Association, Email received March 19, 2026.

Hello DHCS Team,

I apologize we are late with this, but wanted to share our feedback from CHA on the Cal-AIM renewal. Thank you for your partnership. Talk soon,

Adam

Adam Dorsey
Group Vice President, Financial Policy
California Hospital Association
[redacted]

California Hospital Association

SUBJECT: Comments on the Renewal Request of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration

Submitted to: 1115Waiver@dhcs.ca.gov

On behalf of the California Hospital Association (CHA), representing nearly 400 hospitals and health systems across the state, we appreciate the opportunity to provide comments on the Department of Health Care Services' (DHCS) proposed renewal of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration.

CHA strongly supports the overarching goals of the CalAIM initiative and its renewal, including strengthening whole-person care, improving coordination across physical health, behavioral health, and social services, and advancing equity across the Medi-Cal program. Hospitals remain committed partners in these efforts and appreciate DHCS' continued engagement with stakeholders throughout the waiver renewal process.

It is important to note that the policy and fiscal environment surrounding the Medi-Cal program has evolved significantly since many of these initiatives were originally conceived. Federal policy changes and fiscal pressures affecting Medicaid financing and hospital reimbursement have introduced new uncertainties that will shape the implementation and sustainability of the next phase of CalAIM. Hospitals are particularly vulnerable to these shifts given their role as the primary safety-net providers for Medi-Cal members and uninsured Californians.

In addition to these broader considerations, CHA notes that the earlier concept paper identified development of a "comprehensive purchasing strategy" as a core goal for the successor demonstration. The renewal application does not include meaningful detail on this proposal, which CHA hopes reflects DHCS' shifted focus on responding to the current fiscal and policy environment. As we previously noted, hospitals are facing significant financial pressures as a result of federal and state policy changes and reductions in available financing mechanisms and resulting payments. In this context, introducing an overly broad, complex or burdensome purchasing framework could further strain hospital finances and undermine access to care at the worst possible time in the program's history. To the extent this initiative will still be pursued over the course of the next waiver term, we ask DHCS to promptly publish its intended timeline, scope, and objectives for the effort, preferably after meaningful consultation with affected hospitals.

CHA would like to highlight strong support for three critical priorities:

1. **Global Payment Program (GPP)**

The GPP is an essential source of funding for California's public health care systems, enabling hospitals to continue providing care to the uninsured and underinsured. By incentivizing a shift from avoidable, high-cost services to more preventive and community-based care, the program advances equity and efficiency. CHA applauds DHCS' proposal to maintain and strengthen the GPP as a cornerstone of the Medi-Cal safety net. We also support the addition of new GPP services focused on technology, incentives for value-based care, and system transformation efforts - all aimed at reducing costs and improving health outcomes. Given the sharp increase in uncompensated care costs and severe funding reductions looming for all hospitals, we ask that DHCS continue exploring similar payment programs for private and non-designated public hospitals as part of its Medi-Cal transformation efforts.

California Hospital Association

2. **Behavioral Health Integration and Payment Reform**

CHA is disappointed that DHCS did not revisit the original California Advancing and Innovating Medi-Cal (CalAIM) proposal to pilot full integration plans, allowing Medi-Cal managed care plans to assume responsibility for both primary care and behavioral health services. Despite the complexities, integration remains a necessary step toward improving access, reducing fragmentation, and delivering whole-person care in an efficient and cost-effective manner.

Hospitals regularly see the consequences of a divided system — with patients cycling between physical and behavioral health silos, and providers consistently facing unnecessary barriers in securing the reimbursement they are owed — and we urge DHCS to advance integration pilots.

In addition, we urge DHCS to continue to prioritize the full realization of behavioral health payment reform. Most importantly, securing the same improvements in reimbursement for Medi-Cal/Fee-for-Service hospitals as was accomplished during the first CalAIM term for Short-Doyle hospitals and other behavioral health provider types, and implementing a successor supplemental payment stream for hospital psychiatric units upon expiration of pass-through payment authority in 2027.

3. **Strengthening Accountability**

CHA applauds DHCS' renewed focus on strengthening accountability on the part of the various contracted managed care entities it employs. As part of these efforts, we ask that DHCS prioritize oversight of network adequacy compliance and strengthening transparency within the alternative access standard process; balancing the playing field for providers in network contracting with plans, particularly improving enforcement of the existing requirement for plans to maintain contracts with any safety net hospital in their service area(s); and ensuring timely payments to hospitals by all plans.

California hospitals are committed partners in the transformation of Medi-Cal. We share DHCS' vision of a system that improves outcomes, reduces disparities, and strengthens sustainability. To achieve this, the transformation effort must balance ambition with realism — ensuring new or continued initiatives are approvable at the federal level, affordable for the state in the face of diminished federal financial support, and do not undermine the state's ability to deliver on the core tenets of the program.

CHA looks forward to continuing close collaboration with DHCS as the renewals and new initiatives move forward. We appreciate your leadership and commitment to building a stronger Medi-Cal program for all Californians.

Sincerely,

Adam Dorsey,
Group Vice President, Financial Policy
California Hospital Association

Heather Johnson, Turtle Mountain Band of Chippewa, Email received March 18, 2026.

Hello Directors Office (Tyler Sadwith),

I am submitting the following letter on behalf Tolowa Nation regarding comments in response to the Department of Health Care Services' (DHCS) February 10, 2026 Notice of Intent to Submit a Renewal of the CalAIM Section 1115 Demonstration.

Thank you,

Heather Johnson
Turtle Mountain Band of Chippewa
Executive Assistant to the Board
of Governance & Corporate Affairs
UNITED INDIAN HEALTH SERVICES, INC.
Potawot Health Village
1600 Weeot Way, Arcata, CA 95521
[redacted]
Fax: (707) 825-6747
Website https://unitedindianhealthservices.org/
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Dear Director Baass and Director Sadwith:

On behalf of Tolowa Nation, we submit the following comments in response to the Department of Health Care Services' (DHCS) February 10, 2026 Notice of Intent to Submit a Renewal of the CalAIM Section 1115 Demonstration.

While we appreciate DHCS's efforts to renew CalAIM authorities, we must express serious concern regarding the continued exclusion of our Tribal Health Program from access to Traditional Healer and Natural Helper services due solely to our county's non-participation in the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Discriminatory Impact on Rural Tribal Health Programs

Tolowa Ṇation is located in a rural area of California and is not served by a DMC-ODS county. As a result, DHCS's current structure **categorically excludes our program and our patients from accessing Traditional Healer and Natural Helper services**, despite explicit recognition that these services benefit AIAN communities.

This exclusion is not based on clinical need, program readiness, or Tribal eligibility. Instead, it is based solely on geographic location—a factor outside of Tribal control. As applied, this policy discriminates against rural Tribal Health Programs and perpetuates inequities between urban and rural Tribal communities.

Traditional Healing Is Not County-Dependent

Traditional Healer and Natural Helper services are rooted in Tribal culture, not county behavioral health systems. Conditioning access to these services on DMC-ODS participation elevates county infrastructure over Tribal sovereignty and creates an inequitable, two-tiered system of care for AIAN Medi-Cal beneficiaries.

Failure to Operationalize DHCS's Stated Flexibility

The Notice indicates DHCS seeks to "retain flexibility to cover these services for other conditions beyond SUD and for other delivery systems." However, without explicit statewide implementation, that flexibility remains theoretical and inaccessible to Tribal Health Programs like ours.

Traditional healing is inherently holistic and supports wellness, prevention, chronic disease management, behavioral health integration, and cultural continuity. These services should not be restricted solely to SUD treatment.

Centralized Reimbursement and Equity

Requiring Tribal Health Programs to rely on county participation creates fragmented implementation and entrenches inequities. DHCS should adopt a centralized reimbursement approach that allows Tribal Health Programs to directly access

reimbursement for Traditional Healer and Natural Helper services, independent of county systems.

We urge DHCS to:

- Provide statewide authority for Traditional Healer and Natural Helper services;
- Allow Tribal Health Programs to offer these services regardless of county DMC-ODS status; and
- Ensure that rural Tribal communities are not excluded from culturally essential care.
- Expand eligibility to all Medi-Cal members receiving care at Indian Health Programs, regardless of diagnosis; and
- Create a streamlined reimbursement mechanism.

Conclusion

Tolowa Nation urges DHCS to correct the discriminatory impact of the current waiver structure and ensure that rural Tribal Health Programs are not excluded from CalAIM benefits solely due to geography.

Equitable access to Traditional Healer and Natural Helper services is not optional—it is essential to fulfilling Medi-Cal's obligation to AIAN communities and honoring government-to-government responsibilities.

Sincerely,

[redacted]

Asa Matice,
Chairman
Tolowa Nation
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Crescent City, CA 95531