STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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

DRAFT FOR PUBLIC COMMENT

February 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

State of California Department of Health Care Services 1
Section 1 – Introduction 4
CalAIM Section 1115 Demonstration Goals 5
Stakeholder Engagement 7
Five-Year Renewal Request 8
Section 2 - Medi-Cal Section 1115 Demonstration History and Background 15
CalAIM Demonstration (2021–2026) 16
Goals and Objectives of the CalAIM Demonstration 17
Section 3 - CalAIM Demonstration Five-Year Renewal Request 20
Section 3.1 – Reentry Services for Justice-Involved Populations 90-Days Pre-Release 25
Section 3.2 – DMC-ODS: Waiver of the IMD Exclusion for SUD Services 29
Section 3.3 – County Option to Cover Select Outpatient SUD Services 30
Section 3.4 – Recovery Incentives: California's Contingency Management Benefit 32
Section 3.5 – Traditional Healers and Natural Helpers 34
Section 3.6 – Coverage for Out-of-State Former Foster Care Youth 35
Section 3.7 – Chiropractic Services from IHS and Tribal Facilities 35
Section 3.8 – Modification of Asset Test for Deemed SSI Populations 36
Section 3.9 – Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan 37
Section 3.10 – Managed Care Authority to Limit Plan Choice in Certain Counties 38
Section 3.11 – Global Payment Program 39
Section 3.12 – Employment Supports 41
Section 3.13 – BridgeCare Pilots 44
Section 4 – Initiatives Being Discontinued or Transitioned Under CalAIM Section 1115 Authority 48
Recuperative Care and Short-Term Post Hospitalization Housing 48
PATH Initiative 49

DSHP Financing 50
CBAS 51
Low-Income Pregnant Women 51
Section 5 – Demonstration Evaluation Results to Date 52
DMC-ODS Evaluation 52
Recovery Incentives Evaluation 54
GPP Evaluation 55
PATH Evaluation 56
Recuperative Care and Short-Term Post-Hospitalization Housing 57
Reentry Services for Justice-Involved Populations 90-Days Pre-Release 58
Medi-Cal Matching Policy for Dual Eligible Members 59
Managed Care Plan Transition 60
Section 6 – Demonstration Renewal Evaluation 62
Section 7 – Demonstration Financing and Budget Neutrality 78
Expected Enrollment Impact 78
Budget Neutrality Calculation 81
Section 8 - Proposed Waiver and Expenditure Authorities 85
Waiver Authorities 85
Expenditure Authorities 91
Section 9 – Stakeholder Engagement and Public Notice 97
Appendix A – EQRO and Quality Reports 98
2023–2024 DMC-ODS EQRO Report 98
2023–2024 Medi-Cal Managed Care Physical Health External Quality Review Technical Report 99
2025 DHCS Comprehensive Quality Strategy 100
California CMS Form 416 EPSDT/CHIP Report 103

SECTION 1 – INTRODUCTION

The California Department of Health Care Services (DHCS) is requesting 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. California seeks to build upon and consolidate the successes of the CalAIM initiative through this renewal and to renew existing authorities with minimal modifications, discontinue authorities that are no longer necessary, and request authority for new initiatives.

Through the CalAIM Section 1115 demonstration approval in December 2021 and subsequent amendments in the following years, California received federal authority to implement a range of initiatives that have led to broad delivery system, program, and payment reforms across the Medi-Cal program. Key initiatives included: first-in-the-nation approval for the Justice-Involved Reentry Initiative, to provide a targeted set of Medicaid services to youth and eligible adults in state prisons, county jails, and youth correctional facilities in the 90 days prior to release; Recovery Incentives, the only treatment that has demonstrated robust outcomes for individuals with stimulant use disorder; and approval to cover Traditional Health Care Practices for members with substance use disorder (SUD) receiving care at Indian Health Service (IHS), Tribal, or Urban Indian Organization facilities. Since California's approvals, the Centers for Medicare & Medicaid Services (CMS) has granted approval of these critical initiatives for multiple states across the country.[1] As described in further detail below, the state also received approval to offer two Community Supports—Recuperative Care and Short-Term Post-Hospitalization Housing—under the CalAIM Section 1115 demonstration to improve members' health outcomes. California's companion CalAIM Section 1915(b) waiver approval allowed the state to transition and streamline authority for California's managed care delivery systems—Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health Services (SMHS), and Drug Medi-Cal Organized Delivery System

[1] For example, states with approved Justice-Involved Reentry Initiatives include Arizona, Colorado, Hawaii, Illinois, Kentucky, Massachusetts, Maryland, Michigan, Montana, North Carolina, New Hampshire, New Mexico, Oregon, Pennsylvania, Utah, Vermont, Washington, and West Virginia. States with pending Justice-Involved Reentry Initiatives requests include Arkansas, Connecticut, District of Columbia, Louisiana, Maine, Minnesota, New Jersey, New York, and Nevada. States with approved Recovery Incentives include Delaware, Hawaii, Montana, and Washington. States with pending Recovery Incentives requests include Maine, Michigan, and Oregon. States with approved Traditional Health Care Practices (THCP) initiatives include Arizona, New Mexico, and Oregon. States with pending THCP requests include Maine and Utah.

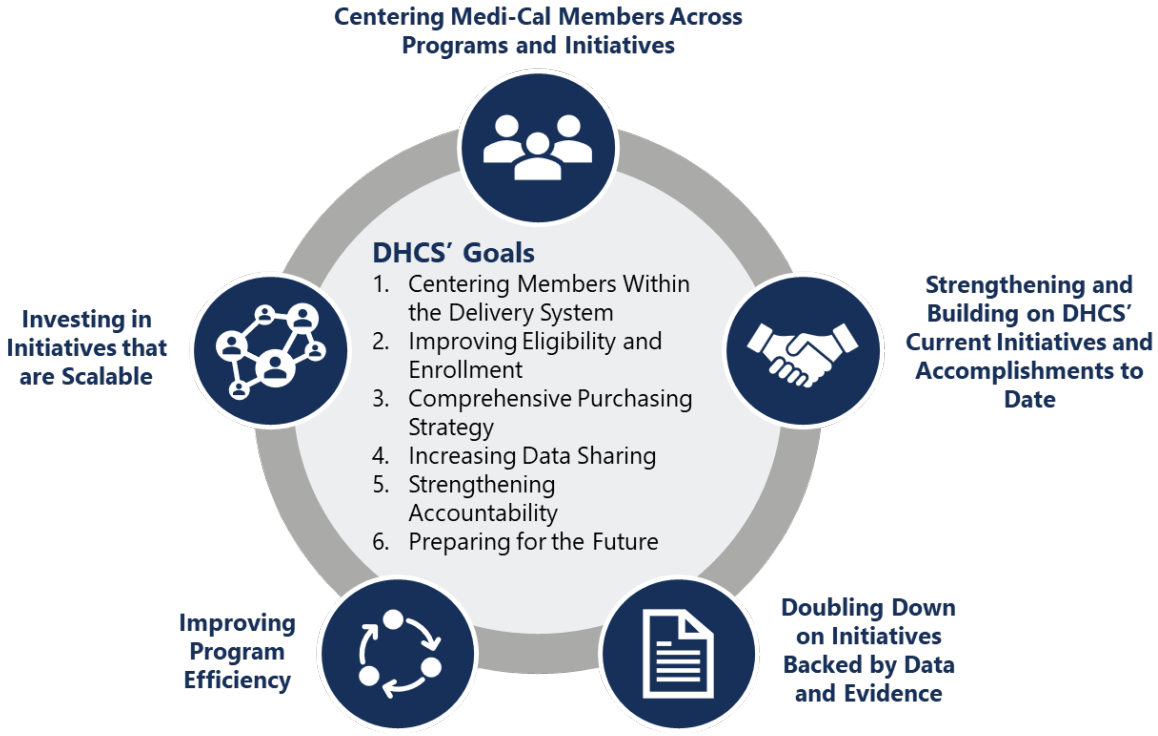
(DMC-ODS)—from its longstanding Section 1115 demonstration to authority under the 1915(b) waiver.

California has made significant strides toward realizing CalAIM's full potential since its launch in January 2022 in close partnership with Medi-Cal managed care plans (MCPs), county behavioral health plans (BHPs), county public health departments, providers, Tribal partners, community-based providers and organizations, the California Department of Corrections and Rehabilitation (CDCR), county sheriffs, and other implementation partners. Through the renewal of the CalAIM Section 1115 demonstration, DHCS seeks to build on prior investments and sustain the unprecedented changes that have led to a more coordinated, person-centered, value-based and efficient health system for California's Medicaid members.

CalAIM Section 1115 Demonstration Goals

Renewing the CalAIM Section 1115 demonstration will enable California to further embed and strengthen the CalAIM initiative, continuing to expand coverage and access to benefits for certain eligible, high-need, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal members across the state. In July 2025, California published a concept paper outlining DHCS' vision, principles, goals, and priorities for Medi-Cal in 2027 and beyond. DHCS articulated several guiding principles to ensure that DHCS' initiatives continue to be effective, impactful, and sustainable. By adhering to these principles as part of the CalAIM renewal, DHCS aims to continue driving meaningful improvements in health outcomes and the overall health care experience for Medi-Cal members while continuing to drive efficiency, strengthen accountability and program integrity, and align payment with value, in concert with statewide health care spending growth management strategies. Leveraging these guiding principles and in response to stakeholder feedback (described in further detail below), DHCS identified several goals that will govern DHCS' efforts to continue to transform Medi-Cal for 2027 and beyond. Renewing key initiatives and obtaining federal authority for new initiatives under the state's CalAIM Section 1115 Demonstration serves as the foundation for DHCS' continued pursuit of its goals.

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



The state proposes three updated, primary goals that seek to expand the reach and impact of CalAIM from 2027 through 2031 that are aligned with California's broader vision for Medi-Cal:

1. Strengthen the ability of DHCS, plans, and providers to identify and intervene early to manage member risk and need through whole person care approaches that optimize member experience;

2. Continue to move Medi-Cal to a more consistent and seamless system by further reducing complexity, strengthening accountability, and improving program efficiency; and

3. Continue to improve quality outcomes and drive delivery system transformation and innovation through value-based initiatives that allow members to receive the right care, at the right time, in the right place, at the right cost.

Over the current CalAIM demonstration period, the state has made significant and meaningful progress in meeting CalAIM's objectives and promoting the objectives of the Medicaid program broadly that will be covered in greater detail in subsequent sections of this application. This extension will enable the state to expand the reach and deepen the impact of key demonstration initiatives and launch new initiatives that align

with CalAIM's primary goals. Key initiatives, including Recovery Incentives, Justice-Involved Reentry Initiative, and Traditional Healers and Natural Helpers, were launched during the current CalAIM demonstration and have already shown promising results. Longer standing demonstration initiatives—such as coverage for out of state former foster care youth and Institutions for Mental Diseases (IMD) waiver authority in DMC-ODS—have expanded coverage and access to medical and behavioral health services across multiple delivery systems for high-needs populations. California is seeking to retain and strengthen these existing demonstration features and to obtain federal approval for new initiatives, including Employment Supports and BridgeCare Pilots, to improve coverage and access to care for high-needs populations. The remainder of this application describes the state's vision for the continued evolution of the CalAIM demonstration.

Stakeholder Engagement

Since the launch of CalAIM in January 2022, DHCS has engaged in extensive stakeholder engagement efforts to support the design and implementation of the various CalAIM initiatives. DHCS leveraged a wealth of feedback, insights, and recommendations shared by our partners through a wide range of forums, such as bi-weekly CalAIM Implementation Advisory Group meetings, regular CalAIM Behavioral Health Workgroup meetings, monthly MCP technical assistance and guidance webinars, weekly meetings with MCP associations, quarterly Stakeholder Advisory Committee/Behavioral Health Stakeholder Advisory Committee meetings, standing meetings with MCPs, BHPs, various county associations, provider associations, advocacy groups, and more; comments and recommendations received through dedicated email mailboxes; and comprehensive feedback provided on draft policy guidance. DHCS also assessed grievance and appeals, monitoring, and quality data and reviewed key findings to analyze efficacy, outcomes, and cost effectiveness of initiatives.

The CalAIM Section 1115 demonstration renewal application is also informed by a series of in-person listening sessions with stakeholders held in regions across the state starting in the fall of 2022 through 2025. Participating stakeholders included Medi-Cal members, community-based providers and organizations, MCPs, BHPs, public health agencies, sheriff's departments, probation agencies, housing service providers, health care providers, and advocates. During these listening sessions, DHCS gained deeper insights into how CalAIM is being implemented on the ground (including identifying successes and areas for improvement), learned how partners are collaborating on multisectoral initiatives (such as the Justice-Involved Reentry Initiative), and explored future opportunities to build on and strengthen CalAIM through the renewal. This renewal was

additionally informed through dedicated structures that DHCS has established to engage with and hear from Medi-Cal members directly, including the Medi-Cal Member Advisory Committee, established in 2023, and the new Medi-Cal Voices and Vision Council. Through this stakeholder and member engagement, DHCS heard a consistent, core theme to focus on expanding, improving and deepening the impacts of the CalAIM initiatives.

DHCS is now seeking public comment on this CalAIM Section 1115 demonstration renewal proposal prior to submission to the federal government.

Five-Year Renewal Request

DHCS is requesting a five-year renewal to continue a subset of the waiver and expenditure authorities approved in our initial CalAIM Section 1115 demonstration and obtain new waiver and expenditure authorities for new initiatives (see Section 3). DHCS also plans to sunset some initiatives—such as the DHCS Providing Access and Transforming Health (PATH) Initiative, an initiative designed to provide time-limited support to community-based providers—and move some of the other initiatives to an alternative authority, choosing not to seek renewal (see Section 4).

The table below provides an overview of the current and proposed new initiatives under the CalAIM 1115 demonstration, noting for each initiative whether DHCS is requesting renewal, is requesting new authority, plans to transition to a currently approved initiative to an alternate authority, or has or will sunset.

Table 1. Crosswalk of CalAIM Demonstration Initiatives and Requested CalAIM Demonstration Initiatives

CalAIM Initiative	Renew Under Section 1115 Authority	Obtain New Section 1115 Authority	Transition Section 1115 Authority	Sunset Section 1115 Authority
Reentry Services for Justice-Involved Populations 90-Days Pre-Release: Targeted Medi-Cal services for justice-involved individuals for up to 90 days prior to release. *(Section 3.1)*	✓			

CalAIM Initiative	Renew Under Section 1115 Authority	Obtain New Section 1115 Authority	Transition Section 1115 Authority	Sunset Section 1115 Authority
DMC-ODS: Waiver of the IMD Exclusion for SUD Services: Federal reimbursement for Medicaid services provided to short-term IMDs receiving SUD services. *(Section 3.2)*	✓			
Peer Support Services (Renamed County Option to Cover Select Outpatient SUD Services Under Renewal): Culturally competent services provided by certified peer support specialists that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. *(Section 3.3)*	✓			
Recovery Incentives: The only intervention that has demonstrated robust outcomes for individuals living with stimulant use disorder, including reduction or cessation of	✓			

CalAIM Initiative	Renew Under Section 1115 Authority	Obtain New Section 1115 Authority	Transition Section 1115 Authority	Sunset Section 1115 Authority
drug use and longer retention in treatment. *(Section 3.4)*				
Traditional Healers and Natural Helpers: Culturally responsive care for members receiving care at IHS, Tribal, or Urban Indian Organization facilities. *(Section 3.5)*	✓			
Coverage for Out-of-State Former Foster Care Youth: Medi-Cal coverage for former foster care youth who are under age 26. *(Section 3.6)*	✓			
Chiropractic Services from IHS and Tribal Facilities: Chiropractic services furnished by tribal providers to Medi-Cal members. *(Section 3.7)*	✓			
Modification of Asset Test for Deemed Supplemental Security Income (SSI) Populations: Medi-Cal eligibility for individuals in select Deemed SSI populations (Pickle Group, Disabled Adult Child group, Disabled	✓			

CalAIM Initiative	Renew Under Section 1115 Authority	Obtain New Section 1115 Authority	Transition Section 1115 Authority	Sunset Section 1115 Authority
Widow/Widower group) by increasing the asset test. *(Section 3.8)*				
Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan: Aligns a dually eligible beneficiary's Medicaid plan with their Medicare Advantage (MA) Plan choice, to the extent the MA plan has an affiliated Medicaid plan. *(Section 3.9)*	✓			
Managed Care Authority to Limit Plan Choice in Certain Counties: Enables the state to limit choice of MCPs in metro, large metro, and urban counties operating under the County Organized Health System (COHS) and Single Plan models. *(Section 3.10)*	✓			
Global Payment Program: Supports public health care systems that provide health care for uninsured Californians through a	✓			

CalAIM Initiative	Renew Under Section 1115 Authority	Obtain New Section 1115 Authority	Transition Section 1115 Authority	Sunset Section 1115 Authority
value-based statewide funding pool. *(Section 3.11)*				
Employment Supports: 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 and community engagement requirements. (*Section 3.12)*		✓		
BridgeCare Pilot: Set of home- and community-based services (HCBS) and caregiver supports to older adults with Medicare and significant health needs with incomes above Medi-Cal eligibility limits who lack resources for adequate care. (*Section 3.13)*		✓		
Community-Based Adult Services: Services and supports for older adults and adults with disabilities to restore or maintain their optimal			✓	

CalAIM Initiative	Renew Under Section 1115 Authority	Obtain New Section 1115 Authority	Transition Section 1115 Authority	Sunset Section 1115 Authority
capacity for self-care and delay or prevent institutionalization. *(Section 4)*				
Recuperative Care and Short-Term Post Hospitalization Housing: Short-term residential setting in which members recover from an injury or illness while obtaining access to primary care, behavioral health services, case management, and other supportive social services. *(Section 4)*			✓	
PATH Initiative: Funds to support the capacity and infrastructure of community partners to successfully participate in the Medi-Cal delivery system and offer Enhanced Care Management (ECM), Community Supports, and pre-release services. *(Section 4)*				✓
Designated State Health Program (DSHP): DSHP financing used to support portions of the PATH program. *(Section 4)*				✓

CalAIM Initiative	Renew Under Section 1115 Authority	Obtain New Section 1115 Authority	Transition Section 1115 Authority	Sunset Section 1115 Authority
Low-Income Pregnant Women: Postpartum benefits for pregnant women with incomes between 109 percent up to and including 138 percent of the federal poverty level (FPL), which includes all benefits that would otherwise be covered for women with incomes below 109 percent of the FPL. *(Section 4)*				✓

Additional details about these initiatives and authorities are described in this renewal request as follows:

- **Section 3** describes the proposed elements of the Section 1115 demonstration renewal request for every initiative DHCS seeks to continue and launch under Section 1115 demonstration authority.
- **Section 4** describes the initiatives authorized under the CalAIM demonstration that have been, or will be, discontinued or which will be transitioned to alternative Medi-Cal coverage authority if determined appropriate by CMS.

SECTION 2 - MEDI-CAL SECTION 1115 DEMONSTRATION HISTORY AND BACKGROUND

California's Medicaid Section 1115 demonstrations date back to 1995, when the state became one of the first in the nation to leverage this flexibility. Through the demonstration, the Los Angeles County Department of Health Services sought to reduce its traditional emphasis on emergency room and inpatient care by building an integrated system of community-based primary, specialty, and preventive care.

- In **2005**, through California's Medi-Cal Hospital Uninsured Care demonstration, the inaugural Section 1115 demonstration, the state supported safety net hospitals with the goal of improving access to care among uninsured individuals by providing funding to public hospitals for uncompensated care (UCC) and creating safety net UCC pools.
- In **2010**, to prepare for full implementation of the Affordable Care Act (ACA) and continue to support safety net hospitals with the goal of improving access to and quality of care, California requested and received approval for the Bridge to Reform demonstration, a five-year renewal of the Section 1115 demonstration, to assist counties in implementing coverage expansions prior to the ACA's historic coverage expansions took effect in 2014, enroll new populations into the managed care delivery system, continue the safety net care UCC pool, and support safety net hospitals through the Delivery System Reform Incentive Program.
- Through subsequent amendments to the Bridge to Reform demonstration, California integrated new populations and geographies into managed care and implemented reforms aimed at improving health outcomes. These reforms included the Coordinated Care Initiative (CCI), which helped rebalance service delivery from institutional care into the home and community. DHCS also launched the Community Based Adult Services (CBAS) program to invest in community-based services to serve older adults and adults with disabilities and prevent institutionalization.
- Building on CCI, California further coordinated care for older adults and people with disabilities eligible for both Medicare and Medi-Cal (dual eligibles) through the Cal MediConnect Duals Demonstration as part of the Center for Medicare and Medicaid Innovation's Financial Alignment Initiative to ensure dual eligibles

received coordinated medical, behavioral health, and long-term services and supports (LTSS) through a single health plan.

- In **2015**, California received approval for the Medi-Cal 2020 demonstration, a subsequent five-year renewal of the Section 1115 demonstration, to test new and innovative care models aimed at improving health care quality and outcomes, ensuring ongoing support for the hospital safety net in California and strengthening Medi-Cal's long-term financial sustainability. Through Medi-Cal 2020, California launched the innovative Whole Person Care pilots to coordinate members' physical health, behavioral health, and social services, with the goal of improving patient outcomes by addressing the comprehensive needs of Medi-Cal members.
- Medi-Cal 2020 supported safety net hospital transformation by establishing the Global Payment Program, a statewide pool of funding that incentivized a shift from high-cost, avoidable services to high value, preventive services and launching the Public Hospital Redesign and Incentives in Medi-Cal Program to provide incentive funding for hospitals tied to ongoing delivery system reforms.
- Other initiatives in Medi-Cal 2020 increased access for individuals with varying levels of care needs. Launch of the specialized DMC-ODS expanded the continuum of SUD services and permitted Medi-Cal reimbursement for SUD services provided to short-term residents of IMDs. DMC-ODS represented a first-in-the-nation approval for a Section 1115 SUD IMD demonstration, paving the path for over thirty states to implement similar programs.
- Concurrently, the Health Homes Program, which was authorized via a state plan amendment and the Medi-Cal 2020 demonstration, offers enhanced and standardized chronic disease management and coordinates the full range of physical health, behavioral health, and community-based LTSS needed by eligible beneficiaries. Together, the Whole Person Care pilots and the Health Homes Program form the bedrock for CalAIM.

CalAIM Demonstration (2021–2026)

In **December 2021,** California received federal approval for the CalAIM initiative, an additional five-year renewal of the Section 1115 demonstration to expand Medi-Cal member access to person-centered care that meets their physical, behavioral, and social needs. The CalAIM initiative retained and advanced many of the initiatives established under Medi-Cal 2020 demonstration. It also established new initiatives designed to expand Medi-Cal member access to innovative care for hard-to-reach populations,

including individuals with SUDs, individuals experiencing homelessness and those who are justice involved through Justice-Involved Reentry Initiative, Recovery Incentives, Recuperative Care, and Short-Term Post-Hospitalization Services. Through the PATH initiative, the state was able to support the start-up costs for non-traditional health care providers, including correctional facilities, offering these critical services. The CalAIM initiative also maintained other core and longstanding 1115 programs, such as the DMC-ODS, CBAS, the Global Payment Program (GPP), and extending Medi-Cal coverage for out-of-state former foster youth.

Through subsequent waiver amendments to CalAIM, California was granted federal authority for the following new initiatives:

- ***Modification of Asset Limit Test for Deemed SSI Populations:*** DHCS received CMS approval on a two-fold request in 2022 to amend the CalAIM Section 1115 demonstration to raise and then eliminate a resource disregard for Deemed SSI groups, specifically the Pickle Amendment group, the Disabled Adult Child group, and the Disabled Widow/Widower group.
- ***Managed Care Authority to Limit Plan Choice in Certain Counties:*** In August 2023, California received federal approval to limit choice of MCPs in metro, large metro, and urban counties operating under the COHS and Single Plan models.
- ***Traditional Healers and Natural Helpers:*** In October 2024, California received federal approval to provide culturally responsive care for Medi-Cal members receiving care at IHS, Tribal, or Urban Indian Organization facilities.

Goals and Objectives of the CalAIM Demonstration

Through CalAIM, DHCS sought to make broad delivery system reform to advance whole person care, address the physical and behavioral health needs of Medi-Cal members, particularly those with substance use needs, those who are unhoused, and/or those who are justice-involved. It also sought to improve health outcomes and quality and coordination of care for all Medi-Cal members and included initiatives to increase access to stabilize and strengthen providers, including an expanded set of health care providers, to serve Medi-Cal populations.

Over the demonstration period, the state has made significant and meaningful progress in meeting CalAIM's objectives and promoting the objectives of the Medicaid program broadly. CalAIM initiatives have increased access to health coverage and improved health outcomes for Medi-Cal members. Additionally, based on DHCS' preliminary

analyses, the CalAIM demonstration has also improved the efficiency and effectiveness of the Medi-Cal program:

- California's Justice-Involved Reentry Initiative launched in October 2024. Currently, the initiative is providing pre-release reentry services in thirty-one state prison sites and twenty-two county correctional facilities across ten California counties. As of September 30, 2025, nearly 35,000 Medi-Cal members have been identified as eligible for pre-release services to support successful re-entry to the community as part of the Justice-Involved Reentry Initiative. Between October 1, 2024 and September 30, 2025, approximately 64,500 services (e.g., physical and behavioral health consultations, laboratory and radiology services) were provided to eligible individuals. Of these, nearly 4,600 were care management services. Through the first quarter of 2025, close to 3,200 eligible individuals engaging in ECM post-release, reflecting successful care transitions as individuals re-enter their communities.
- In 2025, DHCS enrolled dually eligible members who elect to enroll in MA in MCPs affiliated with their MA plan in 17 counties. As of October 1, 2025, 482,572 dually eligible members received more integrated Medicare and Medicaid care through CalAIM's alignment of a member's MCP with their MA plan. These dually eligible members receive more integrated Medicare and Medicaid care as they are matched to Medi-Cal plans that provide wraparound services like personal care and care coordination. In 2026, the Medi-Cal matching plan policy will be implemented in all counties.
- 21 counties cover Recovery Incentives as of June 2025. Roughly 81 percent of all Medi-Cal members live in counties that offer this benefit. As of the end of 2025, more than 11,000 individuals were served by the Recovery Incentives program, and 95.5 percent of urine drug tests (UDTs) submitted by participants were stimulant-negative, surpassing the rate identified in review of existing literature (85.3 percent weighted average).[2] As part of the DHCS interim evaluation, program participants responding to a July 2023 survey reported improvements in health, reduced emergency room visits, better engagement with treatment, and enhanced quality of life.[3]

[2] Urada, D., Antonini, V. P., Padwa, H., Nork, A., Gourley, S., Bass, B., Tsoi, S. Y. C., Cooper, M., Loya, C., Gregorio, L., Zakher, E., Xing, Y., Khurana, D., Lee, A., & Rawson, R. A. (2025, September). *Contingency Management: Evaluation Report – Supplement to the DMC-ODS Interim Evaluation Report* (Attachment D). California DHCS.

[3] Urada et al., 2025.

- Preliminary findings on the two Community Supports authorized under the CalAIM Section 1115 Demonstration—recuperative care and short-term post-hospitalization 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.[4]

DHCS seeks to continue the Medi-Cal transformations initiated to date under CalAIM and build upon CalAIM's transformational foundation.

[4] These findings are based on DHCS' preliminary analysis, which was led by an actuarial firm. DHCS analyzed the impact of these two services by examining the time from July 2022 to June 2024 and analyzing the six months before and six months after the members received a service in 2023. DHCS will complete a full independent evaluation of these two services according to the requirements outlined in STC 17 of the current CalAIM STCs.

SECTION 3 - CALAIM DEMONSTRATION FIVE-YEAR RENEWAL REQUEST

DHCS seeks to continue California's efforts to transform Medi-Cal through the renewal of a subset of existing key and new CalAIM initiatives. Notably, California is focusing on consolidating and expanding the progress made via several existing CalAIM initiatives, requesting new authorities for new initiatives, and moving other existing CalAIM initiatives to alternative authorities. DHCS is requesting a five-year renewal of Section 1115 demonstration waiver and expenditure authorities to continue and obtain new authorities to operate a discrete set of program elements that generally cannot be approved under the Medi-Cal State Plan or Section 1915(b) waiver authorities. Should CMS advise the state that other authorities are required to implement the programmatic vision and operational details outlined in this application, the state will request such waiver or expenditure authority as appropriate. Negotiations between California and the federal government, along with potential state legislative or budgetary changes, may result in further refinements to these requests as California continues to collaborate with CMS.

Following are the elements of the CalAIM Section 1115 demonstration that DHCS proposes to continue under the five-year renewal, with modifications as noted:

- ***Reentry Services for Justice-Involved Populations 90-Days Pre-Release:*** Through the Justice-Involved Reentry Initiative, California covers a targeted set of Medi-Cal services (e.g., comprehensive case management, medication assisted treatment or medications for addiction treatment (MAT), and physical and behavioral health clinical consultation) for up to 90 days immediately prior to a youth or eligible adult's expected date of release from a state prison, county jail, or youth correctional facility. Individuals participating in the Initiative also receive a supply of medications and medically necessary durable medical equipment in hand upon their release. This initiative supports Medi-Cal members in re-entering the community. Since it was launched in October 2024, the Justice-Involved Reentry Initiative has expanded steadily—as of October 2025, the Initiative includes 31 state prison sites and twenty-two county correctional facilities across 10 California counties. County correctional facilities are continuing to "go-live" on a quarterly basis, with all correctional facilities mandated under California state law to implement the initiative by October 1, 2026. DHCS seeks to renew its waiver and expenditure authorities to enable the state to continue to offer these critical services and supports to eligible justice-involved individuals across all its

correctional facilities statewide. Critically, this initiative is key to the success of California's implementation of work and community engagement requirements of H.R. 1. As DHCS prepares for an effective and robust implementation of work and community engagement requirements across Medi-Cal, the infrastructure and processes that correctional facilities and eligibility offices have stood up to administer the Justice-Involved Reentry Initiative are foundational to the state's comprehensive strategy for implementing work and community engagement requirements, in particular for inmates and former inmates who meet the statutory criteria of specified excluded individuals and additional exceptions.

- ***DMC-ODS – Waiver of the IMD Exclusion for SUD Services:*** The DMC-ODS is a non-risk managed care program for the organized delivery of SUD treatment services to eligible Medi-Cal members with SUDs by providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services, which is a county opt-in program. As of January 1, 2025, the DMC-ODS is available in 40 (out of 58) counties, providing access to more than 96 percent of the Medi-Cal population. DHCS continues to support expansion of the program and is actively providing technical assistance to counties that have expressed interest in participating in the DMC-ODS in the future. Counties that have not opted to participate in DMC-ODS run fee-for-service Drug Medi-Cal (DMC) programs where a more limited set of SUD services are offered to eligible Medi-Cal members. The state is seeking a renewal of its expenditure authority allowing federal reimbursement for Medi-Cal services provided to short-term residents of IMDs receiving SUD services covered as part of the DMC-ODS. Other current elements of the DMC-ODS that do not require Section 1115 demonstration authority, including continued authority for the DMC-ODS managed care delivery system and waivers of statewideness and comparability associated with DMC-ODS benefits, will be requested in the companion CalAIM 1915(b) waiver renewal. The expanded continuum of services currently available under Medi-Cal State Plan authority in opt-in counties will remain in place.
- ***County Option to Cover Select Outpatient SUD Services:*** California remains committed to expanding access and coverage to SUD services across the state to address the rising SUD prevalence and further reduce drug-related overdose deaths. To help DHCS advance this goal, the state is seeking waivers of statewideness and comparability to enable DMC counties to offer outpatient SUD State Plan services currently only available at county option in DMC-ODS

counties, including care coordination, recovery services, withdrawal management services, and partial hospitalization, in addition to peer support services. The state is seeking to modify its waivers of statewideness and comparability currently approved for peer support services to enable these additional SUD services to be offered at a DMC county's option. The state is also seeking new authority for DMC counties to opt-in to cover mobile crisis services.

- ***Recovery Incentives:*** California was the first state in the nation to receive CMS approval to cover Recovery Incentives, sometimes referred to as contingency management services, under the CalAIM Section 1115 demonstration. Recovery Incentives are an evidence-based practice to reward participants with stimulant use disorder for meeting treatment goals. DMC-ODS counties elect to provide this and other DMC-ODS benefits and as of June 2025, 21 DMC-ODS counties cover Recovery Incentives. Roughly 81 percent of all Medi-Cal members live in counties that offer this benefit. As of April 30, 2025, the Recovery Incentives program achieved a 95.5 percent rate of negative UDTs among participants who completed the full 24-week protocol, surpassing the rate identified in review of existing literature (85.3 percent weighted average).[5] The state plans to continue to offer this benefit in the DMC-ODS and requests to expand its waivers of statewideness and comparability and the expenditure authority to start offering this benefit in DMC counties.
- ***Traditional Healers and Natural Helpers:*** In October 2024, California received CMS approval of an amendment to the CalAIM Section 1115 demonstration to cover THCPs, defined as traditional healer and natural helper services. This authority grants eligible Medi-Cal members access to culturally based care provided by IHS facilities, Tribal health clinics, and Urban Indian organizations (UIOs) through the DMC-ODS. DHCS requests to renew its existing expenditure authorities with no modifications to continue to cover these services through the DMC-ODS and retain flexibility to cover these services for other conditions beyond SUD and for other delivery systems.
- ***Coverage for Out-of-State Former Foster Care Youth:*** The CalAIM Section 1115 demonstration authorizes Medi-Cal coverage for former foster care youth under age 26 who were in foster care under the responsibility of another state or a tribe when they aged out. DHCS requests a renewal of this expenditure authority.

[5] Urada et al., 2025.

California is not requesting any changes as part of the Section 1115 demonstration renewal request.

- ***Chiropractic Services from IHS and Tribal Facilities:*** As part of the renewal of the CalAIM Section 1115 demonstration in 2021, DHCS received approval to provide reimbursement for chiropractic services provided by IHS and Tribal providers, for which Medi-Cal coverage weas eliminated by state plan amendment (SPA) 09-001, which is the only optional benefit yet to be restored under the Medi-Cal State Plan. The state is seeking to renew its expenditure authority for chiropractic services furnished by IHS and Tribal providers to individuals enrolled in the Medi-Cal program.
- ***Modification of Asset Test for Deemed SSI Populations:*** In 2021, the California legislature directed DHCS to implement a two-phased approach to increase and eliminate the asset limits for low-income individuals whose eligibility is not determined using modified adjusted gross income (MAGI)-based financial methods. In response, DHCS submitted and received CMS approval on a two-fold request in 2022 to amend the CalAIM Section 1115 demonstration to raise and then eliminate a resource disregard for Deemed SSI groups, specifically the Pickle Amendment group, the Disabled Adult Child group, and the Disabled Widow/Widower group. This authority permitted the state to apply a disregard of $130,000 for a single Medi-Cal enrollee and $65,000 for each additional household member effective July 2022. Effective January 1, 2024, DHCS eliminated the asset limits for these populations. DHCS requests to renew its existing waiver and expenditure authorities with one modification—pursuant to recently enacted state budget, the state seeks to reinstate the Medi-Cal asset limit tests for these Deemed SSI populations at $130,000 for an individual Medi-Cal member and $65,000 for each additional household member.
- ***Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan:*** To promote coordination and integration, the CalAIM Section 1115 demonstration allows the state to align a dually eligible member's Medicaid plan with their MA plan choice if the MA plan has an affiliated Medicaid plan. DHCS seeks to renew its expenditure authority without modifications.
- ***Managed Care Authority to Limit Plan Choice in Certain Counties:*** In August 2023, as an amendment to the CalAIM Section 1115 waiver, California received approval from CMS to limit choice of MCPs in metro, large metro, and urban counties operating under the COHS and Single Plan models. The state is seeking to renew this expenditure authority for payments to a managed care entity that

would not meet the otherwise applicable statutory requirement that requires members to have a choice of at least two MCPs.

- ***GPP:*** Since its launch in 2015, the GPP combined demonstration-authorized uncompensated care funding with Disproportionate Share Hospital (DSH) funds and established a new method of compensating participating designated public hospital systems for caring for uninsured individuals focused on cost-effective and higher-value care. DHCS seeks to renew the GPP waiver and expenditure authorities to increase access to, stabilize, and strengthen the providers and provider networks available to serve Medicaid and low-income populations.

Following are the new elements for which DHCS proposes to obtain waiver and expenditure authority under the five-year renewal:

- ***Employment Supports:*** Considering the new federally mandated work and community engagement requirements for expansion adults, DHCS is seeking CMS approval to include Employment Supports as a county opt-in Medi-Cal covered benefit to address barriers to employment, support sustained workforce participation, and promote economic stability among Medi-Cal members.[6] Employment Supports would include job readiness assessments, individualized employment planning, job placement assistance, and post-employment retention services. California also requests funding resources for initial start-up activities to support DHCS and electing counties with planning and development activities to implement Employment Supports.
- ***BridgeCare Pilots:*** DHCS is seeking CMS approval to provide a set of HCBS and caregiver supports as county opt-in to "near duals" defined as low-income Medicare beneficiaries with incomes close to but above Medicaid income requirements—between 138–220 percent FPL—with significant health needs who lack resources for adequate care. The overarching goals of BridgeCare Pilots are to support older adults to remain in their homes and communities, prevent costly institutionalization and impoverishment that leads to Medicaid enrollment, improve health outcomes, and reduce avoidable health care spending in the Medicare and Medicaid programs for this vulnerable population.

Following are detailed descriptions of the programs listed above, along with the rationale for renewal or obtaining authority for each existing or new program. For

[6] United States Congress. (2025). *H.R. 1 – One Big Beautiful Bill Act*, 119th Cong. (enacted July 4, 2025). Public Law No. 119-21, 139 Stat. 72. Retrieved from https://www.congress.gov/bill/119th-congress/house-bill/1/text

continuing programs, DHCS requests to continue the majority with no modifications and seeks some programmatic and technical changes with the GPP.

Section 3.1 – Reentry Services for Justice-Involved Populations 90-Days Pre-Release

In January 2023, California received first-in-the-nation approval to address the significant physical and behavioral health care needs experienced by justice-involved populations. Through this Justice-Involved Reentry Initiative, California covers a targeted set of Medi-Cal services in the 90 days prior to their expected dates of release. Pre-release services include care management, MAT, physical and behavioral health clinical consultation, laboratory and radiology, and the administration of covered medications. Individuals also receive a full supply of medications and medically necessary durable medical equipment (DME) upon release. California's Justice-Involved Reentry Initiative has served as a blueprint for 20 other states with similar waiver requests and/or approvals.

DHCS partnered with the California Department of Corrections and Rehabilitation, California Correctional Health Care Services, county sheriffs, county probation officers and other critical partners, such as BHPs, MCPs, and community-based providers and organizations, to provide Medi-Cal pre-release and reentry services to facilitate successful community reentry for individuals leaving incarceration. Studies demonstrate that individuals face substantially higher risks of mortality and morbidity upon re-entry.[7] Supported by the PATH Initiative, which was approved as part of the renewal of the CalAIM Section 1115 demonstration in 2021 and will sunset in December 2026 as described in Section 4 below, California's implementing partners made significant infrastructure, staffing, technology, and IT investments to enable the provision of these critical services.

Since the initial launch in October 2024, the Justice-Involved Reentry Initiative has expanded steadily—as of October 2025. The initiative includes all thirty-one state prison sites and twenty-two county correctional facilities across ten California counties. As of September 30, 2025, more than 35,000 Medi-Cal members have been identified as eligible for pre-release services as part of the Justice-Involved Reentry Initiative. From October 1, 2024 through September 30, 2025 (based on claims submitted as of September 30, 2025), an estimated 64,500 services—such as physical and behavioral

[7] Kinner SA, Forsyth S, Williams G. Systematic review of record linkage studies of mortality in ex-prisoners: why (good) methods matter. Addiction. 2013;108(1):38-49. 10.1111/add.12010

health consultations, laboratory and radiology services, and care management services—were delivered to eligible individuals.[8] In addition, 14,086 justice-involved individuals received 94,450 prescriptions for the 90-day pre-release period and medications upon release. Five hundred ninety-six justice-involved individuals received 702 pharmacy DME items during the first year of the Initiative. Close to 3,200 eligible justice-involved individuals have enrolled in ECM reflecting successful community-based transitions for individuals reentering their communities.

County correctional facilities can go-live on a quarterly basis upon demonstration of readiness with all California correctional facilities mandated under California state law to go-live by October 1, 2026. DHCS is actively supporting county correctional facilities and their partners with preparing for the go-live of these services by providing policy and operational guidance and continuous technical assistance. State correctional facilities are already live with pre-release services and DHCS continues to provide support to ensure they implement to fidelity.

Objective

This initiative addresses the health care needs of California's justice-involved population and promotes the objectives of the Medicaid program by ensuring justice-involved individuals, including youth, receive needed coverage and health care services prior to release into the community. All youth under 21 and former foster youth between 18–26 years of age housed in youth or adult correctional facilities do not need to demonstrate a health care need to qualify for pre-release services. Eligible youth can be incarcerated at state prisons, county jails, or youth correctional facilities.[9]

The initiative supports successful reintegration into the community post-incarceration and reduces the risk of ending up in the emergency room or requiring costly institutional care and of suffering severe health consequences, including overdose and death. By continuing to bridge relationships between community-based Medi-Cal providers and justice-involved individuals prior to release, California seeks to improve the chances that individuals with a history of substance use, mental illness, and/or chronic disease receive stable and continuous care. This demonstration will continue to seek to improve their health outcomes and reduce Medicaid spending. Specifically, the Initiative aims to:

[8] These figures may be updated as additional claims are submitted within the designated claims submission period.

[9] DHCS received CMS approval to subsume CAA Section 5121 requirements into their Reentry Initiative via their Reentry Implementation Plan, approved October 2024.

- Increase Medi-Cal coverage in the post-release period through standardized Medi-Cal enrollment and suspension processes;
- Improve access to services prior to release to improve transitions and continuity of care into the community upon release;
- Improve coordination and communication between correctional systems, MCPs, BHPs, and community-based providers;
- Improve connections between correctional systems and community-based service providers upon release to address physical and behavioral health care needs;
- Provide interventions for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide related death, overdose, and overdose-related deaths; and,
- Reduce ED visits, hospitalizations, and other avoidable services by connecting justice-involved individuals to ongoing community-based physical and behavioral health services.

After one year of the Justice-Involved Reentry Initiative's launch, DHCS is currently evaluating progress towards achieving the above desired outcomes.

The Justice-Involved Reentry Initiative will strongly support the robust implementation of the new federally mandated work and community engagement requirements, thereby supporting individuals' eligibility for Medi-Cal coverage at application and renewal and advancing the objectives of the Medicaid program. The infrastructure and processes established under the Justice-Involved Reentry initiative will act as a critical foundation for the state's comprehensive strategy for implementing work and community engagement requirements, particularly for inmates and former inmates who meet the statutory criteria of specified excluded individuals and additional exceptions. For example, H.R. 1 requires states to use ex parte data sources wherever possible to verify compliance with or exemption from work and community engagement requirements. The Justice-Involved Reentry Initiative will enable California to perform ex parte determinations based on data produced during its implementation in correctional settings, such as data regarding incarceration status and release date. In addition, the required screenings and assessments provided as part of pre-release services may identify medical conditions that establish exemption from work and community engagement requirements consistent with federal law, such as SUD, a disabling mental health condition, or medical frailty. Further, the transitional care management provided

as part of pre-release services and through an individual's reentry into the community can provide vital linkages to vocational, education, and community service activities. The Justice-Involved Reentry Initiative provides a fundamental framework for a comprehensive approach to work and community engagement implementation, and its renewal is critical to a successful launch of this new federal policy.

Providing up to 90 days of services in the period prior to expected date of release is critical to the success of the Justice-Involved Reentry Initiative. Based on California's experience over the last year implementing pre-release services, correctional facilities and providers need sufficient lead time to arrange services before release. This advance planning is crucial for creating post-release provider relationships and ensuring continuous coverage and care. Most eligible individuals under this Initiative are incarcerated in county jails and have an average length of stay of less than 30 days. A smaller number of individuals with set release dates—typically those who have been adjudicated—are most likely to receive pre-release services during the full 90-day period prior to their release.

Providing enough lead time to arrange services is especially important for individuals receiving pre-release case management and behavioral health treatment, including treatment for mental health and SUDs, as this time is needed to build trust and coordinate appointments with community providers and treatment programs. For example, case management is the linchpin for successful reentry planning and requires sufficient time to be effective for several reasons. First, carceral settings present unique operational challenges for quickly engaging individuals in case management, such as periodic lockdowns, evolving release dates, and limited staffing and facility capacity to provide access to case managers. In most cases, case managers are community-based and must coordinate appointments within limited windows in which they are on-site at a correctional facility and/or virtual appointments can be made. Maintaining the 90-day window for pre-release services is critical for providing enough time for case managers to engage individuals and conduct one-to-two visits at least to develop a care plan and identify referrals for post-release services. It is necessary to conduct at least one to two visits to establish a trusting relationship and ensure retention and continued engagement in community-based care following release; absent 90 days, DHCS is concerned about the risk of post-release engagement failure and unsuccessful care transitions leading to the same adverse health outcomes the demonstration is designed to prevent.

Renewal Request

DHCS seeks to renew its waiver and expenditure authorities with no modifications to enable the state to continue to offer critical pre-release services and supports to eligible justice-involved individuals beginning 90 days pre-release. This initiative does not impact health care delivery system and cost sharing requirements.

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

California created the DMC-ODS program in 2015 to expand access to SUD treatment and provide an expanded continuum of high-quality, evidence-based SUD treatment services. Since 2015, all California counties have had the option to participate in the program to provide their resident Medi-Cal members with an expanded range of evidence-based SUD treatment services. As of January 2025, 40 of California's 58 counties implemented the DMC-ODS, providing access to more than 96 percent of the total Medi-Cal population across the state. DHCS continues to actively engage with additional counties that may wish to opt in to the DMC-ODS, with the goal to expand to eventual statewide access to comprehensive SUD services for Medi-Cal members.

Objective

The objective of the DMC-ODS demonstration is to improve access, quality, and coordination of care for SUD services in participating counties across the continuum of care, including for residential treatment services. The University of California Los Angeles' (UCLA) 2021 evaluation demonstrates that the program has been successful in these areas—there are significant improvements in quality of care within counties that opted into the program when compared with DMC-only counties.[10] UCLA also found that participating in DMC-ODS led to an increase in access to treatment by 7 percent and enhanced care coordination and integration with physical health services for DMC-ODS counties. Overall, DMC-ODS services have high patient satisfaction, with 93 percent reporting positive ratings of their treatment.

Additionally, findings from the DMC-ODS SUD Mid-Point Assessment continue to indicate that the DMC-ODS supports improved outcomes for Medi-Cal members. DMC-ODS member access to any SUD treatment increased by 4.4 percent between the

[10] UCLA David Geffen School of Medicine Integrated Substance Abuse Programs. (2022, April 22). *DMC-ODS FY 2021 evaluation report with appendices (Version 2)*. California Department of Health Care Services. https://www.uclaisap.org/dmc-ods-eval/assets/documents/20220422-DMC-ODS-FY-2021-Evaluation-Report-with-Appendices_V2.pdf

baseline period and the Mid-Point Assessment, with notable increases in access to Residential Treatment (+7.7 percent) and MAT (+10.4 percent). Mid-Point Assessment findings also noted that 74 percent of individuals received the level of care recommended through an ASAM screening or assessment (with member preference being the most common reason for a mismatch in services received). Client satisfaction scores across domains such as access, quality, and care coordination remained consistently high.

Renewal Request

To enable the DMC-ODS to continue to build upon these successes, the state is requesting a five-year renewal of the Section 1115 demonstration expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs receiving DMC-ODS services as part of the comprehensive continuum of SUD care. Other current elements of the DMC-ODS that do not require Section 1115 demonstration authority, including the expanded continuum of services currently available under Medi-Cal State Plan authority and the CalAIM Section 1915(b) waiver, will remain in place. As applicable, renewals of waivers of statewideness and comparability associated with DMC-ODS benefits will be requested in the CalAIM Section 1915(b) waiver. As detailed in Section 3.3 below, the state is requesting to expand its waivers of statewideness and comparability to enable DMC counties that may not be prepared to participate in DMC-ODS to cover outpatient SUD services currently available in DMC-ODS on a county optional basis.

As noted above, the DMC-ODS has been successful in addressing Medi-Cal members' SUD treatment needs; however, the SUD crisis continues to persist. DHCS requests this extension to continue its efforts to expand access to lifesaving treatment in residential and inpatient settings that are IMDs. This initiative does not impact health care delivery system and cost sharing requirements.

Section 3.3 – County Option to Cover Select Outpatient SUD Services

DHCS covers a comprehensive continuum of SUD treatment through the Medi-Cal State Plan. California remains committed to expanding access and coverage to SUD services across the state to connect more Medi-Cal members to care and further reduce drug-related overdose deaths. To help the state advance this goal, DHCS is interested in encouraging DMC counties to opt in to cover certain outpatient SUD services that are currently limited to the DMC-ODS delivery system. DHCS is seeking to allow DMC

counties to offer the following set of outpatient SUD treatment services covered under the Medi-Cal State Plan:[11]

- Care coordination, which consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level;
- Recovery services designed to support recovery and prevent relapse, with the objective of restoring the beneficiary to their best possible functional level;
- Withdrawal management services to assess, observe, and provide medication and MAT to Medi-Cal members experiencing mild to moderate withdrawal; and
- Partial hospitalization to provide clinically intensive programming to address the treatment needs of Medi-Cal members with severe SUD requiring more intensive treatment services than can be provided at lower levels of care.

In addition to the services described above, DHCS is seeking new authority for DMC counties to opt-in to cover mobile crisis services. DHCS also seeks to continue to make peer support services available to Medi-Cal members receiving care in the SMHS and DMC or DMC-ODS. Counties can voluntarily opt in to provide this valuable resource in one or both delivery systems (SMHS, and DMC or DMC-ODS). In alignment with state legislation, DHCS added Medi-Cal Peer Support Specialists as a unique provider type with specific reimbursable services. Peer support services are culturally competent services that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities, such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower Medi-Cal members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery.

As of February 2025, 52 counties include Medi-Cal Peer Support Services as a benefit in one or both of their delivery systems and 99 percent of all Medi-Cal members live in counties that offer this benefit. DHCS released guidance in April 2025 to update and

[11] DHCS plans to transition its SUD clinical standards to the ASAM's fourth edition which may impact how these SUD services are categorized. DHCS plans to update its state plan amendments (SPAs) for impacted services to support the transition. DHCS currently covers withdrawal management as standalone services and plans to embed it as a component of its SUD treatment services as part of the transition.

consolidate requirements for the Medi-Cal Peer Support Services benefit, the Medi-Cal Peer Support Specialist provider type, and state standards for Medi-Cal Peer Support Specialist Certification Programs, including the steps counties that opt in need to take implement these programs. DHCS continues to encourage counties to offer this benefit by providing technical assistance.

Objective

The objective of these outpatient SUD benefits is to treat SUD in the least restrictive setting possible, improve recovery outcomes, and prevent relapses and symptoms of behavioral health disorders, with the goal of promoting improved health outcomes.

Renewal Request

DHCS seeks waiver authority to offer these services at DMC county option, specifically to individuals who meet the criteria for services. This initiative does not impact cost sharing requirements.

Section 3.4 – Recovery Incentives: California's Contingency Management Benefit

California was the first state in the nation to receive CMS approval to cover contingency management under Section 1115 authority. Contingency management is the only intervention that has demonstrated robust outcomes for individuals living with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment. Unlike opioid use disorder and alcohol use disorder, no medications have been approved for the treatment of stimulant use disorder. The standard of care for stimulant use disorder is contingency management.

The Recovery Incentives Program is designed as a standalone intervention that can also be integrated with other evidence-based treatment services, including medications for addiction treatment, as delivered by DMC-ODS providers. The program aims to reduce the number of overdose fatalities and support long term recovery for individuals with stimulant use disorder, including those with poly-substance use disorder (e.g., opioid and fentanyl use).

Consistent with the Trump Administration's Drug Policy Priorities, Recovery Incentives—the name of California's contingency management program—have been shown to reduce illicit drug use among program participants which helps mitigate the flow of drugs into our California communities and support the long-term recovery of individuals with stimulant use disorder. Preliminary observations and participant experiences

indicate potential reductions in utilization of emergency and inpatient services, as well as improvements in economic and housing stability.[12]

DHCS is currently authorized to pilot this benefit in DMC-ODS counties on an opt-in basis and as of June 2025, 21 DMC-ODS plans cover Recovery Incentives. Roughly 81 percent of all Medi-Cal members live in counties that offer this benefit. As of the end of 2025, more than 11,000 participants were served by the Recovery Incentives program statewide, and 95.5 percent of UDTs submitted by participants were stimulant-negative, surpassing the rate identified in review of existing literature (85.3 percent weighted average).[13] This is an important predictor of long-term recovery.

Although California's maximum incentive per client ($599) has been substantially lower than the incentive amounts typically used in research studies, the program still achieved positive outcomes. As part of the DHCS interim evaluation, program participants responding to a survey initiated in July 2023 reported improvements in health, reduced emergency room visits, better engagement with treatment, and enhanced quality of life.[14] Providers observed increased client motivation, self-esteem, and engagement, even among individuals with long histories of substance use.[15] Ninety-two percent of program participants indicated that the program had a positive impact on their use of emergency room and inpatient care.[16] Respondents also reported that the incentives helped them meet basic needs, avoid criminal behavior, and re-enter the workforce. These findings suggest that participation in the program may reduce health care costs improve overall well-being and enable participants to contribute positively to society and the economy. Given the success of this program in participating DMC-ODS counties, DHCS is seeking authority to cover this critical service to DMC county option.

Objective

Medi-Cal coverage of Recovery Incentives services aims to promote recovery among Medi-Cal members living with stimulant use disorder by promoting longer retention in treatment and reduced drug use, ultimately improving members' health outcomes, reducing the rates of ED utilization and inpatient stays and increasing community engagement. This can generate savings for the Medicaid program.

[12] Urada et al., 2025.
[13] Urada et al., 2025.
[14] Urada et al., 2025.
[15] Urada et al., 2025.
[16] Urada et al., 2025.

Renewal Request

California intends to extend this important coverage initiative to continue to provide this benefit to Medi-Cal enrolled individuals with stimulant use disorder. The state requests to renew and expand its waivers of statewideness and comparability and expenditure authority to DMC-ODS and DMC counties at county option. This initiative does not impact cost sharing requirements.

Section 3.5 – Traditional Healers and Natural Helpers

In October 2024, California was one of four states to receive CMS approval to cover THCPs in Medicaid under Section 1115 authority. Beginning in 2025, the state is piloting this coverage through the DMC-ODS by offering Traditional Healer and Natural Helper services to 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.

In March 2025, DHCS released guidance for THCPs, and these services are now covered for Medi-Cal members in DMC-ODS counties. As of November 2025, twelve Indian Health Care Providers have applied to offer THCPs and nine have been approved by DHCS to offer these services to date.

Objective

Through this Initiative, DHCS seeks to improve access to SUD treatment for American Indians and Alaska Natives through IHCPs and to promote access to culturally responsive and evidence-based SUD treatment for American Indians and Alaska Natives. THCPs are expected to improve access to culturally responsive care; support IHS, Tribal, and UIO facilities' ability to serve their patients; maintain and sustain health; and improve health outcomes and the quality and experience of care. This initiative is aligned with federal priorities to enhance access to SUD treatment and Tribal health care.[17]

Renewal Request

To achieve these objectives, DHCS seeks to renew its expenditure authority with no modifications for DMC-ODS services provided by Traditional Healers and Natural Helpers and retain the authority to cover these services for other conditions beyond

[17] In June 2025, CMS issued approvals in Minnesota, New Mexico, Oregon, South Dakota, Washington, and Wyoming to allow IHS and Tribal Clinics to provide such services under SPA authority.

SUD and for other delivery systems. This initiative does not impact health care delivery system or cost sharing requirements.

Section 3.6 – Coverage for Out-of-State Former Foster Care Youth

Young adults who have aged out of foster care often present with complex medical, behavioral, oral, and developmental health problems rooted in a history of childhood trauma and adverse childhood experiences. To ensure access to medically necessary care for such adults, in August 2017, California received CMS approval to provide Medicaid State Plan coverage to former foster care youth under age 26 who were in foster care and were enrolled in Medi-Cal at that time. California sought 1115 authority under the CalAIM demonstration to extend Medi-Cal coverage for individuals who aged out of foster care at age 18 in another state and were enrolled in Medicaid at the time. To comply with SUPPORT Act requirements regarding mandatory coverage for former foster youth, DHCS received approval as part of SPA 23-0009 to cover out-of-state former foster care youth for individuals who turn 18 on or after January 1, 2023. DHCS is seeking continued authority as part of the CalAIM 1115 demonstration to cover this population who turned 18 before January 1, 2023 until they turn 26 years old.

Objective

This Initiative aims to improve health outcomes by extending Medi-Cal coverage to former foster youth who may not otherwise be eligible for coverage.

Renewal Request

California seeks to renew its expenditure authority with no modifications to extend coverage of this population through the CalAIM Section 1115 demonstration. This initiative does not impact health care delivery system or cost sharing requirements.

Section 3.7 – Chiropractic Services from IHS and Tribal Facilities

Under the Medi-Cal 2020 Section 1115 demonstration, DHCS made UCC payments for certain optional services previously eliminated from the Medi-Cal State Plan that are provided by IHS facilities and Tribal health programs operating under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA) to eligible Medi-Cal members. Notably, these services have been restored in the Medi-Cal program except for chiropractic services. UCC payments for these covered services are administered through a contract with the Tribal entities and the California Rural Indian

Health Board, Inc. (CRIHB). CRIHB is a Tribal organization contracting under the ISDEAA that provides medical assistance as a facility of the IHS through a subcontracting process with 18 Tribal health programs. Additionally, CRIHB serves as the central administrator for the Tribal Medicaid Administrative Activities program through contracts with 11 Tribal health programs and for 20 Tribal health programs participating in the Medi-Cal 2020 authorized Tribal Uncompensated Care Waiver Amendment.

CMS approved SPA 21-0044, which authorized the Tribal federally qualified health center (FQHC) provider type in Medi-Cal on February 19, 2021. The Tribal FQHC provider type in Medi-Cal allows Tribal health programs electing this designation to provide FQHC services, including chiropractic services. Therefore, Tribal health clinics that enroll in the Medi-Cal program as a Tribal FQHC will be able to be reimbursed in full for chiropractic services provided to all patients with an effective date of January 1, 2021. DHCS understands, however, that not all Tribal health programs will seek to enroll as a Tribal FQHC, leaving a potential gap in payment and coverage.

Objective

Tribal UCC payments promote the objectives of the Medicaid program by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations in the state and, in so doing, by improving health outcomes for Medicaid members.

Renewal Request

DHCS seeks to renew its expenditure authority to provide Tribal UCC payments to provide reimbursement for chiropractic services. This will ensure that Tribal health programs that do not seek to enroll as Tribal FQHCs can continue to be reimbursed for providing chiropractic services to their Medi-Cal populations. This initiative does not impact health care delivery system or cost sharing requirements.

Section 3.8 – Modification of Asset Test for Deemed SSI Populations

To help ensure access to Medi-Cal for low-income individuals whose eligibility is not determined using the MAGI-based financial methods, the California legislature directed DHCS to implement a two-phased approach to increase and eventually eliminate the asset limits for these populations. In response, DHCS submitted a two-fold request in 2022 to amend the CalAIM Section 1115 demonstration to raise and then eliminate the resource disregard for Deemed SSI groups, specifically the Pickle Amendment group, the Disabled Adult Child group, and the Disabled Widow/Widower group. Effective July

1, 2022, this authority permitted the state to apply a disregard of $130,000 for a single Medi-Cal enrollee and $65,000 for each additional household member. Effective January 1, 2024, DHCS eliminated the asset test for these populations per CMS approval. More recently, the California 2025 Budget Act directs DHCS to reinstate the Medi-Cal asset limit for non-MAGI eligibility groups, including the Deemed SSI groups at $130,000 for an individual Medi-Cal member and $65,000 for each additional household member, effective no sooner than January 1, 2026.

Objective

DHCS seeks authority to reinstate the Medi-Cal asset limit for Deemed SSI groups, specifically the Pickle Amendment group, the Disabled Adult Child group, and the Disabled Widow/Widower group to provide parity with the asset disregard policy for non-MAGI populations covered under the Medi-Cal State Plan (e.g., SPA 21-0053).

Renewal Request

In alignment with state legislation, DHCS requests to renew its existing waiver and expenditure authorities with one modification—the state seeks to reinstate the Medi-Cal asset limit tests for Deemed SSI populations (the Pickle Amendment group, the Disabled Adult Child group, and the Disabled Widow/Widower group) at $130,000 for an individual Medi-Cal member and $65,000 for each additional household member. This initiative does not impact health care delivery system or cost sharing requirements.

Section 3.9 – Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan

Dually eligible members are people enrolled in both Medicare and Medi-Cal. Medicare is the primary payer for medical care, while Medi-Cal wraps around Medicare by providing assistance with Medicare premiums and cost sharing and by covering some services that Medicare does not cover, such as LTSS. As part of CalAIM, DHCS is streamlining policies to promote integrated care for members dually eligible for Medicare and Medi-Cal. The state aligns a dually eligible member's Medicaid plan with their MA Plan choice if the MA plan has an affiliated Medicaid plan.

Objective

This Initiative promotes integration, allowing for integrated appeals and grievances, continuation of Medicare benefits pending appeal, integrated member materials, and care coordination that extends across Medicare and Medicaid benefits. Aligned Medicare and Medicaid plans may also lead to lesser administrative burden (e.g.,

integrated appeals and grievances, streamlined member materials), improved alignment of Medicare and Medicaid provider networks, and increased access to care.

Renewal Request

DHCS seeks to renew its expenditure authority with no modifications to allow the state to keep a member in an affiliated Medicaid plan once they have selected a MA plan unless and until the member changes MA plans or selects Original Medicare. This initiative does not impact health care delivery system or cost sharing requirements.

Section 3.10 – Managed Care Authority to Limit Plan Choice in Certain Counties

California's Medi-Cal Managed Care delivery system consists of five managed care models that vary by county. Each county offers several models, including Two-Plan, COHS, Geographic Managed Care, Regional Model, and Single-Plan. Prior to the launch of the state's commercial plan re-procurement process in 2022, counties had the opportunity to request a change to their managed care model. As part of this process, DHCS conditionally approved model changes for a subset of counties seeking to move to a managed care model that involves one plan per county, either via expansion of an existing COHS model or establishment of a "Single Plan" model that is county-authorized and includes the same beneficiary protections and provider choice assurances. Single Plan models are expansions of plans currently operating as county-driven local initiatives or will otherwise be operating under a county or local authority. As part of an amendment to the CalAIM Section 1115 demonstration, California received CMS approval in August 2023 to limit choice of MCPs in Metro, Large Metro, and Urban counties to allow the state to operate COHS and Single Plan models.

Objective

These changes improve access to and quality of care and accountability. The expansion of the COHS model and Single Plan model to counties build on the existing COHS model in the state, which are among California's highest performing plans.

Renewal Request

DHCS seeks to renew this expenditure authority with no modifications. This allows California to limit choice of MCPs in Metro, Large Metro, and Urban counties and to allow counties to participate, or continue participating in, COHS and Single Plan managed care models. This initiative does not impact health care delivery system or cost sharing requirements.

Section 3.11 – Global Payment Program

California has a long history of providing services to Medi-Cal-enrolled and uninsured patients through its designated public hospital systems. Because the costs of care for these individuals are not fully reimbursed through Medicaid payments, private insurance, or other sources, the provision of such care imposes significant costs on these hospitals. California's designated public hospital systems disproportionately serve these populations and, to remain financially viable, require funding to cover these gaps in reimbursement. Prior to the Global Payment Program (GPP), many of California's uninsured received most of their care in acute settings, such as the ED or other hospital settings, and uncompensated care funding streams were not designed to promote value-based care or delivery system reform.

Since its launch in 2015, the goals of the GPP are consistent with evidence and promotes the Administration priority that improvements in access to outpatient services, including preventive care, primary care, and chronic disease management, can reduce health care costs and improve health outcomes. Beginning in 2015, the GPP combined demonstration-authorized uncompensated care funding with Disproportionate Share Hospital (DSH) funds and established a new method of compensating participating designated public hospital systems for caring for uninsured individuals. Importantly, the GPP provides participating designated public hospital systems with funds for additional low-cost, high-value services that are aimed at improved prevention and chronic disease management, such as visits to a health coach to promote wellness, nutrition education, and technology-enabled care. In so doing, the GPP promotes investment in lower cost services, taking the federal dollar further, and incentivizes the value, rather than the volume, of services.

The objective of the GPP is to compensate designated public hospital systems through a value-based methodology that awards points based on the provision of care in a way that encourages the delivery of care in the most cost-effective settings. The goals of the GPP are to:

- Move away from payments restricted to acute and costly hospital and emergency settings;
- Encourage preventive care, primary care, chronic disease management, and the coordination of care; and
- Encourage the use of technology-enabled care.

DHCS seeks to build on these goals, while further evolving the program in three fundamental ways to create greater incentives and opportunities to provide preventive care and primary care, manage chronic disease, and to increase the risk for earning GPP funding. Specifically, an evolution of the GPP would include the following:

- *Addition of new GPP services*: In recognition of the changing technology landscape and the Administration's goals, the GPP would add services that expand the program's focus on prevention, chronic disease management, and behavioral health. The GPP would leverage, where possible, consumer-facing technologies to assist in personalized treatment plans and real-time monitoring that prevent hospitalizations, reduce costs, and improve outcomes.
- *Addition of risk to earning GPP funding:* In the GPP, the points attributed to high-value services, such as primary care, increased relative to the points attributed to services provided in an emergency room or inpatient setting over the first five years of the GPP, and then remained at these relative increased values. While these incentives were effective in increasing the provision of outpatient care, the new design of the GPP would intensify incentives to encourage ongoing change and value-based care. Specifically, there would be an addition of risk to earning GPP funding by requiring some funding only being earned through the provision of services tied to a new GPP service category that includes existing and new preventive care and chronic disease management services and/or to the achievement of quality and/or utilization outcomes that assess the overall goals of the GPP.
- *Incentivizing investment in system transformation efforts, with GPP funding at risk:* The next GPP would also create a separate sub-pool that would provide funding for system transformation investments that advance several of the Administration's goals, 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, such as overprescribing; and advancing research to inform future health policies and programs, in areas such as nutrition or environmental exposures, which are connected to overall health outcomes.

Objectives

The GPP promotes the objectives of Title XIX by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations, while increasing efficiency and quality of care. Under the existing

GPP structure, designated public hospital systems have put in place a solid foundation for change and provided greater access to primary, specialty, behavioral health, and more than 20 other ambulatory care services, which are less costly than ED care, to California's Medicaid and uninsured populations. With the fundamental programmatic changes proposed above, the GPP would further strengthen the delivery system with a greater range of GPP services and greater incentives to drive system investments that lead to lasting impact and change.

Renewal Request

The first independent evaluation of the GPP, published in 2019, found that the program was successful in rewarding and incentivizing value-based, cost-effective care rather than volume of services. Furthermore, the interim evaluation of the program in the current demonstration continues to show an increase in the provision of both non-behavioral health and behavioral health outpatient services over time.

For these reasons, the state seeks federal approval of waiver and expenditure authorities to continue the GPP using Medicaid DSH and diverted Upper Payment Limit (UPL) dollars through the five-year renewal period (ending December 31, 2031), and to incorporate the substantive modifications to the program described above. These changes would preserve and build on the delivery system improvements achieved in the expiring demonstration period, while adding a focus on preventive care, primary care and chronic disease management and introducing a level of risk to incentivize meeting new components of the GPP.

Section 3.12 – Employment Supports

H.R.1 mandates that Medi-Cal eligible expansion adults demonstrate compliance with or exemption from work and community engagement requirements.[18] In California, an estimated 62 percent of Medi-Cal expansion adults reported working—42 percent full time and 20 percent part time.[19] The CMS Administrator has emphasized the importance of connecting individuals to jobs or work program activities that will help individuals meet the new work and community engagement requirements. Specifically, CMS Administrator Dr. Oz has called on state Medicaid agencies to focus on adjudicating the number of hours an individual worked and to connect individuals to agencies that can

[18] H.R.1 (2025).

[19] Of the remaining Medi-Cal expansion adult enrollees, 9 percent are ill or disabled, 14 percent are caretakers and 6 percent are students. From California Health Care Foundation, "Do Medi-Cal Enrollees Work?" January 25, 2025, available at https://www.chcf.org/resource/do-medi-cal-enrollees-work-policy-glance

assist individuals in finding a job and/or obtaining more hours to meet the new requirements.[20] CMS Administrator Dr. Oz's position aligns with the Congressional Budget Office's research that found that that employment supports in other means tested programs, such as the Supplemental Nutrition Assistance Program (SNAP, or CalFresh in California) and Temporary Assistance for Needy Families (TANF, or CalWORKS in California) have increased employment and income.[21]

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. California is proposing to pilot the provision of Medi-Cal funded Employment Support and is currently evaluating the viability and cost of delivering such services via counties, or county-based entities that can opt in and use intergovernmental transfers, to provide the non-federal share and make these services available.

Objective

The Employment Supports initiative advances the objectives of the Medicaid program by assisting individuals in meeting work and community engagement reporting requirements, thereby supporting their continued eligibility for Medi-Cal coverage at application and renewal. In doing so, it will promote greater continuity of both coverage and care.

Renewal Request

California seeks approval under Section 1115(a)(2) of the Social Security Act to claim federal Medicaid matching funds for Employment Supports services delivered to Medi-Cal 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.[22] For example, Kern County provided enrollees with training on

[20] Dorothy Mills-Gregg, "Oz: State Employment Services Will Pay Vital Role in Medicaid Work Req," Inside Health Policy, October 8, 2025.
[21] Congressional Budget Office, "Work Requirements and Work Supports for Recipients of Means-Tested Benefits," June 2022.
[22] California Department of Health Care Services. (2023, May 4). *Final evaluation of California Whole Person Care (WPC) program*. https://www.dhcs.ca.gov/CalAIM/Documents/Final-Evaluation-of-California-Whole-Person-Care-WPC-Program-05042023.pdf

personal finance, resume building, interview skills, application assistance, and other supportive services, while Solano County hired an Employment Specialist who offered enrollees one-on-one coaching on how to secure a job and maintain employment. It also builds on existing employment and training infrastructure under CalWORKS', California's TANF program, Welfare-to-Work Program which helps adults obtain employment and supportive services. This request draws from the first Trump Administration's approval of another state's Demonstration request for Medicaid reimbursement for employment support services for the state's high-needs Medicaid members.[23]

This demonstration request leverages services and supports that are proven to be effective from CalWORKs Welfare-to-Work program, including job readiness, education and vocational training, subsidized work placements, and case management. The state aims to create a comprehensive, cross-sector approach to addressing unemployment and assisting individuals in maintaining their Medi-Cal coverage. This aligns with broader state goals of promoting whole-person care and advancing economic mobility for Medi-Cal members.

DHCS seeks to provide Employment Supports to Medi-Cal members in the expansion group who have not been found exempt from or compliant with work and community engagement requirements.

DHCS is seeking public input on the types of Employment Supports that will be the most effective in supporting eligible Medi-Cal members. The Employment Supports for which the state is seeking public input include, but are not limited to:

- *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.

[23] Centers for Medicare & Medicaid Services. (2021, May 6). *Special terms and conditions for Building and Transforming Coverage, Services, and Supports for a Healthier Virginia*. U.S. Department of Health & Human Services. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-ca.pdf

- *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, and assistance with linking to high quality childcare, school programs, and transportation assistance.

California requests a waiver of statewideness to allow Employment Supports to be piloted in counties by county-based entities. The state also seeks a waiver of comparability to make Employment Supports available to a subset of expansion adults. Expansion adults who are subject to work and community engagement requirements and live in a county that has opted in to provide Employment Supports will be referred. Finally, California anticipates that DHCS and electing counties will need to engage in planning and development activities to implement Employment Supports. California requests funding resources to support the initial start-up activities.

Section 3.13 – BridgeCare Pilots

In 2021, California released its Master Plan for Aging (MPA), a blueprint for statewide transformational change that prioritizes the needs of the state's growing aging population. One of five key goals in the MPA is to ensure older adults have access to services they need to live at home in their communities and to optimize health and quality of life. As the dual-eligible population continues to grow, DHCS is committed to supporting the "near dual eligible" population—low-income Medicare beneficiaries with incomes just above the Medicaid income limit who need home and community-based care, which Medicare does not typically cover. By 2033, over one million Californians over 75 will be nearing Medi-Cal eligibility. Most of this population will have three or more chronic conditions and mobility limitations, but less than 25 percent will have the resources to cover even a modest amount of home care.[24]

With no private or public market responsibility to meet the LTSS needs for this population, older adults must rely on strained informal caregiving supports and seek care from Medicare-funded institutional services (e.g., ED, hospital, and post-acute care). This leads to suboptimal care outcomes and increased Medicare expenditures for high-cost health care services that could have been avoided through more efficient, less costly, and patient-centered home-based supports. Without access to the HCBS and caregiver supports that are proven to reduce institutional care utilization, result in health

[24] NORC at the University of Chicago. *Understanding California's Middle Income Older Adult Population.* October 3, 2022. Available at: https://www.norc.org/content/dam/norc-org/documents/standard-projects-pdf/NORC%20Forgotten%20Middle%20CA%20-%20Findings%20(1).pdf

care cost savings, and improve member outcomes, this population—especially the moderate-to-severely frail population—is at-risk of impoverishment, Medicare-funded nursing facility stays, and, ultimately, becoming Medi-Cal eligible.

DHCS proposes to pilot the provision of BridgeCare services under Section 1115 demonstration authority to provide a targeted set of HCBS and caregiver supports to "near duals" defined as older adults with Medicare and significant health needs with income just above Medicaid income limits but lack resources for adequate care. Interested local entities can opt-in to BridgeCare to implement the pilot in their region and support the non-federal share for federal Medicaid funding.

Objective

BridgeCare Pilots advance the objectives of the Medicaid program by supporting older adults to remain in their homes and communities, prevent costly institutionalization and impoverishment that leads to Medicaid enrollment, improve health outcomes, and reduce avoidable Medicare and Medicaid health care spending for this vulnerable population. Providing such supports may encourage older adults to develop healthy lifestyle choices and human behaviors (e.g., support with nutrition, improved mobility for physical activity) while residing in their communities and building valuable social connections.

Renewal Request

California seeks approval under Section 1115(a)(2) of the Social Security Act to claim federal Medicaid matching funds to support the provision of the BridgeCare Pilots for individuals enrolled in Medicare who do not meet Medi-Cal eligibility standards and meet the following eligibility criteria. The individual must:

- Be age 65 or older
- Be enrolled in traditional Medicare
- Require the level of care that is typically provided in a skilled nursing facility
- Live at home or in the community
- Meet the following financial eligibility criteria:
    - Have countable income between 138 and 220 percent FPL
    - Have not met their Medicaid share of cost, or do not have enough medical expenses that would meet their share of cost
    - Have countable assets within Medi-Cal asset limits

In addition, DHCS seeks CMS approval to reinvest state-designated shared Medicare savings that will result from the BridgeCare Pilot towards applicable demonstration expenditures. If any savings accrue to Medicare as a result of the pilot, the portion of savings that California would realize would be the "state-designated" shared savings. The remainder of the savings would accrue to the federal government.

Participation in BridgeCare will be voluntary for the individual.

BridgeCare services will include a targeted HCBS benefit, including caregiver supports, to enable participants to remain in their homes and communities, avoid nursing facility entry, avoid preventable emergency and other health care utilization and costs, and delay or avoid entry into the Medi-Cal program.

DHCS expects to develop a list of state-approved BridgeCare services from which local entities will design their pilots. Each pilot will be required to include certain core services and may include additional discretionary services as determined by the local entity.

DHCS is seeking public input on the core and discretionary services that will be the most effective in supporting eligible BridgeCare participants to remain in their homes and communities. The BridgeCare services for which the state is seeking public input include, but are not limited to:

- Core Services Provided 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[25]

[25] CAPABLE is an evidence-based and person-directed, home-based program that addresses both function and health care expenses. The four to five-month program integrates services from an occupational therapist (OT), a registered nurse (RN), and a handy worker who work together with the older adult to set goals and direct action plans that change behaviors to improve health, independence, and safety. Participants learn new skills, exercises, and how to work with additional tools/equipment/home modifications to improve function and safety. CAPABLE focuses on prevention and problem-solving, building skills that participants can use in the future.

- 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

BridgeCare participants will be required to pay cost-sharing up to a specified percent of the average monthly cost of the participant's BridgeCare services. The state expects to develop a cost sharing schedule based on participant income level.

California is also requesting a waiver of statewideness to allow BridgeCare to be piloted in local entities which can include counties or regions that opt in to provide such services. Local entities electing to participate in the BridgeCare Pilot will identify eligible pilot participants, design a service package that includes core and discretionary BridgeCare pilot services, administer services, coordinate care, and support evaluation activities. Subject to DHCS review and approval, a local entity may establish an enrollment cap and develop a waitlist.

SECTION 4 – INITIATIVES BEING DISCONTINUED OR TRANSITIONED UNDER CALAIM SECTION 1115 AUTHORITY

Since the renewal of the CalAIM Section 1115 demonstration in 2021, DHCS has actively implemented a range of initiatives that have led to fundamental shifts in the Medi-Cal delivery system, benefits, and financing structure. As a result of both the CalAIM implementation and evolving federal policy, several authorities in the CalAIM Section 1115 demonstration will be transitioned to other authorities or are no longer needed.

Recuperative Care and Short-Term Post Hospitalization Housing

Advancing whole person care and addressing non-medical health needs is a cornerstone of CalAIM. California's Community Supports—medically appropriate and cost-effective substitute services that address these needs—help Medi-Cal members live healthier lives and avoid higher, costlier levels of care. DHCS' early analysis of the cost effectiveness of Community Supports are compelling.[26] In 2024, DHCS analyzed the impact of 12 Community Supports authorized under managed care in lieu of services (ILOS) authority by comparing the cost of each to the savings generated in terms of reduced use of inpatient, ED, long-term care, and other services. Nine of the twelve Community Supports were already demonstrating cost effectiveness within the study period, and all twelve Community Supports studies were associated with reductions in inpatient and/or ED use.

In addition, DHCS recently analyzed the two Community Supports authorized under the CalAIM Section 1115 Demonstration—and preliminary findings indicate that these services resulted in 29.2 and 10.6 percent reductions, respectively, in aggregate PMPM costs due to decreases in inpatient, outpatient, ED, and long-term care costs.[27] DHCS

[26] Medi-Cal Community Supports are Delivering on Their Promise. DHCS, January 2026. Available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/Cost-Effectiveness-of-California-Medi-Cal-Community-Supports-Fact-Sheet.pdf.

[27] These findings are based on DHCS' preliminary analysis, which was led by an actuarial firm. DHCS analyzed the impact of these two services by examining the time period from July 2022 to June 2024 and analyzing the six months before and six months after the members received a service in 2023. DHCS will complete a full independent evaluation of these two services according to the requirements outlined in STC 17 of the current CalAIM STCs.

remains committed and will continue to work closely with Medi-Cal MCPs, providers, community-based providers and organizations, counties, and other partners to continue to offer these critical, cost-effective services to Medi-Cal members.

California is committed to continuing the full continuum of care that has been provided today under both recuperative care and short-term post hospitalization housing. Specifically, 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, and sunset short-term post hospitalization housing as a separate Community Support. California plans to transition federal authority for recuperative care from Section 1115 waiver authority to Medicaid managed care ILOS authority. ILOS is a permanent option for state Medicaid programs enshrined in federal Medicaid managed care regulations and memorialized in approved MCP contracts. 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. Recognizing CMS has approved recuperative care under various authorities, including Section 1115 demonstration authority and the 1915(i) home and community-based services state plan option, California will seek federal technical assistance from CMS to identify the most appropriate authority for recuperative care and ensure coverage of these services remains uninterrupted for Medi-Cal members.

PATH Initiative

As part of the 2021 renewal of the CalAIM Section 1115 demonstration, DHCS received CMS approval of the PATH initiative—a five-year, $1.85 billion initiative to build up the capacity and infrastructure of on-the-ground partners, such as community-based providers and organizations, hospitals, county agencies, Tribes, and others, to successfully participate in the Medi-Cal delivery system as California launched ECM, Community Supports, and Justice-Involved reentry services under CalAIM.

Due in part to the PATH initiative, more than 429,000 Medi-Cal members received Community Supports and approximately 373,000 Medi-Cal members received ECM from January 1, 2022 through March 31, 2025. Nearly 5,000 Community Supports providers and more than 5,000 ECM providers are contracted by Medi-Cal MCPs to offer these services. MCPs operating in all 58 counties in California offer at least eight Community Supports. Medi-Cal MCP members residing in forty counties (representing 90 percent of all Medi-Cal MCP members) have access to at least ten Community Supports and Medi-Cal MCP members residing in 23 counties (representing 41 percent of all Medi-Cal MCP

members) have access to 14 Community Supports. Additionally, 19 county correctional facilities across ten California counties provide pre-release services as of July 2025.

- Under PATH's Capacity and Infrastructure, Transition, Expansion, and Development (CITED) initiative, DHCS is expected to award approximately $800 million to more than 400 local community-based organizations, community providers, hospitals, local governmental agencies, and other local facilities to support ECM and Community Supports staffing, data systems, and other infrastructure needs to successfully launch and sustain CalAIM services.
- The PATH Technical Assistance (TA) Marketplace serves as a virtual marketplace for TA services where entities can access TA resources from curated and approved Vendors. The TA Marketplace initiative provides funding for providers, community-based providers and organizations, counties, and others to obtain TA resources to establish the infrastructure needed to implement ECM and Community Supports. Through the TA Marketplace, more than 1,600 projects that support CalAIM infrastructure, capacity building, and foster sustainability have been funded thus far.
- The PATH Collaborative Planning and Implementation Initiative funds regional collaborative planning efforts to support implementation of ECM and Community Supports. Through 26 regional groups statewide managed by nine facilitators, over 2,700 registered participants—including community-based providers and organizations, Tribes and Indian Health Care Providers, MCPs, and county agencies—have engaged in identifying gaps and local solutions to implement and sustainably scale CalAIM services.

Over the past five years, DHCS and partners across the state have achieved the goals of the PATH initiative, evidenced by the broad availability of ECM and Community Supports across California and the launch of pre-release services in the state. In light of PATH's success, and consistent with the original intent to provide time-limited support to community-based providers to prepare them for ECM and Community Supports, the state plans to sunset waiver and expenditure authorities for the PATH initiative as part of this renewal.

DSHP Financing

California has utilized DSHP funding to advance delivery system reform initiatives and improve the health of Medi-Cal members. CMS approved the use of DSHP for states that used the "freed up" state funding for initiatives likely to assist in promoting the objectives of Medicaid, such as improving access to high-quality covered services. Under

the CalAIM demonstration, DSHP funding was used to support the following initiatives under PATH: TA Marketplace Initiative, Collaborative Planning and Implementation Initiative, CITED Initiative, and the Justice-Involved Capacity Building Program. Given that CMS has indicated it will no longer approve DSHPs, along with the conclusion of the PATH initiative, DHCS is not seeking to renew its expenditure authority for DSHP.

CBAS

California intends to transition coverage of its CBAS benefit from its CalAIM Section 1115 demonstration to 1915(i) state plan authority to strengthen this benefit as an entitlement. CBAS is an outpatient, facility-based program (e.g., adult day health center) that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation predominantly available through Medicaid managed care to adult Medi-Cal members eligible under the aged, blind or disabled groups meeting functional eligibility for CBAS residing in counties across the state. It is currently available under the managed care and fee-for-service (FFS) delivery systems. As DHCS transitions CBAS into a permanent authority, the Department will seek technical assistance from CMS and work closely with its implementation partners to ensure that it can continue to make the CBAS benefit available with no coverage disruptions for Medi-Cal members receiving this critical service.

Low-Income Pregnant Women

As part of the CalAIM Section 1115 demonstration in 2021, CMS approved the state's authority to provide full-scope Medi-Cal coverage to pregnant women with incomes from 109 percent of the FPL up to and including 138 percent of the FPL (including all benefits that would otherwise be covered for pregnant women with incomes below 109 percent of the FPL) until December 31, 2021. DHCS transitioned the authority for these services from Section 1115 authority to the Medi-Cal State Plan. Since this authority has already sunset, DHCS is not requesting that it be included in the renewal of the CalAIM Section 1115 demonstration.

SECTION 5 – DEMONSTRATION EVALUATION RESULTS TO DATE

As required under the special terms and conditions (STCs) of the CalAIM Section 1115 demonstration, California engaged independent research organizations to evaluate the performance of CalAIM programs, including the DMC-ODS and Recovery Incentives, and the GPP, PATH, recuperative care and short-term post-hospitalization housing, Justice-Involved Reentry Initiative, Medi-Cal Matching Policy for Dual Eligible Members, and Managed Care Plan Transition. The overall evaluation results demonstrate that CalAIM has had significant success in achieving its stated aims, including driving delivery system reform and improving access and quality of care, particularly for high-need members.

Because the many programs included in the CalAIM demonstration have different time frames, structures, and funding streams, the evaluation designs and timelines for the programs also vary. For initiatives where interim evaluation reports, rather than final evaluation reports, have been completed, work on the final evaluations is continuing and will be provided to CMS as required by the demonstration STCs. All of the state's evaluation materials are available on the DHCS website.

DMC-ODS Evaluation

As of August 2025, DMC-ODS has been implemented in 40 counties, which contains 97.3 percent of California's population. DMC-ODS was created to test the impact of expanding access to an evidence-based continuum of SUD services and organizing service delivery to Medicaid-eligible individuals with SUDs. Under DMC-ODS, care is organized according to the American Society of Addiction Medicine (ASAM) Criteria, which are a set of guidelines developed by ASAM to set standards for appropriate assessment, placement, and treatment planning of clients with SUD and co-occurring disorders. DMC-ODS also increases access to residential treatment in institutions with more than 16 beds. The demonstration was also intended to facilitate greater local control, accountability, and administrative oversight.

Interim evaluation results indicate that DMC-ODS has increased access to and the quality of SUD treatment, as well as coordination across SUD and physical health care. For example, DMC-ODS has significantly increased the unique number of clients receiving DMC-funded services by 16 percent since its inception. Rates of initiation to any SUD treatment after an ASAM brief screening are increasing. Medi-Cal members receiving SUD treatment have consistently rated their treatment high over time. Most

(84%) Medi-Cal members receiving treatment agree that their treatment program works with their physical health care providers to support their wellness.

Overall, the data suggest that DMC-ODS is making progress toward most of the demonstration's goals. Specifically, although data in this Interim Evaluation Report are preliminary, and there are currently data gaps that need to be filled in the final Summative Report, particularly for Goals 3 and 4, the preponderance of currently available data suggest progress toward six of the eight goals:

- Goal 1: Increased rates of identification, initiation, and engagement in SUD treatment services.
- Goal 2: Increased adherence to and retention in treatment.
- Goal 3: Reductions in overdose deaths, particularly those due to opioids.
- Goal 4: Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
- Goal 6: Improved access to care for physical health issues
- Goal 8: An effective contingency management program, including cost-effectiveness and effects on beneficiary outcomes.

Evidence was mixed for Goal 5, with fewer readmissions to the same or higher level of care, and Goal 7, with improved health equity.

Recommendations suggested include:

- Explore and address the underlying causes of increasing readmissions to withdrawal management. The evaluation team will continue to explore potential data explanations and reach out to stakeholders for input as needed.
- Explore and address the underlying causes for mixed results on health equity. The evaluation team will continue to explore potential data explanations and reach out to stakeholders for input as needed.
- Continue efforts to expand treatment capacity and support workforce development, both of which are commonly cited barriers to access within DMC-ODS.

Recovery Incentives Evaluation

To address rapidly rising stimulant overdoses, California added Recovery Incentives to DMC-ODS under a new pilot program with implementation beginning in March 2023. Contingency management was provided through the Recovery Incentives Program as a new service, making it ideal for a different set of evaluation methods based on the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework, which is appropriate for the implementation of a targeted new practice. UCLA is in the process of collecting data on the final part of this framework, maintenance, but the program has excelled in the remaining areas of the framework to date:

- Reach: The program reached about 8,500 clients as of June 2025. This new program is currently reaching an estimated one quarter of all California Medi-Cal members in outpatient treatment for stimulant use.
- Effectiveness: The program achieved high levels of retention, engagement, and negative urine drug test results. Clients also overwhelmingly reported that the program led to improved health, reduced stimulant use, reduced use of EDs or inpatient hospitalization, and made them better members of the community.
- Adoption: Over 100 sites had adopted the program as of June 2025. Clinical Laboratory Improvement Amendments (CLIA) waiver requirements[28] were initially a barrier but have since subsided as a challenge. In rural areas, staffing and hiring difficulties, combined with small client populations, may make adoption less compelling.
- Implementation: providers rated the program very positively on an array of measures, though staffing and staff turnover remained challenges.

As noted in the preceding DMC-ODS section, the interim evaluation suggests that California's Recovery Incentives program is a cost-effective program with improved Medi-Cal member outcomes.

[28] All facilities in the U.S. that perform testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under CLIA. Urine tests used in the Recovery Incentives Program are considered "CLIA waived tests." However, DMC-ODS providers must still obtain a CLIA "waived test" certification and be registered with the California Department of Public Health (CDPH) or be accredited by an approved accreditation body. Providers can apply online for both CLIA Waiver and State Lab Registration through Laboratory Field Services, part of CDPH.

Recommendations include convening an expert advisory group to discuss possible ways to further improve and expand the Recovery Incentives Program, which may include the following suggestions:

- Revisit the escalation-reset design of the incentive schedule, particularly whether to retain the "reset" portion, and whether to start with higher amounts to strengthen early engagement.
- Consider strategies to expand the number of participating counties and providers, potentially taking lessons learned from counties that have successfully launched a disproportionately large number of providers, as well as examining barriers faced by counties that have lower numbers of providers and clients.
- Consider strategies to increase enrollment of new clients entering from the community, and referrals from medical and correctional settings, in addition to those referred from residential or other outpatient treatment.
- Explore the feasibility of expanding contingency management to other settings, including primary care (e.g., Federally Qualified Health Centers), mobile units, street medicine, and telehealth.

GPP Evaluation

GPP, launched in 2015 as part of California's Medi-Cal 2020 Section 1115 demonstration and later incorporated into CalAIM's framework, represented a novel approach to funding care for the state's uninsured residents. GPP consolidated two federal and state funding streams for Public Health Care Systems (PHCS) into a single, flexible global budget paid to participating PHCSs on a quarterly basis throughout each payment year. This payment model incentivized PHCSs to shift from a reliance on episodic, high-cost emergency and inpatient services for uninsured individuals toward delivering proactive, patient-centered preventive and outpatient care. The overarching goals of the GPP demonstration are to:

- Improve the quality of care for uninsured service users in participating PHCSs;
- Promote a shift from emergency and inpatient services to lower-intensity, higher-value outpatient and non-traditional services; and
- Strengthen PHCS data systems to help understand and address health inequities.

Interim findings show that PHCSs are achieving or making notable strides toward all three GPP goals. For three out of the five quality measures evaluated, GPP users received care that matched or exceeded levels provided to a comparison group of

Medi-Cal members, while ongoing efforts to improve quality for the remaining two measures and address gaps in care for subpopulations of GPP users across all measures will be monitored for three additional measurement years. For example, GPP users were five percentage points more likely to receive colorectal cancer screenings (60% vs. 55%) and 13 percentage points more likely to undergo screening for depression (80% vs. 67%) than those in the comparison group. As for the second goal, PHCSs have increased the proportion of health services delivered in low-intensity care settings, although PHCSs appear to have more difficulty shifting BH services to low-intensity settings. With respect to the third goal, progress was demonstrated by high rates of self-reported patient demographic information and minimal missing data across the first two years of CalAIM. Increasing data capture for these data elements and strengthening data sharing related to referrals and the use of ECM and Community Supports could further enhance the ability of PHCSs to provide efficient, high-value care to GPP service users.

PATH Evaluation

The PATH initiative served as a foundation for much of CalAIM's implementation by providing funding and technical assistance to build the infrastructure needed to operationalize new Medi-Cal benefits such as ECM, Community Supports, and the Justice-Involved Reentry Initiative. PATH funding was distributed to community-based providers and organizations, local government agencies, and providers—particularly those serving rural and underserved regions—to expand capacity to deliver person-centered, coordinated care. In addition, PATH provided targeted support for correctional facilities and county BH and social service agencies to establish systems for pre-release Medi-Cal applications, suspension processes, and 90-day pre-release services for JI individuals. By the end of 2024, data indicated successful completion of multiple rounds of PATH funding that supported DHCS' goals—particularly goals 1 and 2—for PATH demonstrated by tangible progress in developing local systems for the JI Reentry Initiative and other CalAIM components:

- Goal 1: Increase the number of ECM and Community Supports community-based providers and consequently increase Medi-Cal member ECM and Community Supports utilization according to community needs. Findings indicated:
    - The number of unique participating providers (621 to 2,041) and number of contracts (1,250 to 6,299) increased from 2022 Q1 to 2024 Q3.
    - The total number of users of ECM and/or Community Supports increased per quarter from 82,088 in 2022 Q1 to 256,406 in 2024 Q3, and the total number of members who had ever used these services reached 500,447.

- Goal 2. Improve data collection and information sharing infrastructure among ECM and Community Supports providers. Findings indicated:
    - Most surveyed providers who participated in PATH (63%) reported that they invested in obtaining or modifying existing software or other technology to support billing.
    - Many surveyed providers (70%) also obtained or modified existing electronic health records (EHRs) or care management software to support service delivery of ECM and Community Supports.
- Goal 3. Improve the ability for state prisons, county jails, youth correctional facilities, and their community providers to screen, enroll, change the suspension status, or provide 90-day pre-release services for eligible individuals in Medi-Cal prior to release; and increase the number of eligible individuals screened and enrolled in Medi-Cal prior to release. Findings indicated:
    - In 2022 and 2023, correctional agencies and their county social service department partners collectively received approximately $69.84 million to implement pre-release Medi-Cal application and suspension processes. This funding was described as essential to implement pre-release Medi-Cal application and suspension processes. PATH JI funding were most often used to support development of technology and information technology (IT) systems, collaborative planning, infrastructure, and staffing needed to implement pre-release application and suspension processes.

Recuperative Care and Short-Term Post-Hospitalization Housing

Community Supports, another cornerstone of CalAIM, represent a major innovation in Medi-Cal by allowing MCPs to offer services addressing members' health-related social needs. Two Community Supports—Recuperative Care and Short-Term Post-Hospitalization Housing—are authorized under the CalAIM Section 1115 demonstration, and 12 Community Supports are approved as part of the state's CalAIM 1915(b) Medicaid Waiver for the period of January 1, 2022, to December 31, 2026. An additional Community Support, Transitional Rent, was added in July 2025, authorized under the state's Section 1115 BH Community-Based Organized Networks of Equitable Care and Treatment Waiver (BH-CONNECT). While the impact of receiving Community Supports on health care utilization, outcomes, and costs of care will be measured in the

Summative Evaluation Report, some key interim findings illustrate the positive impact of Community Supports:

- The number of MCPs offering each Community Support and the number of counties in which Community Supports were offered increased between 2022 and 2025. In 2025, six Community Supports were offered by at least one MCP in all 58 California counties (Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Medically Tailored Meals/Medically Supportive Food, Respite Services, and Personal Care and Homemaker Services).
- In assessing the extent to which members receiving housing-related Community Supports were transitioned to other supports, analyses of Quarterly Implementation Monitoring Report (QIMR) data revealed that from January 2022 to September 2024, 35% of Recuperative Care users also received Housing Transition Navigation Services, and that 9% subsequently transitioned to Short-Term Post-Hospitalization Housing.
- Providers rated Community Supports as most effective at improving member access to social services (average rating 4.9 out of 6.0) and as least effective at earlier identification of member needs (average rating 4.4 out of 6.0).
- In a 2024 to 2025 MCP survey, Recuperative Care was one of several Community Supports rated most highly in terms of perceived value for member health or well-being and perceived cost-effectiveness.
- Community Supports were generally perceived by MCPs and providers as addressing important gaps in care within communities and as supplementing existing systems of care and should be sustained if proven cost-effective.

Reentry Services for Justice-Involved Populations 90-Days Pre-Release

The Justice-Involved Reentry Initiative extends select Medi-Cal benefits to eligible individuals immediately prior to and following release from correctional facilities. The intervention fosters connections between carceral and community health care, expands pre-release and post-release services and aims to improve care continuity, address behavioral and physical health needs, and reduce adverse outcomes for justice-involved populations. The evaluation, utilizing a mixed methods approach, focuses on implementation barriers and facilitators, quality of care, care transitions, coordination among systems, and impact on health care investments in both carceral and community

contexts. At this time, the UCLA-RAND Reentry evaluation team has not yet received quantitative data, and qualitative data collection is still in its early phases. The team is actively collaborating with DHCS, CDCR, and county facilities to finalize data requests and secure the quantitative and qualitative data to analyze and present comprehensive findings. Preliminary insights include:

- The initiative has catalyzed new collaborations and workflows across correctional, Medi-Cal, managed care, and community organizations, requiring significant effort needed to align these disparate systems.
- During interviews, stakeholders, such as key informants from Probation, Sheriff's Office, Correctional Health, Social Services/Human Services, Health & Human Services, Public Health, Behavioral Health, and contracted in-reach services providers, emphasized the need for enhanced communication, education, and well-defined handoff protocols to ensure seamless care transitions.
- 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.
- Early investments are focused on infrastructure, staffing, and service expansion, but counties are still in the early stages of full program implementation and service delivery.
- Fragmentation and duplication in reentry planning persist; stakeholders highlight the importance of person-centered care plans to prevent conflicting guidance for individuals upon release.

Medi-Cal Matching Policy for Dual Eligible Members

The Medi-Cal Matching Plan Policy for Dually Eligible Beneficiaries (duals), which launched in 2023, was designed to ensure that, where possible, Medi-Cal managed care members would be assigned to MCPs offered by the same parent organization that administer their MA choices to reduce administrative burden and improve the coordination of care.

Initial results of the matching plan policy highlight the expansion of duals enrollment in D-SNPs (e.g., Medi-Medi Plans) across the state and the alignment of MCP enrollment with MA plan enrollment. The results of the descriptive analyses completed at this time suggest that members are choosing to enroll in a MA plan that aligns with their MCP rather than choosing to enroll in a MA plan and subsequently being required to change

their MCP to match their MA plan. Changes in MCP options, which occurred in January 2024, likely created additional opportunities for members to make MA enrollment changes. The increased integration of managed care services across Medicare and Medi-Cal should result in more seamless delivery of services and create further incentives for members to remain enrolled in their Medi-Medi Plans and aligned MA plans. The evaluation cannot answer whether individuals found changing their MCP harder and thus settled on aligning their MA plans, where possible, because they perceived MA enrollment was more straightforward.

Managed Care Plan Transition

The Managed Care Plan Transition streamlined managed care models across 15 counties, transitioning approximately 1.2 million members to either a County Organized Health System (COHS) or Single Plan model. This restructuring aims to simplify administration, enhance oversight, and promote consistent access to services statewide. This Interim Evaluation Report presents baseline findings from the early phase of the transition (January 2021–December 2023), focusing on member demographics, access and quality indicators, and stakeholder perspectives. The primary goals of the Managed Care Plan Transition are to:

- Maintain or improve overall access to and continuity of care.
- Maintain or improve quality of care.
- Maintain or improve access to high-quality, continuous care among historically marginalized and under-resourced populations.
- Reduce administrative complexity for MCPs.
- Maintain MCP accountability and improve transparency.

Initial findings show that the initiative has generally advanced the Department's intended goals:

- During the baseline period, the 15 counties included in the MCP Transition performed better than the counties not included in the transition on certain care access metrics, including well-child visits at 15- and 30-months, prenatal and postpartum care, and 7-day and 30-day follow-up rates after ED visits for mental illness.
- Transition counties had lower meningococcal and tetanus, diphtheria toxoids and acellular pertussis (TDAP) vaccine rates, compared to non-transition counties, but

the two groups had comparable rates of human papillomavirus (HPV) vaccinations.

- During the baseline period, MCP Transition counties performed slightly better than non-MCP Transition counties on all-cause readmission rates. However, transition counties had slightly lower breast cancer screening rates than non-transition counties.
- During the baseline period, there was some evidence of disparities between urban and rural counties, with the urban transition counties outperforming their rural counterparts on child and adolescent well-care visits, prenatal and postpartum care, and follow-up after ED visits for mental illness. However, rural counties had lower rates of all-cause readmissions than urban counties.
- MCPs reported significant upfront administrative burden including staffing and infrastructure investments. These demands required rapid scaling of internal operations and reallocation of resources to meet transition timelines. Infrastructure investments (e.g., staffing, data systems) were made to support transition. These investments were essential to ensure continuity of care and minimize disruption for members and providers.

SECTION 6 – DEMONSTRATION RENEWAL EVALUATION

During the five-year renewal period, DHCS will contract with independent third parties to evaluate the demonstration, collaborating with CMS where necessary to update evaluation and monitoring plans as required by federal guidance. As DHCS seeks to continue to expand the reach of these initiatives, many of which began at different times throughout the current waiver term, and strengthen longstanding initiatives, DHCS plans to continue analyzing many of the hypotheses approved under the current CalAIM demonstration. Based on DHCS' evaluation expertise and experiences to date with the current CalAIM demonstration, the Department proposes some minor modifications to better evaluate the initiatives' effectiveness at meeting DHCS' goals.

As required by the CalAIM Section 1115 demonstration STCs, the Department submitted a CalAIM evaluation design to CMS in June 2022 and has revised several times to reflect the impacts of several waiver initiatives over the course of the demonstration period. The latest evaluation design, approved by CMS in November 2025, includes PATH, GPP, Medi-Cal Matching Plan Policy for Dually Eligible Members, Justice-Involved Reentry Initiative, and the Managed Care Plans Transition. DHCS also submitted and received CMS approval of a separate DMC-ODS evaluation design in July 2023 and submitted a THCP evaluation design for CMS review in August 2025.

Consistent with past practice, the evaluation design will detail the independent evaluator's approach for analyzing findings, and the evaluation reports will carefully explore and explain the limitations of the evaluation design and the integrity and appropriateness of the data and the analytic methods used to support the study. The evaluation will include use of comparison groups wherever possible, establish or identify baseline data, measure the programs, and explore the meanings of the findings in a lessons-learned format. The evaluation will aim to ensure sufficient causal factors and population effects. Table 2 outlines the proposed hypotheses for new and renewed initiatives.

Table 2. Evaluation Hypotheses that DHCS Proposes to Include in Renewal

Hypotheses	Evaluation Approach	Data Sources
New Initiatives		
Employment Supports		
Employment Supports will support Medi-Cal enrollment.	DHCS will track enrollment data.	» Medi-Cal Eligibility Data System (MEDS) » California Statewide Automated Welfare Systems (CalSAWS)
Employment Supports will reduce Medi-Cal disenrollment at renewal.	DHCS will track disenrollment data at renewal.	» MEDS » CalSAWS
Employment Supports will support continuity of care.	DHCS will track utilization of Medi-Cal services of individuals who received Employment Supports.	» California Medicaid Management Information System (CA-MMIS) » Post Adjudicated Claims & Encounters System (PACES) » Short Doyle » Medi-Cal Rx » California Dental Medicaid Management Information System (CD-MMIS)
BridgeCare Pilots		
BridgeCare Pilot participation will delay or avoid Medi-Cal enrollment among BridgeCare Pilot participants.	DHCS will compare the expected Medi-Cal enrollment rates for the "near duals" population eligible for the BridgeCare Pilot with the enrollment rates among program participants.	» MEDS

Hypotheses	Evaluation Approach	Data Sources
BridgeCare Pilot participation will reduce total current and future Medicaid and Medicare spending among BridgeCare Pilot participants.	DHCS will compare the expected total Medicare and Medicaid expenditures for the total near-dual population eligible to receive services with the actual expenditures incurred by BridgeCare pilot participants.	» Medicare claims data » Medicaid claims data
Renewing Initiatives		
Reentry Services for Justice-Involved Populations 90-Days Pre-Release		
The Justice-Involved Reentry Initiative will increase coverage for eligible Medi-Cal members.	DHCS will continue to evaluate through a comparison of number of individuals pre-release and post-release: » Medicaid Coverage » Eligibility screening » Eligibility » Suspended status	» Medicaid claims data » Correctional agency data
The Justice-Involved Reentry Initiative will increase access to services prior to release and improve transitions and continuing of care upon release for eligible Medi-Cal members.	DHCS will continue to evaluate through a comparison of number of individuals pre-release and post-release: » Pre-release care management » Pre-release medication billing » Pre-release MAT treatment » Pre-release prescription fills	» Medicaid claims and encounter data » Correctional agency data » State hospital inpatient discharge data

Hypotheses	Evaluation Approach	Data Sources
	» Post-release prescription fills » Pre-release behavioral health treatment » Medically necessary medications » Visit with an ECM provider » Medicaid services » Provider beneficiary rate » Wait time » Percent of incarcerated individuals found eligible for Justice-Involved Reentry Initiative services after screening	
The Justice-Involved Reentry Initiative will improve coordination between correctional systems, Medicaid and Children's Health Insurance Program (CHIP) systems, MCPs, and community-based providers. The Justice-Involved Reentry Initiative will improve communication between correctional systems, Medicaid and CHIP systems, MCPs, and community-based providers.	Interviews with individuals released from prison, jail, and juvenile facilities could cover: » Challenges/facilitators in transitioning to the community after release (e.g., number of available providers) » Continuity of care from incarceration to community » Effectiveness of case managers Interviews with key stakeholders could cover:	» Individual stakeholder interviews

Hypotheses	Evaluation Approach	Data Sources
	» Newly established communication channels between correctional systems and community-based providers, Medicaid and CHIP systems » Data sharing put into place » Handoff protocols between prisons, jails, juvenile facilities and community	
The Justice-Involved Reentry Initiative will be associated with increased services (post-reentry) associated with improved quality of care, such as medication-assisted treatment, care coordination, and enhanced care management.	Examination of service utilization patterns during pre-release and post-release periods, such as uptake of key services supported under the state's reinvestment plan: » Medication-Assisted Treatment (MAT) » Enhanced Care Management (ECM) » Care coordination Interviews with key stakeholders could cover: » ECM needs and services received » Coordination and delivery of key services » Utilization and quality of services	» Medi-Cal claims and encounter data » Interviews with key stakeholders

Hypotheses	Evaluation Approach	Data Sources
The Justice-Involved Reentry Initiative will improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs.	Interviews with individuals released from prisons, jails, and juvenile facilities could cover: » Health care needs of participants » Provision of services during 90-day in-reach period » Transition services provided, including case manager and medications upon release, appointments made in the community » Community Supports needed and received » ECM services needed and received Interviews with key stakeholders could cover: » Coordination of care between carceral settings (prison, jail, youth correctional facilities) and community service providers (behavioral health, medical care, social services) » Type of formal arrangements (e.g., memorandums of understanding, regular meetings, etc.) to facilitate connections	» Individual stakeholder interviews

Hypotheses	Evaluation Approach	Data Sources
	between carceral settings and providers » Facilitators and barriers and how these may vary by type of services provided	
The Justice-Involved Reentry Initiative will increase access to interventions for behavioral health conditions, access to long-acting injectable anti-psychotics, and access to medications for addiction treatment for SUDs for eligible Medi-Cal members. The Justice-Involved Reentry Initiative will reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths for eligible Medi-Cal members.	DHCS will continue to evaluate: » Post-release SUD treatment » Post-release mental health treatment » Post-release MAT » Post-release necessary medications » Receipt of behavioral health condition interventions » Medications for addiction treatment for SUDs » Suicide-related ED visits » Suicide-related inpatient hospitalizations » Suicide-related deaths » ED utilization for SUD » Inpatient stays for SUD » Overdose-related deaths » Decompensation	» Medicaid claims data » Correctional agency data

Hypotheses	Evaluation Approach	Data Sources
The Justice-Involved Reentry Initiative will reduce post-release ED visits, inpatient hospitalizations, and all-cause deaths for eligible Medi-Cal members.	DHCS will continue to evaluate: » All-cause deaths » All-cause emergency room visits » All-cause inpatient hospitalizations	» Medicaid claims data » Correctional agency data
DMC-ODS: Waiver of the IMD Exclusion for SUD Services and Recovery Incentives		
Medi-Cal members receiving SUD services in DMC-ODS will receive clinically indicated care that supports retention in treatment and positive treatment outcomes.	DHCS will continue to evaluate: » Timely access to the level of care and/or recommended services indicated in ASAM screening or assessment » Transitions between levels of care, including transitions to other specialty SUD care after a residential stay	» California Outcomes Measurement System Treatment (CalOMS-Tx) » DMC claims » MCP/FFS data
DMC-ODS implementation will be associated with reductions in utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	DHCS will continue to evaluate: » Utilization (e.g., days), including admissions and readmissions » Paid claim amounts	» DMC claims » MCP/FFS data » CalOMS-Tx
Effective implementation of Recovery Incentives will lead to improvements in	DHCS will continue to re-evaluate:	» Client surveys » DMC claims

Hypotheses	Evaluation Approach	Data Sources
client retention, discharge status, self-reported outcomes, drug test results, and will reduce rates of overdose deaths, and utilization of acute care or emergency services among clients participating in the Recovery Incentives Program.	» Days in treatment, engagement, discharge status, self-reported satisfaction and improvement in health, SUD, arrests, ED and inpatient hospital utilization, costs, deaths » Rates of positive, negative, and missed drug screens	» MCP/FFS data » CalOMS-Tx » Death data » Stimulant drug tests/incentive manager vendor
Traditional Healers and Natural Helpers		
Facilities that are billing for THCP provide greater access to culturally responsive SUD care compared to facilities that chose not to opt-in for billing of THCP services.	DHCS will continue to evaluate: » Medi-Cal reimbursement utilization and assess changes in service availability » Changes in patient volume and demand for culturally responsive SUD services	» DMC-ODS claims » Facility-level survey » Practitioner interview » Member survey » Community focus groups
Facilities that are billing for THCP provide greater access to culturally responsive SUD care and, therefore, contribute to improved reported well-being of their Medi-Cal member population utilizing the THCP benefit.	DHCS will continue to evaluate: » Perceived benefit of THCP to the general health/well-being of patients with SUD and suspected SUD. » Self-reported well-being and health, spirituality, and feelings of cultural connectedness	» Practitioner interview » Member survey » Community focus groups

Hypotheses	Evaluation Approach	Data Sources
	» Engagement in other DMC services and connectedness to health care system	
If "THCP coverage" is being provided to IHCPs, then the number of facilities and practitioners offering THCP services under the demonstration will increase.	DHCS will continue to evaluate: » Number of facilities providing THCP » Number of practitioners delivering THCP	» DHCS facility data » Facility-level survey
Implementing the demonstration will increase the number of American Indians/Alaskan Native individuals receiving THCP.	DHCS will continue to evaluate: » Number and percentage of individuals receiving THCP » Common combinations of THCP with evidenced-based practices, behavioral and medical; referrals » Evidence-based practices (required by BHIN) (i.e. MAT/MOUD, CBT, MI, etc.) offered at the facility » Levels of satisfaction of THCP and perceived benefits of THCP » Facility outreach to the community regarding the benefit; outreach/promotion to patients at facility	» DMC-ODS claims » Practitioner interview » Member survey » Facility-level survey » Community focus groups

Hypotheses	Evaluation Approach	Data Sources
The range and types of services covered under the THCP benefit demonstration will increase, leading to increased access/options of care.	DHCS will continue to evaluate: » Number and percentage of services provided by Traditional Healer vs. Natural Helper; group vs. individual » The different THCPs offered at this facility (open-ended response) » The process facilities used to identify or select the Traditional Healers or Natural Helpers who provide THCP services » Where are the THCP services being provided? (e.g. within "four walls", home-based setting, visits at other facilities, etc. home-based setting, visits at other facilities, etc.)	» DMC-ODS claims » Practitioner interview

Hypotheses	Evaluation Approach	Data Sources
THCP will be preferred as culturally responsive integrated care and utilization of THCP will increase due to coverage through Medicaid and/or CHIP.	DHCS will continue to evaluate: » Perspectives on utilization rates and barriers to utilization » Perceived benefits of culturally responsive care » Satisfaction with THCP services » Number of facilities choosing not to opt in due to difficulties reimbursing/applying for the coverage » Number of THCPs not covered under this benefit » Promotion and outreach regarding the benefit to IHCPs » When members first learned about the benefit » Member's confidence in understanding of the benefit and which services are covered	» Member survey » Facility survey » Practitioner interview » Community focus groups

Hypotheses	Evaluation Approach	Data Sources
Managed Care Authority to Limit Plan Choice in Certain Counties		
Counties with COHS and Single Plan Models will maintain or improve Medi-Cal members' overall access to and quality of care.	DHCS will continue to evaluate: » Network adequacy » Access to care grievances » Adults' access to preventative and ambulatory services » Child and adolescent well-care visits » Immunizations for adolescents » Timeliness of prenatal and postpartum care » Follow up after ED visit for mental illness » Follow up after hospitalization for mental illness » Outpatient mental health provider-to-member ratio » Psychiatric provider-to-member ratio » Colorectal cancer screening » Breast cancer screening » Plan all-cause readmissions » PQI #90 Prevention Quality Overall Composite	» Enrollment data » DHCS grievance data » DHCS network adequacy monitoring data » Managed Care Accountability Set (MCAS) measurement data

Hypotheses	Evaluation Approach	Data Sources
Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan		
Duals in Medicare-Medicaid Plans (MMPs) will be less likely to change plans than those in other aligned plans that are not MMPs and less likely than those in unaligned D-SNPs.	DHCS will continue to evaluate: » Overall MCP enrollment churn rate, with comparisons. » Knowledge of the MCP enrollment process among Duals enrolled in MA plans affiliated with the MCP to their MA plans in Medi-Cal Matching Plan Policy counties versus those in Original Medicare as measured in duals survey. » Reason(s) for changing MCP at time of Duals survey.	» The Medi-Cal Matching Plan Policy evaluation will use monthly Medi-Cal enrollment data » Complete MA and MCP plan lists for this period, other available routinely collected data as feasible (e.g. delegate plan assignments if not within the DHCS data silo) » MA and MCP plan descriptions (routinely available data and possible supplemental information from plan representatives) » Duals survey data
Duals who request to change their MCP and who change their plans will be satisfied with the process for doing so during the target period.		
Duals in Medi-Medi Plans will be more satisfied with the mandatory alignment of their MCP to their MA plan choice compared to Duals who are in in other type of MA plans.		
Duals in counties with the policy will be more knowledgeable and will be more satisfied with the policy.		
GPP		
Public Health Care Systems (PHCS) improved the quality of care for the uninsured.	DHCS will continue to evaluate: » Colorectal Cancer Screening » Diabetes: HbA1c Poor Control	» Claims data » Medical record documentation (e.g., structured and unstructured EHR data, clinical registry data,

Hypotheses	Evaluation Approach	Data Sources
	» Preventive Care and Screening: Screening for Depression and Follow-Up Plan » Breast Cancer Screening » Cervical Cancer Screening » Other quality measures depending on data availability (e.g., Developmental Screening in the First Three Years of Life)	pharmacy, and lab data)
PHCS increased the use of outpatient services and non-traditional services over the course of the GPP.	DHCS will continue to evaluate the following utilization measures: » GPP non-behavioral health outpatient non-emergency, emergency, and inpatient med/surg services » GPP behavioral health outpatient non-emergency, emergency, and inpatient med/surg services » GPP non-traditional services » Ambulatory care-sensitive ED visits » Ambulatory care-sensitive hospitalizations	» PHCS-submitted encounter-level and aggregated data » HCAI Patient Discharge Data (PDD) and ED Data » HCAI Encounter Data

Hypotheses	Evaluation Approach	Data Sources
	» 30-day all-cause hospital readmission rates » All-cause ED utilization	

SECTION 7 – DEMONSTRATION FINANCING AND BUDGET NEUTRALITY

This section describes the demonstration initiatives for which DHCS anticipates financing changes and provides budget neutrality calculations for all demonstration initiatives. DHCS is requesting "hypothetical" treatment—as expenditures that would have been eligible to receive FFP elsewhere in the Medicaid program—for budget neutrality purposes for several demonstration initiatives; receiving this treatment will be subject to California's negotiations with the federal government.

Expected Enrollment Impact

The state is proposing to reinstate the Medi-Cal asset limit tests for non-MAGI Deemed SSI populations described in the table below at $130,000 for an individual Medi-Cal member and $65,000 for each additional household member. DHCS submitted and received CMS approval on a two-fold request in 2022 to amend the CalAIM Section 1115 demonstration to raise and then eliminate a resource disregard for Deemed SSI groups. This authority permitted the state to apply a disregard of $130,000 for a single Medi-Cal enrollee and $65,000 for each additional household member effective July 2022. Effective January 1, 2024, DHCS eliminated the asset limits for these populations.

Table 3. Deemed SSI Populations

Eligibility Group Name	Social Security Act and CFR Citations
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increases *Since April 1997 (also known as the "Pickle" group)*	» 1939(a)(5)(E) » Section 503 of Public Law 94-566 » 42 CFR 435.135
Disabled Widows and Widowers	» 1939(a)(2)(C) 1939(a)(2)(E) » 1634(d) » 42 CFR 435.137 » 42 CFR 435.138
Disabled Adult Children	» 1939(a)(2)(D) 1634(c)

The renewed Section 1115 demonstration will continue to authorize full-scope Medi-Cal benefits for out-of-state former foster youth. As described in Section IV, the state's authority to provide full-scope Medi-Cal coverage to pregnant women with incomes from 109 percent of the FPL up to and including 138 percent of the FPL has transitioned from Section 1115 authority to the Medi-Cal State Plan. Since this authority is now

sunset, DHCS is requesting this authority to be removed from the CalAIM Section 1115 demonstration.

Specific historical and projected estimates of the number of former foster youth and pregnant women gaining full Medi-Cal under the demonstration are provided in Tables 4 and 5 below.

Table 4. Historical Enrollment for Out-of-State Former Foster Care Youth, Deemed SSI Populations

	Historical Enrollment				
Population	**DY 18** ***1/1/22 – 12/31/22***	**DY 19** ***1/1/23 – 12/31/23***	**DY 20** ***1/1/24 – 12/31/24***	**DY 21** ***1/1/25 – 12/31/25***	**DY 22** ***1/1/26 – 12/31/26***
Out-of-State Former Foster Care Youth[1]	225	235	207	212	218
Deemed SSI Groups[2]	26	35	35	35	35

[1] Enrollment figures are estimated counts of unique beneficiaries based on an estimated percentage, derived using information from Medi-Cal 2020 & CalAIM 1115 Demonstration Progress Reports, of Out-of-State Former Foster Care Youth within the applicable aid code. Enrollment estimates for DY 21 and DY 22 are projections.

[2] Enrollment figures are estimated counts of unique beneficiaries of the Deemed SSI population. Enrollment estimates for DY 21 and DY 22 are projections.

Table 5. Projected Enrollment for Out-of-State Former Foster Care Youth and Deemed SSI Populations

	Projected Enrollment				
Population	**DY 23** ***1/1/27 – 12/31/27***	**DY 24** ***1/1/28 – 12/31/28***	**DY 25** ***1/1/29 – 12/31/29***	**DY 26** ***1/1/30 – 12/31/30***	**DY 27** ***1/1/31 – 12/31/31***
Out-of-State Former Foster Care Youth[1]	225	232	239	246	253
Deemed SSI Groups[2]	36	37	38	39	40

[1] Enrollment figures are estimated counts of unique beneficiaries based on an estimated percentage, derived using information from Medi-Cal 2020 & CalAIM 1115 Demonstration Progress Reports, of Out-Of-State Former Foster Care Youth within the applicable aid code.

[2] Enrollment figures are estimated counts of unique beneficiaries in the Deemed SSI Groups population. Deemed SSI Groups are a stable population with a minimal annual growth of 2%.

Table 6 provides information on the number of beneficiaries enrolled in each of the major eligibility categories on a historical basis; Table 7 provides information about projected enrollment under California's current projections. Overall, 13.6 million beneficiaries are expected to be enrolled in Medi-Cal during the first year of the renewed demonstration and 13.3 million by Year 5.

Table 6. Historical Enrollment by Category of Aid

	Historical Enrollment (in thousands)[1]				
Category of Aid	**DY 18** ***1/1/22 – 12/31/22***	**DY 19** ***1/1/23 – 12/31/23***	**DY 20** ***1/1/24 – 12/31/24***	**DY 21** ***1/1/25 – 12/31/25***	**DY 22** ***1/1/26 – 12/31/26***
Families and Children (not CHIP)	6,450	6,532	6,313	5,972	5,720
CHIP	1,282	1,270	1,242	1,219	1,215
ACA Expansion	4,898	5,102	5,076	4,976	4,824
Seniors and Persons with Disabilities	2,231	2,288	2,374	2,490	2,559
Other	43	42	44	45	45
Total	**14,904**	**15,234**	**15,049**	**14,702**	**14,363**

[1] The enrollment counts presented above are drawn from eligibility data extracted from the Management Information System/Decision Support System (MIS/DSS) data warehouse. Individuals that receive only restricted scope services are excluded from the counts. The enrollment counts are grouped according to major categories of aid presented in the November 2025 Medi-Cal Estimate. Enrollment counts from the MIS/DSS warehouse are not final for calendar year 2025 and so are adjusted to account for expected future adjustments. Enrollment counts for periods following January 2026 are based on projections in the November 2025 Medi-Cal Estimate.

Table 7. Projected Enrollment by Category of Aid

	Projected Enrollment (in thousands)[1]				
Category of Aid	**DY 23** ***1/1/27 – 12/31/27***	**DY 24** ***1/1/28 – 12/31/28***	**DY 25** ***1/1/29 – 12/31/29***	**DY 26** ***1/1/30 – 12/31/31***	**DY 27** ***1/1/32 – 12/31/32***
Families and Children (not CHIP)	5,515	5,440	5,432	5,432	5,432
CHIP	1,207	1,206	1,206	1,206	1,206
ACA Expansion	4,282	4,078	4,068	4,068	4,068
Seniors and Persons with Disabilities	2,573	2,549	2,546	2,546	2,546
Other	44	44	44	44	44
Total	**13,621**	**13,317**	**13,296**	**13,296**	**13,296**

[1] The projected enrollment by Category of Aid data represents statewide caseload enrollment data. The enrollment projections presented above are based on the November 2025 Medi-Cal Estimate. Caseload assumptions include impacts from the enactment of the H.R. 1 (Public Law No. 119-21), reinstatement of the Asset Limit Test, and the enrollment freeze on full-scope state-only coverage for individuals aged 19 and older who are not able to demonstrate satisfactory immigration status.

Budget Neutrality Calculation

DHCS reports on a quarterly basis the financial data associated with the state's historical expenditures under the current CalAIM demonstration period to demonstrate performance against budget neutrality caps.

Based on the programmatic details described above, California has estimated projected spending for the renewal period. Since a major goal of CalAIM is to move a number of the innovations and initiatives authorized under the preceding demonstration into the Medi-Cal State Plan and a consolidated 1915(b) waiver beginning with the CalAIM 1115 Waiver, we saw a significant decrease in expenditures between the Medi-Cal 2020 waiver against final values for the CalAIM 1115 Waiver. We are seeing a slight decrease in total expenditures for the renewal due to the removal of CBAS, PATH, DSHP, and Health Related Social Needs (HRSN) services from the renewal. With those services being excluded, all other MEGs associated with the CalAIM 1115 renewal are seeing a 16.75% decrease in aggregate expenditures across the entire duration of the renewal as compared to the CalAIM 1115 waiver.

For the purposes of public notice and comment, the state has summarized in the tables below the projected expenditures for the renewal. The state will include final projections in the Demonstration renewal request submitted to CMS; final numbers may differ as California continues to finalize financial data demonstrating the state's historical expenditures under the current CalAIM demonstration. As in the current demonstration, California will establish budget neutrality for these items by building estimates into detailed budget neutrality tables.

Table 8. Historical Expenditures, CalAIM Demonstration

	Historical Expenditures (in thousands of dollars)[1]				
Expenditure Authorities	**DY 18** ***1/1/22 – 12/31/22***	**DY 19** ***1/1/23 – 12/31/23***	**DY 20** ***1/1/24 – 12/31/24***	**DY 21** ***1/1/25 – 12/31/25***	**DY 22** ***1/1/26 – 12/31/26***
Justice-Involved Reentry Initiative	$0	$0	$1,471	$99,601	$183,188
DMC-ODS: IMD Waiver	$367,549	$422,452	$545,741	$572,889	$ 601,534
Recovery Incentives	$0	$1,528	$6,156	$13,875	$17,228
Traditional Healers and Natural Helpers	$0	$0	$0	$13,538	$17,945
Out-of-State Former Foster Care Youth	$341	$488	$482	$526	$581
Chiropractic Services from IHS and Tribal Facilities	$358	$383	$202	$332	$623
Asset Limit	$10	$191	$201	$259	$264
GPP	$2,577,959	$2,867,465	$2,869,461	$2,956,347	$3,009,178
HRSN[2]	$76,046	$49,301	$86,436	$161,677	$236,605
PATH	$22,844	$114,678	$196,957	$653,718	$629,842
DSHP	$0	$323,213	$323,213	$323,213	$323,213
CBAS	$703,930	$750,694	$857,427	$937,147	$983,536
Total	**$3,749,037**	**$4,530,393**	**$4,887,747**	**5,733,122**	**6,003,737**

[1] Expenditure amounts are the aggregate sum of actual expenditures as of September 30, 2025, as reported to CMS, plus future expenditure adjustments applicable to DYs 18–22. DY 21 and DY 22 are based on projected expenditures for the remainder of the demonstration.

[2] HRSN (Recuperative Care and STPHH) DY 21 and DY 22 projected expenditures are based on the percentage of Community Supports PMPM rates as of October 2025 that is attributable to Recuperative Care and STPHH.

Table 9. Projected Expenditures, CalAIM Demonstration

	Projected Expenditures (in thousands of dollars)				
Expenditure Authorities	**DY 23** ***1/1/27 – 12/31/27***	**DY 24** ***1/1/28 – 12/31/28***	**DY 25** ***1/1/29 – 12/31/29***	**DY 26** ***1/1/30 – 12/31/30***	**DY 27** ***1/1/31 – 12/31/31***
Justice-Involved Reentry Initiative	$244,992	$257,120	$269,847	$283,205	$297,223
DMC-ODS: IMD Waiver	$584,466	$613,689	$644,373	$676,592	$710,421
Recovery Incentives	$18,089	$18,994	$19,994	$20,941	$21,988
Traditional Healers and Natural Helpers	$20,177	$26,392	$34,525	$45,165	$59,088
Out-of-State Former Foster Care Youth[1]	$610	$640	$672	$705	$740
Chiropractic Services from IHS and Tribal Facilities[2]	$675	$733	$795	$862	$935
Asset Limit	$535	$573	$613	$657	$703
GPP[3]	$3,071,214	$3,124,122	$3,178,088	$3,233,133	$3,289,280
Employment Supports	$272,370	$314,856	$506,373	$608,877	$723,964
BridgeCare Pilots	$8,021	$11,811	$15,241	$15,431	$15,342
Total	$4,221,149	$4,368,930	$4,670,521	$4,885,568	$5,119,684

[1] Out-of-state Former Foster Care Youth estimated expenditure projections are based on the estimated increase in rates applicable to the specified aid code.

[2] IHS Chiropractic Services estimated expenditures are based on average encounters and average change in rates from prior years.

[3] GPP projections assume DSH Allotments will increase by 2% each year. Projections assume the UC split will remain at 20.371%. UC Pool funding is included in projections.

SECTION 8 - PROPOSED WAIVER AND EXPENDITURE AUTHORITIES

DHCS intends to maintain the relevant waiver and expenditure authorities previously approved under the CalAIM Section 1115 demonstration as part of this renewal with minor to no modifications. DHCS is also proposing new relevant waiver and expenditure authorities for new initiatives as part of this renewal and will be seeking CMS technical assistance in validating the necessary authorities. DHCS is also proposing to discontinue coverage of initiatives under Section 1115 demonstration authority and transition these initiatives to other authorities. Under the authority of Section 1115(a)(1) of the Act, California is requesting the renewal of approved waiver and expenditure authorities to implement the CalAIM Section 1115 demonstration through December 31, 2031.

To the extent that CMS advises the state that additional authorities are necessary to implement the programmatic vision and operational details described above, the state is requesting such waiver or expenditure authority, as applicable. California's negotiations with the federal government and potential legislative or budget changes could lead to refinements in these lists.

Waiver Authorities

Under the authority of Section 1115(a)(1) of the Act, California is requesting the renewal and start of the below waiver authorities to implement the CalAIM Section 1115 demonstration.

Table 10. Waiver Authority Requests

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
Title XIX Authorities		
1. Section 1902(a)(13)(A) (insofar as it incorporates Section 1923) DSH Requirements	» To exempt the state from making DSH payments, in accordance with Section 1923, to a hospital which qualifies as a disproportionate share hospital during any year for which the Public Health Care System with which the disproportionate share	Yes

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
	hospital is affiliated receives payment pursuant to the GPP.	
2. Section 1902(a)(1) Statewideness	» NEW: To enable the state to provide Employment Supports to Medi-Cal members on a geographically limited basis. » NEW: To enable the state to provide BridgeCare services on a geographically limited basis. » NEW: To enable the state to provide care coordination, recovery services, withdrawal management services, and partial hospitalization within electing DMC counties to members on a geographically limited basis. » To enable the state to operate the demonstration on a county-by-county basis. » To enable the state to provide DMC-ODS services to short-term residents on a geographically limited basis. » To enable the state to provide Recovery Incentive services to qualifying DMC-ODS and DMC members only in participating DMC-ODS and DMC counties that elect and are approved by DHCS to provide Recovery Incentives. » To enable the state to provide peer support specialist services within electing DMC counties. » To enable the state to provide mobile crisis services within electing DMC counties. » *(*Medicaid *Requirements Not Applicable to these Medicaid Expenditure Authorities)* To enable the state to provide pre-release	Yes, with modifications to allow the state to geographically limit the provision of Employment Supports, select outpatient SUD services, and BridgeCare Pilots

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
	services, as authorized under this demonstration, to qualifying members on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.	
3. Section 1902(a)(10)(B) and 1902(a)(17) Amount, Duration, and Scope and Comparability	» NEW: To enable the state to make Employment Supports available to a subset of expansion adults. » NEW: To enable the state to offer a varying set of benefits to Medi-Cal members eligible for Employment Supports. » NEW: To enable the state to provide care coordination, recovery services, ambulatory withdrawal management, and partial hospitalization within electing DMC counties to individuals on a geographically limited basis. » NEW: To enable the state to provide mobile crisis services within electing DMC counties. » To enable the state to provide DMC-ODS treatment and withdrawal management services for SUD, for short-term residents, in facilities that meet the definition of an IMD that are not otherwise available to all members in the same eligibility group. » To enable the state to provide Recovery Incentives in approved DMC-ODS and DMC counties, to eligible individuals with SUDs under the DMC-ODS and DMC programs that are not otherwise available to all members in the same eligibility group.	Yes, with modifications to reinstate the Medi-Cal asset limit for Deemed SSI groups, waive comparability for Employment Supports, and allow for DMC to waive comparability for Recovery Incentives and other outpatient SUD services

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
	» To enable the state to provide peer support specialist services within electing DMC counties. » To enable the state to apply targeted resource disregards of $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of ten household members as of January 1, 2027 for the following populations: i. The Pickle Group under Section 1939(a)(5)(E) of the Act and 42 CFR 435.135; ii. The Disabled Adult Child group under Sections 1634(c) and 1939(a)(2)(D) of the Act; and iii. The Disabled Widow/Widower group under Sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138. » *(Medicaid Requirements Not Applicable to these Medicaid Expenditure Authorities)* To enable the state to provide only a limited set of pre-release services to qualifying members that are different than the services available to all other members outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration.	
4. NEW: Section 1902(a)(8) Reasonable Promptness	» NEW: To enable the state to prioritize and limit the number of Medi-Cal members who receive Employment Supports. » NEW: To enable the state to prioritize and limit the number of individuals who receive BridgeCare services.	No

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
5. Section 1902(a)(84)(D) Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release	» To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in Section 1902(a)(84)(D) of the Act for eligible juveniles described in Section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in Section 1902(nn)(2) in alignment with Section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.	Yes
6. Section 1902(a)(23)(A) Freedom of Choice	» NEW: To enable the state to limit the providers who are authorized to deliver Employment Supports. » NEW: To enable the state to restrict freedom of choice of provider for individuals receiving benefits through BridgeCare Pilots. » (Medicaid Requirements Not Applicable to these Medicaid Expenditure Authorities) To enable the state to require qualifying members to receive pre-release services, as authorized under this demonstration, through only certain providers.	Yes, with modifications to allow the state to limit provider choice for Employment Supports and the BridgeCare Pilots.
7. Section 1902(a)(27) and 1902(a)(78)	» *(*Medicaid *Requirements Not Applicable to these Medicaid Expenditure Authorities)* To enable the state to not require carceral providers to enroll in Medi-Cal to provide,	Yes

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
Requirements for Providers Under the State Plan	order, refer, or prescribe pre-release services as authorized under this demonstration.	
8. Section 1902(a)(10)(B), 1902(a)(23), and 1902(a)(1) Comparability; Freedom of Choice; Statewideness	» *(*Medicaid *Requirements Not Applicable to these Medicaid Expenditure Authorities)* To the extent necessary to allow the state to offer the coverage described in Expenditure Authority 15 only if the covered THCPs are received through IHS facilities, facilities operated by Tribes or Tribal organizations under the ISDEAA, or facilities operated by UIO under Title V of the Indian Health Care Improvement Act by Medicaid members who are able to receive services delivered by or through these facilities. These sections of the Act are not applicable to the extent necessary to allow the state to phase in implementation of the coverage described in Expenditure Authority 15 to subsets of members otherwise eligible for that coverage in limited regions of the state.	Yes
9. Section 1902(a)(14) Cost Sharing	» NEW: To enable the state to impose premiums, deductions, cost sharing, and similar charges for individuals participating in BridgeCare Pilots that exceed the statutory limitations.	No
Title XXI Authority		
10. Section 2102(d)(2) Coverage of Certain Screening, Diagnostic, and	» To enable the state not to provide coverage of the screening, diagnostic, and case management services identified in Section 2102(d)(2) of the Act for targeted low-income children as a state plan benefit in the 30 days prior to the release of such	Yes

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
Targeted Case Management Services for Low-Income Children in the 30 Days Prior to Release	targeted low-income children from a public institution, to the extent and for the period that the state instead provides such coverage to such targeted low-income children under the approved expenditure authorities under this demonstration. The state will provide coverage to targeted low-income children in alignment with Section 2102(d)(2) of the Act at a level equal to or greater than would be required under the state plan.	
11. Section 2107(e)(1)(D) Requirements for Providers under the State Plan	» *(Title* XXI *Requirements Not Applicable to the Title XXI Expenditure Authority)* To enable the state to not require carceral providers to enroll in Medi-Cal to provide, order, refer, or prescribe pre-release services as authorized under this demonstration.	Yes

Expenditure Authorities

Under the authority of Section 1115(a)(2) of the Act, California is requesting the renewal of approved expenditure authorities so that the items identified below, which are not otherwise included as expenditures under Section 1903 of the Act shall, through December 31, 2031, be regarded as expenditures under the state's Title XIX and XXI plans as relevant.

The expenditure authorities listed below promote the objectives of title XIX in the following ways:

- Expenditure Authority 1 promotes the objectives of Title XIX by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations in the state.
- Expenditure Authorities 1, 5, and 9 promote the objectives of Title XIX by increasing efficiency and quality of care through initiatives to transform service delivery networks to support better integration, improved health outcomes, and increased access to health care services.

- Expenditure Authorities 2, 3, 4, 6, 7, 8, 10, 11, and 12 promote the objectives of Title XIX by improving health outcomes for Medicaid and other low-income populations in the state.

Table 11. Expenditure Authority Requests

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
Title XIX Authorities		
1. Expenditures related to the GPP for Public Health Care Systems	» Expenditures for payments to eligible Public Health Care Systems to support participating Public Health Care Systems providers that incur costs for uninsured care under a value-based global budget structure.	Yes
2. Chiropractic Services Provided by IHS and Tribal Facilities	» Expenditures for chiropractic services for which Medi-Cal coverage was eliminated by SPA 09-001 that are furnished by IHS/Tribal providers to individuals enrolled in the Medi-Cal program.	Yes
3. Expenditures Related to DMC-ODS for Residential and Inpatient Treatment for Individuals with SUD	» Expenditures for otherwise covered Medicaid services furnished to qualified DMC-ODS members who are primarily receiving treatment and withdrawal management services for SUD as short-term residents in facilities that meet the definition of an IMD.	Yes
4. Expenditures Related to Recovery Incentives	» Expenditures for Recovery Incentives services provided to qualifying DMC-ODS and DMC members who reside in a DMC-ODS or DMC county that elects and is approved by DHCS to pilot the Recovery Incentives benefit.	Yes
5. Expenditures Related to Align Dually Eligible	» Expenditures under contracts with Medicaid plans that do not meet the requirements under	Yes

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan	Section 1903(m)(2)(A)(vi) of the Act insofar as that provision requires compliance with requirements in Section 1932(a)(4)(A)(ii)(I) of the Act and 42 CFR 438.56(c)(2)(i) to the extent necessary to allow the state to keep a beneficiary in an affiliated Medicaid plan once the beneficiary has selected a MA plan unless and until the beneficiary changes MA plans or selects Original Medicare.	
6. Expenditures Related to Coverage for Out-of-State Former Foster Care Youth	» Expenditures to extend eligibility for full Medicaid State Plan benefits to former foster care youth who are under age 26, were in foster care under the responsibility of another state or tribe in such state on the date of attaining 18 years of age, or such higher age as the state has elected, and were enrolled in Medicaid on that date.	Yes
7. Expenditures for Modification of Asset Test for Deemed SSI Populations	» Expenditures to extend eligibility for individuals in the following Deemed SSI populations who are eligible based on applying a targeted asset disregard of $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of ten household members as of January 1, 2027 for the following populations: i. The Pickle Group under Section 1939(a)(5)(E) of the Act and 42 CFR 435.135; ii. The Disabled Adult Child group under Sections 1634(c) and 1939(a)(2)(D) of the Act; and	Yes, with a technical modification

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
	iii. The Disabled Widow/Widower group under Sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.	
8. Expenditures Related to Reentry Services for Justice-Involved Populations 90-Days Pre-Release	» Expenditures for pre-release services provided to qualifying Medicaid members and members who would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.	Yes
9. Expenditures Related to Managed Care Authority to Limit Plan Choice in Certain Counties	» Expenditures under contracts with managed care entities that do not meet the requirements in Sections 1903(m)(2)(A)(vi) and 1932(a)(3) of the Act in so far as implemented at 42 CFR 438.52(a) to the extent necessary to allow the state to limit the choice of MCPs in Metro, Large Metro, and Urban counties in California and to allow counties to participate or continue participating in COHS and Single Plan managed care models.	Yes
10. Expenditures Related to Traditional Healers and Natural Helpers	» Expenditures for THCPs received through IHS facilities, facilities operated by Tribes or Tribal organizations under the ISDEAA, or facilities operated by UIOs under Title V of the Indian Health Care Improvement Act, by Medicaid members who are able to receive services delivered by or through these facilities.	Yes
11. NEW: Expenditures	» Expenditures for Employment Supports provided to qualifying demonstration	No

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
Related to Employment Supports	members who reside in counties that elect to provide Employment Supports. » Expenditures for state and local planning and development activities for initial start-up of Employment Supports.	
12. NEW: Expenditures Related to BridgeCare Pilots	» Expenditures for BridgeCare Pilot services by entities that elect to and are authorized by the state to operate an approved BridgeCare Pilot program provided to eligible individuals ages 65 and older, who are enrolled in traditional Medicare, meet nursing facility level of care, reside in home and community based settings with incomes between 138–220 percent federal poverty level who are not otherwise eligible for Medi-Cal. » To authorize the reinvestment of state-designated shared savings towards applicable demonstration expenditures. To calculate the amount of state-designated shared savings available for use under this authority, a calculation will be made to determine the difference between projected and actual total Medicare costs. A baseline projected cost will be determined and actual costs will be compared against the baseline.	No
Title XXI Authorities		
13. Expenditures Related to Reentry Services for Services for Justice-Involved	» Expenditures for pre-release services provided to qualifying demonstration members who would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the	Yes

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
Populations 90-Days	expected date of release from a participating state prison, county jail, or youth correctional facility.	
14. Expenditures Related to Traditional Healers and Natural Helpers	» Expenditures for THCPs received through IHS facilities, facilities operated by Tribes or Tribal organizations under the ISDEAA, or facilities operated by UIOs under Title V of the Indian Health Care Improvement Act by CHIP members who are able to receive services delivered by or through these facilities.	Yes

SECTION 9 – STAKEHOLDER ENGAGEMENT AND PUBLIC NOTICE

DHCS will update this section following completion of the public comment period.

APPENDIX A – EQRO AND QUALITY REPORTS

2023–2024 DMC-ODS EQRO Report

Executive Summary (Full Report Available Here)

Behavioral Health Concepts (BHC), Inc., under contract with the State of California Department of Health Care Services (DHCS), evaluated the access, timeliness, and quality of Drug Medi-Cal Organized Delivery Systems (DMC-ODS) provided to Medicaid members by all 31 of the state's DMC-ODS Plans. This report presents statewide findings from External Quality Reviews (EQRs) conducted in California during fiscal year (FY) 2023–24, marking BHC's seventh and final year as the External Quality Review Organization (EQRO) for the substance use disorder (SUD) systems of care.

EQRs are intentionally retrospective, reviewing the DMC-ODSs' work accomplished in the prior 12 months and the prior years' service data. The performance measures (PMs) for FY 2023–24 reviews primarily focus on claims data from calendar year (CY) 2022, calculated by the California External Quality Review Organization (CalEQRO), as the most current and complete 12-month data set available at the beginning of the review year. Additionally, prior to each review, DMC-ODSs submitted data on service timeliness, which was validated and reported in the Timeliness chapter of this report. This year's statewide report also includes more tables with Plan-specific data.

DMC-ODS review findings are derived from a combination of PM analysis, documents submitted by the Plans, and qualitative information gathered from group discussions. DMC-ODS Plans submit a significant number of documents prior to reviews, demonstrating work accomplished, challenges faced, and improvements made in the prior 12 months. Each DMC-ODS's Final Report is posted online.[29]

This report presents findings from reviews of DMC-ODSs, conducted over one to three days, mostly via video conference, though some were in-person visits. Using Centers for Medicare and Medicaid Services (CMS) EQRO Protocols and involving key stakeholders, CalEQRO facilitated discussions on access, timeliness, and quality of care, including performance improvement projects (PIPs) and review of a current Information Systems Capability Assessment (ISCA). In addition, an attachment follows this report, containing the Executive Summaries from each DMC-ODS Final Report. The data extracted from the DMC-ODS Final Reports provided the basis for the statewide findings, themes, and

[29] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS' website: https://www.dhcs.ca.gov/services/MH.

recommendations. This statewide report includes both qualitative and quantitative findings based upon aggregated statewide information.

2023–2024 Medi-Cal Managed Care Physical Health External Quality Review Technical Report

Executive Summary (Full Report Available Here)

As required by Title 42 Code of Federal Regulations (CFR) Section (§)438.364, the California Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual, independent, technical report that summarizes findings on the quality, timeliness, and accessibility of health care services provided by Medi-Cal Managed Care program (MCMC) plans, including opportunities for quality improvement.

The *2023–24 Medi-Cal Managed Care Physical Health External Quality Review Technical Report* provides a summary of the external quality review (EQR) activities of DHCS' MCMC physical health plans (i.e., managed care health plans [MCPs] and population-specific health plans [PSPs]). DHCS does not exempt any plans from EQR.

In addition to summaries of EQR activity results, the *2023–24 Medi-Cal Managed Care Physical Health External Quality Review Technical Report* includes HSAG's assessment of the quality, timeliness, and accessibility of care delivered to MCMC members by MCPs and PSPs and, as applicable, recommendations as to how DHCS can use the EQR results in its assessment of and revisions to the DHCS Comprehensive Quality Strategy.[30] Annually, DHCS thoroughly reviews the EQR technical report to determine how the results contribute to progress toward achieving the DHCS Comprehensive Quality Strategy goals as well as whether DHCS needs to revise the Comprehensive Quality Strategy based on the results presented in the EQR technical report.

This *Medi-Cal Managed Care Physical Health External Quality Review Technical Report Executive Summary of Findings* provides a high-level summary of the notable findings included in the *2023–24 Medi-Cal Managed Care Physical Health External Quality Review Technical Report*. This executive summary will sometimes collectively refer to the MCPs and PSPs as "plans."

[30] California Department of Health Care Services. (2022, February 4). *Comprehensive Quality Strategy 2022*. https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf

2025 DHCS Comprehensive Quality Strategy

Executive Summary (Full Report Available Here)

The Department of Health Care Services' (DHCS) envisions a future where Medi-Cal helps people live longer, healthier, and happier lives. In this whole-system, person-centered, and population health approach to care, health care services are only one element of supporting better health in the population. Partnerships with Medi-Cal members, communities, community-based organizations, schools, correctional facilities, public health agencies, counties, and health care systems will be essential to preventing illness, supporting needs, addressing health disparities, and reducing the effects of poor health.

Since the 2022 Comprehensive Quality Strategy (CQS), DHCS has made significant progress toward this vision. Through California Advancing and Innovating Medi-Cal (CalAIM) and broader Medi-Cal transformation efforts, Medi-Cal is providing more comprehensive preventive and personalized care that spans the physical and mental health needs of Californians. We're strengthening mental health and substance use disorder services and better integrating them with physical health care. New benefits and services, such as Enhanced Care Management (ECM), community health worker, and Community Supports, are helping members with health-related social needs that can impact their health, like getting help with obtaining and keeping housing and accessing medically tailored meals to support a member's short-term recovery.

Importantly, DHCS has built upon the lessons learned from COVID-19 on the necessity of local partnerships and integration across sectors. Via the new Medi-Cal Managed Care Plan (MCP) contracts implemented in 2024, MCPs now have partnerships with a broad array of local partners, including local health jurisdictions, schools, county Behavioral Health Plans (BHP), child welfare entities, and others. DHCS' revised policy on how both MCPs and county BHPs conduct community assessments and partner with local health jurisdictions is strengthening and centering community and member voices in guiding policies and programs upon which they rely.

While DHCS has made significant progress, much work remains to solidify, stabilize and scale these interventions so they can reach all 58 counties and nearly 15 million Medi-Cal members.

The 2025 CQS continues this journey. The revised CQS:

- Provides an overview of all DHCS health care, including managed care, fee-for-service (FFS), and other programs.

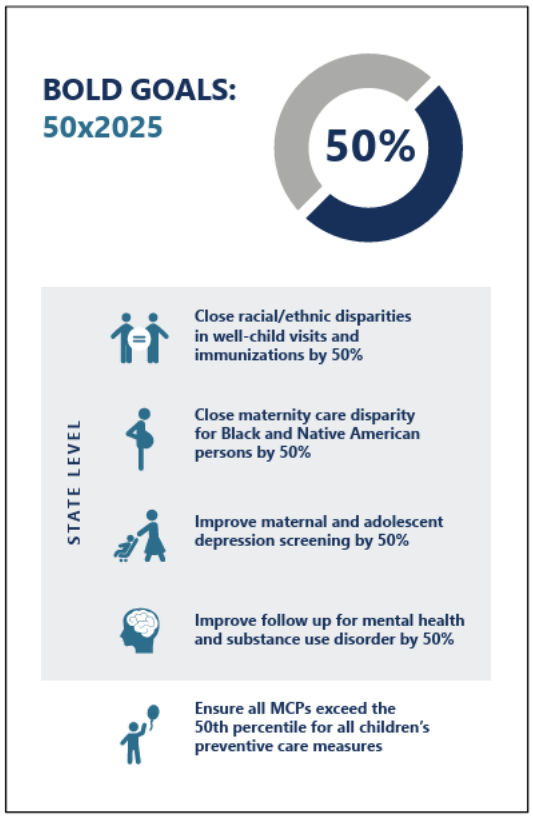
- Includes overarching quality and health equity goals, with program-specific objectives, including goals that are still in progress from the 2022 CQS.
- Reinforces DHCS' commitment to reducing health disparities in all program activities.

Section 1 of the CQS, in accordance with the 2016 Managed Care Final Rule, provides an overview of the Medi-Cal program and the quality management structure at DHCS, including the process for developing and reviewing the CQS.

Section 2 outlines DHCS' quality and health equity strategy. Based on fundamental quality assurance and performance improvement (QAPI) practices, the CQS identifies key drivers of health outcomes at the individual and system levels and proposes a comprehensive strategy to improve them. The CQS continues key quality efforts as outlined in the Medi-Cal Transformation policy framework, CalAIM, and incorporates newer initiatives, such as the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative and Behavioral Health Transformation, which further strengthen behavioral health services and advance whole person care.

The CQS goals and guiding principles (summarized below) are a continuation of DHCS' goals in its 2022 CQS, which are continued as a part of DHCS' currently approved 1915b and 1115 waivers. These goals are built upon the Population Health Management (PHM) framework that is the cornerstone of Medi-Cal Transformation and aims to take a more comprehensive whole-person, upstream approach to achieving health outcomes. They also stress DHCS' commitment to improving health outcomes, addressing health disparities member involvement, and accountability in all our programs and initiatives, and for all populations.

Section 2.3 of the CQS specifically outlines the implementation of PHM, which aims to help *all* members stay healthy via preventive and wellness services, identify and assess member risks to guide care management and care coordination needs, and identify and mitigate social drivers of health to reduce health care disparities. In the 2022 CQS, DHCS identified three clinical focus areas—children's preventive care, maternal outcomes and birth equity, and behavioral health integration—as foundational priorities and areas where significant improvement was needed. To further these priorities, DHCS launched the Bold Goals *50x2025* initiative, which has made significant progress on key measures in these clinical focus areas, but is not yet complete so are continued in this updated CQS. The 2025 CQS continues to emphasize these clinical focus areas and expands its population health approach to include behavioral health delivery systems, establishing 14 population-level outcomes for improvement. This behavioral population health work is also focused on key priority populations, which currently experience disproportionate health disparities and poor outcomes: individuals with behavioral health conditions who are chronically homeless and/or experiencing homelessness, those at risk of, or experiencing, justice system involvement, child-welfare involved youth, and individuals at high risk of institutionalization.



Section 2.4 of the CQS outlines specific clinical goals across the Medi-Cal program. Goals with measurable targets are included for each managed care delivery system (Medi-Cal managed care, behavioral health, and dental). These goals were identified to ensure a comprehensive quality approach across multiple populations. A complete set of all measures reported and tracked across Medi-Cal programs are available in **Appendix D**.

Similar to the 2022 CQS, DHCS recognizes that the Health Equity Roadmap and value-based payment (VBP) program initiatives, designed to address health disparities and improve outcomes while addressing costs, are critical levers to improving high quality care for all Medi-Cal members. In the 2025 CQS, **Section 2.5**, DHCS builds upon the work done in the last three years and outlines its strategy for community and member engagement in Medi-

Cal policies and programs. In **Section 2.6**, DHCS furthers its VBP portfolio, especially around primary care spending and alternative payment models, in partnership with the Office of Health Care Affordability.

Section 3 of the CQS outlines significant changes at DHCS in terms of its quality management structure and managed care monitoring and oversight activities. Building upon the centralized Quality and Population Health Management (QPHM) program, which was created as part of the 2022 CQS, DHCS has significantly aligned and standardized managed care policies across delivery systems, instituted standard, proactive monitoring strategies (including user-friendly public dashboards) to support transparency, and implemented standard accountability and enforcement measures, including financial sanctions.

DHCS is unwaveringly committed to addressing quality and health equity in Medi-Cal, as described in this strategy. We have made much progress in Medi-Cal Transformation over the past three years, but our work is not yet complete, and in these times of change and uncertainty, it is perhaps even more vital for our nearly 15 million members. The journey we have been on is already yielding measurable results, and our members, communities, and partners need us to complete it.

California CMS Form 416 EPSDT/CHIP Report

The 2024 Form 416 EPSDT/CHIP report (file name: EPSDT416StateRpt2024.pdf; pages 13–15) is available at https://www.medicaid.gov/medicaid/benefits/downloads/fy-2024-data.zip.