Ventura CalAIM PATH Collaborative

October 16, 2025

BluePath HEALTH

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Today's Agenda

Time	Agenda Item	Presenter
12:00-12:10 pm	Welcome and Introductions	BluePath Health
12:10-12:20 pm	Provider Success Stories	Conejo Health
12:20-12:45 pm	MCP Policy Updates – Closed Loop Referrals (CLRs)	
12:45-1:30 pm	Provider Networking Lunch and Roundtable Conversations	

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Housekeeping & Announcements

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Community Agreements

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Community Agreements

Acknowledge different perspectives and expertise.

Assume positive intent, acknowledge impact, and clarify to avoid assumptions.

We all have a role in the solution.

Adapted from Decolonizing Design Community of Practice // Guiding Principles & Community Agreements

2025 Collaborative Aim Statement

By December 2025, the Collaborative will strengthen local implementation of CalAIM by creating a sustainable network of providers. We will accomplish this through hosting quarterly peer learning sessions and at least 2 workforce development trainings.

- Strengthen the capacity of providers to sustainably deliver CalAIM services
- Build education and awareness of CalAIM among members, providers, and community partners to drive referrals
- Increase ECM & Community Supports referrals and care coordination among providers

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Local CalAIM Successes: Conejo Health

Conejo Health

Conejo Health

Cal-AIM Success Stories

- CHW
- ECM

(and challenges..)

Conejo Health

www.conejohealth.com

Substance Use Navigator/Community Health Worker

- Provides **immediate support** to individuals in the ED Experiencing substance use and SDOH related crises.
- Engages patients through **motivational interviewing** and **harm reduction**, helping navigate immediate needs and treatment options.
- **Coordinate warm handoffs** to medical, behavioral health, and community-based services, ensuring continuity of care beyond the ED
- Staff with **lived experience** provide direct connections and peer-led support for patients in crisis.

Conejo Health

www.conejohealth.com

Patient Success

Patient, M. B. presented at Ventura County Medical Center ER in late October of 2024. Patient was experiencing abdominal pain and jaundice due to alcohol use disorder. Patient expressed a strong desire to change and enter a life of recovery.

- SUN called the 24-hour substance use services ACCESS phone line with the patient in the ER.
- Patient was assigned a care coordinator and scheduled for an ASAM assessment with a clinician.
- SUN followed up with the patient after her ASAM assessment was completed. Patient was enrolled into outpatient services through Ventura County Behavioral Health
- Patient will have one year of recovery on 10/30/2025
- Patient's health has improved dramatically.
- Patient attends AA meetings daily for support.
- Patient has returned to work, goes to the gym regularly, and has incorporated a healthy diet in her life with the help of CHW’s and primary care physicians.

Conejo Health

www.conejohealth.com

Enhanced Care Management

Patient-centered care coordination for individuals with complex medical and social needs. ECM connects patients to medical, behavioral health, and community services, ensuring they receive the right care at the right time.

Conejo Health

www.conejohealth.com

Patient Success

In late 2024 and early 2025, Mr. M experienced significant challenges related to substance use, leading to multiple visits to the Emergency Room for complications associated with fentanyl and methamphetamine use. These frequent ER visits highlighted his ongoing struggle with addiction and the urgent need for structured support and connection to long-term treatment resources.

- 6/17/2025- Patient presented to ER for Suboxone refill after relapse.
  SUN in ED at VCMC secured MAT Clinic appointment. Referral made to Conejo Health ECM.
- 6/18/2025-Care Manager followed up with patient to enroll into the ECM program. ECM assisted patient in reconnecting with VCBH SUS. ECM facilitated admission to Khepera House for SUD inpatient treatment (admitted next day).
- 7/22/2025- Patient signed up for RSS program including 12 months of sober living (covered by GCHP Medi-Cal).
- 7/31/2025- ECM guided patient in completing online application with Department of Rehabilitation. Secured intake appointment for career counseling, job skill training, and CDL (Commercial Driver's License).
- 9/24/2026- Patient secured full-time employment in powder coating.
- 9/26/2025- Mr. M graduated from Khepera House detox & inpatient treatment program. Transitioned to 12-month sober living.

Conejo Health

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Managed Care Plan Updates: Closed-Loop Referrals Updates

Closed-Loop Referral (CLR) Overview

Definition
Closed-Loop Referral (CLR): A referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a *known closure*. A **known closure** occurs when a Member's initial referral loop is completed with a known outcome.

Background

- CLR requirements effective on July 1, 2025 solely apply for two services:
  - ❑ Enhanced Care Management – all Population of Focus (PoF)
  - ❑ Community Supports – all services upon go-live, except Sobering Centers
- The goal is to increase the share of Medi-Cal Members successfully connected to the services they need by identifying and addressing gaps in referral practices and service availability.
- DHCS intends to expand similar CLR requirements to other applicable services (i.e. CHW) over time. An official timeline has not been shared other than for BH services beginning in some time in 2026.

Requirement Components

Tracking Referral: Track a minimum set of data elements for each referral

Supporting Referral & Closure: Provide assistance with referral and processing, notifying members and referring entities and work with providers to troubleshoot challenges

Monitoring Referrals: Monitor data to resolve challenges across referral partners, internal operations, and providers

*DHCS has shared that they are giving Plans a 1-year grace period to implement systems and processes for CLR for ECM/CS after the CLR policy is effective on July 1, 2025.

Sources: CLR Implementation Guidance May 2025, Closed-Loop-Referral-FAQs May 2025

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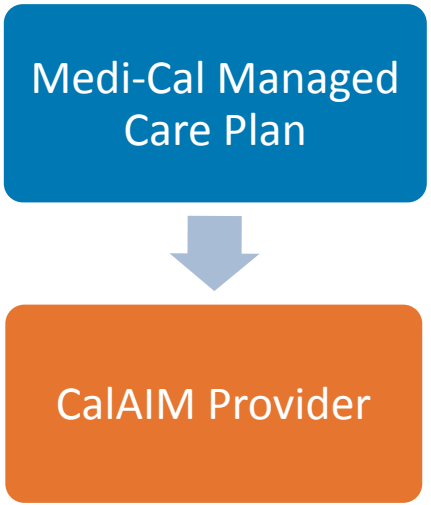
What is a Member Information File (MIF)?

Member Information Files (MIFs) contain a list of members assigned to an ECM and/or CS Provider. These files include details that can help contact and engage new enrollees, as well as information about their health and service use to support care management.



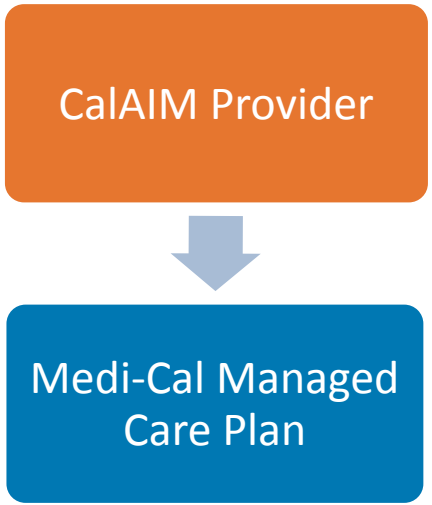
A	B	C	D	E	F	G	H	I
ECM Member Record: *(New; Continuing; Returned; Termed)*	**Member CIN#**	**Member First Name**	**Member Last Name**	**Member Date of Birth** *(MM/DD/YYYY)*	**Referring Organization Name (NEW)**	**Referring Individual Name** Last name, First name **(NEW)**	**Referring Individual Phone Number** 0000000000 **(NEW)**	**Referring Individual Email Address (NEW)**

Sources include CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers and ECM Provider Return Transmission File template.

KAISER PERMANENTE

What is a Return Transmission File (RTF)?

Return Transmission Files (RTFs) contain updates from ECM and/or CS Providers about services delivered to assigned members. These files help Managed Care Plans (MCPs) track member progress, understand service outcomes, and close the loop on referrals. They include details such as whether services were provided, if the member could be reached, and reasons for referral closure.



A	B	C	D	E	F	G	H	I
Member CIN#	Member First Name	Member Last Name	Member Date of Birth *(MM/DD/YYYY)*	Member New Address *(1=Yes; 0=No)*	Member Homelessness Indicator *(1=Yes; 0=No)*	Member Residential Address	Member Residential City	Member Residential Zip

Sources include CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers and ECM Provider Return Transmission File template.

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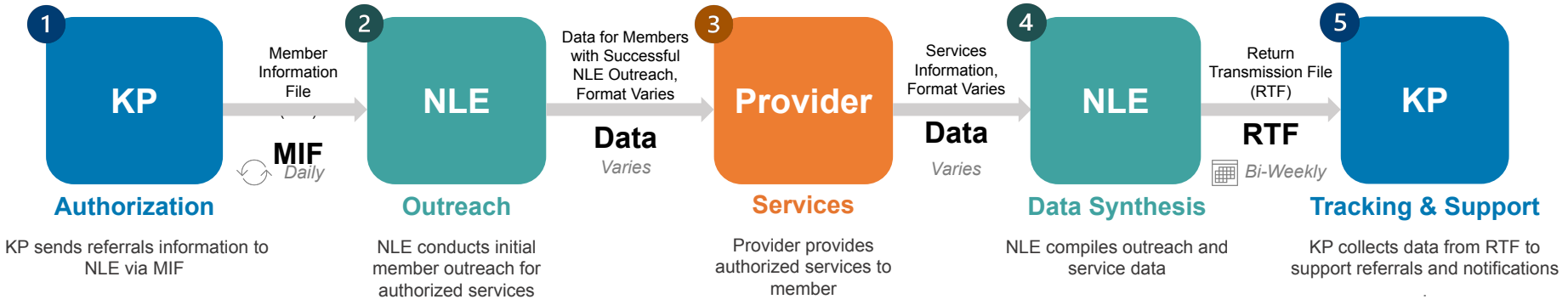
Kaiser Permanente ECM & CS Provider Reporting Changes Due to CLR Guidance

- Data elements will be updated on the MIF and RTF to meet Closed Loop Referral (CLR) data requirements, *including but not limited to*:
  - Contact Information for Referring Organization / Person
  - Referral Status: Pending, Accepted, Declined, Outreach Initiated, Referral Loop Closed
  - Reason for Referral Loop Closure: Services Received, Service Provider Declined, Unable to Reach Member, Member No Longer Eligible for Services, Member No Longer Needs Services or Declines, Other, Authorization Denied *(determined only by KP)*
- For more information on how **CLR** and **MIF/RTF** updates may impact your organization, please contact your contracted **Network Lead Entity** (Full Circle Health Network, Independent Living Systems, Partners in Care).

Referral Information Workflow



KAISER PERMANENTE

Last updated: July 2025

Gold Coast Health Plan℠
A Public Entity

Closed-Loop Referrals (CLR)

GCHP Staff

Integrity

Accountability

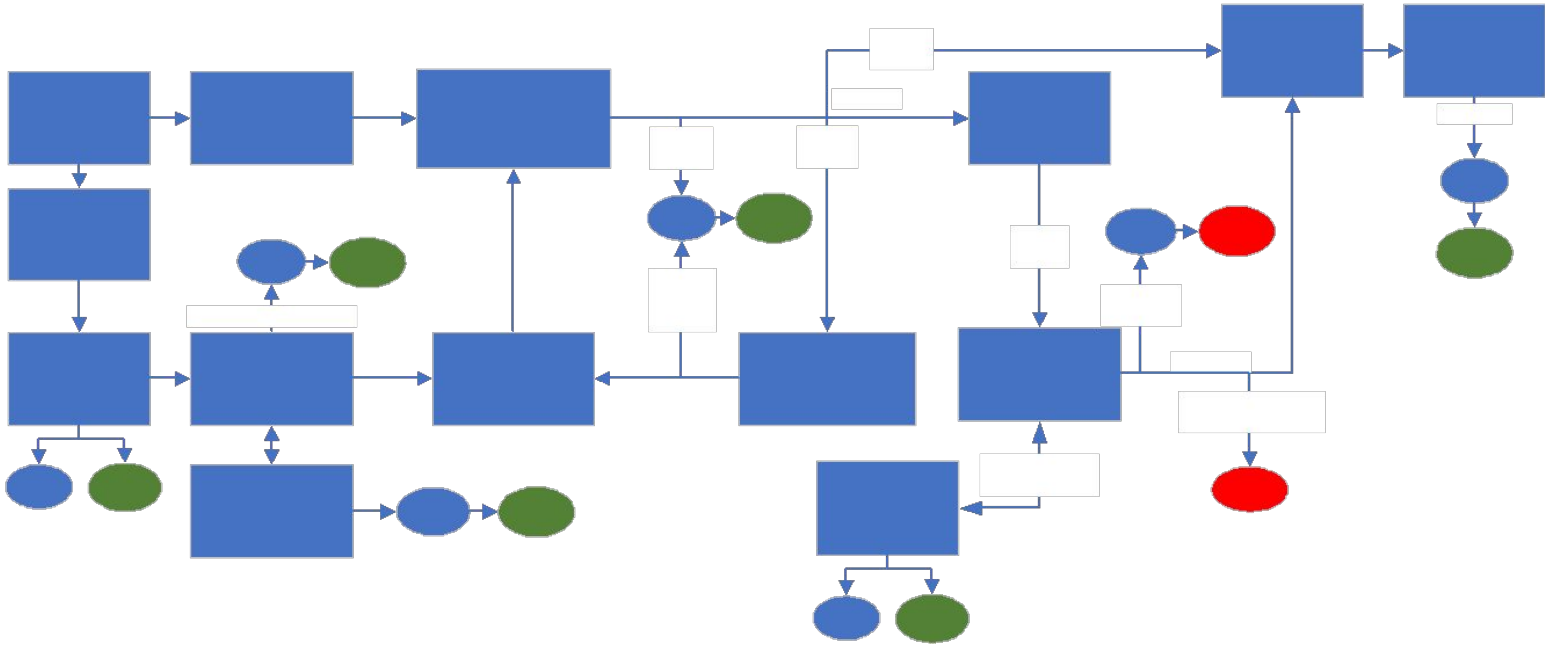
Collaboration

Trust

Respect

711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Closed Loop Referrals - Process



CLR Minimum Data Elements

- 45 minimum data elements
  - **Member Information** (CIN, Gender Code, Race/Ethnicity Code, Guardian or Conservator, etc.)
  - **Referral Initiation** (Date of Referral, Referring Organization, Referral Type, etc.)
  - **Referral Authorization** (Date Request Received, Referral Authorization Status, Authorization Effective Date)
  - **Referral Processing** (Date Referral Sent to Servicing Provider, Referral Status, Date of Referral Status, etc.)
  - **Referral Loop Closure** (Reason for Referral Loop Closure and Date Referring Entity Notified of Referral Loop Closure)
- Referring Agency, Member, MCP, and ECM/CS Provider all play a role in the data collection process!!

Tracking Referrals: Provider Roles & Responsibilities

- **GCHP's Responsibility:** Collect, store, and utilize the minimum data elements.
- **Provider Responsibility:** Report specific data elements to GCHP monthly via the Return Transmission File (RTF).
- Key **ECM and CS** RTF Updates/Changes (Effective July 1, 2025):
  - ADD - **Referral Status:** Accepted, Declined, Pending, Outreach Initiated, Referral Loop Closed.
  - ADD - **Date of Referral Status:** Date associated with the status update.
  - ADD - **Reason for Referral Loop Closure:** Required if status is 'Declined' or 'Referral Loop Closed' (e.g., Services Received, Unable to Reach Member, Service Provider Declined, etc.).
  - CS ONLY - ADD – **Transitional Rent:** Yes/No (1,0) flag to indicate if Member is receiving this Community Support service.
  - Continue to include field header and report as blank – **Status of Member Engagement** (ECM) and **Current Status of Member Engagement** (CS)
- **Data Timeliness:** Updates must be received by the 5th of the month are crucial for MCP support and monitoring.
- **Data Compliance:** Adherence to HIPAA, 42 CFR Part 2, etc., is essential.

Referral Status – Updates from the Provider

- **Accepted -** This status indicates that the **referral has been received and accepted** by the Enhanced Care Management (ECM) or Community Supports provider. The provider is prepared to engage with the member and deliver the referred services.
- **Declined -** A referral may be marked as **Declined** if the provider is **unable to accept the referral** for reasons such as:
  - Lack of capacity
  - The member is outside the provider's service area
  - Other operational or eligibility-related constraints
    MCPs (Managed Care Plans) are expected to document and track the reasons for declined referrals in accordance with DHCS policy
- **Pending -** This status is used when the referral has been **received but not yet acted upon**. It may be awaiting review, triage, or assignment to a care team. It reflects an intermediate state before acceptance or outreach.
- **Outreach Initiated -** This status indicates that the provider has **begun outreach efforts** to contact the member and engage them in services. It shows active follow-up is underway, even if the member has not yet been reached or enrolled.
- **Referral Loop Closed**
  This status is used when the referral has reached a **known and documented conclusion**. This could mean:
  - Services were successfully delivered
  - The member declined services
  - The referral was otherwise resolved
    Closure must be supported by data, such as confirmation from the provider or documentation in the Return Transmission File (RTF)

Tracking Referrals: Key MIF Updates for ECM

- Key **MIF** Updates/Changes (Effective July 1, 2025 – **Implementation Date for GCHP TBD**):
  - **Best Contact Method for Member/Caregiver**
  - **Best Contact Time for Member/Caregiver**
  - **Referring Organization Name**
  - **Referring Individual Name**
  - **Referring Individual Phone Number**
  - **Referring Individual Email Address**
  - **Referring Individual Relationship to Member**
  - **Referral Type**
    - One code per Member, options include: (1) Community Referral; (2) Identified by the MCP (e.g., through available data).

Tracking Referrals: Key CS Auth Updates for CS

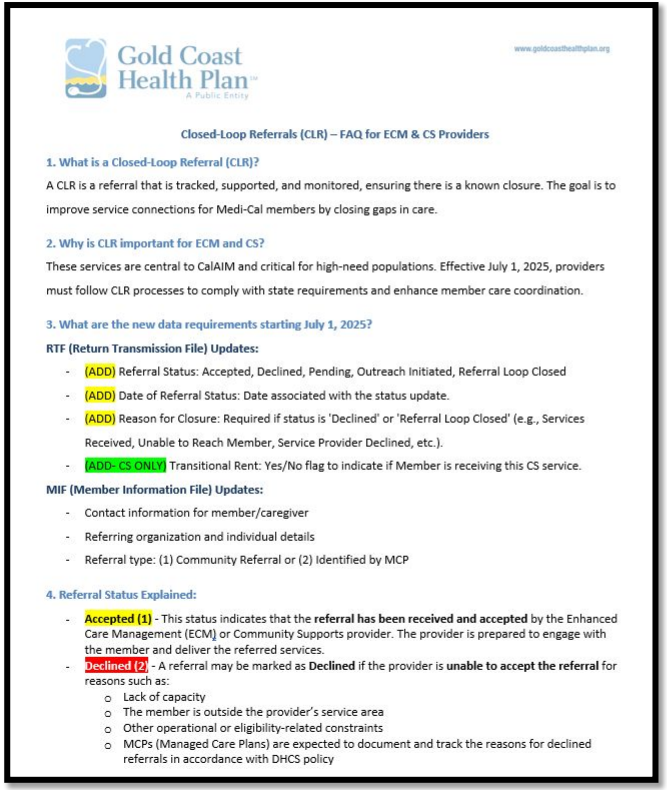
- Key **Community Supports Authorization Status File** Updates/Changes (Effective July 1, 2025 - **Implementation Date for GCHP TBD**):
  - **Authorization Effective Date (MM/DD/YYYY)**
  - **Referral Type**
    - One source code per Member. Source codes will include: 1. Community Referral; 2. Identified by the MCP
  - **Transitional Rent**
    - Listed as a data element in the Community Supports Information

Data Exchange Schedule

File Name	Frequency of Transmission	Data Flow
(ECM) Member Information File	Weekly – Mondays at 10 am	GCHP to Providers
(CS) Authorization Status File	Weekly – Mondays at 10 am	GCHP to Providers
(ECM, CS) Provider Return Transmission File	On or before the 5th every month by 5:00 pm	Providers to GCHP
(ECM) Initial Outreach Tracker File	On or before the 5th every month by 5:00 pm	Providers to GCHP
~~Member Referral File~~	~~On or before the 5th every month by 5:00 pm~~	Discontinued

Next steps, Questions, Issues, Q&A

- Questions?
- Please contact calaimreporting@goldchp.org moving forward rather than any one individual from GCHP.



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Closed-Loop Referrals (CLR) – FAQ for ECM & CS Providers

1. What is a Closed-Loop Referral (CLR)?

A CLR is a referral that is tracked, supported, and monitored, ensuring there is a known closure. The goal is to improve service connections for Medi-Cal members by closing gaps in care.

2. Why is CLR important for ECM and CS?

These services are central to CalAIM and critical for high-need populations. Effective July 1, 2025, providers must follow CLR processes to comply with state requirements and enhance member care coordination.

3. What are the new data requirements starting July 1, 2025?

RTF (Return Transmission File) Updates:

- (ADD) Referral Status: Accepted, Declined, Pending, Outreach Initiated, Referral Loop Closed
- (ADD) Date of Referral Status: Date associated with the status update.
- (ADD) Reason for Closure: Required if status is 'Declined' or 'Referral Loop Closed' (e.g., Services Received, Unable to Reach Member, Service Provider Declined, etc.).
- (ADD- CS ONLY) Transitional Rent: Yes/No flag to indicate if Member is receiving this CS service.

MIF (Member Information File) Updates:

- Contact information for member/caregiver
- Referring organization and individual details
- Referral type: (1) Community Referral or (2) Identified by MCP

4. Referral Status Explained:

- **Accepted (1)** - This status indicates that the **referral has been received and accepted** by the Enhanced Care Management (ECM) or Community Supports provider. The provider is prepared to engage with the member and deliver the referred services.
- **Declined (2)** - A referral may be marked as **Declined** if the provider is **unable to accept the referral** for reasons such as:
  - Lack of capacity
  - The member is outside the provider's service area
  - Other operational or eligibility-related constraints
  - MCPs (Managed Care Plans) are expected to document and track the reasons for declined referrals in accordance with DHCS policy

Closed Loop Referrals Q&A

- What are best practices for CalAIM providers completing the RTF file?
- Where do you see the greatest opportunities for providers to work together to address referral tracking and communication challenges?
- How can CalAIM providers and MCPs partner more effectively on closed loop referrals?

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Provider Networking

Provider Networking Table Topics

- Supporting Immigrant Communities
- Behavioral Health
- Justice-Involved Initiative
- Housing Resources
- Supporting Older Adults
- Motivational Interviewing

What is your biggest challenge or concern in [topic area] — and how might our Collaborative help address it or elevate solutions?

Looking Ahead

Wed. Nov. 19 11am-12:30pm **on Zoom**	**All Tri Counties Collaborative Meeting**
Wed. Dec. 17 11am-12:30pm **on Zoom**	**All Tri Counties Collaborative Meeting**

Register for the Collaborative:

BluePath HEALTH

Thanks for joining!

Questions? pathinfo@bluepathhealth.com

BluePath HEALTH

Office Hours

Appendix

Medi-Cal Voices and Vision Council Application

The Voices and Vision Council offers a dedicated space for Medi-Cal members, MCPs, providers, community-based organizations, and state partners that work with Medi-Cal members to provide direct input to the DHCS executive leadership team regarding Medi-Cal program policies, programs, and implementation.

Access the Application here:

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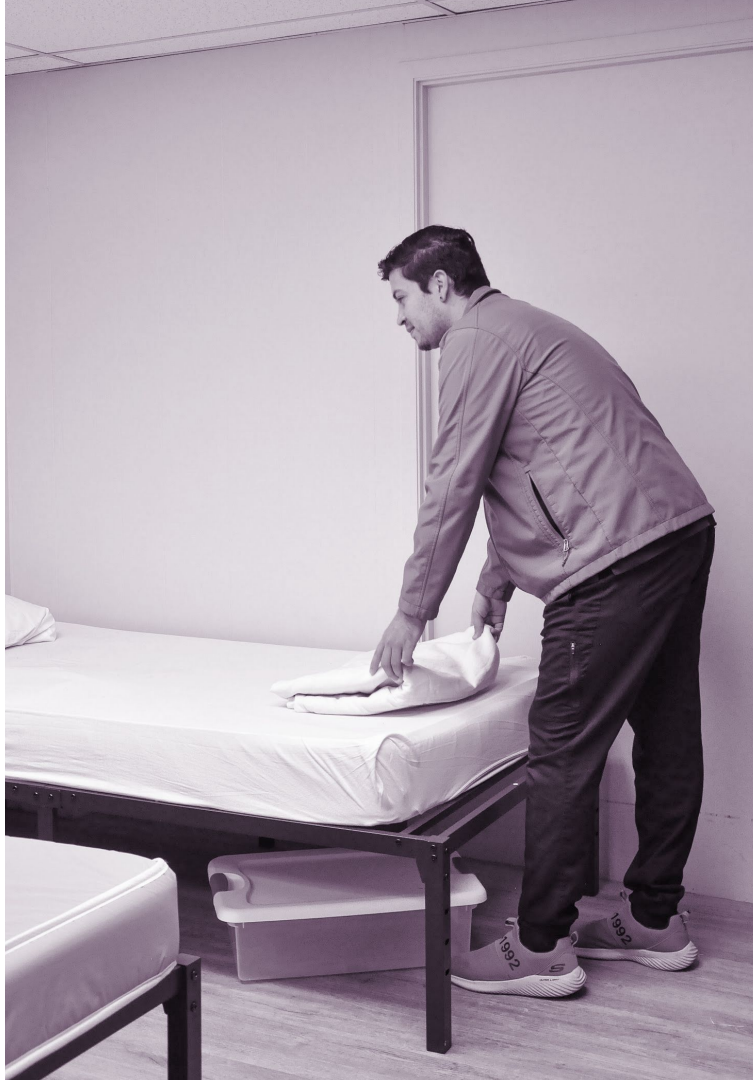
Local CalAIM Successes: Good Samaritan Shelter

GSS CalAIM Services

PATH Meeting – August 20, 2025

CalAIM at GSS: Overview

- ECM services launched 7/1/2023
- SM Sobering Center launched 10/1/2023
- HTNS/HD/HTSS launched 10/1/2023
- STPH launched 1/1/2024
- Day Hab launched 7/1/2024
- SB/SLO Sobering Centers launched 8/1/2024
- Recuperative Care launched 7/1/2022 in SM, 8/1/24 in Lompoc, 8/7/25 in SB



Total Unduplicated Clients Served under CalAIM

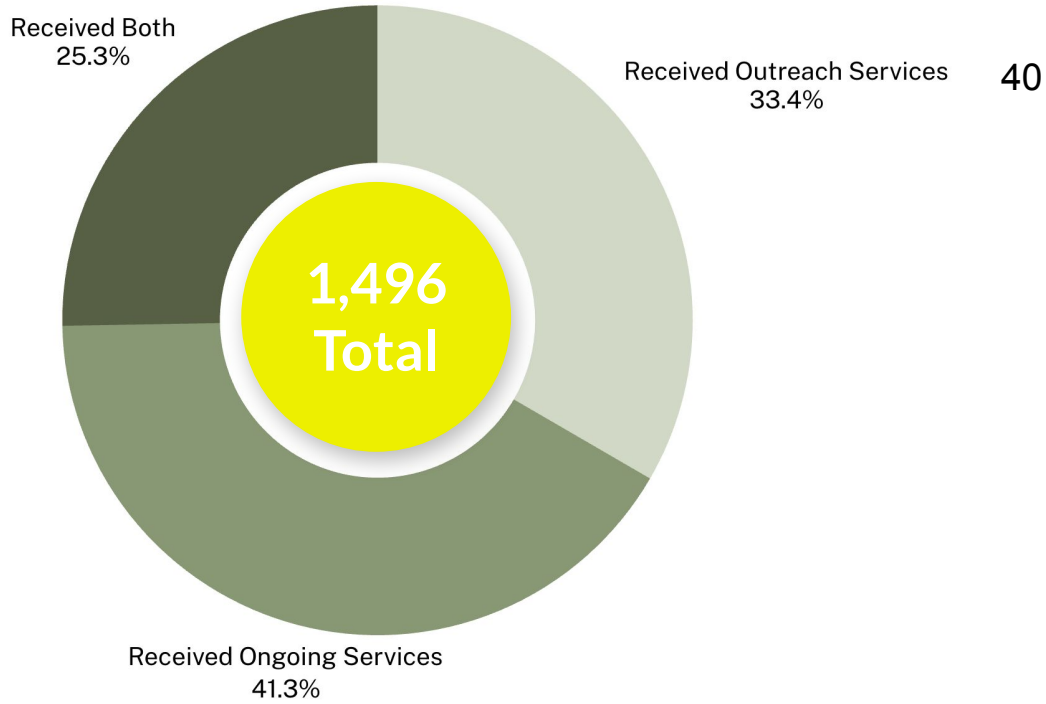
(July 1, 2023 – 6/30/2025)

Enhanced Care Management

1,010 Received Outreach Services

1,251 Received Ongoing Services

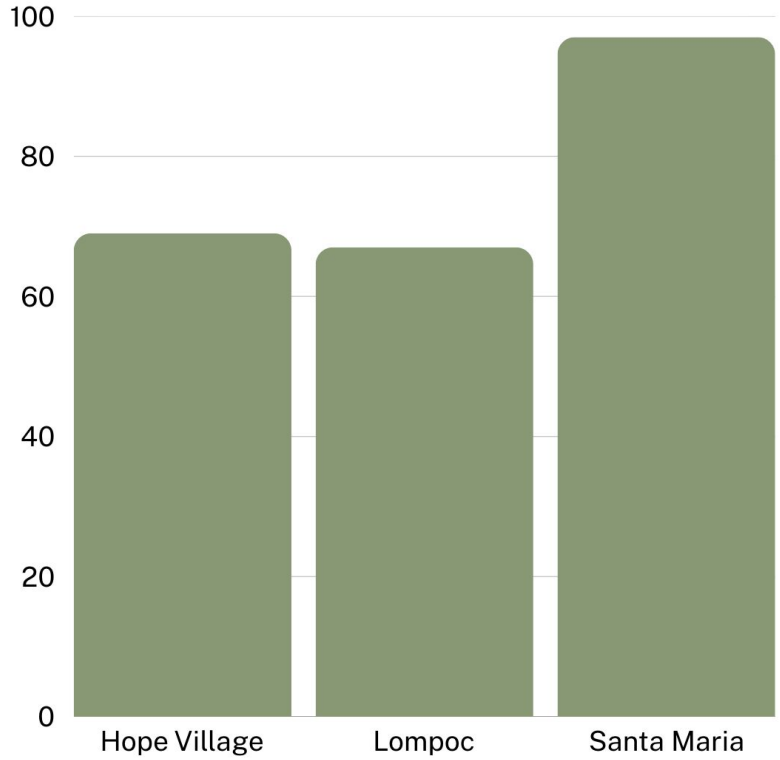
765 Received services from both Outreach and Ongoing



Recuperative Care

211 total unduplicated clients served by RCP

- 69 clients received services from Hope Village Recuperative Care
- 67 clients received from Lompoc Recuperative Care
- 97 clients received services from Santa Maria Recuperative Care

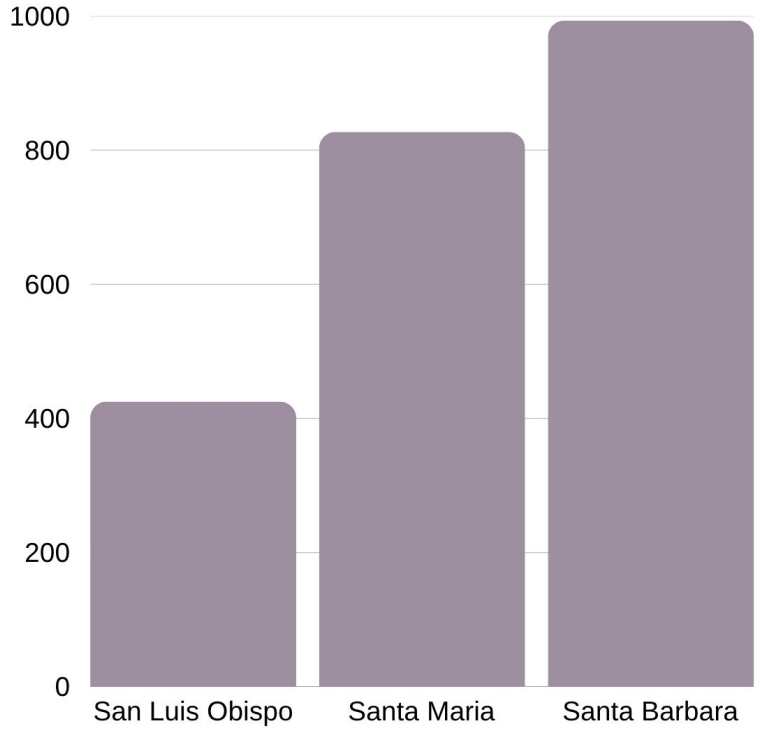


Sobering Centers

425 Clients served at SLO Sobering Center

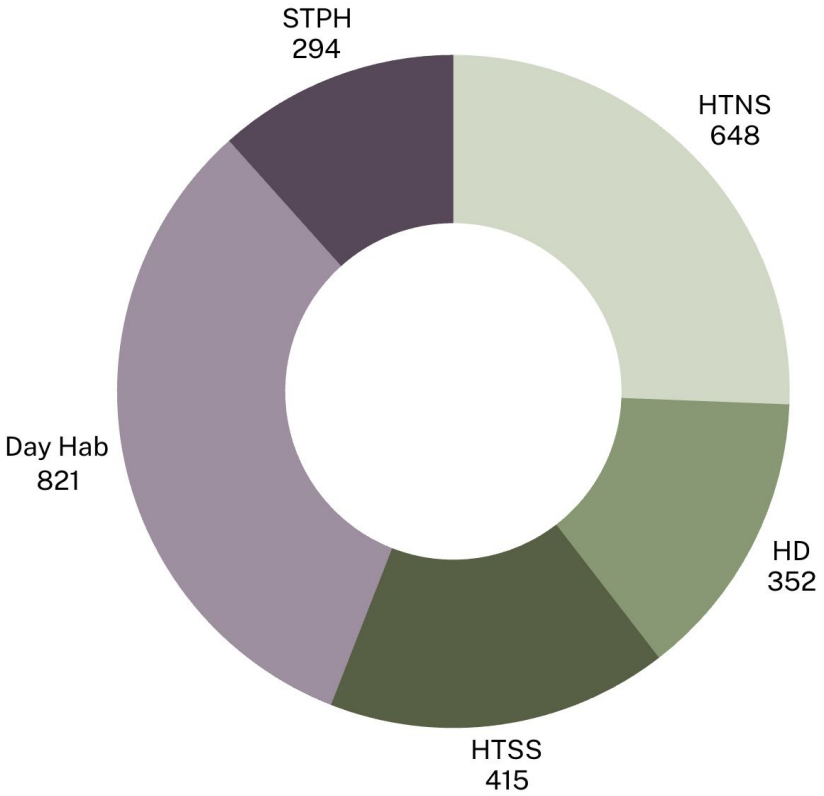
827 Clients served at SM Stabilization Center

993 Clients served at Santa Barbara Sobering Center



Other Community Supports Services

- 648 clients received services from Housing Transition & Navigation Services
- 352 clients received services from Housing Deposits
- 415 clients received services from Housing Tenancy and Sustaining Services
- 821 clients received services from Day Habilitation
- 294 clients received Short Term Post Hospitalization services



- Services rendered primarily face to face
- Best practices:
  - ECM - contact at minimum once per week
  - Housing Navigation/Sustaining - contact at minimum twice per month
- STPH services implemented at 11 shelter programs county wide
- Day Hab services implemented at 11 shelter programs countywide + permanent supportive housing programs
- ECM and Housing Trio services implemented throughout all shelter, residential treatment, outreach and housing programs
- Wraparound services implemented as much as possible
  - Example: ECM + Day Hab + RCP + HTNS + HD = client success!

ECM/HTNS

The Housing Navigation Team has been actively supporting this individual through HTNS services, in collaboration with shelter staff providing Enhanced Care Management (ECM). This client presents as a complex case, living with a serious mental illness that has significantly impacted his life since early adulthood. His most recent episode of homelessness began after the sale of his home, which was triggered by a divorce and unresolved back taxes.Through the ongoing, coordinated efforts of Housing Navigators and ECM Case Managers, the client received consistent and compassionate support. Utilizing motivational interviewing techniques and the principles of radical acceptance, the team was able to help the client shift his perspective—ultimately leading to his decision to accept the proceeds from the sale of his home.With these funds, he was able to purchase a new home and is now receiving housing retention services through Good Samaritan Shelter. This client has been enrolled in the Housing Navigation Team (HNT) program for over 18 months.

HTNS/HTSS/ECM

The Housing Navigation Team has been providing ongoing support to this client through HTNS services. Her episode of homelessness was triggered by domestic violence and the recent loss of her mother. Despite these challenges, she was rapidly housed with the assistance of housing deposit funds and is now focused on achieving long-term self-sufficiency. Previously a Registered Nurse, she allowed her license to lapse due to personal hardships and a single criminal conviction. Now safely housed and engaged in Housing Retention Services, she is working closely with the Department of Rehabilitation to pursue a Bachelor of Science in Nursing. Her goal is to further her education and reinstate her RN license. She is also actively enrolled in Enhanced Care Management (ECM) services, receiving additional support as she continues her journey toward stability and independence.

Client Stories

SOBERING CENTER

We had a married couple show up together, but came in separately. They were both unhoused, and heavy alcohol and meth users. We connected the wife with outreach, and then she went to Dignity Moves shelter, got a job at UPS, and recently graduated from the culinary program at Good Sam. We helped her husband get into the Santa Barbara Rescue MIssion residential treatment program and he just graduated from their 1 year program in July. They are both still clean and sober.

STPH/HTNS

Client has resided at Safe House in an STPH since 12/2024 and was connected to HTNS services. She is on disability and has had many medical issues arise during her time here and has been receiving STPH services. Despite all her medical concerns she keeps her head up and continues to look for housing. She just received exciting news that she was selected to get permanent housing in an apartment in Santa Maria. We are all very excited to see her grown and transition to her new life out of the shelter.

Permanent Supportive Housing - the power of HTSS

"Joe," was struggling with a high-paced work environment and new housing responsibilities as a young adult at Buena Tierra when we first met him. Joe had barely engaged in services with Good Samaritan after experiencing homelessness, and was hesitant to reach out for support. He was struggling with budgeting, often missing rent due to overspending, and was in jeopardy of losing his housing.

Upon gaining trust with case management supports over the first few months, we suggested he may benefit by enrolling in HTSS to identify personal goals, and receive support in achieving them, one step at a time. Joe agreed to enroll in HTSS, and discussed current goals and obstacles. He shared he was struggling with his mental health. With support from the Good Samaritan team, we offered to connect Joe in receiving mental health support from the Crisis Stabilization Unit.

From there, Joe identified he was unable to manage the fast-paced work environment he was at, and wanted to take time to reset and look for new employment. Joe started attending regular therapy appointments, and worked with us to find a more fitting job. He started meeting weekly to discuss current goals, one of them being new employment, after stabilizing his mental health. Joe discussed coping skills that worked for him and got a new job at a retail store that was much more fitting.

From there, Joe started working on budgeting with and came up with a payment plan to pay his overdue rent and save money monthly. Joe then transitioned into going to SBCC part-time, while continuing to work part-time.

Joe is now in good standing at Buena Tierra, and reports being very happy with his recent accomplishments being enrolled in HTSS and receiving regular support. Joe is currently saving money to potentially move into his own housing or buy a car, and reports being proud of what he's accomplished so far!

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CalAIM Renewal Concept Paper

Background and Purpose

- In July 2025, DHCS released the “Continuing the Transformation of Medi-Cal” Concept Paper outlining its vision and goals for Medi-Cal beyond 2026
- The plan continues DHCS’ transformation efforts from CalAIM to make Medi-Cal **more coordinated, person-centered, and equitable**
- While the Medicaid waivers that created CalAIM expire at the end of 2026, California plans to apply for a renewal to enable CalAIM programs to continue

Key Goals for the Renewal Period (2027-2031)

Centering Members in the Delivery System

Ensure Medi-Cal policies and initiatives are member-centered, focusing on improving their access to care and health outcomes.

Improving Eligibility and Enrollment

Streamline and improve application and eligibility processes to ensure timely and accurate enrollment for all eligible members.

Comprehensive Purchasing Strategy

Develop a Medi-Cal purchasing strategy that incentivizes high-quality care, ensuring it’s delivered at the right time and cost.

Key Goals for the Renewal Period (2027-2031)

Increasing Data Sharing

Improve data sharing and coordination among Medi-Cal plans, providers, and community partners to enhance care coordination and member outcomes.

Strengthening Accountability

Improve accountability across managed care, fee-for-service, and behavioral health services to enhance access and quality of care.

Preparing for the Future

Ensure the Medi-Cal system is prepared to meet the health needs of California's aging population and continue to evolve through 2030

CalAIM Waiver Renewal

- Federal waiver authority is **not** required to continue ECM or 12 Community Supports categorized as In Lieu of Services (ILOS).
  - Concept paper: *"No Section 1115 or 1915(b) authority is needed for California to operate ECM."*
  - Concept paper: *"Community Supports covered as ILOS are not dependent on DHCS' current CalAIM Section 1115 or 1915(b) waiver approvals."*
- DHCS proposes to continue and strengthen several services in the next waiver, including the Justice-Involved Reentry Initiative, Community-Based Adult Services, Traditional Healers, and more.

CalAIM 2027-2031 Waiver Renewal Plan

☑ Will be renewed under waiver authority:

- Section 1115: Recuperative Care, Short-Term Post-Hospitalization Housing, Contingency Management, Aligned Enrollment for Dually Eligible Members, Limiting Managed Care Plan Choice, IMD Waiver for SUD Services, Chiropractic from IHS/Tribal Facilities, Out-of-State Former Foster Care Youth, Global Payment Program, Asset Test Modification (Deemed SSI)
- Section 1915(b): Medi-Cal Managed Care (statewide), Dental Managed Care (Sacramento), Specialty Mental Health Services, DMC-ODS program.

⇆ Will transition to other CMS-approved authority (not renewed in waiver):

- Enhanced Care Management (ECM) – operates under managed care authority.
- 12 Community Supports (ILOS) – operate under managed care authority.

⃠ Will not be renewed in waiver:

- PATH Initiative, DSHP (to support PATH), Extended Postpartum Benefits for Low-Income Pregnant Women.

DHCS Waiver Renewal Estimated Timeline

July 2025
Release of Concept Paper

Oct./Nov. 2025
Post Draft 1115 Waiver Application

January 2026
Submit Application to Federal Government (CMS)

July 2026
Target Approval Date

January 2027
New Waiver Launch

CalAIM Renewal Concept Paper: Public Comment

It is open for public comment

through August 22, 2025.

Comments should be submitted to

1115Waiver@dhcs.ca.gov.

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Looking Towards 2026

2026 Dates and Milestones

January 2026

- Technical Assistance Marketplace Closes for new applications
- Transitional Rent Go-Live Date
- DHCS CalAIM Renewal submission to federal government
- Medi-Medi Plans (D-SNP) Expansion Statewide

January 31, 2026: Data Exchange Framework (DxF) Milestone

- Voluntary Signatories to the DxF, including community-based organizations, county agencies, and social services organizations, begin exchanging data

December 31, 2026

- PATH Initiative sunsets

Behavioral Health Connect (BH-Connect) Overview

BH-CONNECT (Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment) is a five-year demonstration intended to expand access to community-based behavioral health care for Medi-Cal members and aims to reduce reliance on inpatient and institutional care.

Core Components and Initiatives

Evidence-Based Practices (EBPs)

- All counties must provide fidelity-based EBPs for children and youth under 21, including High Fidelity Wraparound (HFW), multisystemic therapy (MST), and more, consistent with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and medical necessity
- Counties may opt in to cover select EBPs for adults including Assertive Community Treatment (ACT) and more

Children and Youth Initiatives

Community Transition In-Reach Services*

Populations of Focus

- Children & youth in child welfare
- Individuals experiencing or at risk of homelessness
- Justice-involved individuals

**Counties may opt in to cover, though not required*

Behavioral Health Connect (BH-Connect) Implementation Timeline

Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Q1 2026			**Q2 2026**			**Q3 2026**			**Q4 2026**		

Q1 2026

- Counties submit a draft of their Integrated Plans to DHCS.
- Counties must cover Transitional Rent as a mandatory benefit for Behavioral Health Population of Focus. Coverage for other eligible populations remain optional.

Q2 2026

Counties submit final FY 2026-2029 draft of their Integrated Plans to DHCS.

Q3 2026

July 1, 2026 – County Integrated Plans for behavioral services under BH-CONNECT become effective statewide.

- Behavioral Health Services Act goes into effect.
- DHCS, in collaboration with stakeholders, will also publish biennial lists of approved evidence-based and community-defined practices.
- Required elements and timelines for County Behavioral Health Outcomes, Accountability, and Transparency Reports are established by DHCS.

Q4 2026

DHCS will launch the service to track the availability of inpatient and crisis stabilization beds statewide as part of enhanced transparency and system reform.

Go-Live Date

High Fidelity Wraparound (HFW) Concept Paper: Public Comment

It is open for public comment

through 5 pm P.T. on August 28, 2025.

Comments should be submitted to **BH-CONNECT@dhcs.ca.gov** with the subject line:

Comments on Proposed Medi-Cal HFW Service Requirements Aligned with National Practice Standards

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Q&A

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MCP Updates

Recent TA Marketplace Updates (as of June)

- DHCS is applying four new limitation criteria for current and new Project Eligibility Applications (PEAs), and Scopes of Work (SOWs), and Budgets in the review queue and any projects moving forward:
  1. Projects will be approved only for ***new*** TA Recipients, unless applying for Transitional Rent Support or as determined by DHCS
     - Note that organizations that participate in a TA project with a HUB or HUB-like entity are allowed to have their own independent project so long as they adhere to the other criteria.
  2. Limitation of one TA Project per TA Recipient
     - If a TA Recipient submits a batch of projects, they will be required to work with the TA Vendor to select the one project they wish to pursue that meets their immediate TA needs.
  3. Limit TAM Projects to Non-Contracted TA Recipients Needing Contracting Support
     - TA Recipients that are not yet contracted with a managed care plan for ECM and/or Community Supports will be required to provide a rationale for how their proposed TA project will support their contracting efforts. For example, a Recipient may have a project in Domain 1 to support their workflows to prepare for billing to an MCP for ECM services. The Recipient and Vendor should note that this is a requirement to become contracted with the MCP.
  4. TA Projects may not exceed $150K and must be within one year
     - TA Vendors and Recipients should work together to create a TA project application that meets a Recipient's most immediate needs within these requirements.
- Projects that do not meet the criteria above will either be sent for rework or not be accepted.
- Please note that projects must also meet the policies outlined in the TA Vendor Policy Guide and TA Recipient Policy Guide.

Resources for Supporting Immigrant Communities

NATIONAL IMMIGRATION LAW CENTER

Health Care Providers and Immigration Enforcement: Know Your Rights, Know Your Patients' Rights

805UNDOCUFund

805 Immigrant Rapid Response Network Resources (English and Spanish) and Upcoming Trainings

SAFE & SOUND

Migrant Family Safety Plan Toolkit (English and Spanish)

DHCS Community Supports Cost Report

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

- Members who used at least one of the **Housing Trio Community Supports (which includes Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services)** had reduced inpatient (24.3%) and emergency department use (13.2%) in the six months that followed receipt of the service(s).

The recently published DHCS Community Annual Report highlights the cost-effectiveness of Community Supports and their impact on reducing ED visits, hospitalizations, and long-term care

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Questions?

Volume 1 Community Supports Revisions

- DHCS released updated Community Supports definitions for the following services in February 2025, with minimal changes released in April:
  - Assisted Living Facility (ALF) Transitions
  - Asthma Remediation
  - Community or Home Transition Services
  - Medically Tailored Meals/Medically Supportive Food
  - Personal Care and Homemaker Services (PCHS)
- These new definitions are effective **July 1, 2025**
- Added **HCPCS Codes** for all Community Supports definitions

Community Supports With No Significant Updates (Volume 1)

- The following services do not have major definition updates:
  - Environmental Accessibility Adaptations (Home Modifications)
  - Respite Services
  - Sobering Centers

Community Supports Revisions: Medically Tailored Meals Definitions

Medically Tailored Meals (MTM): Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

Medically Tailored Groceries (MTG): Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

Community Supports Revisions: Medically Supportive Food

Medically Supportive Groceries: Preselected foods that follow the DGA* and meet recommendations for the recipients' nutrition-sensitive health conditions.

Produce Prescriptions: Fruits and vegetables, typically procured in retail settings, such as grocery stores or farmers' markets, obtained via a financial mechanism such as a physical or electronic voucher or card.

Healthy Food Vouchers: Vouchers used to procure pre-selected foods that follow the DGA* and meet recommendations for the recipients' nutrition-sensitive health conditions, via retail settings such as grocery stores or farmers' markets.

Food Pharmacy: Often housed in a health care setting, providing patients with coordinated clinical, food, and nutrition education services targeted at specific nutrition-sensitive health conditions. The healthy food "prescription" includes access to a selection of specific whole foods appropriate for the specific health condition(s) that follow the DGA* and meet recommendations for the targeted health condition(s).

*DGA = Dietary Guidelines for Americans

Community Supports Revisions: Eligibility Criteria

Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to):

Cancer(s) Cardiovascular disorders Chronic kidney disease Chronic lung disorders or other pulmonary conditions such as asthma/COPD Heart failure Diabetes or other metabolic conditions Elevated lead levels End-stage renal disease, High cholesterol Human immunodeficiency virus Hypertension	Liver disease Dyslipidemia Fatty liver Malnutrition Obesity Stroke Gastrointestinal disorders Gestational diabetes High risk perinatal conditions chronic or disabling mental/behavioral health disorders

Community Supports Revisions: Asthma Remediation

- Asthma Self-Management Education and In-Home Environmental Trigger Assessments are now covered under the Asthma Preventive Services (APS) Benefit (transition effective January 2026)
- Streamlines eligibility and documentation requirements
- Clarifies eligible supplies
- Confirms that supplies do not need to be delivered at a single point as long as service complies with $7500 lifetime maximum

Community Supports Revisions: Nursing Facility Transition

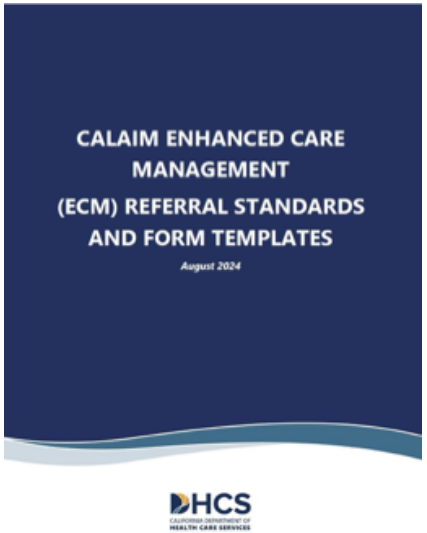
- Clarifies that members residing in private residences or public subsidized housing can be eligible for this support
- Clarifies that there are two distinct components of this Community Support:
  - Time-limited transition services and expenses
  - Ongoing assisted living services (not room and board, but support with Activities of Daily Living, meal prep, transportation, companion services, etc)

Community Supports Revisions: Community Transition Services

- Clarifies that members may receive Housing Transition Navigation, Housing Deposits, and/or Home Modifications at the same time as Community Transition Services
- Clarifies that there are two distinct components of this Community Support:
  - Transitional coordination services (securing housing, landlord communication, etc.)
  - One-time set-up expenses (security deposits, utility set-up fees, air conditioner or heater, etc.)

ECM Referral Standards and Form

DHCS developed new ECM Referral Standards and Form Template to streamline and standardize ECM Referrals made to Managed Care Plans (MCPs) from providers, community-based organizations, and other entities.



The new ECM Referral Standards define the information that MCPs are expected to collect for Medi-Cal members being referred to an MCP for ECM.

The new **ECM Referral Form Templates** are forms for use by MCPs and referring organizations that prefer a PDF or hard copy form to make a referral.

ECM Referral Standards and Form

The ECM Referral Standards and Form Templates define the following:

- Medi-Cal Member Information
- Referral Source Information
- Eligibility Criteria for Adults and Children/Youth
- Enrollment In Other Programs
- Referral Transmission Methods – including guidance encouraging batch referrals

***Note: The ECM Referral Standards will not change the existing processes for the MIF and RTF.**