Tri Counties CalAIM PATH Collaborative

October 21, 2026

BluePath HEALTH

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Housekeeping

- Please ensure you are **muted**
- **Use the chat** to ask questions relevant to the topic(s) at hand
- Unmute and share your questions or comments during **Q&A**
- Add your organization to your Zoom Name
    - Click **Participants**, hover over your name in the list and click **More**, select **Rename** from the drop-down menu, and enter your name and organization as you would like it to appear

Meeting Calendar
January 21
February 18
March 18
Week of April 13th (in-person)
May 20
June 17
July 15
August 19
Week of September 14th (in-person)
October 21
November 18
December 16

Meeting slides will be shared with participants and posted to our resource center

Thank you for joining us in September!



In September, BluePath Health hosted two in-person convenings. Provider spotlights highlighted relationship-building and collaboration, themes that carried into our provider networking segments. Thank you to **Gold Coast Health Plan**, **Kaiser Permanente**, and **CenCal Health** for sharing timely updates!



Meeting Materials

9/17 Ventura Slides

9/23 SB/SLO Slides

Today's Agenda

Time	Agenda Item	Presenter(s)
10:00-10:05 am	**Welcome and Introductions**	BluePath Health
10:05-10:35 am	**Outreach to Sustainability: Panel Management**	Primary Care Development Corporation
10:35-11:00 am	**Regional-Specific Updates** • **[BREAKOUT ROOM]** CenCal Health Plan Updates • **[MAIN ROOM]** Behavioral Health Services Act (BHSA) Integrated Plan Updates - Courtney Lubell	

We invite you to follow along!

In March, we covered the following financial sustainability tools:

- Institute for Healthcare Improvement (IHI) and Healthy Connected Communities Strategies' Funding and Implementation worksheet
- Camden Coalition's Budget Estimator
- BluePath Health's Financial Reconciliation Tool.

For today's session, navigate to **Tri Counties CalAIM Resource Center** and find the resource that we'll cover during today's segment under "Financial Sustainability Tools:"

Primary Care Development Corporation's Panel Management Tracker

*All resources can be found at the **Tri Counties CalAIM Resource Center**.*

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Financial Sustainability Tools Overview: From Outreach to Sustainability

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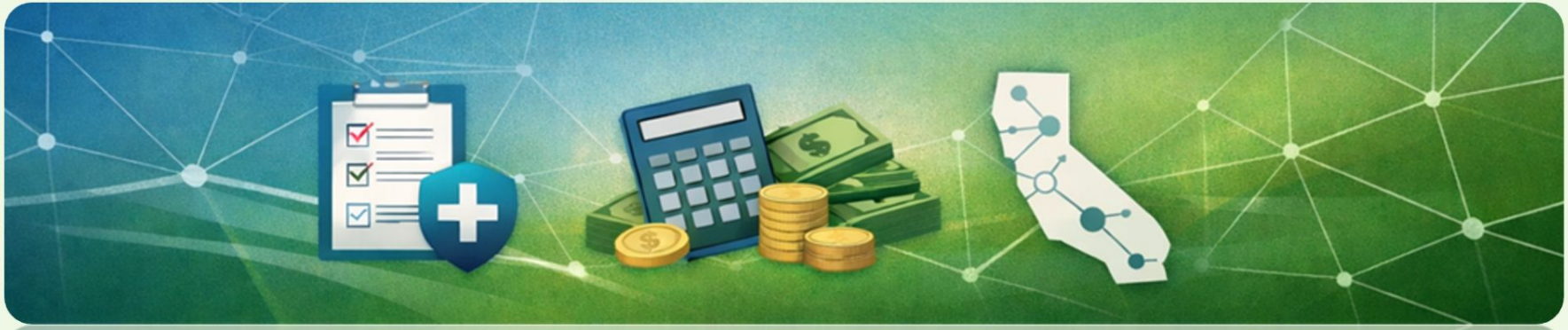


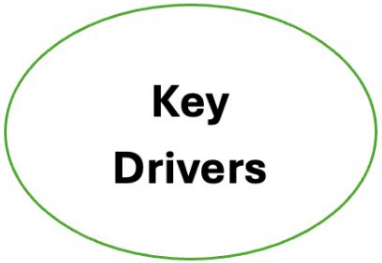
From Outreach to Sustainability

October 21, 2026

Primary Care Development Corporation

Image Source: OpenAI (ChatGPT)

Changing CalAIM environment



A HR1 and other federal policy changes are creating uncertainty for Medi-Cal providers.

B Financial pressures are increasing the need to maximize existing resources.

C DHCS and Managed Care Plans continue to emphasize accountability through performance reporting and measurable outcomes.

D Organizations need reliable operational data to monitor performance and support long-term program sustainability.

The Sustainability Challenge

1	Grant cycles and pilot funding create start-stop programs that end when the funding does.
2	Payment models keep shifting — from grants and pilots to PMPM and value-based arrangements.
3	CalAIM providers face rate pressure and evolving Managed Care Plan contract expectations.
4	Programs that cannot demonstrate financial viability struggle to survive budget scrutiny.

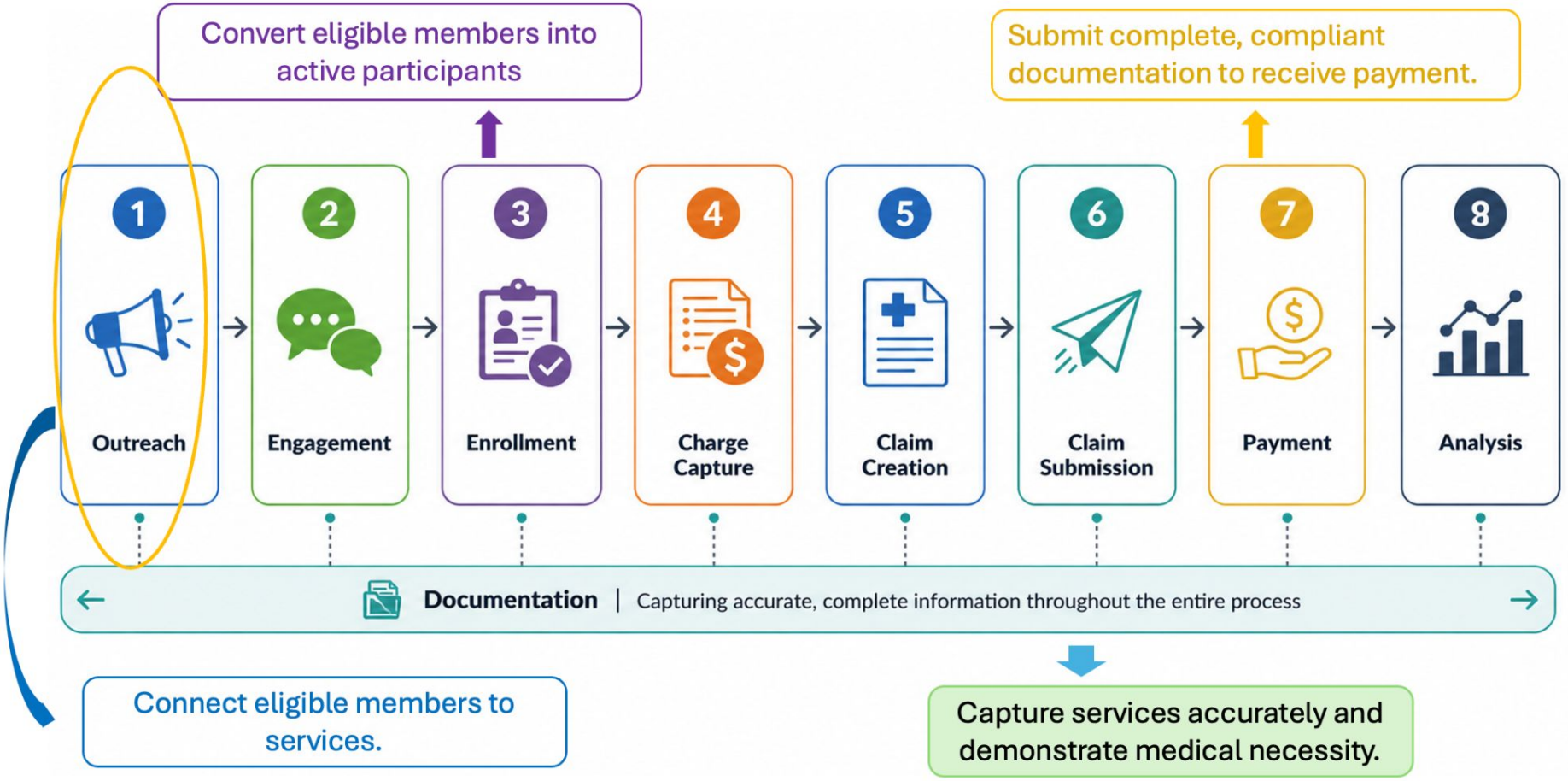


Image Source: OpenAI (ChatGPT)

Outreach to Enrollment

Well managed

- ✓ Increases successful client engagement and enrollment
- ✓ Improves referral conversion rates
- ✓ Reduces delays in service initiation
- ✓ Strengthens documentation and compliance
- ✓ Improves operational performance and financial sustainability

Poorly managed

- Fewer eligible clients enroll
- Staff spend more time on repeated outreach attempts
- Referrals become delayed or expire
- Documentation gaps increase compliance risk
- Downstream care coordination and reimbursement are affected

Common Operational Outreach Challenges

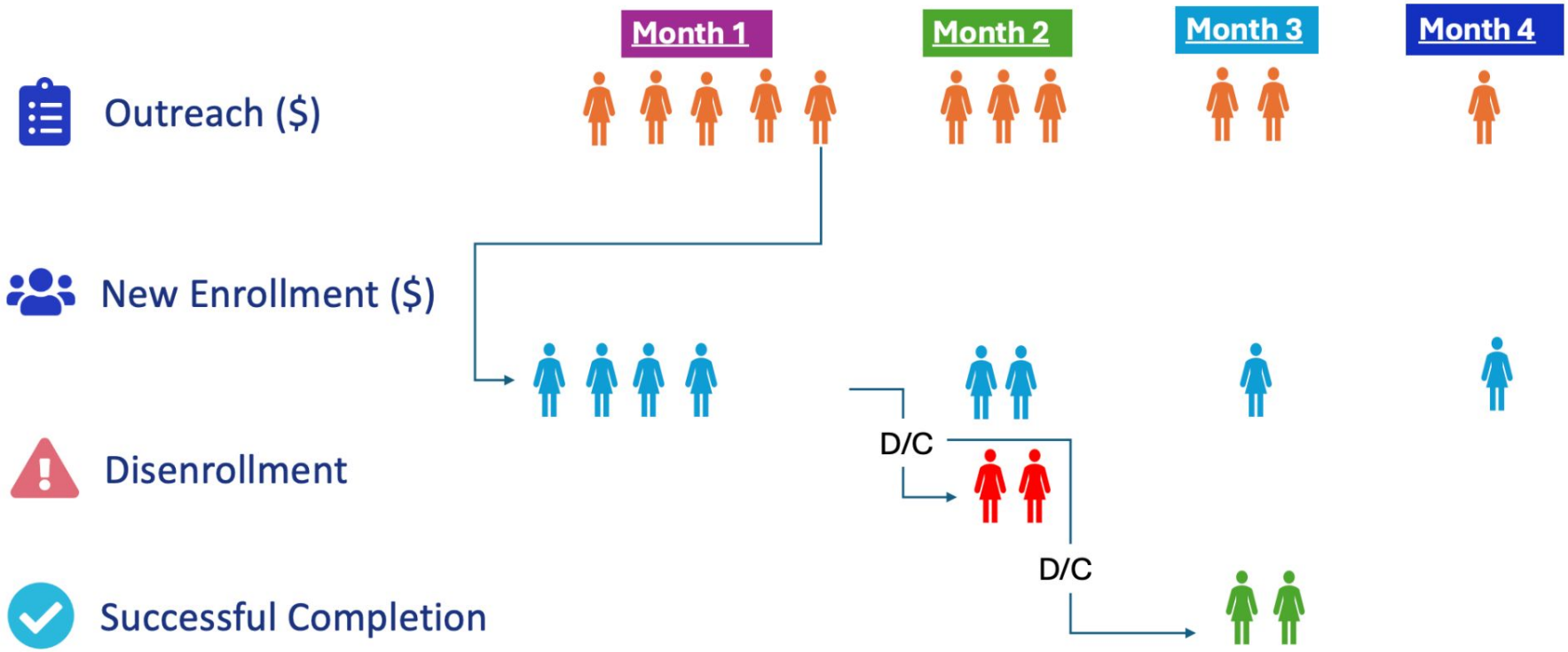
Multiple referral pathways with limited standardization

Inconsistent tracking of outreach and referral activity

Limited visibility into referral volume vs. enrollment yield

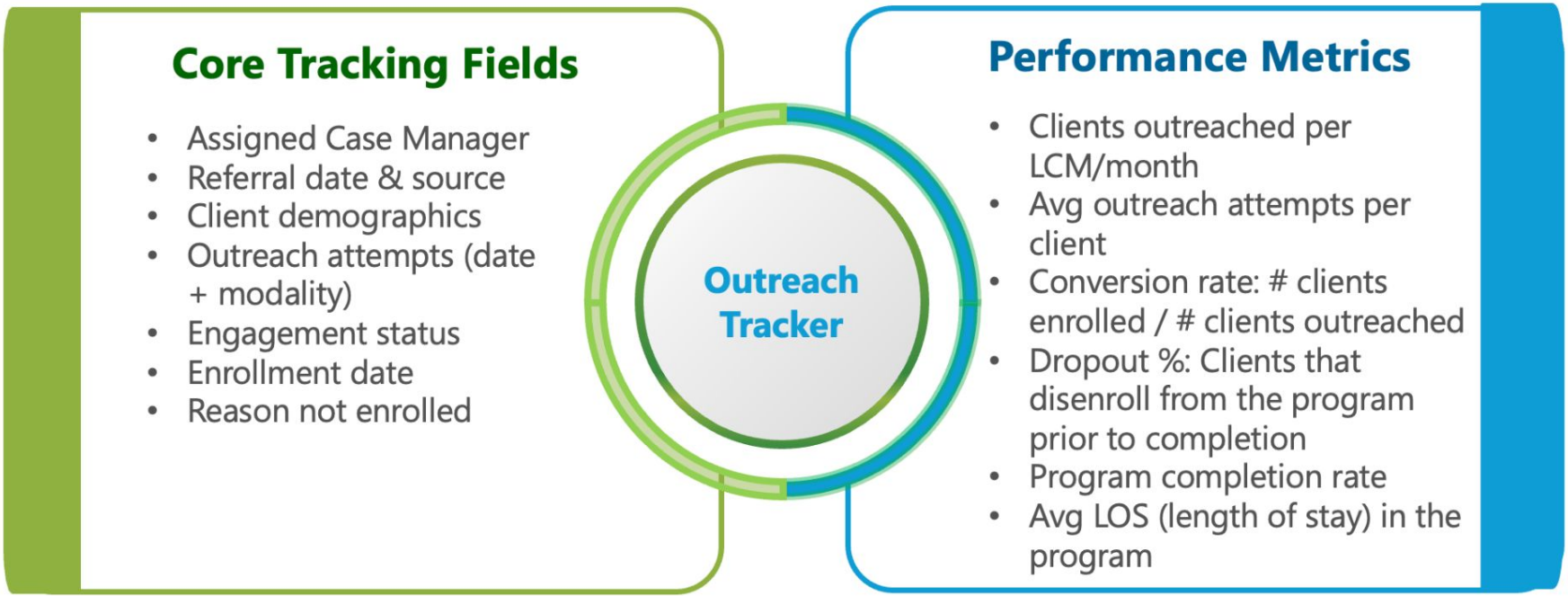
Difficulty understanding where and why conversion breaks down

Outreach Funnel -> Panel Management



Track performance as members move through the program. These metrics drive financial performance.

What Should an Outreach Tracker Include?



Acuity & Panel Management

Panel sizes must be both financially sustainable and clinically manageable.

Acuity = the level of medical complexity and care intensity a member requires.

We recommend structuring panels to maintain a balanced mix of higher- and lower-acuity members, supporting:

- Workload stability — distributing clinical demand evenly across care teams
- Quality outcomes — ensuring appropriate attention and resources for all acuity levels
- Revenue predictability — maintaining a consistent and sustainable payer/risk mix

Acuity Score	Definitions
1	One touch per month
2	Two touches per month
3	Three touches per month
4	Four touches per month

Month	Jul-25	Aug-25	Sep-25
Total Clients (Total clients assigned to each case manager)			
RN Care Manager	1	1	1
BH Care Manager	2	2	2
Care Coordinator	0	0	0
Community Health Worker	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total Clients	3	3	3
Acuity Score (Calculated by adding total acuity of each client assigned to each case mana			
RN Care Manager	3	4	4
BH Care Manager	8	8	8
Care Coordinator	0	0	0
Community Health Worker	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total Acuity	11	12	12

Source: Definitive Healthcare, n.d.

Outreach Tracker Tool

Assigned Care Manager	Status	Referral Source	Auth Start Date	Auth Exp. Date	Auth No	Language	Phone Number	MRN	First Name	Last Name	DOB	Date of 1st Attempt	1st Method	1st Result
Maria Garcia	Engaged - Scheduling	MIF File	01/15/2025	07/15/2025	AUTH-202501:	Spanish	(555) 123-4567	MRN-00421	Joe	Smith	03/22/1978	01/16/2025	Telephonic	No Answer



The tracker is not just a log — it's structured data that drives performance metrics and financial decisions.

Lessons from the Field: What Stronger Programs Do Differently

- Drawing on experience supporting CalAIM providers:



Making CalAIM Work For Your Bottom Line

Contract Assumptions	Know your revenue streams: PMPM rate, outreach and enrollment, quality incentives. Understand panel size commitments, and what services are covered.
Outreach-to-enrollment Conversion	This is your #1 leading indicator. Low conversion = shrinking panel = declining revenue.
Panel Size & Staffing Ratios	Match staffing to realistic caseloads. Overloading care managers drops engagement, hurting quality and billing.
Billing Timeliness & Performance	Ensure claims are submitted timely and that all eligible services are being billed.
Productivity and Service Utilization	Make sure your team knows what your organization offers and has a workflow to connect members to all eligible services.

Reframing the Question

Old Question

"Can we afford this program?"

Treats the program as a fixed cost to absorb	Invites a yes/no decision with little nuance	Ignores levers like volume, payer mix, and rates	Framed around a single budget year

New Question

What does this program need to sustain itself?"

Defines the volumes, rates, and staffing that make the math work	Opens strategic options instead of a yes/no decision	Surfaces the levers leadership can actually pull	Supports multi-year planning, not just this budget cycle

Key Operational Takeaways

Track outreach and engagement intentionally

Right-size and structure staffing strategically

Model financial sustainability before scaling

Standardize workflows early

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Please complete the evaluation!

Your feedback helps us improve our trainings and plan future learning opportunities.

Scan
Open your camera and scan the QR code.

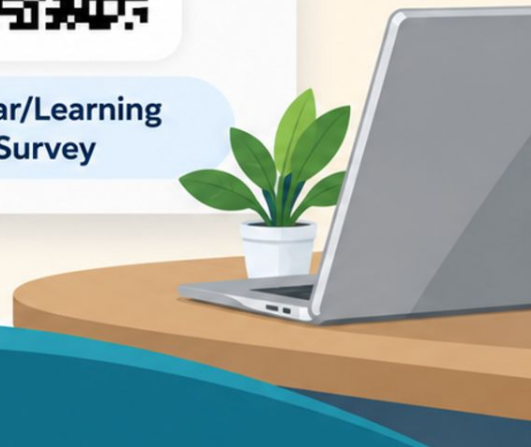
Share
Complete the short survey (2–3 minutes).

Make a difference
Help us create more relevant and impactful content.

Scan me!

Post-Webinar/Learning Session Survey

Your feedback matters!



Contact us

We’re here to help!
Reach out to our team.



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Primary Care Development Corporation

Thank you!

Regional-Specific Updates

Join **Room #1** if you work in San Luis Obispo and/or Santa Barbara Counties.

Stay in the **main session** if you work in Ventura County.

*Note: Meeting recordings will be available on our **Resource Center**.*

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Behavioral Health Services Act (BHSA) Updates

Courtney Lubell, Special Projects BHSA Manager

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A Department of Ventura County Health Care Agency

Fall 2026

BEHAVIORAL HEALTH SERVICES ACT (BHSA) COMMUNITY PLANNING PROCESS (CPP)

Community Town Halls on the Future of Behavioral Health Care

Courtney Lubell, MA, PMP
BHSA Manager

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OVERVIEW OF PROPOSITION 1 AND THE BEHAVIORAL HEALTH SERVICES ACT (BHSA)

What is the BHSA?

Origin: Approved by voters as Proposition 1 in March 2024, taking full effect July 1, 2026.

Purpose: Modernizes and renames the old Mental Health Services Act (MHSA) without changing the 1% tax on personal income over $1million.

Core Focus: Targets individuals with the most serious behavioral health and mental health needs.

BHSA Requirements: Funding Allocations



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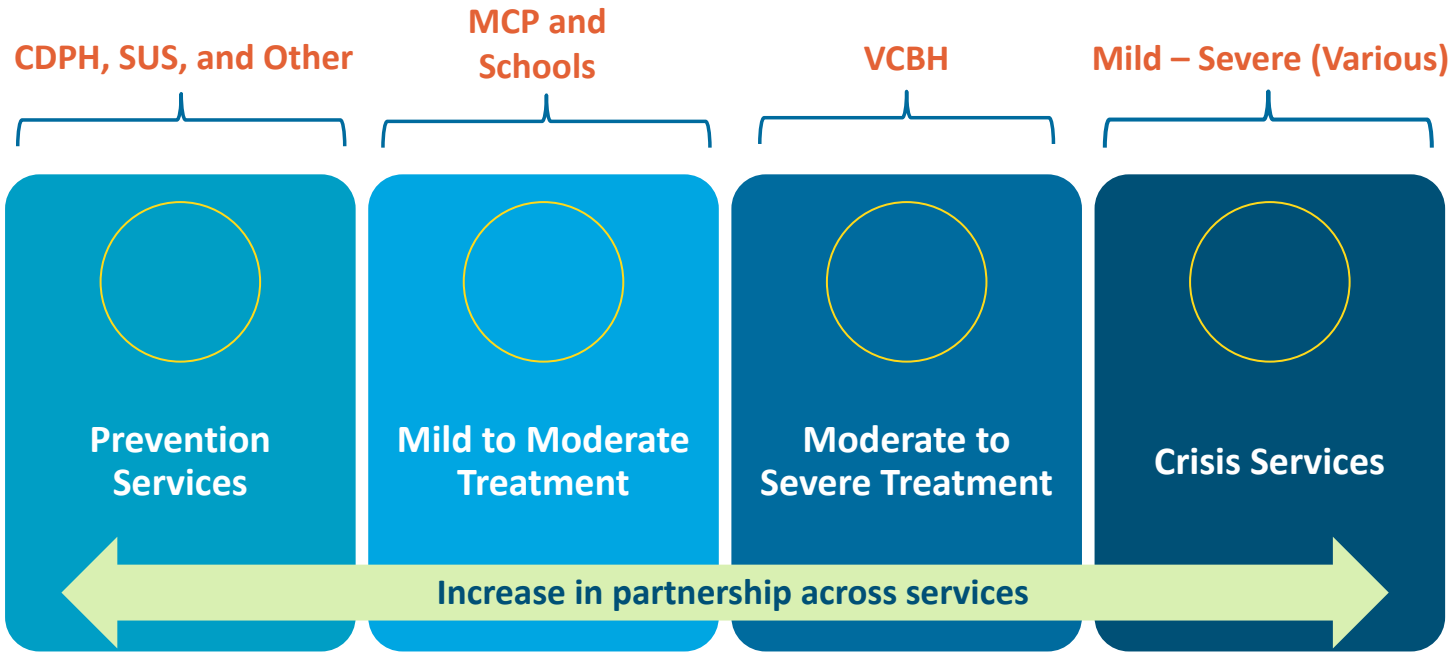
MHSA to BHSA Structural Comparison

Feature	MHSA (old)	BHSA (new)
Scope	Mental Health Conditions Only	Mental Health **+ Substance Use Disorders (SUD)**
Housing Funds	No mandatory county-wide set-aside	**30% mandatory set-aside** for housing
Prevention Oversight	Managed at local County level	**Moved** to state Level (CDPH)
Innovation	Mandatory stand- alone fund category	**Eliminated**; Integrated as an option into other services
Evidence Based Mandates	Not mandated	**Requires** several EBP to adhere strictly to state –defined fidelity standards
Data and Tracking	Fragmented county by county data	**Uniform** Individual Service Level (ISL) Reporting and overall Medi-Cal report out

Improving Partnerships to Meet BH Needs



CDPH: California Department of Public Health
SUS: VCBH Substance Use Services
MCP: Managed Care Plans

Beyond the BHSA

Service Eligibility and Service Criteria

Who Qualifies for County Behavioral Health Services

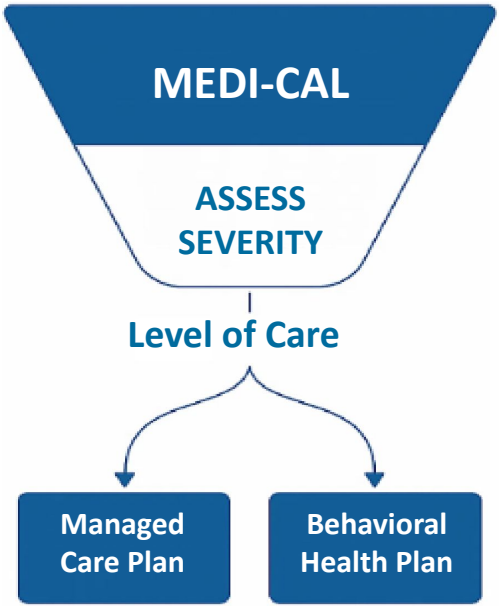
Must be **Medi-Cal eligible** and meet **medical necessity criteria** for Specialty Mental Health or Drug Medi-Cal Organized Delivery System services.

Determined by **diagnosis**, **functional impairment**, and **intensity of need** per Title 9 of California Code of Regulations and California Department of Health Care Services criteria.

Individuals with commercial insurance, Medicare-only, or other non-Department of Health Care Services contracts are **not eligible for California Department of Health Care Services contracted care** unless specified under certain public-safety or Behavioral Health Services Act programs.

Uninsured individuals may be eligible through Realignment or Behavioral Health Services Act safety-net funding when they meet Serious Mental Illness or Substance Use Disorder criteria.

Eligibility Funnel



The County Safety-Net Function

Who the County Serves as Safety Net

- Medi-Cal beneficiaries meeting California Department of Health Care Services criteria for specialty behavioral health or substance use disorder treatment.
- Uninsured residents with serious mental illness or a substance use disorder when funding is available through non-Medi-Cal sources.
- Individuals under court or public-safety mandate: Community Assistance, Recovery, and Empowerment (CARE) Act; Lanterman-Petris-Short (LPS) conservatorship; forensic diversion.

Who We Do *Not* Serve as Safety Net

- Individuals with **commercial or employer-based insurance**.
- Individuals whose needs fall within the **Managed Care Plan's mild-moderate** scope.
- Populations covered under **non-Department of Health Care Services contracts** (e.g., private insurance, non-Medi-Cal Employee Assistance Programs).

The County is not a general behavioral health provider — it is the **specialty safety net** for the Medi-Cal system and other public-mandate populations.

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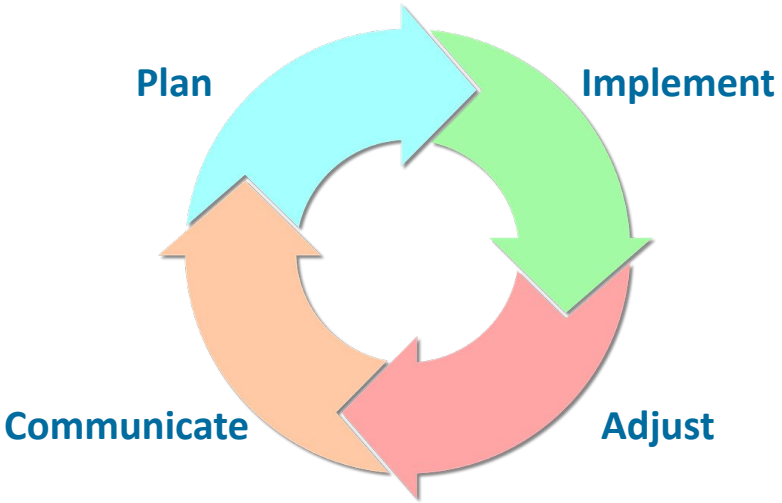
INTEGRATED PLAN OVERVIEW

BHSA Integrated Plan Overview



- Serve as a three-year, countywide BH spending and service plan (FY26-27-FY28-29)
- Align with statewide and local goals to improve outcomes and reduce disparities
- Promote equity and culturally responsive care
- Demonstrate transparency and accountability

How will the Integrated Plan be updated?

Annual updates with a formal BHSA Local Planning Process every three years



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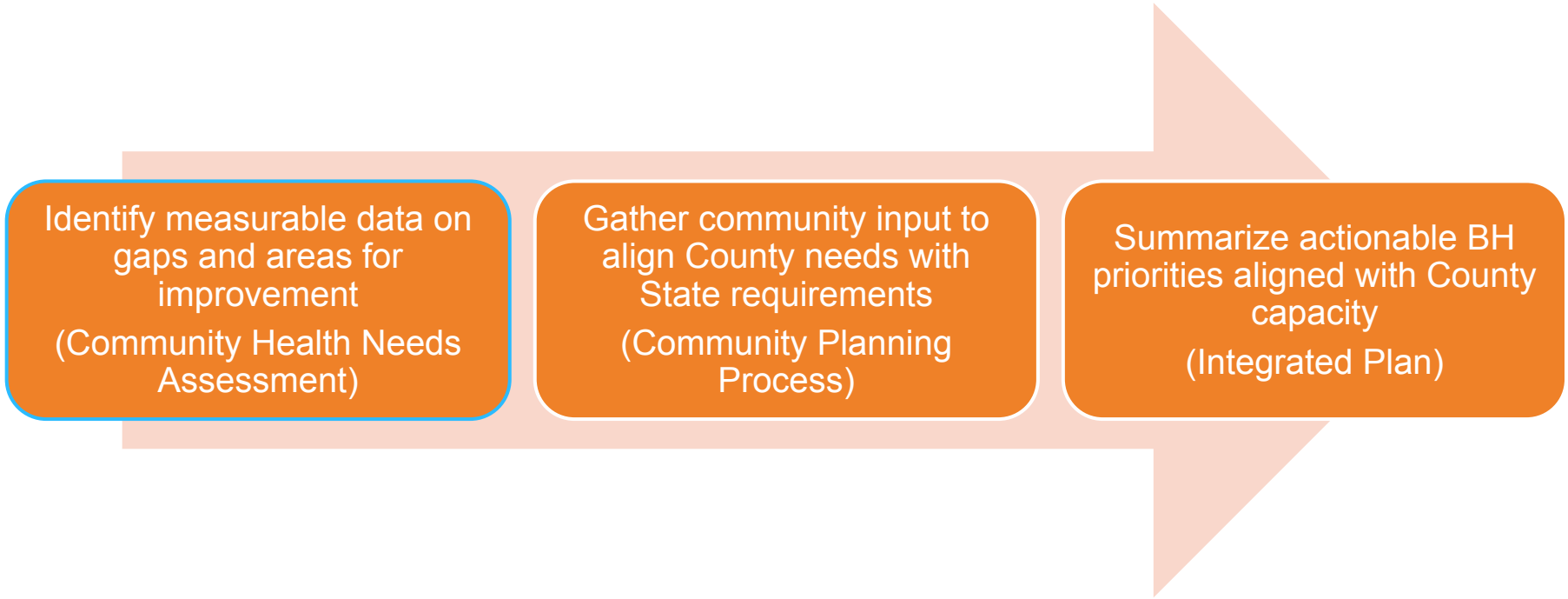
How did Ventura County arrive at an Integrated Plan?



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HOW THE INTEGRATED PLAN ADDRESSES STATE AND LOCAL GOALS

CPP Summary: 4 Areas and 10 HMA Recommendations

System Coordination

- Create or enhance a cross-agency referral and navigation system.

Access and Quality of Care

- Advance culturally and linguistically responsive care, alongside tailored intensive services to specialized populations.
- Guarantee seamless transitions between levels of care.

Workforce Development

- Integrate peer specialists across all levels of care.
- Invest in workforce recruitment and retention.
- Train the BH workforce to meet the needs of specialized populations

Supportive Services and Interventions

- Provide family education to provide resources and support to families.
- Expand non-congregate and gender-responsive housing and include wraparound supports.
- Seek ways to maintain dedicated funding for suicide prevention.
- Preserve VCBH's presence in underrepresented communities, partnering with trusted local CBOs for outreach and education.

VENTURA COUNTY BEHAVIORAL HEALTH

System Coordination - Integrated Plan Examples

System Coordination

Create or enhance a cross-agency referral and navigation system

- **Reinforce** education efforts and community awareness through CBOs for **how and when to connect** to Specialty Mental Health and Substance Use Services**.**
- Leverage the CalAIM Justice-Involved Initiative to strengthen collaboration with the Sheriff's Office and Probation to **increase referrals coming from jail for both adults and juveniles.**
- Increase collaboration with the Superior Court, Sheriff's Office, the Offices of the Public Defender and County Counsel to **expand treatment and services** for those with serious mental illness **under the CARE Act**.
- Facilitate a county-wide effort with participation from the area hospitals (both county and private), law enforcement agencies, Emergency Medical Services, and others to **prepare for the changes to rules governing involuntary holds under Senate Bill 43.**

Access and Quality of Care - Integrated Plan Examples

Access and Quality of Care

Advance culturally and linguistically responsive care, alongside tailored intensive services to specialized populations

Guarantee seamless transitions between levels of care.

- **Grow an FSP for TAY,** an early intervention program for **Veterans**, and **housing supports for seniors**.
- **Introduce Level of Care (LOC) Assessment tool** to improve accurate placement of individuals.
- Embed Youth/Family and adult FSP **Intensive Case Management (ICM) within clinics** for seamless **LOC transitions.**
- **Train clinical staff on specialty populations** (TAY, Veterans, LGBTQ+, and Older Adults)
- Increase Access to Care through the **Mobile Wellness Van**.

Workforce Development- Integrated Plan Examples

Workforce Development

Integrate peer specialists across all levels of care.

Invest in workforce recruitment and retention.

- **Expand Internships** and recruitment of **bi-lingual and bi-cultural students** and those with **lived experience**.
- **Address disparities** in the **workforce internship programs** and stipends may be expanded to include positions such as: Doctoral, Peer, PsychTech/LVN, and Employment Specialists.
- **Expand the number and placement of peers** across all programs and create a training program for staff.
- **Provide targeted trainings that emphasize cultural perspectives** that make up local communities (including: Latinx, Indigenous populations, LGBTQ+, older adults, homeless, dually diagnosed and youth ages 0 to 5).
- **Train** mental health clinical staff on **co-occurring disorders** to **integrate MH and SUS Treatment**.

Supportive Services and Interventions - Integrated Plan Examples

Supportive Services and Interventions

Launch a family education initiative to provide resources and support to families

Expand non-congregate and gender-responsive housing and include wraparound supports.

Seek ways to maintain dedicated funding for suicide prevention.

Preserve VCBH's presence in underrepresented communities, partnering with trusted local CBOs for outreach and education

- Increase and improve **Family Behavioral Health resources and educational efforts** through community engagement and Community Based Organizations (CBOs).
- Launch new **Intensive Case Management Team specifically focused on housing,** serving individuals with serious BH needs who also face chronic homelessness or housing instability
- Create a **new tracking tool to regularly monitor and track data** on referrals and utilization of housing services
- **Expand rental subsides** and investing in **new housing initiatives**.
- **Partner with Public Health** to continue Suicide Prevention efforts.
- **Train and assist** more than 25 Prevention and Early Intervention (PEI) **providers** to assess and support **transition to BHSA**.

VENTURA COUNTY BEHAVIORAL HEALTH

From County Plan to Statewide Goal Performance

How Ventura County's BHSA Integrated Plan is designed to move the numbers DHCS tracks statewide

BHSA Integrated Plan

Ventura County

- Housing Intervention (30%)
- Full Service Partnerships (35%)
- BH Services & Supports (35%)
- Early Intervention & Prevention

Broader Population Reach

Medi-Cal Members

- Earlier identification & care linkage
- MCP Community Supports coordination
- Housing stability & retention
- Fewer crisis-level episodes

Statewide Performance

Goals Reported to DHCS

- BHOATR outcome measures
- Reduced chronic homelessness
- Improved SUD & EI outcomes
- Stronger county scorecard results

Stronger county-level execution of the Integrated Plan is the mechanism by which Ventura County moves its own outcomes — and the statewide measures built from them.

VENTURA COUNTY BEHAVIORAL HEALTH

Phase 2 measures: VCBH and partner performance

ACCESS + UNTREATED CONDITIONS

- 1+ and 3+ BH services for people with MH or significant MH needs
- SUD treatment initiation and engagement (IET-I / IET-E)
- 7-day follow-up after ED visits for substance use or mental illness
- Evidence-based practices for significant MH needs (2029)

INSTITUTIONALIZATION + SUICIDE

- Institutional stays and transition support (2029)
- 7-day follow-up after hospitalization for mental illness
- Deaths by suicide and repeat ED visits or hospitalization for self-harm

CHILD + FAMILY STABILITY

- Foster care involvement and specialty BH services for foster youth
- BH services for parents, guardians and pregnant/postpartum people with significant BH needs
- Wraparound, ECM or intensive care coordination for foster youth (2029)

HOMELESSNESS

- Homelessness among people with significant BH needs
- Housing services for significant BH needs and homelessness risk
- FSP and housing services for that population (2029)

JUSTICE INVOLVEMENT

- Incarceration and repeat incarceration (2029)
- BH services within 14 days of release for eligible reentry enrollees*
- Continued addiction medication within 30 days of release*

CARE EXPERIENCE + EQUITY

- Cultural sensitivity of care in specialty MH and DMC-ODS services
- Disparities in BH services for MH and significant MH needs
- Multi-system involvement among people with BH needs (2029)

Reminder: 6 Statewide and 2 Local Goals



Goals to Improve Well Being
1. Access to care*
Care experience ++
Prevention and treatment of co-occurring physical health conditions
Quality of life
Social connection
Engagement in school
Engagement in work



Goals to Decrease Adverse Outcomes
2. Untreated BH conditions*
3. Institutionalization*
4. Homelessness*
5. Justice involvement*
6. Removal of children from home*
Suicides++
Overdoses

Equity will be embedded across these goals

*6 Required Priority Statewide Behavioral Health Goals
+2 Additional Goals (*County selected based on Community Input*)

VENTURA COUNTY BEHAVIORAL HEALTH

Annual Update IP Changes

Updates we know so far…..

- Moved Board and Care Acquisitions from BHSS to Housing Interventions
- Updated Early Intervention Providers following the Request for Proposal (RFP) awards.
- Clarifying Club House BH-Connect Opt-in
- Updated Gold Coast Community Reinvestment section
- Updating Phase II Statewide Performance Measures
- Updating all client #'s based on FY24-25 for Year 2.
- Updated IP Budget for Year 2 only.
- Updating all new DHCS required sections (Cultural Competency Plan, etc).

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COMMUNICATING AND ENGAGING THE COMMUNITY

SUGGESTIONS FOR THE NEXT STAGE

Community Planning Process (CPP): MHSA to BHSA

	MHSA (Foundation)	BHSA (Current)
Governing Plan	Three-Year Program & Expenditure Plan, with required Annual Updates	Three-Year Integrated Plan (IP); Annual Updates continue but no longer require a full CPP
Planning Cycle	Community Program Planning Process (CPPP) — conducted annually	Community Planning Process (CPP) — tied to the IP, every three years
Scope of Engagement	County-level input focused solely on MHSA priorities	Broader county & regional planning; integrates with public health and Medi-Cal managed care partners
Statewide Accountability	No statewide outcome-goal alignment requirement	Must align with DHCS's 14 statewide behavioral health goals; performance tracked via BHOATR
Approval Path	BHAB review → Board of Supervisors approval → DHCS submission	30-day public comment → BHAB public hearing → CEO approval → BOS approval → DHCS submission (by June 30)

Discussion: What would you like to see as part of future Community Engagement and Opportunities for Input?

Town Halls open to anyone

(In-person and online)

In Reach to existing meetings and forums

Focus Groups with specific stakeholders or populations

Online Surveys and Public Comment Pages

How do you want to be engaged?

VENTURA COUNTY BEHAVIORAL HEALTH

Hearing from Everyone: A Survey to Complete

Thank You for attending and sharing your ideas and opinions. We would like to capture some feedback from everyone before we end today.



County Resident Survey



Encuesta para Residentes del Condado

VENTURA COUNTY BEHAVIORAL HEALTH

Common Acronyms

BHSA (Behavioral Health Services Act): The legislative component (SB 326) of Prop. 1 that reforms the previous MHSA, modernizing it to better serve Californians with BH needs.

BHSS (Behavioral Health Services and Supports): Expanded set of programs and resources for behavioral health.

CBO: Community Based Organization

CDPH: California Department of Public Health

CFS: Child and Family Services

COE: County Office of Education

CPP: Community Planning Process

CSU: Crisis Stabilization Unit

DHCS: Department of Health Care Services

EBP: Evidence-based practices such as High Fidelity Wraparound (HFW), Functional Family Therapy (FFT), and Multi-Systemic Therapy (MST)

ED: Emergency Department

EI: Early Intervention

FSP: Full Service Partnerships (FSP)

MAT: Medication for Addiction Treatment

MCP: Managed Care Plans (MCP like Gold Coast, Kaiser)

MHSA (Mental Health Services Act): The previous act that funded mental health services through a 1% tax on personal income over $1 million.

Prop. 1: The ballot measure that enacts the reforms and funding mechanisms for the behavioral health system.

SMHS: Specialty Mental Health Services for those with more severe conditions or greater acuity

SUD (Substance Use Disorder): A key focus of the reforms under Prop. 1 to include and expand services for individuals struggling with drug and alcohol addiction.

SUS: Substance Use Services

VCBH: Ventura County Behavioral Health

Looking for more information on these Stakeholder Engagement efforts being reviewed?

This presentation is a **high-level summary** of all efforts over more than 18 months. Each section presented here today has a dedicated full report which you can review.

Links to full documents

- Proposition 1 Resources – https://hca.venturacounty.gov/behavioral-health/bhsa/community-planning-process/
- VCBH Executive Summary of CPP Findings - https://hca.venturacounty.gov/behavioral-health/bhsa/community-planning-process/
- VCBH CPP Report - https://hca.venturacounty.gov/behavioral-health/bhsa/community-planning-process/
- Community Health Needs Assessment (CHNA) - https://www.healthmattersinvc.org/
- Community Health Improvement Strategy (CHIS) https://www.healthmattersinvc.org/

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CenCal Health Plan Updates

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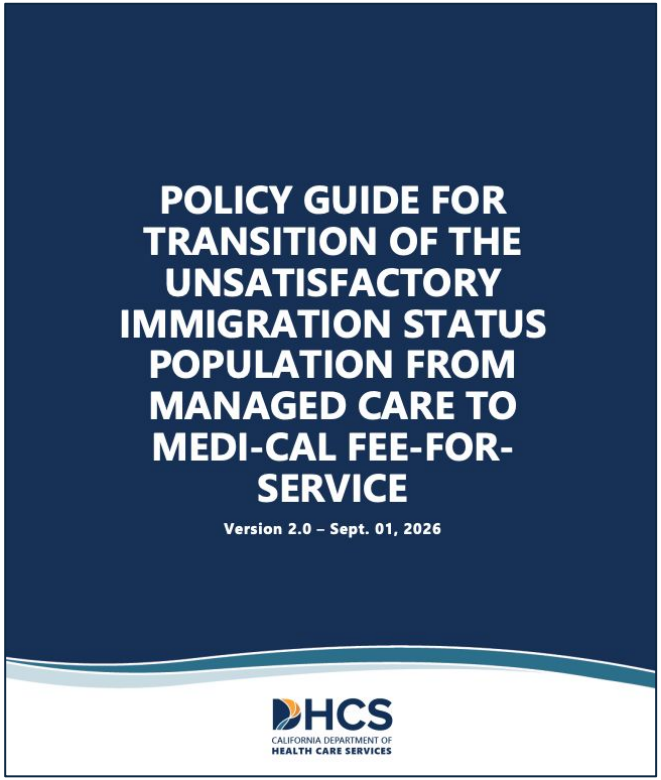
Major Federal and State Policy Changes

Key Change	Effective Date	Affected Population(s)
Public Charge Final Rule	September 18, 2026	Applicants for Lawful Permanent Residence (LPR)[1]
H.R. 1: Community Engagement / Work Requirements	January 1, 2027	New Adult Group, ages 19 to 64 (with numerous exemptions)[2]
H.R. 1: Retroactive Coverage Limit	January 1, 2027	New Adult Group, ages 19 to 64 and Medi-Cal members seeking Medi-Cal outside the New Adult Group[3]
Transition to FFS Medi-Cal	January 1, 2027	Adults with Unsatisfactory Immigration Status (UIS)[4]
CalAIM Waiver	January 1, 2027	All Medi-Cal members
H.R. 1: 6-Month Eligibility Checks	March 1, 2027	New Adult Group, ages 19 to 64 (with some exemptions)[5]

**As of October 2026. Policy developments are fast-moving, and subject to change*

Updated Policy Guide for Transition of Members with UIS to Fee-for-Service



On September 1, 2026, DHCS released an updated policy guide addressing the transition of members with Unsatisfactory Immigration Status (UIS) to Fee-for-Service (FFS) Medi-Cal. This transition will go into effect beginning **January 1, 2027.**

Who does this apply to?

Unsatisfactory Immigration Status is an immigration category that includes individuals that have not yet achieved citizenship status, lawful permanent residency, or other Qualified Non-Citizen (QNC) status.

[DHCS: UIS Transition Policy Guide]

Adapted from slides created by HealthBegins

UIS Member Transition to Fee-for-Service

Beginning January 1, 2027, Medi-Cal members with Unsatisfactory Immigration Status (UIS) will transition to Medi-Cal Fee-for-Service (FFS).

Before: Enrolled in an MCP

- Assigned to and enrolled in an MCP
- Can access Enhanced Care Management (ECM), Community Supports, and other MCP-administered services
- MCP authorizes, coordinates, and pays for covered services

January 1, 2027



After: Enrolled in FFS

- No longer assigned to an MCP
- Not eligible for MCP-only services, including ECM and Community Supports
- Receives Medi-Cal-covered services through FFS from providers enrolled to bill FFS

[DHCS: UIS Transition Policy Guide]

Adapted from slides created by HealthBegins

CHW Services for UIS Members

CHW services remain a reimbursable Medi-Cal FFS benefit when ordered, supervised, and billed by an enrolled provider.

State-approved CHW scope of service for transitioning UIS members

Health Navigation

Connect members to community resources, interpretation, appointments, and transportation.

Medi-Cal Enrollment

Help members keep Medi-Cal active and complete documentation for programs like CalWORKs or CalFresh.

Health Education

Deliver health education, coaching, and goal-setting for chronic physical or mental health conditions.

Screening & Assessment

Screen for unmet social determinants of health (SDOH) and share findings with the licensed provider.

Support & Advocacy

Serve as a cultural liaison so members understand and can follow their plan of care.

HealthNet: CHW Services Provider Manual

Adapted from slides created by HealthBegins

Upcoming Webinar

CalAIM Best Practices and Sustainability Toolkit

Friday, October 30, 2026
10:00 a.m. to 11:00 a.m. PDT
Advanced Registration Required

DHCS is hosting a public webinar on applying the CalAIM Best Practices and Sustainability Toolkits in real-world settings, covering: funding, change management, staffing, and common mistakes to avoid. Speakers include representatives from HC2 Strategies, the Kings Tulare Homeless Alliance, and Public Health Innovation Lab.

Learn more on the Collaborative Planning and Implementation webpage or email questions to collaborative@ca-path.com.

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End-of-Meeting Poll



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Thank you for joining and see you at our virtual meeting on November 18!

Questions? Please email pathinfo@bluepathhealth.com.

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