CALIFORNIA IMPROVEMENT NETWORK WEBINAR

Making CalAIM Work in a Constrained Fiscal Environment

The benefits are permanent. The eligibility is narrowing.
What we do with the next twenty weeks.

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THE QUESTION THIS HOUR ANSWERS

How do you sustain Enhanced Care Management, Community Supports, and cross-sector partnerships when budgets are tighter and workforce capacity is stretched?

1

Cross-sector strategies to keep CalAIM moving despite the uncertainty

Where the handoff between plan, county, and provider holds or breaks. Slide 9.

2

Emerging financing and contracting approaches to stabilize implementation

Braided funding that survives one source drying up, and four contract asks. Slides 10 and 11.

3

Lessons from county-level implementation you can apply now

What counties learned about the step down out of Enhanced Care Management. Slide 14.

The arc: what is changing, what is worth protecting, and what a provider can do by January. One ask follows.

The benefits are permanent. The eligibility is narrowing.

PERMANENT

Built into the core structure of Medi-Cal managed care, not temporary pilots.

Two independent confirmations. In June the Department of Health Care Services called these core structure rather than pilots. Its waiver page states that Enhanced Care Management needs no waiver authority to continue.

NARROWING, EFFECTIVE JANUARY 1, 2027

Refined criteria for both benefits, written into the enacted budget.

- Enhanced Care Management: eligibility criteria, service definitions, utilization management, and payment.
- Select Community Supports: referral pathways, eligibility criteria, service definitions, and utilization management.

December 31 is not the cliff. January 1 is. So the live question is no longer whether the model survives, it is who we still reach when the criteria tighten.

Sources: DHCS, New Data Reinforce California's Commitment to Whole-Person Medi-Cal Care, June 26, 2026. DHCS Section 1115 Waivers page. DHCS FY 2026-27 Budget Act Highlights, July 2026.

Six changes land on the same date

January 1, 2027

Enhanced Care Management	A service intensity floor of three or more services a month. Low-touch, predominantly remote or generalized care management stops counting as ECM.
Community Supports	All fourteen move to standardized minimum enrollment requirements. Nutrition referrals must come from the member's health care team. They are In Lieu of Services, elected by each plan.
State-funded immigrant members	About two million Californians move from managed care to fee for service, which ends their access to both benefits. Dyadic services remain available for the direct benefit of a child under 21 who is a member.
Work and community engagement	H.R. 1 requirements begin for the Affordable Care Act adult expansion population, alongside six-month renewals replacing annual.
Retroactive coverage	Shortens to one month before application for adult expansion, two months for others, effective no sooner than this date.
Managed care organization tax	The current tax expires December 31, 2026. A renewed, federally compliant tax takes effect.

For safety-net providers serving large immigrant populations, the third row is the largest operational change in the budget. From today, about twenty weeks.

Sources: DHCS FY 2026-27 Budget Act Highlights, July 2026. DHCS Refinements and Efficiencies for Community Supports and ECM fact sheet, May 2026. Federal guidance of September 2025 on state-funded immigrant coverage.

THE CHALLENGE

The coverage risk is procedural, and that makes it addressable

44,000

projected disenrollment in 2026-27 from H.R. 1

rising to 1.3 million by 2029-30

3.5M

subject to the work requirement in January 2027

after exemptions are applied

66%

of unwinding disenrollments were procedural

not based on eligibility

Most people who lose coverage still qualify for it.

A process failed to reach them in time. On August 1, roughly two hundred people in Nebraska became the first in the country to lose coverage under these rules. That is a coordination problem, and coordination is what California has spent four years learning to build.

Sources: DHCS FY 2026-27 Budget Act Highlights, July 2026. Legislative Analyst's Office. Hickman, Mason, Cantor, "The Equity Cliff," Health Affairs Forefront, July 29, 2026. Nebraska terminations reported by NPR and Tradeoffs, July 31, 2026.

THE EVIDENCE

The evidence answers whether it works. Who we keep is a separate question.

Cost effectiveness is measured on people who received a service.

Narrowing referral pathways changes who enters the denominator.

Utilization management surfaces first as unpaid work.

The outreach still happens. The authorization arrives late, or never.

The clearest example is already written.

From January, nutrition referrals must come from the member's health care team, and Community Supports providers may no longer request authorization directly.

Which means the design work for the next twenty weeks sits in the referral pathway, not in the service definition.

THE OPPORTUNITY

Scaffolding comes down when the money stops. Structure carries the building.

The coordination layer is the connective work between services: outreach that finds someone before a claim exists, the warm handoff, the multidisciplinary team, and the record that follows a member across organizations.

SCAFFOLDING

- Grant funded and time limited
- Incentive dollars and pilot cycles
- Technical assistance that ends on a date
- Coordination assumed inside a rate, named nowhere

STRUCTURE

- A named cost with a named owner
- Financing braided across more than one source
- Relationships that survive a contract cycle
- Data that follows the member, not the funder

In a lean year the coordination layer is the easiest line to cut and the hardest to rebuild, because it is people. It is also what makes a narrowed benefit still reach the right people.

The Readiness Architecture

Four layers, and they run as a loop: financing enables infrastructure, infrastructure enables capabilities, capabilities unlo ck better contracts. A plan contracts against your weakest layer, not your average.

	Emerging	Developing	Established · high performing	Leading	Your score
LAYER 0 **Trust, relational capital, community governance**	**Neighborhood presence** Input is advisory only	**Named population expertise** Accountability emerging	**Multi-generational credibility** Structural decision rights	**Community co-governance** Protected in contract terms	1 to 5
LAYER 1 **Capabilities and maturity**	**Single service, referral based** Informal documentation	**Multi-service coordination** Some outcomes tracking	**Enhanced Care Management capable** Quality improvement in place, workforce ladder, data driven	**Population health management** Value-based evidence, peer faculty	
LAYER 2 **Infrastructure**	**Paper or spreadsheet** No formal billing, no federal privacy compliance	**Basic client relationship management, some claims** Federal privacy basics, informal sharing	**Billing and case management** Integrated, Data Exchange Framework ready, closed loop referral	**Fast Healthcare Interoperability Resources enabled** Direct plan data integration, predictive	
LAYER 3 **Financing**	**Grant dependent, no reserves** Single funder, renewal risk	**Mixed grants and contracts** 30 to 60 day cash flow risk	**Diversified, 90-day reserves** Rate negotiation, per member per month contracts	**Value-based risk sharing** Equity financing, social enterprise	

In the organizations I assess, the highest-acuity work most often sits Developing to Established. The gap is not failure. It is underfunded potential.

Community-based Provider Readiness Framework (Frontline Organization Readiness Assessment), Hickman Strategies LLC. The Data Exchange Framework is California's statewide health data sharing agreement. Federal privacy compliance refers to HIPAA.

Cross-sector work succeeds or fails at the handoff

WHERE THIS COMES FROM

Many of us on this call have four years or more of CalAIM implementation experience.

THE SHORT VERSION

Child development calls this parallel play. Side by side, same toys, no coordination. It is a stage children pass through on the way to something.

Field observations, not research.

A referral is a transaction. A handoff is a relationship.

Counties that close the loop treat the warm introduction as the deliverable. The action: name the receiving organization before the member leaves the setting, and make sure the member knows who is calling next.

Somebody convenes, and the work is seldom funded.

One person or organization holds the table together, and no budget line pays for it. The action: find out who holds yours, and whether anyone pays them.

Trust and data sit in different organizations.

Keeping a member covered needs both. The action: for your highest-risk population, name one accountable organization, one escalation path, and about five live connections per member rather than a sprawling referral list.

Equity lives in the handoff too. The members who fall out of a cross-sector process are the ones the process was hardest for, and that is a design question rather than an engagement question.

Braid the financing. Do not rent it.

COMMUNITY REINVESTMENT

All Plan Letter 25-004

Initial plans are due to DHCS by September 1, 2026, covering the 2027 to 2029 investment period. DHCS encourages plans in the same county to align and pool. Attestations from the Local Health Jurisdiction and County Behavioral Health are required.

PROGRAM DOLLARS

ECM and Community Supports rates

The operating base. Coordination cost belongs in the rate conversation and in the contract. It is the only durable source of the three. And the 1115 renewal proposes a new Employment Supports benefit: job readiness, planning, placement and retention for members subject to the work requirement.

ONE-TIME CAPITAL

Rural transformation and philanthropy

California Rural Health Transformation moves $233.6 million in its first budget period, of which $39 million went to Accelerator Partner grants this summer. Build with one-time money, then sustain through Medi-Cal.

Reinvestment is a share of net income, so it moves with margin and thins under pressure. Treat it as the start of a financing design.

Sources: DHCS Community Reinvestment Policy and FAQs (APL 25-004), updated May 2026. HCAI California Rural Health Transformation Accelerator Partner Request for Applications, 2026.

Four things to change in the next contract cycle

Fund coordination as a named line

Name it as a line in the budget. Unnamed costs get trimmed first.

Ask for volume visibility

Fixed staffing against plan-controlled assignment, with no minimum volume warranted, puts the entire volume risk on the provider.

Write the data flow into the budget

If the agreement requires an integrating care management record, the cost of that system belongs in the same document.

Protect relational continuity

Termination for convenience with no transition provision moves the entire risk of the relationship onto the community organization.

Every one of these serves the plan too. Each makes the provider more likely to still be delivering in 2029, which is what the plan is buying.

THE FLOOR UNDER ALL THREE

Three things to measure and document before January

1

Audit your service intensity first

The new floor is three or more services a month. DHCS put statewide delivery near 1.8 for adults and 1.4 for children. Measure your own number before the plan measures it for you.

2

Instrument referral to authorization

Measure the drop between referral received, authorization granted, and first billed encounter. Closed loop referral has been required since July 2025 and DHCS began monitoring compliance in July 2026, so the closure reason is owed to you. If you are contracted, the plan portal already shows referral status today. Use the access you have, and ask when the file does not arrive.

3

Write functional impairment into the care plan

From January, a diagnosis alone will not carry the medical frailty exemption. The sentence describing what a member cannot do belongs in every assessment and care plan. For a director, that is a documentation standard and a chart-review question, starting now.

All three run on what you already have. They are the floor under everything else in this hour, not a fourth list to remember.

THE FLOOR UNDER ALL THREE

Your populations of focus are mostly exemption categories

H.R. 1 conditions coverage for expansion adults on 80 hours a month of work, school, training, or volunteering, starting January 1, 2027. It also exempts whole categories of people, and Enhanced Care Management already serves most of them.

ECM POPULATION OF FOCUS	MAPS TO AN H.R. 1 EXEMPTION
Serious mental health or substance use needs	**Medically frail, and drug or alcohol treatment participation**
At risk of long-term care institutionalization	**Medically frail, disability affecting activities of daily living**
Nursing facility residents returning to community	**Medically frail**
Youth who have aged out of foster care	**Former foster care youth under 26**
Adults and youth leaving incarceration	**Incarcerated within the last three months**
Pregnant and postpartum, birth equity	**Pregnant or receiving postpartum coverage**

Three cautions. Homelessness by itself is not an exemption, and CMS said so directly. The interim final rule adds a second test for medical frailty, and a federal judge declined to pause it on July 30, so January 1 is now a planning certainty. And for anyone subject to the requirement, both the exceptions and the hours themselves are judged on the month before.

Sources: CMS interim final rule CMS-2454-IFC, June 1, 2026, effective July 31, 2026. Commonwealth of Massachusetts et al. v. Oz et al., D. Mass., preliminary injunction denied July 30, 2026. DHCS ECM Policy Guide populations of focus.

When a member steps out of ECM, build the next step now

THE RULE

Community Health Worker services cannot run at the same time as Enhanced Care Management. They can run before it begins and after it ends.

So a member who no longer meets the refined ECM criteria in January has a reimbursable next step, if the pathway exists before they need it.

HOW THE TWO BENEFITS PAY

- Enhanced Care Management is per member per month, typically authorized for twelve months with reauthorization every six.
- Community Health Worker services are fee for service in thirty-minute units, up to four units per member per day, under a supervising Medi-Cal provider.
- DHCS recommends up to twelve units a year, with more allowed when a licensed provider writes it into the care plan.

Four things to do before January

- Confirm whether your organization can bill Community Health Worker services, and who your supervising provider is.
- Write the step-down into your discharge workflow, so graduating from ECM starts a referral rather than ending one.
- Train care managers on the concurrency rule, because a same-day overlap is a denied claim.
- Ask your plan how it will handle members who move out of ECM eligibility on January 1.

Source: Intrepid Ascent, Step Up / Step Down: A Guide to the Non-Duplicative Intersections of ECM and CHW Services, February 2026, developed with the Contra Costa CalAIM PATH Collaborative Planning and Implementation ECM and CHW Work Group.

BONUS TAKEAWAY · NOT ON THE INVITATION

Five moves a community organization can start this month

1

Map your members

Which of the people you serve are adult expansion-group members, and which of them already sit in an exemption category? Most organizations can build that list from the roster they already hold.

2

Name what only you know

Employment, school, caregiving, functional impairment. Two of the four short-term hardship exceptions are granted only when the member asks, and the guidance names nobody to tell them.

3

Ask your partners what they need, and in what form

Plans, county agencies and local conveners such as United Way chapters are counting on partner organizations to fill data gaps. Some counties are already convening for this; others are waiting for someone else to move.

4

Name who opens the closed loop referral file

Then name who acts on what is in it, and ask when it does not arrive. Plans owe a status answer in one business day, and DHCS is monitoring that too.

5

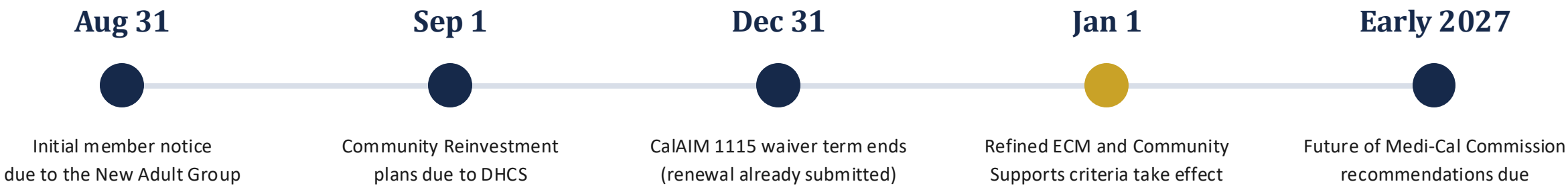
Offer volunteer hours, and count them to a standard

Volunteering counts toward the eighty hours a month. Counting it takes a structured program, tracked dates and hours, and a named contact who can confirm participation.

The rule created new information flows and new openings, and assigned an owner to neither. That is the argument for page two.

SCALE

Five windows, all of them open right now



Each of these is a decision point where field evidence carries weight, and one operational ask sits under all of them: get access to your members' redetermination dates and build outreach around them.

The Commission has asked for roughly five recommendations, so a specific, local, well-evidenced ask carries further than a comprehensive one. Public comment runs through the Commission's input channel and its bi-weekly public forums.

THE ONE ASK

Write two pages by September 1

PAGE ONE

What your coordination backbone costs

- The staff who hold the relationships
- The data work that makes a handoff real
- The outreach that happens before any claim exists
- One defensible annual number

PAGE TWO

Who runs it

- One accountable owner, named
- Authority to convene across sectors
- Accountable to the care model, not to one funder
- Sized to the readiness your region actually has

Then send them to one person who can act on them. Your managed care plan, your county, or the Commission’s public comment channel. One, not all three. September 1 is the day plans file their reinvestment plans for 2027 through 2029, so being in that conversation before it starts is most of the work.

THE PARTNERSHIP

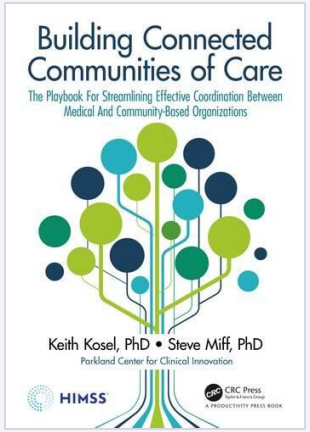
California has the policy architecture, the implementation evidence, and the practitioner capacity. What it lacks is time.

Constraint is not the reason to retreat. It is the condition under which the backbone finally gets built. None of us builds it alone.

Energy and persistence conquer all things. Write the number. Name the owner. Send it to one person before September 1.

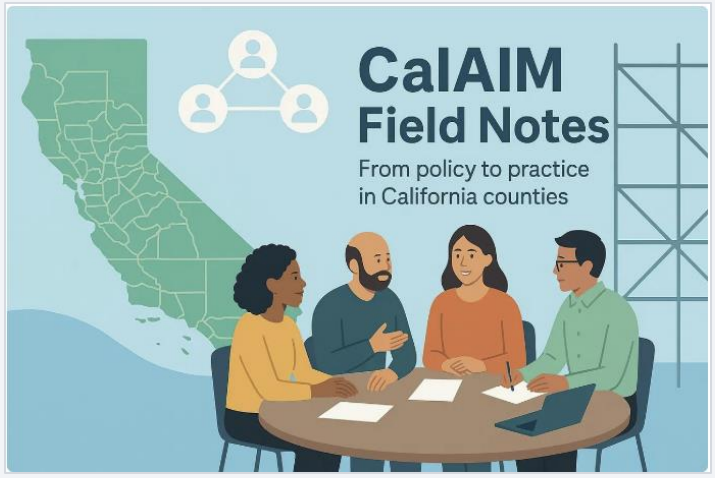
STAY IN TOUCH

Where this work continues



Building Connected Communities of Care

Keith Kosel and Steve Miff, PCCI. The practical guide to coordination between medical and community-based organizations. Jim serves as a Senior Advisor to PCCI on Medicaid strategy, market growth and the federal Rural Health Transformation Program.



CalAIM Field Notes, free to subscribe

On-the-ground dispatches from California's Medicaid transformation, and a working notebook for the possibilists inside CalAIM. More than 4,800 subscribers. Read the archive and subscribe at calaimfieldnotes.substack.com.

Or write to me at jim@hickmanstrategies.com and I will send you the readiness grid as a scoring worksheet.

FROM HERE ON, REFERENCE

Appendix

1

Where the detail lives

Every source behind every number in this deck, plus the Health Affairs piece and CalAIM Field Notes.

2

Three questions for the room

The discussion prompts, and the offer to send you this deck's readiness grid as a scoring worksheet.

3

If the waiver comes up

December 31 is not the cliff. January 1 is. The DHCS language in full.

4

The program at scale

Enhanced Care Management and Community Supports growth through the most recent quarterly report.

These four slides stay in the circulating deck. Nothing behind this page is cut; it is held for the conversation and for whoever reads the deck later.

GO DEEPER

Where the detail lives

The federal picture in full

Jim Hickman, Abner Mason, and Jeremy Cantor, "The Equity Cliff: Federal Medicaid Cuts Are About To Undo California's Health System Gains," Health Affairs Forefront, July 29, 2026.
healthaffairs.org/content/forefront/equity-cliff-federal-medicaid-cuts-undo-california-s-health-system-gains

Ongoing field notes

CalAIM Field Notes

calaimfieldnotes.substack.com

On-the-ground intelligence from California's Medicaid transformation, published through the waiver renewal.

Primary sources behind every number in this deck

DHCS ECM and Community Supports Quarterly Implementation Report through Q3 2025 (June 2026) · DHCS 1915(b) Annual Report on In Lieu of Services and Community Supports cost-effectiveness fact sheet (June 2026) · DHCS FY 2026-27 Budget Act Highlights (July 2026) · DHCS Community Reinvestment Policy and FAQs, All Plan Letter 25-004 · HCAI California Rural Health Transformation Accelerator Partner Request for Applications

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OVER TO YOU

Three questions for the room

1. **Where in your referral pathway do you lose the most people, and do you have a number for it yet?**
2. **How many of your current members would hold an exemption if the documentation were written today?**
3. **What happens to a member who falls outside ECM criteria on January 1, and who owns that handoff?**

One offer before we open it up. Write to me and I will send you this grid as a one-page worksheet you can score against your own contracts.

December 31 is not the cliff. January 1 is.

WHAT MANY PEOPLE BELIEVE

The CalAIM waiver expires December 31, so Enhanced Care Management and Community Supports are at risk.

The waiver term does end on December 31, so this is an easy reading to land on. It sends planning energy to the wrong process.

WHAT DHCS ACTUALLY SAID

- Enhanced Care Management does not require waiver authority to continue as a managed care plan benefit, and therefore will be maintained.
- Community Supports operate as In Lieu of Services under managed care authority. DHCS has reaffirmed they remain unaffected and will continue.
- The Section 1115 renewal went to CMS in May 2026 for a 2027 to 2031 term. The 1915(b) renewal follows in the third quarter of 2026.
- DHCS repeated it to PATH facilitators in June: ECM does not rely on CalAIM demonstration renewal, and will remain available to managed care members in all counties.
- BH-CONNECT, which carries Transitional Rent, is already approved through December 2029.

Federal risk is real and it's elsewhere. CMS rescinded its health-related social needs guidance, left existing approvals intact, ended Designated State Health Program authority, and will let the BH-CONNECT workforce programs lapse.

Sacramento decides who receives these benefits on January 1. That is good news, because Sacramento is closer to this room than CMS is.

The program is at scale, and still growing fast.

453,000 members reached by Enhanced Care Management since 2022

227,500 served in the third quarter of 2025 alone, up 59 percent year over year

528,000 members reached by Community Supports, across 1.5 million services

191,000 Community Supports users in the third quarter of 2025, up 40 percent

Access has kept pace. 94 percent of Medi-Cal members can reach at least ten Community Supports, and 78 percent can reach all fifteen. Participation among children and youth grew 90 percent over the year.

Source: DHCS Enhanced Care Management and Community Supports Quarterly Implementation Report through Q3 2025, released June 26, 2026.