Questions the Hour Could Not Reach

Written answers from the California Improvement Network webinar, Making CalAIM Work in a Constrained Fiscal Environment, August 18, 2026. Jim Hickman, Hickman Strategies LLC.

Eight questions came in through the chat and the evaluation survey without getting an answer on the call. They are answered here, with sources named so you can check the work and take it to your own board or your own plan.

No one who asked a question is identified. Everything here is current as of August 24, 2026.

A RESOURCE SHARED IN THE CHAT

A participant put the Catalyst for Community-Led Reinvestment site in the chat, which lists county-by-county Medi-Cal plan Community Reinvestment contacts and amounts. The site is community built. It is not a state index and DHCS does not maintain it, so treat it as a starting map and confirm anything load-bearing against the plan itself.

https://catalyst-cri.netlify.app/

The governing documents are All Plan Letter 25-004 and the DHCS Community Reinvestment FAQ. Initial reinvestment plans are due September 1, 2026, covering the 2027 to 2029 investment period, with funds exhausted by the close of 2029. Public health and county behavioral health attestations are required. DHCS explicitly encourages plans in the same county to align and pool their reinvestment, which is the most useful sentence in the letter and the one almost no one is acting on.

QUESTION ONE

Have you encountered instances where the cross-sector work was funded well? What happened there?

When cross-sector coordination is funded well, it is almost always funded temporarily. PATH is the largest example California has run. The work performs while the money lasts, relationships form that would not have formed otherwise, and then the funding ends and the structure dissolves because no one owns it and nothing pays for it. That is not a failure of the collaboratives. It is a design feature of how we financed them.

Coordination survived the end of its grant where these conditions held.

- The coordination function was attached to an entity that had another reason to exist and another revenue line, so the convening survived as a side effect of something durable.
- The funder paid for staff time and not for convenings. A coordinator with salaried hours keeps the work moving between the meetings, which is where coordination actually happens.
- A plan or a county named one accountable owner, in writing, and gave that person a job description with the function in it.

In one county collaborative, all four managed care plans voluntarily submit quarterly enrollment and referral data to a neutral convener, though nothing in their contracts requires it, and they went on to co-build a

shared billing and claims resource list for providers. Nobody was paid to do that. It held because the convener was trusted by all four and because the data answered a question the plans also wanted answered.

Coordination is not a line item in any Medi-Cal rate today. It is the work every one of these programs assumes and none of them purchases. I filed a written comment with the Future of Medi-Cal Commission on July 23, 2026 making exactly that ask, under the subject line Fund the coordination layer. The three actions in it were to put coordination in the base payment tier, to name a local accountable owner, and to use coordination as the retention and learning instrument. That is the fight worth having over the next two years.

QUESTION TWO

Members get primary care from one system and specialty care from another. How does information move between them, who should oversee that flow, and should there be a centralized coordination entity?

California has a specific answer to part of this and no answer at all to the rest.

What exists

- **The Data Exchange Framework**, California's statewide health data sharing agreement, sets the legal obligation to exchange. Signatories are required to share, which is the part people forget when they treat data sharing as voluntary.
- **The CalAIM consent registry and master person index** rolled out July through August 2026 and are live now. Consent management has been the practical blocker in most cross-system workflows, and this is the state's attempt at it.
- **Medi-Cal Connect** carries the Longitudinal Member Record. The DHCS one-pager "What is Medi-Cal Connect" sets Release 6 in the fourth quarter of 2026, which is when local county providers, health care delivery partners and tribal partners get access for the first time. Worth knowing before you plan around it: DHCS states publicly, and by design, that Medi-Cal Connect is not a real-time health record.
- **Closed Loop Referral** is the piece most directly relevant to ECM and Community Supports, and it is further along than most people realize.

Closed Loop Referral, precisely

The requirement went live July 1, 2025 for ECM across all populations of focus and for 13 Community Supports, with sobering centers excluded because those services are often delivered in real time. DHCS gave plans a grace period and began actively monitoring for compliance July 1, 2026. What changed this year is enforcement, not the rule.

The standard is that the plan notifies the referring entity within seven business days of receiving service provider data, by electronic method unless both parties agree otherwise. That is a DHCS standard from its Closed Loop Referral Implementation Guidance, not one plan's policy choice.

Exclusions change what you should expect to receive. Referral loop closure noticing does not apply where the referral was placed by the member, their guardian or caretaker, or their family or friends. It also does not

apply to health-plan-generated referrals drawn from internal data. So the closure file will not cover every referral you care about.

The move that beats waiting for a file: if a referring entity or a member inquires about the status of a closed loop referral, the plan must respond within one business day, and DHCS monitors compliance on that requirement specifically. You can ask.

On who should own it

California has built the data flow and has not funded an owner for it. That is the gap. A statewide central entity will be too far from the care to close a loop on a specific member on a specific Tuesday. Leaving it to each provider produces exactly what we have, which is a system where responsibility shifts at every handoff and members get lost in the procedural space between organizations.

The owner should be local, accountable to the care model instead of to a single funding stream, and paid for in the base rate. County-level is usually the right altitude because that is where the plans, the county agencies and the community organizations already have to be in the same room. What that owner needs is not a new system. It is a job description, a budget line and the authority to ask a plan a question and get an answer.

QUESTION THREE

On the medical frailty exemption, is there a consensus or gold standard format for documenting it?

There is no national form and California has not published one. The federal rule is specific enough to build your own documentation standard against. Build to it now instead of waiting for a template.

The governing text is CMS-2454-IFC, Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 FR 33348, published June 3, 2026 and effective July 31, 2026, with a correction at 91 FR 39028 on June 29, 2026 that republished sections 435.557 and 435.558 in full. If you are reading the June 3 version of those two sections, read the corrected text instead.

What the rule actually requires

- The categories at 42 CFR 435.554(c)(5) are blind or disabled status under Social Security Act section 1614, substance use disorder, a disabling mental disorder, a physical, intellectual or developmental disability that significantly impairs one or more activities of daily living, and a serious or complex medical condition. Every one of the five also requires that the condition significantly impair the ability to comply.
- The activities of daily living limit attaches to one category only, the fourth. It does not govern the other four. The six activities are bathing, dressing, transferring, walking, toileting and eating. Instrumental activities such as shopping and meal preparation are outside the test, because the statute makes no reference to them.
- The evidence specification runs across three domains: the condition itself, utilization including inpatient, intensive outpatient and substance use disorder services, and level of impairment, meaning need for assistance with one or more activities of daily living. Acuity-score algorithms built on administrative claims are acceptable.

- Documentation may come from physicians, nurse practitioners, physician assistants, psychologists, counselors and therapists, clinical social workers, and others credentialed by the state. That list is wider than most organizations assume, and it means a licensed clinical social worker on your staff can write documentation that counts.
- Substance use disorder frailty applies regardless of whether the member is in active treatment, and it reaches early recovery under twelve months and sustained recovery from one to under five years. States must have a process for self-identification, including after a relapse.
- The state maintains a diagnosis list that must be auditable, justifiable, revised regularly and available to CMS on request. If a member's condition is not on the list, the state must have a reasonable process for that member to request individual consideration. Ask DHCS for the list and for the process.
- Self-attestation under penalty of perjury is available once per period of enrollment beginning January 1, 2028, after which documentation is required at the next regular renewal. In a six-month renewal environment, an attestation-based frailty exclusion reverifies in about six months.

What matters most for your operations

First, the rule states that the absence of adjudicated claims or encounter data altogether, and the absence of particular claims or types of claims, may not be used to determine ineligibility for the exclusion based on medical frailty. A thin claims record shifts the burden toward documentation. It does not disqualify a member.

Second, the state must establish processes to use the reliable information it already holds before requesting additional information from the member. That explicitly includes adjudicated claims from the preceding twelve months and encounter data for the preceding twelve months. The preamble says states are required to access this information even where doing so requires system builds.

Your encounters are encounter data. The documentation you are already producing is part of what the state is obligated to look at first. What most care plans are missing is not the diagnosis, which is usually captured. It is the functional limitation. Write down what the member cannot do without assistance, in the language of the six activities of daily living, and date it. That single habit is the highest-yield documentation change available to you before January.

QUESTION FOUR

DHCS seems to want Community Supports utilization up while plans are under financial pressure and want it down. As a Community Supports provider, how would you manage that tension and keep plans opting in and approving authorizations?

The two pressures are not symmetric, and the difference decides what to do about them.

What DHCS did effective January 1, 2027 is narrow eligibility while keeping every service. All fourteen Community Supports move to standardized minimum enrollment requirements. Nutrition referrals for Asthma Remediation, Medically Tailored Meals and Medically Supportive Food must come from the member's health care team, and provider-initiated authorization requests are prohibited. Housing Transition

and Sustaining eligibility tightens past an initial six-month period, and Housing Transition Navigation payments reduce or stop in months with no services. Nothing was eliminated. The doors got narrower.

The evidence is on your side

DHCS's own utilization and cost-effectiveness report, released June 26, 2026, found that ten of the twelve Community Supports authorized as In Lieu of Services demonstrate cost-effectiveness within the study period of January 2023 through June 2024. Keep the denominators straight when you cite this, because mixing them up will cost you credibility in a plan meeting. There are fourteen Community Supports, thirteen of them authorized as In Lieu of Services, and the cost-effectiveness study covers twelve. Short-Term Post-Hospitalization Housing is folding into a redesigned Recuperative Care model, so figures that read fifteen describe an earlier period. The range runs from 1.2 percent for asthma remediation to 79.9 percent for personal care and homemaker services.

In the same release DHCS described ECM and Community Supports as built into the core structure of Medi-Cal managed care, not temporary pilots. That is the state's language, and it belongs in your next conversation with a plan.

What to do in the room

- Lead with a number. Bring the plan your own cost-avoidance arithmetic for your own population, even if it is rough and even if you have to caveat it. A denominator changes what kind of conversation you are having with a medical director.
- Find out where you are actually losing members, and ask your plan for the numbers instead of assuming. Where collaboratives have published referral and approval counts, approval rates have run close to one hundred percent and Community Supports denials near zero. Either the authorization decision is not where members are lost, in which case your effort belongs before the referral and after the authorization. Or referrals are being screened tightly before they are ever submitted, in which case the loss is upstream and invisible in the approval data. Ask for both numbers, referrals submitted and members who never reached a referral, because only the second one tells you which reading is true in your county.
- Get into the rate conversation. DHCS maintains a Community Supports Pricing Resource, last updated in December 2025, and has been gathering cost drivers and programmatic components from providers to update it, circulated through the PATH collaboratives and not posted as an open call. The Recuperative Care round has closed and others are expected without published dates. Ask your plan or your collaborative facilitator to send you the next one that covers a service you deliver. It costs a chief executive, finance lead or program director two to three hours, and it is the cheapest rate influence available to a community organization in this state.
- Build the clinical referral relationship now. The January change to nutrition referral sources is the clearest signal DHCS has sent about where this is going. Eligibility is increasingly decided in the referral pathway rather than in the service definition. If your referrals come from your own outreach, you have a January problem that no amount of service quality will solve.

QUESTION FIVE

What is your recommendation for sustainability for smaller local organizations?

Master billing before anything else

A senior leader at a California health plan put it to me this way: five-plus years into CalAIM, a consensus is forming among plans that organizations unwilling to build or buy administrative billing infrastructure probably should not be operating in ECM or Community Supports. Billing infrastructure is the price of admission. If you are small, buying it costs less than building it.

Know your volume and know what the plans think about it

Plans are watching enrollment volume closely. The minimum viable ECM census has moved up, and informal thresholds are circulating among plans for flagging organizations for scrutiny or non-renewal. This is plan behavior, not DHCS policy, and no plan will publish it. Ask your contract manager directly what census level keeps you in good standing. The worst outcome is learning the number after the renewal decision.

Encounter intensity is the new operating standard

Effective January 1, 2027, ECM carries a service intensity floor of three or more services per month, and predominantly remote, generalized or non-individualized care management stops counting as ECM. DHCS told PATH collaborative facilitators in June 2026 that second quarter 2025 data showed average adult encounters near 1.8 and child encounters near 1.4, against that three-plus expectation. Beginning in 2026, DHCS adjusts plan payment for ECM based on services actually delivered, which means a region delivering low-intensity ECM sees its future rates fall. If you are at one touch a month, you have a rate problem as well as a compliance problem.

Know the Community Health Worker step-down cold

Community Health Worker services may not be billed for a member concurrently enrolled in ECM, but they may run before ECM begins and after it ends. That makes CHW the reimbursable continuation for members who fall outside the refined January ECM criteria, and it is the single most underused financing move available right now.

- Group education is billable. CPT 98960 covers face-to-face self-management education with one patient, 98961 with two to four, and 98962 with five to eight. Covered services are health education, health navigation, screening and assessment, and individual support and advocacy. An ICD-10 code is required.
- DHCS issued a statewide standing recommendation covering all members who meet the eligibility criteria, up to twelve units per member per year. That satisfies the written-recommendation requirement for the CPT codes and largely retires the objection that you need a physician recommendation for each member. Beyond twelve units, a licensed provider writes a plan of care.
- A community-based organization or local health jurisdiction may serve as the supervising provider without a licensed provider on staff. The supervising provider submits the claims.
- Services to the parent or guardian of a member under 21 are covered when they are for the direct benefit of the member, billed under the member's Medi-Cal identification. If the caregiver is not on Medi-Cal, the member must be present.
- The G codes are stricter and are a separate pathway. G0019 and G0022 require an initiating evaluation and management visit with a licensed provider within the preceding six months, and the statewide standing recommendation cannot be used for them.

Go deep on one population instead of wide on several

A plan will keep a provider that is the only real access point to a population it is accountable for, even when that provider scores imperfectly on an audit. That access value is real inside plan decision-making, even where it is not written into any formal scoring. What protects a small organization is being irreplaceable to one population the plan has to answer for.

Write two pages

Page one is a defensible annual number for what your coordination backbone actually costs, the work that keeps members connected and that no rate pays for. Page two names one accountable owner for it. Send those two pages to one recipient who can act on them. Doing this before your next contract conversation changes the conversation from a request for more money into a proposal about a cost the plan is already absorbing somewhere else.

QUESTION SIX

What is the reduction in CalAIM funding that is budgeted in California?

There is no single number. The enacted budget carries three separate reductions and they differ by more than an order of magnitude.

All figures below are from the 2026-27 Budget Act, Department of Health Care Services Highlights, dated July 1, 2026, which is the enacted budget. May Revision figures are still circulating in decks and briefings around the state and they do not match.

The CalAIM benefit reductions

- Enhanced Care Management: General Fund savings of $41.4 million in 2026-27 and $99.2 million ongoing, from refined eligibility criteria, service definitions, utilization management criteria and payment adjustments, effective January 1, 2027.
- Community Supports: General Fund savings of $26.9 million in 2026-27, $58.8 million in 2027-28, and $51.0 million ongoing.
- Together, roughly $68.3 million General Fund in 2026-27.

The two much larger reductions that are not CalAIM benefit cuts

- Moving state-funded immigrant members from managed care to fee for service: a reduction of $637.1 million total and $524.9 million General Fund in 2026-27, rising to $1.6 billion total and $1.3 billion General Fund ongoing, with $39 million General Fund in 2026-27 added for care coordination and navigation for that population. This change cuts no service definition at all. It moves roughly two million people out of managed care, which ends their access to ECM and Community Supports as a consequence of the delivery system they are in.
- The work and community engagement requirement: a reduction of $357.6 million total and $90.3 million General Fund in 2026-27, rising to $9.6 billion total and $2.4 billion General Fund by 2029-30. Projected disenrollments are 43,000 in 2026-27 and 1.1 million by 2029-30.

The distinction to carry out of this

The CalAIM benefit refinement is the smallest of the three. The delivery system change is far larger. The work requirement is the largest over time. If your organization is budgeting against a general sense that CalAIM is being cut, you are budgeting against the smallest number in the package and you are probably missing the one that will actually hit your census.

The enacted budget maintains the current PACE rate cap effective January 1, 2027. The reduction to the actuarial lower bound was a May Revision proposal that did not survive into the final budget. Elimination of the optional adult acupuncture benefit also did not survive. If a deck in front of you carries either one, it is May Revision material.

QUESTION SEVEN

Are there coalition opportunities for organizations in the ECM space?

Yes. The most concrete one runs on the Community Reinvestment cycle.

Community Reinvestment pooling

Under All Plan Letter 25-004, initial Community Reinvestment plans are due September 1, 2026 for the 2027 to 2029 investment period, with funds to be exhausted by the close of 2029. Funding obligations were issued in April 2026. Public health and county behavioral health attestations are required. DHCS explicitly encourages plans in the same county to align and pool their reinvestment.

That pooling provision is the opening. A single organization asking one plan for reinvestment dollars is competing with every other applicant. A group of providers bringing an aligned county-level proposal to all the plans in that county at once is answering a coordination problem the plans already have, and is doing it in the exact form DHCS said it wanted.

September 1 is the plans' submission date with DHCS, not yours, and a proposal arriving in late August lands after the filing is already drafted. The date that matters to a provider comes after it. Under Section IV of the All Plan Letter, plans must post their approved Community Reinvestment plans on their own websites, and each posted plan carries the projected allocation of funds across every Community Reinvestment activity, county by county. When your plan posts, find your county, read what the plan committed to, and bring your two pages against that. The investment period runs through 2029, so the allocation conversation stays open long after the filing closes.

Provider-convened sustainability structures already exist

In at least three regions of California, providers have built essentially the same successor structure to the PATH collaboratives, independently, without coordinating with each other. All of them are provider-convened and none of them is funded. If one is forming near you, join it and stop building your own. If none is, the fact that three regions arrived at the same design separately tells you the need is general and the structure is obvious once you look at the problem.

Employment Supports in the 1115 renewal

The Section 1115 renewal proposes Employment Supports as a new Community Support: job readiness assessment, employment planning, placement and retention services for non-exempt New Adult Group members subject to the federal work requirement, for the renewal period January 1, 2027 through

December 31, 2031. This is the state proposing to pay for the activity that federal law now requires, and it is the cleanest shared use case for a pooled reinvestment conversation.

CMS states in the interim final rule that Medicaid-covered employment services are not work programs meeting the definition, and it names 1915(c) supported employment and 1915(i) services specifically. What satisfies the requirement is the referral to a qualifying work program. The Medicaid service itself does not.

The one funding channel the federal rule names

New 42 CFR 438.58(b) bars states from using a managed care plan to determine member compliance with the community engagement requirement. Plans can do outreach and education, and they can share data they already hold with the state to inform whether the requirement applies to someone. Those costs cannot go into capitation rates and cannot be counted as value-added services.

There is one door. Where a plan voluntarily provides a service that meets the value-added services definition at 438.3(e)(1), that service can be included in the medical loss ratio numerator as incurred claims. That is the only funding channel the federal rule names for this work, and it pairs directly with the September 1 reinvestment filing. If you are building a coalition proposal, build it so it can be described in both frames at once.

QUESTION EIGHT

How can we use what is left to make up for what was taken away?

Start from an accurate inventory, because a good deal of what people believe is being taken away is not going anywhere. All of the following is live on January 1, 2027.

- **Enhanced Care Management.** DHCS's own Section 1115 waiver page states that ECM does not require waiver authority to continue as a managed care plan benefit and will therefore be maintained. December 31, 2026 is not a cliff for ECM. January 1, 2027 is the date that changes operations, and it is a state budget decision.
- **All fourteen Community Supports,** operating as In Lieu of Services under managed care authority, with tighter and standardized enrollment requirements.
- **Transitional Rent,** which is mandatory and sits under BH-CONNECT through December 2029.
- **Community Health Worker services,** including group education under the CPT codes and the statewide standing recommendation, available before ECM and after it ends.
- **Dyadic services,** for children under 21 and their parents and caregivers, billed under the child's Medi-Cal identification, with non-Medi-Cal-eligible caregivers covered where the service directly benefits the child. The design constraint to know is that the benefit is built to work inside the pediatric primary care clinic and attaches to the periodicity schedule for behavioral, social and emotional screening or to medical necessity.
- **Family therapy under Non-Specialty Mental Health Services.** Plans are required to provide it to members under 21 with a mental health diagnosis, or with persistent mental health symptoms in the absence of a diagnosis. That second clause reaches the undiagnosed struggling young person and it is one of the most underused provisions in Medi-Cal.

- **Community Reinvestment under APL 25-004,** with the pooling provision described above.
- **Employment Supports,** proposed in the 1115 renewal.

Nearly 453,000 members have received ECM since 2022, with almost 227,500 in the third quarter of 2025 alone, up 59 percent year over year, and children and youth participation up 90 percent. More than 528,000 members have used Community Supports since launch across more than 1.5 million services. Ninety four percent of members can access at least ten Community Supports and 78 percent can access all of them. These are the numbers of a program that is still growing.

What this does not cover

None of these instruments replaces coverage for a person who loses it. A member disenrolled for a paperwork failure is uninsured, and no Community Support fixes that. What the surviving instruments give you is a set of paid ways to stay in contact with people while the eligibility rules move underneath them, and staying in contact is what determines whether someone comes back onto coverage in ninety days or never.

That is the work in front of all of us between now and January. The benefits are permanent. The eligibility is narrowing. Everything worth doing in the next four months lives in that gap.

RESOURCES REFERENCED IN THE SESSION

DHCS Coverage Ambassador webinar series. DHCS is running a train the trainer session on August 27, 2026, from 11 a.m. to noon Pacific, covering Medi-Cal six-month renewals and the work and community engagement requirements, with guidance on helping members keep coverage as more H.R. 1 changes take effect. Advance registration is required. Spanish translation and live captions are provided. If your organization talks to members about their coverage, this is the state's own training channel for the January changes, it runs as a series, and it costs nothing. Recordings and future sessions are posted on the same page.
https://www.dhcs.ca.gov/ambassadors/Pages/Webinars.aspx

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

CalAIM Field Notes. On-the-ground dispatches from California's Medicaid transformation, published Thursdays.
https://calaimfieldnotes.substack.com/

The Readiness Architecture worksheet. The four-layer grid from the presentation, as a two-page worksheet you can score your own organization against. Circulated with these answers.

The DHCS value framework session. The July 2026 Medi-Cal Value Strategy public webinar, held July 9, 2026, which included a fireside chat with Health Plan of San Mateo featuring Chris Esguerra, now the incoming DHCS Chief Quality and Medical Officer and Deputy Director of Quality and Population Health Management. The slides are posted. Note that the fireside chat portion is not included in the posted deck, so that segment is available only in the recording. DHCS takes questions at vbp@dhcs.ca.gov.
https://www.dhcs.ca.gov/file/all-comer-value-strategy-webinar-2026-pdf/

Primary sources cited above

- 2026-27 Budget Act, Department of Health Care Services Highlights, July 1, 2026.
- DHCS Medi-Cal Transformation utilization and cost-effectiveness report, released June 26, 2026.
- DHCS Section 1115 Waivers page, on ECM continuation and Community Supports authority.
- All Plan Letter 25-004, Community Reinvestment, and the DHCS Community Reinvestment FAQ.
- CMS-2454-IFC, 91 FR 33348, June 3, 2026, with the correction at 91 FR 39028, June 29, 2026.
- DHCS Closed Loop Referral Implementation Guidance and the DHCS Closed Loop Referral FAQ.
- DHCS Medi-Cal Provider Manual, Community Health Worker Preventive Services, and the DHCS CHW Billing and CHW G Codes FAQs.
- DHCS Dyadic Services benefit page and All Plan Letter 22-029.
- DHCS one-pager, What is Medi-Cal Connect, and the DHCS About RSST page.
- DHCS Stakeholder Update, August 17, 2026, on the Coverage Ambassador webinar series.
- DHCS briefing to PATH Collaborative Planning and Implementation facilitators, June 3, 2026, attended first-hand. Encounter figures from that briefing are approximate.

If it would help to walk the readiness grid against your own plan contracts, I will do that with you. Thirty minutes, no charge, and you keep whatever comes out of it.

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