CalAIM and Community-Based Organizations

A Fresno County Qualitative Study 2025

February 3, 2026

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KEY TAKAWAYS

- **Community-Based Organizations (CBOs) are interested in participating in CalAIM in Fresno County. They face a steep learning curve**, lacking clear guidance on required steps, timelines, and billing processes, which slows participation among organizations providing eligible services.
- **Infrastructure and financial readiness are major barriers,** especially for smaller CBOs that are unfamiliar with medical-model billing, insufficient reimbursement rates, and the administrative burden of fragmented funding streams.
- **Trust and community relationships are CalAIM's strongest asset**, with CBOs uniquely positioned to reach underserved populations. At the same time, those **populations are at risk of being left out** due to system efficiency requirements and capacity constraints.
- **Managed Care Plans value CBO partnerships and also operate on different timelines and expectations**, creating misalignment around readiness, budgeting, referral processes, and contracting criteria.
- **Urgency is rising as federal waiver uncertainty approaches at the end of 2026,** making it critical to strengthen CBO infrastructure, secure new funding for technical assistance, and build cross-sector coordination to sustain CalAIM's goals to create a more coordinated, person-centered, and equitable health system.

Executive Summary

The introduction of CalAIM (California Advancing and Innovating Medi-Cal) in 2022 offered a new opportunity for community-based health and social services programs, organizations, and initiatives utilizing some form of community health workers (CHWs). This could be system navigation, client education, or specific services. While some distinct CHW models are employed in Fresno County (e.g., community health worker, home visitation staff, promotora), there are overlapping goals to leverage new and existing funding to increase the number of families and individuals able to receive the critical CalAIM supports. While some organizations have begun partnering with managed care plans to leverage CalAIM dollars, many have not due to a wide range of administrative and other challenges. The goal of this qualitative study was to learn what is working well and what the specific challenges and opportunities are for CBOs to access CalAIM benefits so that solutions might be found to increase participation.

Medi-Cal as health insurance, traditionally operates on a fee-for-service Medi-Cal model that pays for a health service visit, often by time increment and level of complexity. The conditions surrounding and impacting a patient's health, often referred to as social determinants of health, may be noted but are not addressed by the provider as it is considered outside their scope. California Advancing and Innovating Medi-Cal (CalAIM) is a five-year statewide initiative launched in January 2022 to improve outcomes for Medi-Cal enrollees, especially those with complex needs, by addressing social determinants of health. For the first time, Community-Based Organizations (CBOs) have the potential to bill Medi-Cal for some portions of their services to managed care plans (i.e., health plans), if contracted by the health plan to do so. This requires a major shift in their operations to bill CalAIM for those health plan members that CBOs serve.

Three years into its implementation, California's goal to transform Medi-Cal to "create a more coordinated, person-centered, and equitable health system" (California Department of Health Care Services) seems to be leaving behind many Fresno County CBOs, especially those serving hard-to-reach populations. Many have only a general awareness or partial implementation and financial realization of CalAIM's opportunities.

Many Fresno County CBOs – especially those serving hard to reach populations - have only a general awareness or partial implementation of CalAIM.

The ambitious statewide timeline to roll out CalAIM has been slow for Fresno County CBOs for several reasons. Fresno County is a Medical Shortage Area that would have greatly benefited from prioritization for higher reimbursement and implementation incentives. The County has both a rural and urban population, and dozens of smaller CBOs regularly serve as conduits to government services and health care for highly diverse and underserved residents of multiple languages, income levels, and cultures. Based on interview comments, both the CBOs and the MCPs have lacked understanding and communication about contracting needs and requirements, as well as how to address them.

Unlike a fee-for-service Medi-Cal financial billing model, CBOs have been primarily funded by philanthropic grants, contracts with county or state departments to extend government services to hard-to-reach groups, and fundraising events. Individual donors are in short supply in the county as compared to urban areas of the state. The mission of community-based organizations tends to concentrate on improving certain societal conditions, and they often become some of the most trusted sources of information and resources for residents. While each CBO is mission-driven and has a unique focus, they primarily

concentrate on meeting the needs of those they serve and fulfilling grant or contract outcomes, often through a wide range of time-intensive, individualized services and supports.

Therein lies the focus of this qualitative study. Few Fresno County CBOs serving the intended CalAIM target populations have initiated or completed health plan contracts and begun billing for CalAIM reimbursement. Health plans indicated they had "a full panel … with areas of opportunity for youth and service providers." Previous anecdotes from meetings with CBOs raised the question of whether CBOs, especially those working with those most in need, were sufficiently prepared to contract with health plans if they had not started. If not, what are the barriers?

Barriers gained clarity for all sides through conversations and interviews with 27 different organizations, including primarily CBOs of varied types, the two major Medi-Cal managed care plans in the county (CalViva Health and Anthem Blue Cross), four administrative hubs, and a third-party technical assistance provider. California's shifting economic situation over the past two years, along with changes in the federal government, has made adding CalAIM reimbursement more important for CBOs and government agencies as they must increase combining funding sources to provide essential resident services.

Reducing the barriers to the most elemental thematic level:

- During the first 30 months of CalAIM implementation, there was limited initial understanding and information about the steps CBOs would be required to complete and the time needed to meet those requirements to contract with a health plan.
- CBOs had limited information and understanding of how to calculate financial viability under CalAIM and of how to estimate the additional braided funding that might be needed in both the start-up phase and later upon reaching full productivity levels.
- Rates were not initially shared with a potential CBO before a health plan received and approved the CBO's application to move forward on a contract. (After a couple of years, this began to change.) This made financial calculations even more difficult.
- One of the earliest impacts that CBOs recognized is that reimbursement levels do not adequately cover administrative documentation, mileage, or services such as child care during appointments or translating documents received by clients to explain what was needed. Under grants or contracted services, these elements are intended to be built into the overall budget and are not tracked separately. Consequently, initial CalAIM participation interest was low, and taking a "wait and see" attitude was common to see if it was "worth it."

- CBOs had little knowledge of where to find support or guidance on shifting to a new Medi-Cal billing structure. The newness of this fee-for-service approach for most CBOs made it difficult for them to identify or articulate their challenges and find solutions.
- Many CBOs learned too late about the availability of technical assistance (TA) through the TA Marketplace to support education, set up billing systems, navigate the health plan contracting process, prepare PATH-CITED funding applications for infrastructure support, and understand how important health plan and PATH-CITED applications would be for their financial and contracting health. Larger, more sophisticated organizations were able to take advantage earlier.

> Missing in the local CalAIM implementation was a process to help each sector understand the other and develop a shared level of understanding before implementation.

- Information could have helped explain how to communicate a culture shift within their organizations so that productivity for services rendered becomes as important a measure as meeting client goals and outcomes.
- Federal changes, including Medicaid cuts and immigration policy shifts, heightened fear and insecurity for families, and CBOs prioritized supporting and guiding residents. When the same landscape changes affected health plans and the state, a top priority was to solidify successes in CalAIM and find ways to maintain the forward momentum. Both are important and simultaneously are counter to each other's needs for CalAIM implementation in the county.

Since the national, state, and county landscapes changed during the study, the recommendations take that into account. A study that initially focused on identifying barriers has become more urgent as the CalAIM Enhanced Care Management and Community Supports pilot waiver is set to end in December 2026.

Essentially, the Medi-Cal insurance field and the social services sector operate under different mental models. What was missing in the local CalAIM process was a mechanism to help each understand the other and develop a shared understanding before implementation could succeed.

Recommendations Summary

1. Focus immediate attention on strengthening CBO infrastructure to implement CalAIM and obtain philanthropic or other funding for this type of technical assistance and support.

2. Develop a shared understanding among the health plans, CBOs, and the state regarding the true costs and the required outcomes the parties need to meet.
3. Identify possible legislative support for the above.
4. Develop a dedicated ad hoc cross-sector working group to facilitate the recommendations and incorporate the "why" behind the implementation components for the different sectors involved.

The specificities that led to the recommendations are provided in the full report. The recommendations are also expanded on pages 26 and 27, with additional focus on 2026.

Introduction and Background on CalAIM

California Advancing and Innovating Medi-Cal (CalAIM) is a five-year statewide initiative launched in January 2022 to improve outcomes for Medi-Cal enrollees, especially those with complex needs. It received a federal waiver through 2026 to operate as a demonstration pilot with an ambitious implementation timeline. The goal is that "Medi-Cal members will have access to new and improved services to get well-rounded care that goes beyond the doctor's office or hospital and addresses all of their physical and mental health needs. These changes are part of a broad transformation of Medi-Cal to create a more coordinated, person-centered, and equitable health system that works for all Californians" (California Department of Health Care Services). For the first time, non-Medi-Cal services related to social determinants of health can be billed for specific populations and/or needs that affect their health, allowing Community-based Organizations (CBOs) to bill for some of the services they provide.

CalAIM prioritizes:

- Population health approach
- Prevention
- Social determinants of health attention and services
- Transforming services for communities that are under-resourced or face structural racism

CalAIM implementation focuses on multiple initiatives toward the overarching goal of transforming Medi-Cal. All initiatives include the following goals in some form.

- Make public health systems and managed care plans more responsive, equitable, and outcomes focused.
- Match the right services at the right time with the right provider for the right person.
- Implement Medi-Cal payment reform toward the longer-term goal of moving from fee-for-service to outcomes-based and/or a per member per month payment.
- Require managed care plans to coordinate access to services provided by counties and community-based organizations (CBOs) addressing social determinants of health.[1]

The mission of CBOs usually focuses on a target population or a gap in the social fabric of society to improve well-being or opportunity. They operate like any business needing capital, reserves, a balanced budget, strong cash flow, and capable staff. A Board of Directors provides financial oversight and selects the top executive. Any "profit" in a year is directed back into the organization. Generally, salaries and/or benefits are lower than in the governmental or private sector to keep costs lower. This is especially true for newer or smaller organizations.

CBOs in Fresno County are typically funded through three major sources. Depending on the organization's years in operation, size, internal capacity, and its ongoing mission to "meet the moment" in societal need, CBOs may rely on one, two, or all three of these sources.

1. Contracts with county or state agencies following a competitive bid selection process.
2. Grants, whether government-based or philanthropic, are obtained primarily through a competitive process that reflects the funder's interests.
3. Fund development through time-intensive "friend-raising" events and individual donors, which usually cover expenses for operations and program elements that are not eligible for contracts or grants but are important to meeting their mission.

The first two sources typically fund a range of services related to contextual need in the community or neighborhood, with all service components budgeted and invoiced monthly or quarterly against the contract or grant agreement. Accounting is provided to the funder at year end against the projected budget. It should be noted that anything outside their contracts and grants, such as working in collaborations, bringing in new technology and training staff, ongoing staff development, or the full cost of operations are rarely included in the first two sources. This can mean that important needs must occur "off the side of their desk" for senior management or budget staff time, so that service target goals are not negatively impacted by these activities.

CBOs addressing societal needs focus on two levels: 1) the individual receiving the service and 2) the environmental or social factors surrounding their clients' conditions that need improvement.

Individuals or families needing support toward economic stability, mobility, or wellbeing in human or social services that focus on social determinants of health, such as poverty, food, housing, or mental health, are served by compassionate, dedicated people, often from the communities they serve. Staff build trust through their support, enabling further service referrals if needed.

The CBO is trying to use various strategies and data to educate society that the circumstances of the individuals they serve are the product of systems in society. They use advocacy, collaboration, or other means to build communities to address and change these systems. The core belief is that systems need improvement or individual changes made will often not last or spread enough to enact lasting, community change.[2]

Historically, the medical model assumes that the individual is responsible for identifying their symptoms, bringing them to the attention of the appropriate professional, and that professional's capability will improve their life. While that works for many health situations, it does not work for many others, such as the impact of trauma, pollution, or poverty. The individual returns to the same circumstances.

> The core belief for CBOs is that systems need improvement, or the individual change from services the CBO provides will not last or spread enough to enact change.

CalAIM strives to bring the social services model into the health environment, which operates in a medical model, to better build relationships for identifying root causes and providing support. A challenge has been the level and method of payment formulas for those services related to social determinants of health. This is true for all types of organizations, not just CBOs.[3]

> A CalAIM challenge for CBOs has been the payment level and method of the formula using the medical model for those services related to social determinants of health.

There is a fundamental change in business practice orientation with CalAIM for most non-medical providers, moving from a social services construct to a medical model that is incident based or per-member-per-month reimbursement.

Medi-Cal/Medicaid has never paid full costs for services for any medical or clinical provider, regardless of whether fee-for-service, incident-based, or a per-member-per-

month payment. While CalAIM broadens the scope of non-medical services covered by Medi-Cal, the reimbursement rates for these services also do not cover the full cost of care. To receive the highest possible reimbursement, CBOs and agencies providing CalAIM non-clinical services through incident-based payment must track as many eligible member interactions as possible. They must also ensure the CalAIM reimbursement structure aligns with their organizational budget and mission. For example: instead of a Community Health Worker/promotora (CHW) focusing primarily on client needs and supporting them with resources, there is now a dual focus on client needs and productivity in the number and type of services provided that are reimbursable. These are major shifts in mental models and business practices.

There is now a dual focus on client needs and productivity.

The health plans become responsible for contracting with providers, which now include CBOs, to provide the full range of services required for the various initiatives and target populations. Under CalAIM:

- CBOs invoice the health plan their contracted rate(s) for services rendered.
- The health plan approves the invoice and is responsible for invoicing the state and managing any required back-up documentation.
- Once the funds are received, reimbursement is provided back to the CBO.

Since the launch of CalAIM in 2022, policy refinements from the state for the various initiatives have been ongoing, which have increased administrative needs to CBOs and managed care plans alike after contracts were executed. Community Health Workers have also been approved as a covered benefit for state Medi-Cal fee-for-service and can be billed with specific codes for set rates. These rates are based on time with the client and do not include administrative time or any code for rural areas, which incur higher mileage costs.

Cal AIM fundamentally changes business practices for most non-medical providers.

The California Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion and Development (CITED) funding to enable the transition, expansion and development of Enhanced Care Management (ECM) and Community Supports capacity and infrastructure. **ECM and Community Supports are two major areas of CalAIM** services and funding opportunities for community-based organizations that are contracted separately with separate requirements and MCP applications to participate**.** The multiple and different applications add to the complexity and administrative time to

CBOs. **These two initiatives were the primary focus of the interview process** for all involved in this study.

PATH-CITED funding held its last round of applications in May 2025, completing the total $1.5 billion provided statewide for capacity building and infrastructure during the five-year period. Additional funding for health plans is almost completely (if not fully) spent to utilize as incentives for providers by providing staffing and infrastructure transitional funding (known as IPP – Incentive Payment Program) for local markets.

Federal waivers for Medicaid have a five-year expiration date and need renewal approval. The CalAIM demonstration project that includes ECM and Community Supports is set to expire on December 31, 2026. In July 2025, the state developed a concept paper to continue California's transformation of Medi-Cal for another five-year federal waiver. Planning is now occurring if federal waivers are not approved. **Most of the services in Enhanced Care Management (ECM),** the most complex to implement for CBOs, **have already been approved by the Center for Medicare and Medicaid Services (CMS) as a covered benefit for Medicaid in California** because of the demonstration project**,** even if the new waiver proposal is not approved.

State planning is occurring if a federal waiver is not approved to continue CalAIM implementation.

It appears that CalAIM Community Supports services are now officially combined with ECM to fall under the final approval as a Medicaid benefit already provided by CMS. The California Department of Health Care Services (DHCS) CalAIM website has been updated to show Community Supports on the ECM site together instead of separate sections. The cover sheet of the June 2025 Community Supports initial evaluation uses the language "in lieu of services" that in the current waiver allows MCPs to contract with providers and CBOs for Social Determinants of Health (SDoH) services related to health care.[4] As of the end of November 2025, the KFF (formerly known as the Kaiser Family Foundation) national tracker on federal waiver activity shows the 25 states approved with SDoH in their waivers for demonstration projects and six states with pending waivers that include SDoH. California's CalAIM waiver showing SDoH "in lieu of services" is listed for Community Supports as approved.[5] There have also been verbal statements from state-level staff in public meetings indicating 12 of 14 Community Supports are now covered by Medicaid as a benefit.

The CHW benefit for Fee-for-Service Medi-Cal is a state Medi-Cal benefit and not under the federal Medicaid waiver.

Project Description, Objectives and Research Questions

The study was initiated because anecdotal reports from other collaborative meetings indicated that key community-based organizations (CBOs) serving diverse populations were not yet included in health plan CalAIM networks. This feedback highlighted a gap in network coverage and informed the decision to launch the research.

Project planning occurred prior to the 2024 presidential election. The change in administration slowed implementation of the study but has had the benefit of greater understanding of needs in the current environment by the conclusion.

As interviews began, a statewide report from the California Health Care Foundation[6] suggested the Central Valley had stronger familiarity for CalAIM and implementation than those on the ground appeared to know. A more recent CHCF report published in January 2026[7] offers more of the full context beyond CBOs on the impact of CalAIM in the region and confirms CBO difficulty participating and the very high-level reasons.

The study plan design focuses on the impact of CalAIM implementation for CBOs in Fresno County. Cradle to Career Fresno County and First 5 Fresno County partnered to conduct key informant interviews with the identified organizations, collaborating with Central Valley Health Policy Institute (CVHPI) to develop the questions. CVHPI provided data collection and analysis for the project. The team aimed to gauge the organizations' knowledge and experiences with the CalAIM contracting and billing processes in the Central Valley. Perspectives were also sought from health plans, technical assistance providers, and administrative hub providers to provide a well-rounded understanding of the issues.

Goal

- Understand how CalAIM is being implemented now and identify opportunities to maximize its impact and better coordinate it in our region.

Objectives

- Identify where local community-based organizations (CBOs) are in the CalAIM process.
- Capture CBO and Managed Care Plan insights into their successes and challenges with the CalAIM contracting and implementation process.
- Assess how to maximize CalAIM and the coordination of braided funding opportunities

Research Questions

- How are local entities experiencing the implementation of CalAIM?
- What are barriers and opportunities for:
    - Helping CBOs be successful in implementing CalAIM within their organizations?
    - Systems at the regional and state level to support CBO CalAIM implementation?

Research Methodology

Quantitative Data

- Pre-survey for the CBOs to determine the size of staff and budget range of organizations, number of staff that could be involved in CalAIM services, and roles of those in the teams being interviewed
- Survey completion for CBOs for any changes in TA Marketplace provider use since the interview

Qualitative Data

- Qualitative interviews
- Technical Assistance Meeting with CBOs and a Technical Assistance Provider

Analysis

- Descriptive Survey Analysis
- Grounded Theory Coding and Theme Analysis

Methods

The Central Valley Health Policy Institute (CVHPI) team collaboratively developed semi-structured interview questions for CBO and health plan participants. Cradle to Career Fresno County (Fresno C2C) and First 5 Fresno County (First 5 Fresno) individuals conducted additional interviews with the Chief Operational Officers (COO or equivalent) of two administrative hubs and with the Technical Assistance (TA) Marketplace provider's COO, whose representative conducted the technical assistance meeting for eligible CBOs in September. Qualitative data themes from all interviews are included in this report. The interview guide was developed in collaboration with the planning committee, which included senior representatives from the Department of Public Health, Cradle to Career Fresno County, First 5 Fresno County, Centro La Familia Advocacy Services, the Central Valley Community Foundation Fellow coordinating a community-health workgroup in the Sierra San Joaquin Jobs (S2J2) initiative, and the Central Valley Health Policy Institute at Fresno State. The interview guide for the Managed Care Plans was developed after reviewing initial findings from the CBO interviews.

The planning committee reflected on the final themes and consulted on recommendations and the direction of next steps. Highlights from the report were shared with the interviewed CBOs in mid-January 2026 for their input on recommendations and their viewpoints on next steps, given the changing landscape since the research began. Determination of the priorities of recommendations and/or additional recommendations will lead to the next phase of action.

Data Collection

- Qualitative data were collected through interviews with key informants, including local CBOs, the Fresno County Department of Public Health, a third-party

administrator, and two Managed Care Plans. During each interview, the CVHPI team documented and collected data in the form of detailed notes.
    - In addition, the team distributed a pre-survey for participants to self-report on basic information about the organization, like size and capacity, as well as familiarity with the CalAIM contracting process.
- Interviews with CBOs were conducted from February 2025 to May 2025 and were interactive. They often included some education on CalAIM or organizational support opportunities when needed or desired.
- A separate meeting for newly participated CBOs occurred in September 2025 in a different format, providing an overview from a TA Marketplace provider with an opportunity for questions. A survey also was conducted on the number of CBOs now contracting or in process, as well as any now billing, for all those previously interviewed through May.
- Interviews for Managed Care Plans occurred in September 2025.
- Interviews for administrative hubs occurred in October and November 2025.
- Federally Qualified Health Centers were not included in this sample. Although they were originally intended to be included, the federal landscape may yield many changes to these systems. Interviewing them later may be more impactful to understanding their adoption of CalAIM.

Data Analysis

- A thematic analysis was conducted to analyze all data collected from the interviews from both the CBOs and the Managed Care Plans. Data was coded by the CVHPI research team with two members independently coding one set of interview notes, followed by a team review of four people to ensure accuracy and address inconsistencies.
- Final themes and codes were analyzed using Claude Opus 4 and fact-checked by Dr. Tania Pacheco-Werner of Central Valley Health Policy Institute.
- Data was reviewed to fact check the findings by Brooke Frost, Cradle to Career Fresno County and Hannah Norman, First 5 Fresno County. Hannah and/or Brooke conducted the interviews and had first-hand knowledge of what was discussed. The final themes presented here also reflect that feedback.

Results

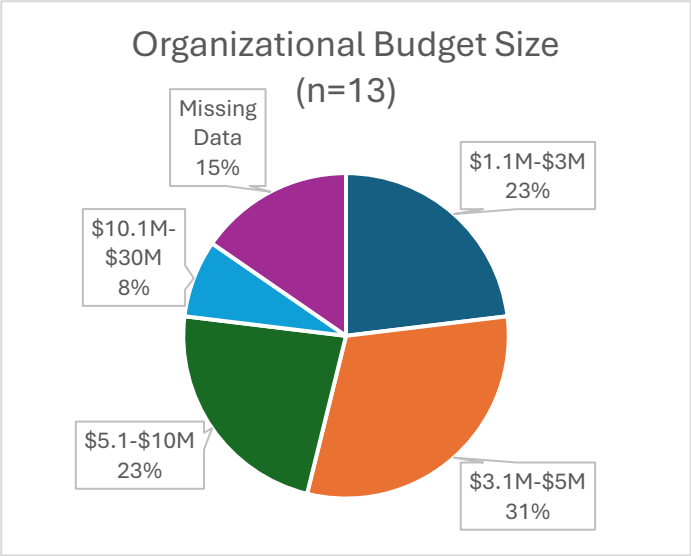
There was a wide range of CBO participants in organizational size and knowledge of CalAIM specifics, although there was high familiarity that CalAIM existed and its general intent. In addition, the interviews were intentionally designed to share high level background information and interviewers provided resources when desired. The semi-structured interviews were in two parts: 1) current knowledge and experience with CalAIM and 2) involvement with braided funding and level of braided funding implementation practices. A list of all participant organizations interviewed is provided in the Appendix.

Participating Organizations – Total 27

- 19 Community-based organizations
    - 13 completed the pre-survey, although questions may have not been answered by all those completed.
    - The majority of those interviewed were CBOs with the Home Visitation/CHW Network coalition which serves families throughout the County.
- 1 local government agency department/division
- 1 regional third-party administrator (TPA), which also had a team of CHWs of its own
- 1 technical assistance provider for TA Marketplace
- 2 Managed Care Plans
- 3 Administrative-only Hubs

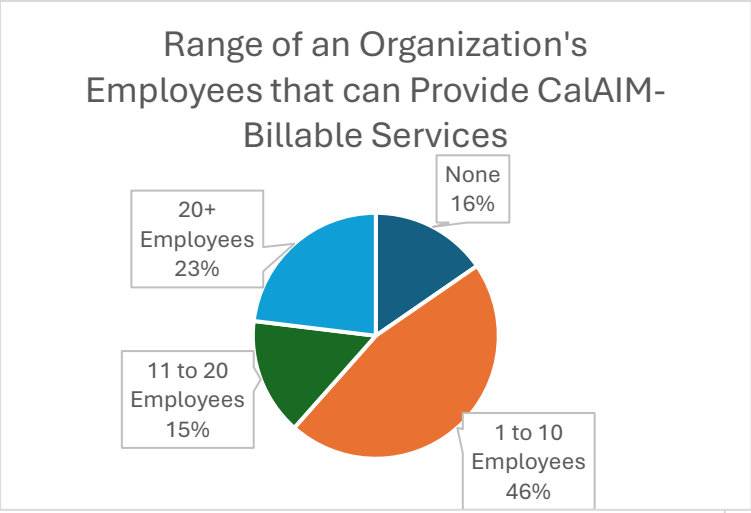
The Fresno County CBOs provide services primarily to both urban and rural clients. Rural services occur virtually or in-person, whereas urban locations are usually in-person.

- Urban and rural regions: 16
- Urban regions only: 5
- Rural regions only: 1

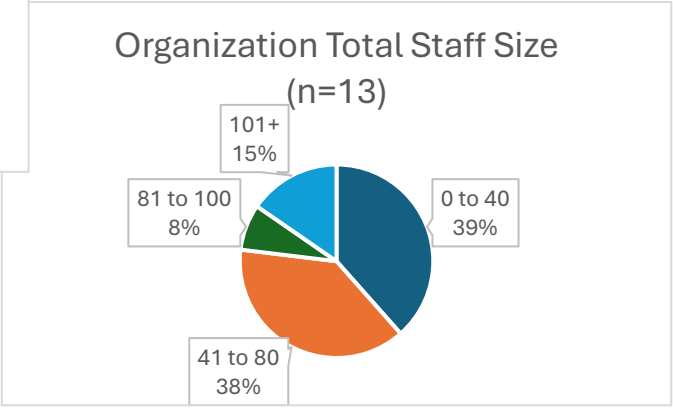


Quantitative Results

Organizational size and total staff numbers per organization depict the range of CBOs of those interviewed, even if incomplete. When asked about the number of staff that can provide CalAIM-billable services, almost half were in the lowest range of employees at 1-10.



Discussing pre-survey responses in interviews showed confusion on the question about current billing occurring for either Medi-Cal or CalAIM services. This may be due to the survey question not being clear to respondents or that CBO interpretation of the question assumed a positive answer if they were presently attempting to contract (or even desired to contract) with the health plan on the area they would bill for Medi-Cal or CalAIM. This



rendered inaccurate results for a quantitative baseline in Medi-Cal or CalAIM billing experience when compared to what was learned through the interviews and through follow-up questions.

Similar confusion occurred in pre-survey responses to the question about which managed care plans CBOs are already CalAIM contracted with, are in the process of contracting with, or are considering contracting with in the future.

Reviewing pre-survey answers in interviews opened the door to probe further on level of knowledge of the process to become contracted with the health plans and the different CalAIM billable services. It also became an opportunity to educate and provide resources for assistance such as sources to learn more about the specifics of CalAIM, roundtables, a direct TA Marketplace link, county partners they could talk with about their TA experience, or a direct connection to a possible TA provider.

CBO Thematic Analysis

Every theme identified below became even more complex to address as federal policies changed in 2025. Instead of juggling two simultaneous operational challenges, they now need to juggle three.

- **Challenge 1** – Maintain the capacity to serve clients and regular operations.
- **Challenge 2** - Learn about CalAIM, the steps and timeline for becoming health plan partners when unfamiliar with a Medi-Cal model and its impacts, and the organizational changes that require mental and business model shifts for implementation.
- **Challenge 3** – Assess Medicaid and federal waiver changes in California, evaluate potential impacts on their organization, begin contingency planning, and maintain staff morale.

The tension for CBOs around the challenge priorities and the impact on clients cannot be overstated.

The individuals and families most affected by the difficulties of addressing two, and now three, large challenges simultaneously are those supported by CBOs. Without trusted CBOs, government agencies or health plans are only partially successful, or sometimes unsuccessful, in reaching our community's most underserved and under-resourced residents. The tension around addressing these three challenges and the impact on clients cannot be overstated.

A steep learning curve creates the paradox of access

Three years into CalAIM's launch, many CBOs are not fully aware of CalAIM opportunities, even though they already provide eligible services. A strong sub-theme is the challenge of identifying the first step toward the final step of billing CalAIM. Finding a summary of all the steps needed appears nonexistent. Interviewees repeatedly asked for one that would provide an overview for internal review and planning to develop the necessary infrastructure and processes, with an anticipated timeline culminating in billing.

> "We are in the stage of learning what we don't know." Executive Director of urban/rural serving CBO

CalAIM infrastructure as an organizational cultural transformation created implementation complexity even for "successful" organizations

> "We are spending lots of our own money to not spend someone else's little money."
> *Executive Director, rural/urban serving CBOs*

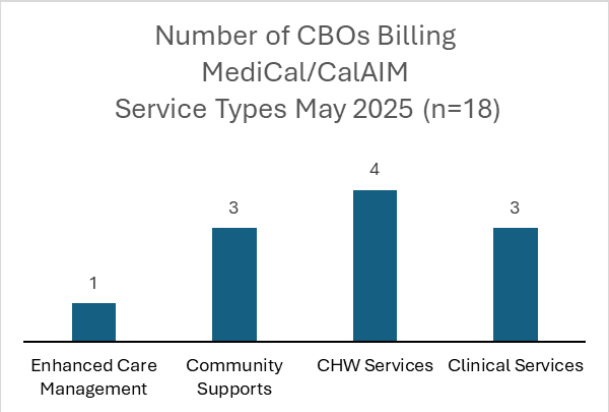
The very few who were already billing reported a multi-year timeline from the beginning of the process to the first bill. It then takes six months to a year to begin gaining sufficient invoice reimbursement to provide any sort of sustainability. For those who were smaller, the development or overhaul of their systems was and is a big feat. Key to being able to advance to the next step was PATH- CITED funding. However, even finding out about such funding can be a challenge to smaller organizations. This may be due to the capacity to track or apply, a lack of relationships with government agency staff, existing coalitions, or others to alert them, diverse language needs, or geographic location that exacerbates relationship development as a start. Few were able to do so and now it is no longer available.

Financial sustainability occurs through fragmentation: Multi-funder coordination remains unintegrated and burdensome

- Organizations must fragment their services and funding to survive, undermining the holistic care that CalAIM purports to support.
- Fragmenting services creates administrative complexity in tracking.
- The cost/benefit ratio for CBOs is unclear for this type of contract over the long term.
- CalAIM involvement may be challenging for mission-driven organizations intentionally serving specific communities. They work to improve access, provide culturally appropriate education, offer translation in less common languages, and assist with navigation and appointments that require extra time and costs.

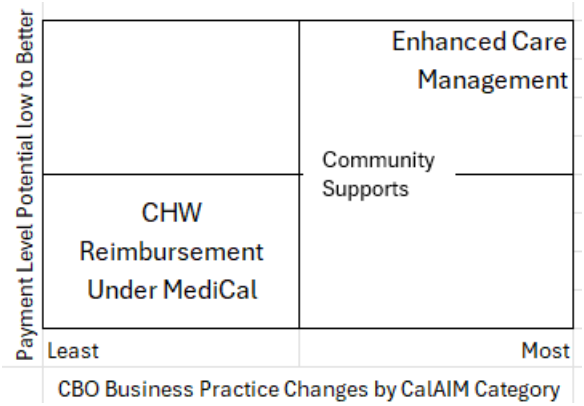
- Different reporting requirements from each funder create additional barriers.
    - Different reporting requirements for county vs. state vs. philanthropic funding vs. CalAIM health plans makes "tracking timesheets a challenge."
- There is no person-level tracking across funders or payors for narrative or quantitative reports to avoid duplication.
    - Unclear implementation details can lead to delayed or denied MCP reimbursement for CBO providers. For example, when multiple CBOs submit CHW-only invoices for the same type of service for the same MCP member, the plan reimburses the first submission and may take 30–90 days to notify any other. Similar delays occur when a Community Services contracted CBO is unsure about levels of preauthorized services for the CBO if other family members elect to receive services.
    - Braided funding for services that are comprised of CalAIM reimbursement and philanthropic sources requires strong administrative and accounting practices to avoid audits citing supplantation.
- The following questions concern CBOs: Can or will government entities remain non-participants, while being champions for implementation, or are they now planning and/or will they need to implement this model for their own internal programs too? Will their contracts with CBOs for ongoing services be impacted by government billing through CalAIM?
- There is concern that government agencies could contract directly with health plans and bill CalAIM without involving currently contracted CBOs, particularly in a climate of shrinking federal funding and state budget deficits.
    - This shift could create financial instability for CBOs and contribute to mission drift. It may also weaken provider-client relationships and reduce access to services for clients who are harder to reach due to cultural, linguistic, disability-related, or geographic barriers.
    - Expanding whole-family care within government systems can also strain their internal capacity. Legislative changes frequently redirect departmental priorities, reducing bandwidth for previously established community commitments.
- Access to MCP system-like selection of becoming a provider and resources like PATH-CITED funding can create competition among CBOs for limited opportunities.
- MCPs appear to now have a greater interest in full-service providers across the entire age, target population, geography, and service type continuums for contracts.
    - State or national providers are moving into the area and directly contacting CBOs to subcontract in some form. Residents are unable to recognize CBOs they already trust in these arrangements since sub-contractors are not published in MCP directories. In addition, those administrative funds are moving outside of Fresno County.
- There is fear of alleged fraud or lack of compliance at the expense of their own uncompensated labor. "We are spending lots of our own money [to avoid these perceptions related to invoicing] to not spend someone else's little money."

Financial sustainability utilizing CalAIM is a concern. Not only are the rates considered insufficient by CBOs, but it is also a multi-step and time-consuming process to first apply to a health plan, be approved by the plan, implement new infrastructure, train staff, and help staff understand how to document for invoicing back-up and the organization's accounting audit.



At the conclusion of the initial CBO interview period in May, billing had just begun for only a small portion of the CBOs. By January 2026, nine organizations had invoiced health plans, four for ECM and six for Community Supports.

Stand-alone CHW reimbursement is considered by CBOs to be the least profitable but the easiest to bill.

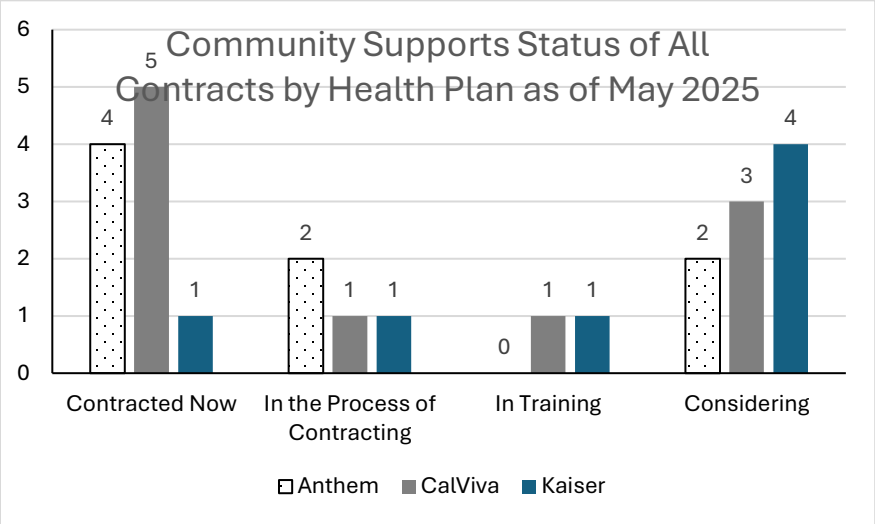


Community Supports offers payment for services that some CBOs already provide with infrastructure and organizational requirements that are easier to accomplish.

Once they understand ECM, many CBOs learn they already help their clients navigate the systems involved, provide client education for families, and deliver the services or support the different targeted populations they cover. They have just not previously itemized or tracked their work the way ECM billing requires. It also requires a greater shift in business practices, Medi-Cal billing expertise, more sophisticated information systems, increased internal policies and procedures, a Medi-Cal licensed provider, and a longer ramp-up and implementation preparation phase. ECM has the highest potential reimbursement.

Only one CBO interviewed had experience billing ECM in the primary interview phase ending in May. At the end of September, four CBOs submitted ECM invoices to a health plan. All acknowledge that they are learning and do not expect financial viability in the first year of billing.

The size of the CBO, organizational capacity, and business acumen appear to impact how many contracts with health plans are sought for the Cal AIM benefit (ECM or Community Supports), with billing for CHW services a last priority for some mid to larger CBOs. Small CBOs seem to start contracting with CHW reimbursement as it requires the least level of contract development with health plans and a simple invoice developed for submission. It also is the least profitable for those with lower budgets.



Why it works: Established community trust and potential for deep community impact

CBOs have the trust of the communities they serve and are actively engaged with their clients to improve their lives in ways that government bureaucracy finds difficult to sustain. Health plans acknowledge that the relationships and trust built by CBOs with their clients are critical to the success of the CalAIM model. CBOs acknowledge that their usual sources of grant funding, including philanthropic, local government, state, and federal sources, are uncertain, which has increased their willingness to try CalAIM even with its many challenges. There are also positive stories from CBOs about how CalAIM benefits, such as housing placement, day habilitation, and transitional rent support, have helped families.

There are populations at risk

Although CalAIM has equity at the forefront, CBOs serving special populations felt that their needs didn't fit within the CalAIM Medi-Cal model. Those serving people with disabilities or with specific language needs felt the model did not or could not match their clients with the services people in the communities need. New and growing populations have languages that CBOs currently lack staff or person-level translation services for, which are needed for relationship-building and trust.

> System efficiency requirements might exclude the populations most in need of services.

Those serving rural communities felt like their services had to be limited or that they could not provide the level of services they wanted for families if the model was to be sustainable for their organization.

System efficiency requirements might exclude the populations most in need of services.

Managed Care Plan Thematic Analysis

Managed Care Plans reaffirmed their commitment that CBOs are critical to CalAIM's success. At the same time, their health plan network deadlines for the state differed from CBO entry timelines that CBOs could achieve. There appears to be an incongruence between the actual and perceived nimble agility of a CBO and the internal capacity available to move on their timelines. There also appears to be an expectation that CBOs will understand how to make financial projections using a Medi-Cal billing model to the best advantage. The fact that health plans were trying to adjust to changing state policies and develop their own systems for CalAIM simultaneously with CBO contracting exacerbated CBO difficulty to engage.

Managed Care Plans view their CalAIM work as embedded in communities through trusted CBOs/Providers

- MCPs value CBOs already addressing SDoH issues.
- MCPs value CBO lived-experience staffing.
- CBO is responsible for budget needs, forecasting, and a knowledgeable point person for billing.
- MCPs have moved attention from start-up to implementation efficiency.
- CBO must drive referrals, not the MCP.

- MCPs identify and partner with trusted organizations/providers who are already working on Social Determinants of Health (SDoH) issues.
- MCPs aim to reinforce and bolster CBOs/Providers' mission statements.
- CalAIM meets people where they are and there has been nothing like this in the past.
- MCPs estimate that at least 90% of approved providers have been contacted with the opportunity to use incentive payment program (IPP) funds for staffing, infrastructure, training, and upfront (startup) costs.
- CalAIM should expand existing operations and not change what CBOs/Providers are already doing.
- A key element of success is lived-experience staffing for those in the field.

MCPs' assessment criteria for CBO/Provider's capacity to contract with Managed Care Plans is unclear

- MCPs screen CBOs/providers to assess their capacity to work together but were unclear about what criteria need to be met.
- TA providers and third-party administrators also screen CBOs/providers for their capacity to work with MCPs and the CBO contracting readiness.

CBO/Provider budgeting is a problem at several stages of the contracting process

- CBO/provider is responsible for forecasting capacity and budget when considering embarking on contracting through CalAIM funds.

    - MCPs stated they need to consider the number of referrals that can be made consistently.
    - MCPs want to know there is an internal point person with knowledge of Medi-Cal billing and CBO/provider capacity.
- The MCPs differ in their reimbursement method; one believed that pay per service (with creativity) allows for greater reimbursement and revenue compared to a per member per month rate.
- Currently, MCPs are focused on efficiency of implementation – not startup of ECM or CS because IPP funds are either gone or almost gone, depending upon the plan.
- There is potential for organizations to go out of business if they do not update their current infrastructure to administer MCP contract requirements.

"There is potential for CBOs to go out of business if they do not improve current business practices to administer MCP contract requirements."
- Managed Care Plan participant

Referrals are a Bottom Line in the Work

- Relationships with MCPs are stronger when CBOs prioritize contracting and a strong referral process workflow.
- Contracts with those serving children is a gap.
- MCPs need to keep state timelines for implementing target populations; now moving to Justice-involved population

Referrals for services from MCPs or non-contracted entities are an issue

- MCPs noted that the CBO/Provider has to drive referrals, not the MCPs.
    - Successful implementers already have a base of patients that they regularly work with to provide referrals.
    - MCPs may provide referrals but are not the driving force.
- It has been a major MCP challenge to get non-contracted stakeholders to refer patients to organizations who can provide ECM or Community Supports.

Work at all levels is relationship driven for greatest success

- Relationships with CBOs/Providers were stronger when the CBO/Provider was agile and highly motivated to see the contracting process through.
    - Agility depends on the CBO/Provider's ability to highly prioritize contracting and establishing a high-functioning referral process workflow, rather than trying to fit it into existing contracts and grantmaking work.

- MCPs must adhere to strict federal and state policy standards that many CBOs/Providers find difficult to meet.
- Success improved when CBOs/Providers made themselves available and responsive to the MCPs.
- The working relationship between MCPs and the agencies they need for their network may vary across counties. In Fresno, specific MCPs may not be perceived by CBOs as a childhood services stakeholder.
    - MCPs noted that if the CBO does not have the bandwidth to go with two MCPs, then they choose the one that is perceived as a childhood stakeholder.
- Other counties may be more integrated across systems than Fresno County.
- One MCP interviewed may not have been actively collaborating with certain county departments prior to CalAIM, making collaboration and integration of CalAIM workflows difficult.
    - An example cited was difficulty working with Child Welfare Services (CWS) departments as there were no pre-existing relationships with CWS staff. Previously, MCPs had little to no contact with Social Services departments, as they were not involved in health-related contracts for the MCPs.

> "For ECM…we are investing in CBOs but as a managed care plan, we have to show results. Sometimes the easiest way is to go with the larger scale firms." - MCP Participant

- MCPs are making the effort to bring on local CBOs and not overly rely on outside firms doing CalAIM work across California.

MCPs have identified children as a gap in services and a priority target population

- Although there are challenges in services across the SDoH spectrum (e.g., rural and mental health), children are the only priority gap in services identified by MCPs' recent assessments.
- Connections for respite for children and families have been very difficult.

Shifting Priorities in Service Needs

- MCPs are shifting their CalAIM priorities toward the next target population to meet housing needs for justice-involved individuals and ensure continuity of coverage and care beyond incarceration.
    - This type of work requires specialized knowledge and

> "We don't need more of anybody [CBOs/Providers], but we need more depth of understanding and referral training." – MCP Participant

training to provide adequate wrap-around services and housing services for this population.

- Dollars are shifting for behavioral health billing and responsibilities. The county behavioral health departments were responsible for all behavioral health services to the state and contracted with the health plans to provide mild to moderate level services. There was a complex billing process between the county and health plans to ensure the health plans were reimbursed. Under the Behavioral Health Services Act/Proposition 1 passage, this changed.
    - Health plans are now responsible for contracting behavioral health services for the CalAIM initiatives for mild to moderate level service needs. They now receive those provider/CBO invoices, bill the state, and reimburse the providers/CBOs.
    - Department of Behavioral Health is responsible for an integrated planning process for State submission with an extensive list of partners related to behavioral health outcomes at all intensity levels across the mental health continuum.

Uncertainty about the future of CalAIM

- Both health plans expressed concern about program sustainability.
- The waiver issue creates uncertainty about how operations will continue beyond December 2026.
    - Planning for that future is a challenge since no [federal] decision [on the proposed waiver] has been made yet.
- There is certainty from the MCPs that ECM and Community Supports will have ample programming if CBOs continue to make referrals.

MCPs are confident that ECM and Community Supports will have ample programming if CBOs continue to make referrals.

Technical Assistance Insights from Technical Assistance Marketplace Provider and Administrative Hubs

Technical Assistance (TA) Marketplace Providers began operating in 2023 after a state application and vetting process. Their services are paid for by the State and are free through 2026 to those CBOs and agencies embarking on adding CalAIM reimbursement. It was up to the organization to find a TA Marketplace provider that matched its organizational needs. TA providers were consistently added, with more than 1,000 eventually listed. The state underwrites the TA Marketplace providers through 2026, and new applications accepted must have projects completed by December 2026.

Administrative hubs as a category lack a consistent definition. Each varies depending on their scope of work. The one consistent factor is that they provide invoice services on

behalf of the CBO to the health plan or the State and take a percentage of services reimbursed as their administrative fee.

TA Effectiveness Challenges

- Complexity remains high: Despite TA being available for more than 2 years, many community organizations still struggle to understand how to participate.
- Translation to practice gap: A TA provider may help with understanding but not always with practical implementation.
- Organizations using TA providers are preparing for the end of funding. Not all operational elements may be completed.
- What happens now for CBOs as TA marketplace is ending?

> What happens now for CBOs as TA Marketplace ends?

Gaps in Current TA Offerings

- More hands-on support is needed with MCP-specific requirements (given the variation across plans).
- Ongoing support is needed rather than one-time consultations, which will be expensive for CBOs to bear the cost once all TA Marketplace contracts sunset on December 31, 2026, or for those who did not have time to conduct a project for the whole range of assistance needed in 2025.
- Support for data integration and interoperability challenges among systems utilized are needed.
- There's recognition that organizations serving marginalized communities need specialized TA to navigate system requirements while maintaining their community connections.

Administrative Hub Variances

- Administrative hub rates for their administrative fee to CBOs ranged from 10% to 40%.
- Through the interviews, four administrative hubs in Fresno County were identified. Only one was known at the outset of the interview process.
    - Pear Suite has a CHW network component and an administrative hub component. They have their own contracts with health plans, allowing CBOs to serve as their subcontractors, but these CBOs are not listed in provider directories. They provide some technical support.
    - Full Circle is an administrative hub that provides no CBO technical support for contracts with health plans. They are the contracted provider with the health plan and none of the CBOs they administer are listed in directories.
    - Fresno County Superintendent of Schools (FCSS) leads a multi-county, 39 district coalition of smaller districts to bill for schools under the Multi-payer Fee Schedule for School-linked Behavioral Health. These codes and rates differ from those used by CBOs/MCPs.

        - If a CBO working with a school under the FCSS Coalition wishes to utilize the administrative hub for the district, the CBO would need to join the coalition and utilize their administrative fee.
    - HOPE Hub under Fresno Community Health Improvement Partnership (FCHIP). Care Coordination Agencies hire local Community Health Workers (CHWs) to diminish linguistic and cultural barriers and improve health within their communities. The evidenced-based Pathways Community HUB Institute℠ Model encourages CHWs to perform services until completion. This was a known administrative hub entity and has been focused on paying CBOs based on outcomes achieved per their pathway model. FCHIP bills Medi-Cal for CHW services and in Community Supports. Their CBOs are not listed in provider directories.

Discussion

Both CBOs and health plans have the member's improved health and well-being as a member outcome goal. The systems and models within which they operate differ, including funder expectations for results. This means all parties need to understand what others need to achieve results. This has been difficult to achieve and has contributed to the slower pace of CBO uptake in initiating the contracting process. **To truly achieve this level of cultural change in operations for both sectors requires clear, planned communication**, executed by an entity that understands the needs of both, prior to implementation, and then works together with the same level of understanding of expectations, processes, and outcomes.

> This level of cultural change is most successful with strong and frequent communication across systems to level-set understanding about each system and determine implementation needs.

Despite California DHCS's best efforts, **the timeline provided could not achieve that level** because both DHCS and the managed care plans were developing new systems almost simultaneously with the implementation of CalAIM. Neither system seemed to know which local CBOs had made the greatest progress with target populations that included marginalized groups, and there was little time to immediately roll out ongoing communication about opportunities, assistance, and support. **There was little time to recognize and understand the social services model of operation these CBOs operated under and to provide the level of assistance needed to incorporate a new-to-them financial model.** Mind-set shifts take years, and **health plans needed to meet state timelines for building a local network about which local CBOs had little initial knowledge or were unable to meet** due to lack of resources and personnel capacity.

The change in national administration and its orientation to health care is also affecting all parties. The change in the federal environment toward Medicaid waivers was not likely anticipated at the time of initial waiver approval by California DHCS. On the one hand, moving so quickly in the first three years (with or without the local CBOs) had the benefit of many services under California's waiver becoming approved as federal Medicaid benefits. These can be maintained should a second waiver not be approved. On the other hand, many CBOs may lose the opportunity to gain much-needed technical and infrastructure assistance unless other means can be identified. The intended integration of services to address social determinants of health that affect member wellbeing and improved health are difficult to maintain in a climate of restricted funds that often can enhance competition instead of collaboration.

> The financial and operational stress from the changing national context will rise for government and CBOs alike… ultimately affecting clients/members the most.

As state and federal funding to counties and organizations continues to decline for a variety of economic and legislative reasons, financial and operational stress will rise for government and CBOs alike. Ultimately, this most negatively affects the clients and residents each entity is committed to serving and supporting. A strong commitment to building integration and collaboration can be instrumental in improving systems to enhance resident health and well-being. Strong leadership and shared values matter.

Study Limitations

Although a wide range of CBOs were reached, the focus was on social services CBOs, so some providers contracted with health plans are not included. Not all CBOs initially contacted chose to participate for various reasons, including timing or lack of response, though these were few. The quantitative elements cited are not generalizable, both because of the number obtained and because not every participant completed every question. Health plans were unable to provide directories in a format that would allow cross-comparisons of those in their network with those interviewed, and specific organization involvement in networks was deliberately avoided during interviews. Future studies could include a broader range of providers to capture the full range of barriers and opportunities associated with CalAIM moving forward.

Recommendations and Next Steps

When this project was conceived, the goal was to identify improvements to increase local CBO participation in CalAIM after identifying the obstacles. Although it is still a project goal, the political and environmental landscape affects priorities and timelines. Now the specter of CBO survival arises in the mix of effort, and county agency employee retention

efforts that could affect their own and CBO success bear ongoing monitoring and as much transparency as possible.

Overall Recommendations

- Focus on strengthening CBO infrastructure in all aspects before the current California federal waiver ends for CalAIM and the ECM and Community Supports components.
- Focus on how to operationalize braiding funding for future financial stability.
- Assuming the state maintains its goal of improving health outcomes for residents and integrating social determinants of health with physical and mental health services, develop a shared understanding among all parties regarding CBO true costs of providing services in Fresno County and the health plan's state-required outcomes and timelines they are mandated to achieve.
- Advocate to legislators that CDHCS revise health plan rate structures in Fresno County (and others) that will more closely allow individual county contextual factors to be addressed.
- Identify and solicit immediate philanthropic funding for focused CBO education and the implementation of CalAIM billing and technical assistance support.

Recommendations for 2026

1. With the help of CBOs, invite all Fresno County and neighboring county CBOs who might benefit from CalAIM reimbursement to a summit in the first quarter of 2026 to lay out the landscape of opportunity and decisions. Include breakouts by level of familiarity and implementation. Include health plans as both presenters and learners, among others.
2. Identify and secure funding for ongoing coaching and/or infrastructure support for 2026 and beyond.
3. Develop a pilot involving a mix of rural and urban, larger and smaller CBOs to develop true costs for services provided under CalAIM and Medi-Cal for the Department of Health Care Services, health plans, federal/state legislators, county agencies, and philanthropic funders.
4. Create a cross-sector local working ad hoc committee to design, manage, and implement the recommendations.
    a. Cross-sector at minimum is defined as CBOs working with rural, urban, mixed language, disabilities, and both larger and smaller in size and budget, county agencies, health plans, Cradle to Career Fresno County backbone staff, First 5 Fresno County staff, and a Sierra-San Joaquin Jobs (S2J2) Community Health workgroup representative.
5. Educate state legislators and their staff on key points and determine if there are any future legislative opportunities.
6. Show the value of CBO work in CalAIM and the related investment through a small evaluation, a case study, a cost-effectiveness study, or all three.

Appendix

Participating Organizations

Community Based Organizations
BLACK Wellness and Prosperity Center
CA Health Collaborative
California Farmworker Foundation
Centro Binacional para el Desarrollo Indígena Oaxaqueño
Central Valley Children's Services Network
Centro La Familia Advocacy Services
Comprehensive Youth Services
Cultiva La Salud
Cultivating Communities Together
Easterseals
Exceptional Parents Unlimited
Fresno Immigrant and Refugee Ministries
Fresno American Indian Health Program
Fresno HOPE/FCHIP
Reading and Beyond
Sia's Place
Valley Center for the Blind
West Fresno Family Resource Center
Westside Family Preservation Services

Government Agency
Fresno County Department of Public Health, Maternal Child Health and Health Policy and Wellness Divisions

Managed Care Plans
CalViva Health
Anthem Blue Cross - Medi-Cal Managed Care

Technical Assistance Provider
TRUE Management, LLC

Third Party Administrators
Fresno Community Health Improvement Partnership (FCHIP) – HOPE Hub
Fresno County Superintendent of Schools, Student Services Division
Full Circle
Pear Suite

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Authors

Brooke Frost, Tania Pacheco, Emanuel Alcala, Hannah Norman

Research Team

Tania Pacheco, Central Valley Health Policy Institute
Emanuel Alcala, Central Valley Health Policy Institute
Brooke Frost, Cradle to Career Fresno County
Hannah Norman, First 5 Fresno County

Planning Committee

Tania Pacheco, Central Valley Health Policy Institute, Fresno State
Emanuel Alcala, Central Valley Health Policy Institute, Fresno State
Elize Bradley, Central Valley Community Foundation, Sierra-San Joaquin Jobs initiative
Margarita Rocha, Centro La Familia
Valerie Tinoco, Centro La Familia
Linda Gleason, Cradle to Career Fresno County
Brooke Frost, Cradle to Career Fresno County
Fabiola González, First 5 Fresno County
Hannah Norman, First 5 Fresno County
Joe Prado, Fresno County Department of Public Health
Claudia Sandoval, Fresno County Department of Public Health
Ge Vu, Fresno County Department of Public Health

End Notes

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