CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

CALAIM MANAGED LONG TERM SERVICES AND SUPPORT AND DUALS INTEGRATION WORKGROUP

Date: June 25, 2025

Time: 11:00 a.m. – 12:30 p.m.

Number of Speakers: 4

Duration: 1 hour 26 minutes

Speakers:

- Cassidy Acosta
- Anastasia Dodson
- Laura Miller
- Christopher Tolbert

TRANSCRIPT:

00:00:53 — Cassidy Acosta — Slide 1

We have some great presenters with us today, including Anastasia Dodson, Deputy Director in the Office of Medicare Innovation and Integration at DHCS, Christopher Tolbert, Section Chief in the Office of Medicare Innovation and Integration at DHCS, and Dr. Laura Miller, Medical Consultant in the Division of Quality and Population Health Management at DHCS.

A few meeting management items to note before we begin. All participants will be on mute during the presentation. As a reminder, the quarterly MLTSS and Duals Integration Workgroups are designed to provide stakeholders with the opportunity to ask questions. We ask that plans that join these calls hold their questions for the multiple other workgroup venues that they have with the department throughout the month.

Please feel free to submit any questions you have for the speakers via the chat. During the discussion, if you would like to ask a question and or provide comments and feedback, please use the raise hand function and we will come around to unmute you. The PowerPoint slides and all meeting materials will be available on the DHCS website soon and you can find a link to where those will be posted in the Zoom chat.

0:01:53 — Cassidy Acosta — Slide 2

We'll ask folks to add their organization to their Zoom name. You can do this by clicking on the participants icon at the bottom of the window, hovering over your name and the participants list on the right side of the Zoom window, clicking more and selecting rename from the drop-down menu. From there you can enter your name and add your organization as you would like it to appear.

0:02:17 — Cassidy Acosta — Slide 3

For today's meeting, we'll begin the call by hearing about the 2026 Medi-Medi Plan expansion followed by stakeholder Q&A. Then, we will discuss the Dual Eligible Special Needs Plan, or D-SNP, implementation updates, which will be followed by a second stakeholder Q&A. After that, there will be an update on the 2026 D-SNP State Medicaid Agency Contract, or SMAC, and Policy Guide. And finally, we will have a Duals Data spotlight, which will be followed by our last stakeholder Q&A for this meeting. And we will end today's workgroup with some information on upcoming meetings as well.

With that, I'll transition over to Anastasia to walk us through the workgroup purpose and structure.

00:02:55 — Anastasia Dodson — Slide 4

Thank you so much, Cassidy, and welcome everyone. We've been having this workgroup meeting series for several years now. We're holding this meeting quarterly as a stakeholder collaboration hub for CalAIM MLTSS and integrated care for dual eligible beneficiaries. We want to get feedback from all of you. We want to share information about what's coming up and what we're working on. We have a charter that's posted. But overall, we want to emphasize that we really value our partnership with you all, whether you're advocates, members, caregivers, providers, health plans, and of course CMS, we're all working together to improve care for dual eligible members.

00:03:46 — Anastasia Dodson — Slide 5

We're going to start with an update on the expansion of the Medi-Medi Plans. We have them in 12 counties and they're expanding to additional counties in 2026. For those of you who have joined this meeting already before in prior years, this is not new. But I know that sometimes now as we're talking with stakeholders in additional counties that you may be new to this meeting or new to the idea. The next few minutes are really focused on making sure everybody's up to speed, what are the basics of what's happening with Medi-Medi Plans in California, where are we going for 2026. And then after we talk about the basics, then we're going to have more technical topics that are familiar to those of you who've been working on this D-SNP area for some time. For now, I want to make sure everybody's on the same page. Let's go to the next slide.

00:05:01 — Anastasia Dodson — Slide 6

Okay, great. There are about 1.7 million Californians that have both Medicare and Medi-Cal, people who are dually eligible for Medicare and Medi-Cal. About half of those dual eligible members are enrolled in some type of Medicare Advantage plan and that does include D-SNPs. And then about half are in Original or Fee-For-Service Medicare, and that's statewide and it varies by county. That's on the Medicare side. Now for dual eligibles on the Medi-Cal side, they are all enrolled in Medi-Cal managed care. So again, dual eligibles are all enrolled in Medi-Cal managed care plans. But on the Medicare side, about half are in a Medicare plan and half are in Original, Fee-For-Service Medicare. Next slide.

00:06:04 — Anastasia Dodson — Slide 7

With these two different delivery systems, two different programs, dual eligible members need to navigate across both, and it can be quite challenging. People who are dually eligible for Medicare and Medi-Cal have high rates of chronic conditions, whether

it's heart disease, high blood pressure, diabetes, dementia, etc., all factors that mean that they use a lot of services, need a lot of care, but again, have to navigate both sets of systems. We have an approach in CalAIM to have Medi-Medi Plans. It's already in place this year and has been for some years already in a number of counties. You can see the list of 12 counties on the screen here, that includes large Southern California counties. And we do already have enrollment of 330,000 people who are dually eligible that are in Medi-Medi Plans as of 2025. What's new is that we are expanding the availability of those Medi-Medi Plans in 2026. Next slide.

00:07:20 — Anastasia Dodson — Slide 8

From a member perspective, Medi-Medi Plans are one plan. They have one card, one phone number to call, one organization that's administering both sets of benefits. But, there are two separate contracts. There's the Medi-Cal plan contract and there's the D-SNP contract. The D-SNP contract is important because it's with CMS. Medicare sets requirements around network adequacy and Medicare makes payments to these Medi-Medi Plans for doctor visits and hospital stays. On the Medi-Cal side, Medi-Cal covers the cost sharing. Also, Medi-Cal covers long-term services and supports and transportation. So combined together, the D-SNP plus the Medi-Cal plan equals the Medi-Medi Plan. The last thing I want to emphasize on this slide is that enrollment in Medi-Medi Plans is voluntary, just like enrollment in any type of Medicare plan. Next slide.

00:08:33 — Anastasia Dodson — Slide 9

This map shows you in orange the counties where Medi-Medi Plans are already currently available for voluntary enrollment. You can see the large Southern California counties, some counties in the Central Valley as well as in the Bay Area and Sacramento. In the dark blue, those are the counties where Medi-Medi Plans will be newly available in 2026. Polka dot shows some of the North Bay Area, that's where at least one plan is going to be offering a Medi-Medi Plan in 2026. And then the lighter medium blue in the northernmost part of the state, that's where Medi-Medi Plans are going to be available later, in 2027, 2028, we will see. But dark blue, that's a lot of what we're talking about for the new changes coming up in 2026. And you can see that's more areas in the Central Valley, Central Coast, Bay Area and Imperial County. Next slide.

00:09:46 — Anastasia Dodson — Slide 10

This is an illustration meant to emphasize that Medi-Medi Plans are required to coordinate across all different types of Medicare and Medi-Cal benefits. That includes Medicare benefits like doctor visits, hospital stays, prescription drugs, labs, and includes

things that can cross over between Medicare and Medi-Cal, like durable medical equipment, long-term services and supports, nursing facilities, mental health, and dental. So, there are very detailed and structured care coordination requirements for Medi-Medi Plans. A lot of them are set by the federal government. The D-SNP structure is a national model. And then in California we have some additional care coordination requirements that we call California Integrated Care Management, CICM. We will talk more about that later in the call, but CICM is something that's very similar to ECM and you may have heard of ECM again as a CalAIM initiative. Next slide.

00:11:03 — Anastasia Dodson — Slide 11

Another piece to think about with Medi-Medi Plans is that there are some benefits in Medi-Cal that are carved out like IHSS. I want to assure you that joining a Medi-Medi Plan does not impact someone's IHSS benefits. The County IHSS agency still is the entity that determines the number of IHSS hours, and members can still have the right to hire, fire, and manage IHSS providers.

With that said, one of the really important pieces of Medi-Medi Plans is that they are required by the federal government to coordinate all Medicare and Medi-Cal benefits, including those benefits that are carved out, from the Medi-Cal plan. That includes IHSS, the Multipurpose Senior Services Program, County Behavioral Health, and Medi-Cal Dental. Those benefits are not directly administered by Medi-Cal plans, but they are Medi-Cal benefits. The Medi-Medi Plans need to coordinate with County Behavioral Health agencies, county IHSS agencies, MSSP programs, and the Medi-Cal Dental program to make sure that their members get access to those services and get referrals. The health plan is aware of what is already happening with those benefits so they can make sure to have the appropriate care coordination. Next slide.

00:12:42 — Anastasia Dodson — Slide 12

A question that sometimes comes up is, “if someone is joining a Medi-Medi Plan, can they still get Community Supports?” The answer is yes. Community Supports are through the Medi-Cal plan, and they can be authorized just the same as if the person was not in a Medi-Medi Plan. The one thing, though, is that the Medi-Medi Plan does need to coordinate Community Supports and all other Medi-Cal benefits. So, it's important that the same organization is administering the Medicare and the Medi-Cal piece, as they need to coordinate that.

For ECM, there is a difference. Someone who joins a Medi-Medi Plan, instead of ECM, they can receive additional care coordination services that we call CICM. It's very similar to ECM. But we had some confusion when we tried to have a name that sounded similar

to ECM, so we just call it CICM. But again, care management is provided by the member's D-SNP and that includes clinical care management for chronic conditions. One of the things we know about people who are dually eligible is that they do have, in addition to needs for long-term services and supports and home and community-based services, a lot of chronic conditions like diabetes, heart disease, and dementia, so there's a need for a clinical approach as well. Next slide.

00:14:25 — Anastasia Dodson — Slide 13

So the provider network in the Medi-Medi Plan is, for the most part, a Medicare provider network. Medi-Medi Plans are required to meet the CMS Medicare requirements for provider networks. That's very important for people. If they choose to enroll in a Medi-Medi Plan, they want to see things like if their doctors are in that network, are they assigned a new doctor, do they have access to their specialist they're already seeing? So that provider network is set and monitored by CMS Medicare.

There is a provision that if a provider that someone is seeing is not currently in the Medi-Medi Plan's network, that the health plan and the provider can come to an agreement. It does not have to mean that the provider is signing up ongoing, but they can have a temporary agreement so that the member can keep seeing that provider. The other thing I want to emphasize is that CMS — they make the rules around enrolling in a Medicare health plan — allows people who are dually eligible to enroll in a Medi-Medi Plan any month of the year. So, people who are dually eligible are not limited to the regular open enrollment periods. If they want to join a Medi-Medi Plan, they can also leave a Medi-Medi Plan, disenroll, any month of the year, and go to Original or regular Medicare. I know there's a lot of information, but we do have information on our website about all of these concepts. Next slide.

00:16:09 — Anastasia Dodson — Slide 14

What does it mean for someone to join? They must have both Part A and B, Medicare and Medi-Cal, they have to be 21 years or older, and they have to live in one of the counties where a Medi-Medi Plan is available. Again, we have about 330,000 to 340,000 dual members in those 12 counties that are enrolled in a Medi-Medi Plan already. And we have a list of the current plans on the DHCS website because each plan has their own particular name. We just say Medi-Medi Plan as a generic term to describe the types of plans. Next slide.

00:16:41 — Anastasia Dodson — Slide 15

We are doing a lot of outreach meetings, and in fact, right after this meeting, we have a meeting with CHPIV, Imperial County. There's a lot of meetings going on right now with local stakeholders. We have an email inbox — info@calduals.org — for any questions. We have a webpage with a lot of information about Medi-Medi Plans. And of course, we are partnering with local HICAPs and local legal aid organizations through the Medi-Medi Ombudsman Program. Next slide.

00:17:27 — Anastasia Dodson — Slide 16

Again, we have lots of stakeholder information. We're sharing that information through workgroups. We will have another webinar on July 30th for anyone who'd like to join, and we're going to be particularly doing outreach in the meantime to County IHSS, County Behavioral Health, County Social Services agencies, HICAPs, HCBS Waiver agencies, etc. We're going to be having more meetings with independent living centers as well. You'll see the announcements in your inbox just like they came for this meeting.

00:18:12 — Cassidy Acosta — Slide 17

Great. Thanks so much for that presentation, Anastasia. I think we have just a minute or two for questions before we need to shift over into our next presentation. I do see that there is a comment in the chat specifically around ECM providers, but wanted to pause here to see if there are any additional questions that folks would like to raise at this point.

00:18:40 — Anastasia Dodson — Slide 17

I see the comment in the chat about ECM and I would just caution that the D-SNPs already exist, and they can already partner with community-based providers if it's appropriate. And that's a topic that we're tracking and aware, but I don't think the chapter has been fully written on that just yet. So, let's wait and see. I wouldn't say that dual eligibles are losing access to those providers, but glad for the feedback and let's keep discussing it.

00:19:30 — Cassidy Acosta — Slide 17

Thanks, Anastasia. In the interest of time, I think we'll move on to the next presentation, but I think this is perfectly timed because we're going to talk a little bit more about California Integrated Care Management. So, I'm going to move to the next slide and I'll pass it over to Dr. Laura Miller to tell us a little bit more about CICM.

Oh, we can't hear you, Laura. I just requested for you to unmute.

00:19:59 — Laura Miller — Slide 18

Okay. Can you hear me now?

00:20:01 — Cassidy Acosta — Slide 19

You sound great.

00:20:02 — Laura Miller — Slide 19

Okay. Thank you so much. My name is Laura Miller. I'm a primary care physician and I've been involved with D-SNP and the California Integrated Care Management policy. I will be sharing some updates for calendar year 2026. Next slide.

00:20:20 — Laura Miller — Slide 20

We're going to talk a little bit about D-SNP care management. One thing to help understand the difference between ECM and CICM is that a D-SNP by its structure, by its required Model of Care, is relatively heavy on care management. So, we really struggle with that duplication with ECM. And Anastasia alluded to this, we'll talk about California Integrated Care Management, which is the care management under the D-SNPs. Next slide.

00:21:00 — Laura Miller — Slide 21

ECM is a Medi-Cal benefit. It supports members with complex needs, and these are members who engage with multiple delivery systems. It's a whole person, integrated, interdisciplinary approach to care. It's intended to be high-touch, person-centered, and provided primarily through in-person interactions with members where they live, seek care, and prefer to access services. It's part of the broader California population health management system. And as noted here, the Medi-Cal plans are required by the ECM portions of the contract to contract with community-based organizations for ECM care. That is part of Medi-Cal ECM, as the managed care plans must contract with community-based organizations. The “must contract” portion and the financial institutions are not included on the D-SNP’s side. Next slide.

00:22:15 — Laura Miller — Slide 22

In contrast and similarly, care coordination is a primary responsibility of D-SNPs by the federal government. Federal guidance states that D-SNPs must provide robust care coordination. So, all the D-SNPs must submit a Model of Care. That care management includes but is not limited to Health Risk Assessments, care plans, and care teams for each D-SNP member and Interdisciplinary Care Team. In their Models of Care, D-SNPs are also required to identify specific populations for care management. Oftentimes, those specific populations in the classic D-SNP are focused on clinical entities, for

diabetes, congestive heart failure, etc. We have cited the NCQA website, where folks can learn more about the Models of Care and D-SNPs. And what we have done in building CICM, we have put state requirements on top of the federal, Medicare requirements. And again, we want clarity, and we want non-duplication. Next slide.

00:23:46 — Laura Miller — Slide 23

As we've stated, D-SNPs are held to those robust federal guidelines and there is overlap with the D-SNP Model of Care and Medi-Cal ECM. They're both robust care management models for complicated populations. The DHCS policy for 2026 continues to be that the D-SNPs are responsible for care management for their own members. If you recall, we had a transition where, slowly over time, D-SNPs took on that care management as people were transitioning. But now the D-SNPs, both EAE and non-EAE, are responsible for care management for their D-SNP members who might have otherwise qualified for Medi-Cal ECM. They don't qualify for Medi-Cal ECM because they have elected a D-SNP. But we want those folks to get robust care management, hence the special attention to care management and the California-specific requirements.

Duals who are in Original Medicare or other Medicare Advantage plans can get ECM. So, the majority of duals in California are in Original Medicare or another MA plan, so they can indeed get Medi-Cal ECM if they qualify. For CICM, we're talking about just duals who are in D-SNPs. Next slide.

00:25:48 — Laura Miller — Slide 24

Now, I'm going to talk about more details about California Integrated Care Management, the D-SNP care management. So, we added specific requirements to reflect the vulnerable populations that we know the state has. As I've stated, federal guidance is that members get robust care coordination from D-SNPs, and with CICM, we layered on additional requirements. As Anastasia noted, we initially had used the term ECM-like, and it's complicated calling it ECM-like. Hence the term California Integrated Care Management, CICM, which will officially launch with calendar year 2026.

The CICM policy applies to members who may be eligible to receive Medi-Cal ECM, and they address additional populations, including members with documented dementia needs. Dementia is a huge concern, and those patients, people and their family members, have distinct needs. The last piece on this slide is that we're still using the term ECM-like through calendar year 2025. It doesn't change the care that people are getting. It's a name change. Next slide.

00:27:36 — Laura Miller — Slide 25

These are the state-specific requirements. The CICM populations do reflect the Medi-Cal ECM populations of focus, those very vulnerable people, and we do include adults with documented dementia needs. With regards to CBO contracting, I noted earlier that CBO contracting and the care in ECM is required to be with community-based organizations for ECM. For CICM, CBO contracting is recommended. We recommend it in part because these are very vulnerable populations, and a lot of our community-based organizations have very specific and highly refined skill sets for taking care of these folks. But it is a recommendation. Also, within D-SNPs, there is already a requirement for liaising with multiple community organizations.

In terms of in-person engagement, we are encouraging plans to provide that care management primarily through in-person interactions. And for adults experiencing homelessness, D-SNPs are required to provide in-person care. Again, people experiencing homelessness are in a very complicated and vulnerable situation. It is hard for them to receive telephonic care. So, in-person engagement is required for those people. Next slide.

00:29:28 — Laura Miller — Slide 26

This is a listing of the CICM populations of focus. You'll note that all those dot points reflect the ECM populations of focus with the addition of adults with documented dementia needs. And you'll see a lot more information in that hyperlinked CY 2026 D-SNP Policy Guide. Next slide.

00:29:57 — Laura Miller — Slide 27

Again, this is a little bit more on the relationship with CBOs. D-SNPs are encouraged to contract with CBOs, and specifically those CBOs that serve CICM populations, to augment D-SNP plan-based care. We did list suggested community-based provider types, and you can find that in Appendix C of the Policy Guide. Next slide.

00:30:28 — Laura Miller — Slide 28

In terms of in-person engagement, it prioritizes culturally appropriate and accessible communication strategies to meet the unique needs of members. Members should expect that CICM interactions take place primarily in person or through a visual, real-time interactive telehealth encounter. Again, for folks experiencing homelessness, CICM must be provided in person. In addition to the state's specific guidance, federal Medicare regs require that all D-SNPs provide, at least on an annual basis, a face-to-face encounter for the delivery of health care, care management, or coordination services.

And again, either in person or through a visual real-time interactive telehealth encounter. Next slide.

00:31:23 — Laura Miller — Slide 29

These are the continuity of care requirements. So, for members who join a D-SNP on or after January of 2026, if they're already receiving ECM from their Medi-Cal plan, the D-SNPs will provide ongoing continuity of care with the existing Medi-Cal ECM provider, when possible, for up to 12 months. Next slide.

00:31:53 — Laura Miller — Slide 30

We did add the additional requirements for adults with documented dementia needs, recognizing the very complex needs of these members. So, members living with dementia can receive the care of trained dementia care specialists in their care team. Dementia care specialists may also be included when developing that care plan. You'll see in the Policy Guide a full outline of the requirements for adults experiencing dementia. Next slide.

00:32:26 — Laura Miller — Slide 31

I am done with that discussion on care management. Hopefully, that has been helpful, and I will pass the mic to Anastasia.

00:32:40 — Anastasia Dodson — Slide 31

Thanks so much, Dr. Miller. Don't see any more questions. Okay, I see one more. Cassidy, is it okay to look at this question, now? I don't know if Dr. Miller needs to sign off soon.

00:33:00 — Cassidy Acosta — Slide 31

I think that Dr. Miller might need to sign off soon. Dr. Miller, are you able to stay on for a moment to answer a question?

00:33:08 — Laura Miller — Slide 31

I can. I will just put my camera back on. Okay.

“How can case managers like APS know if a Medi-Medi is a D-SNP or Original?” By looking at the card. Well, they won't have their Medicare card: the red, white, and blue card. If they are in a D-SNP, they should have a D-SNP plan card. So that is one way to know it. Anastasia, your thoughts?

00:33:51 — Anastasia Dodson — Slide 31

Also, the Medi-Cal plan, they will know. So, if there's a care manager from the Medi-Cal plan, they can know. And there is a way to look in AEVS for people who are accessing that. But if someone is not accessing AEVS, then I would suggest, like you said, ask the member or ask their Medi-Cal plan.

00:34:20 — Cassidy Acosta — Slide 31

Thank you both. All right. I know that we're getting some additional questions in, but I think that Dr. Miller might have to step out. We will have additional time for questions after our next presentation on the Default Enrollment Pilot. So, Anastasia, I'll pass it back to you.

00:34:34 — Anastasia Dodson — Slide 31

Thanks so much. Okay. So, we started this discussion about this Default Enrollment Pilot last fall. This is just an update on that pilot. Next slide.

00:34:47 — Anastasia Dodson — Slide 32

Back in 2024, we started a pilot for just a few health plans, a small number of members, so that when a dual eligible member is enrolled in one of the pilot Medi-Cal plans, when they become eligible for Medicare due to age or disability, that member will receive two notices and is automatically enrolled into the Medi-Medi Plan affiliated with their Medi-Cal plan, unless the member chooses a different Medicare option. Next slide.

00:35:32 — Anastasia Dodson — Slide 33

This pilot does not impact dual eligible members who are already enrolled in Medicare or people who are enrolled in Medicare and then newly enroll in Medi-Cal. It's just for a small number of members each month, and you can see some of those numbers in the bottom part of the slide. Again, it's for people who are in Medi-Cal and then they are newly enrolling in Medicare because of age or disability status.

You can see the example for San Diego County. In June of 2025, was 113 members that were default enrolled. San Mateo County had 30 members for Health Plan of San Mateo. So, it's a very modest pilot. Next slide.

00:36:22 — Anastasia Dodson — Slide 34

So, Community Health Group, Health Plan of San Mateo, and Kaiser in San Mateo are the plans that are participating in the Default Enrollment Pilot. Community Health Group started in June of 2024, about a year ago, sending their initial 60-day notices; in January, Health Plan of San Mateo they sent their initial 60-day notices; and then on May 1st,

Kaiser Permanente in San Mateo County started their initial 60-day notices. And each of those plans have met with local stakeholders to discuss the pilot. Next slide.

00:37:00 — Anastasia Dodson — Slide 35

In this pilot, a member receives a written notice 60 days and another one 30 days before the month that they become eligible for Medicare. That notice comes with a choice to join the Medi-Medi Plan and information about how the member can decline enrollment prior to the effective date. The notice also has information about HICAP, the Ombudsman, and all those resources for helping to make a decision. The Medi-Cal plan also makes an outreach phone call to that member to let them know about their choice, let them know about the upcoming transition and their right to opt out. All those notices were reviewed by advocates, stakeholders, DHCS, and the federal government's CMS. Next slide.

00:37:57 — Anastasia Dodson — Slide 36

This is level setting the options for someone who is eligible for the pilot. They can still choose their Medicare coverage. If they want to be enrolled in their Medi-Cal plan's Medi-Medi Plan, they don't have to do anything. Enrollment will start the month the member becomes eligible for Medicare.

Option two, if the member does not want their Medi-Cal plan to provide their Medicare coverage, if they don't want to join that Medi-Medi Plan, they can choose another option, Original Medicare or another Medicare Advantage plan. Enrollment in Medi-Medi Plans is voluntary, and members always have the option to choose which Medicare delivery system they enroll in. And again, as I said earlier in the webinar, there are federal requirements and regulations that allow dual eligibles to enroll in Original Medicare any month of the year and enroll in a Medi-Medi Plan any month of the year. They don't have to wait for open enrollment to go to Original Medicare or a Medi-Medi Plan. Next slide.

00:39:15 — Anastasia Dodson — Slide 37

Now, looking at continuity of care, as we talked about earlier, and one of the benefits we see in this pilot is that because these folks are already getting their care through that Medi-Cal plan network, in most cases, they can keep their primary care physician and/or specialist when they join the Medi-Medi Plan because they'll be with the same health plan organization. There's a high level of overlap between the Medi-Cal provider network and the Medicare provider network for these members. And again, just like in all cases for dual eligibles, members don't pay a premium, they don't pay for doctor

visits, or other medical care as long as they go to a provider that works with their Medi-Medi Plan. Next slide.

00:40:08 — Anastasia Dodson — Slide 38

This is some data, and we will definitely post the slides. It's just showing the percent of members who got a notice and then did enroll in the health plan, by month. And then it also shows, after being enrolled, what percentage of members then disenrolled later within 90 days. And you can see that the numbers on the percent who are enrolled via default go sort of in the mid-70s up to 85% in May. And then on the disenrolled within 90 days, that kind of varies a lot, as high as 13.5% and as low as 2.2%. Next slide.

00:40:59 — Anastasia Dodson — Slide 39

This has data for Health Plan of San Mateo. Let's keep going.

00:41:03 — Anastasia Dodson — Slide 40

Okay. So, any questions on that?

00:41:09 — Cassidy Acosta — Slide 40

Great, thanks so much, Anastasia. We do have some time now for questions. I think that we have a couple of other questions in the chat specifically around ECM, Anastasia, if we want to take some of those while folks circle back with some potential questions around default.

00:41:23 — Anastasia Dodson — Slide 40

Okay.

00:41:24 — Cassidy Acosta — Slide 40

One question that we got in the chat is specifically around counties who are not getting a D-SNP in 2026 and asking whether ECM eligible members would stay with ECM until a D-SNP is launched in that county.

00:41:38 — Anastasia Dodson — Slide 40

Yes, and I do want to say, even in counties where D-SNPs are being launched, an individual has a choice of whether or not they would like to enroll in a Medi-Medi Plan. There's no requirement to enroll in a Medi-Medi Plan, so they can stay with ECM regardless of whether it's in a county where D-SNPs are not being launched or in a county where D-SNPs are being launched, there's no requirement to enroll in a Medi-Medi Plan.

00:42:19 — Cassidy Acosta — Slide 40

Thanks, Anastasia, I think that there's also a question in the chat specifically around HCBS Waivers, whether or not those impact or affect D-SNP and ECM benefits and services.

00:42:31 — Anastasia Dodson — Slide 40

So, there's no particular requirement or prohibition on enrolling in a D-SNP, whether someone is in an HCBS Waiver. In the HCBS-DD Waiver, we know that regional centers are an important partner and we expect that all D-SNPs and Medi-Medi Plans will be coordinating as appropriate and as needed with regional centers for members who are getting regional center services. So, first of all, that's the expectation that's written into the contract with D-SNPs, and it's the expectation already to some degree on the Medi-Cal plan side.

So, that said, again, there's no prohibition or requirement either way for someone who's getting regional center services to enroll. There's no prohibition for them not to be able to enroll in a Medi-Medi Plan or a D-SNP. As far as ECM, that's a different topic. I'm not an expert on how ECM interacts with someone who's getting regional center services. So, I won't be able to answer that question.

00:43:56 — Cassidy Acosta — Slide 40

Thanks, Anastasia. One more question around ECM and then I think we can wrap up this section and move into our next presentation. But we've got a question specifically around "ECM automatically being delivered with a D-SNP HMO." So, I think it might be helpful to talk a little bit more just to reiterate the differences between the Medi-Cal ECM and how CICM will work in 2026 for D-SNPs.

00:44:19 — Anastasia Dodson — Slide 40

Right. I see the chat, D-SNP HMO Senior Advantage plan, that's a Medicare Advantage plan that is a D-SNP, and ECM is a type of service that's available through a Medi-Cal plan. A D-SNP is a Medicare plan. So, if someone is enrolled in a D-SNP, the care coordination requirements from the federal government are very similar to ECM, plus there's some additional state requirements. Instead of ECM for folks who are in a D-SNP, they get the full federal Medicare care coordination requirements, which are robust and then layered on top is CICM.

So, I know there's comments in the chat about the "role of community organizations," but I would say that the federal care coordination requirements for all D-SNPs are very

similar to ECM and in fact a better fit in some cases because they're more clinically oriented and dual eligibles have a lot of clinical conditions. Again, heart disease, diabetes, hypertension, etc.

00:45:48 — Anastasia Dodson — Slide 40

And I do see that other question about "Sacramento County denied ECM." Again, there are requirements for care coordination in the D-SNP model that are very similar to ECM. So, it is true, if they join a D-SNP, join a Medi-Medi Plan, they don't get ECM. But they get still a very high level of care coordination. And we would want to hear and we could pass along to CMS, if there are specific patient or member examples you have of someone who needs more intense care coordination and they're not getting it as a D-SNP member. We want to hear about that because we do have high expectations for the plans and we want to make sure that there's no disadvantage for the member in joining a D-SNP.

Are they going to get that care coordination from the plan versus a CBO? That is possible. But again, there's a lot of delegation in California across Medicare and Medi-Cal. I would just say, let's see specific examples and we will hold the plans accountable, but I don't want to say there's some disadvantage. We don't think there's a disadvantage in getting plan-based care coordination under the D-SNP model.

00:47:27 — Cassidy Acosta — Slide 40

Thanks, Anastasia. I think with that we can move into our next presentation, which is going to be on the 2026 D-SNP SMAC and Policy Guide. So, I'll turn it back to you, Anastasia.

00:47:38 — Anastasia Dodson — Slide 41

Okay, great. I see the question on AEVS. And AEVS is typically for health plans and for providers. So, back to the APS folks, I wouldn't bother chasing AEVS as much as just talk to the health plans that your client is enrolled in and then they can help you sort it out. Talk to the Medi-Cal plan and if you know what the Medicare plan is, talk to the Medicare plan. Okay, now let's talk about this SMAC and Policy Guide. Next slide.

00:48:11 — Anastasia Dodson — Slide 42

Every year, we publish and we have plans sign a State Medicaid Agency Contract, that's the contract that each D-SNP has with a State Medicaid Agency. And then we're going to talk a little bit about the Policy Guide. The SMAC and the Policy Guide go hand in hand, and we have an updated version of each one each year. We did have the SMAC

contract draft that we shared with plans and advocates in February. We got their feedback, and we finalized the SMAC for 2026. We have sent it out to the health plans for their review and signature, and we will be posting, very shortly, the SMAC boilerplates, which are the templates that we use for the D-SNPs. And already though you can look on our DHCS website to see the 2025 SMAC and 2024, '23, '22, those are posted on our website. Next slide.

00:49:18 — Anastasia Dodson — Slide 43

Again, we have the 2026 SMAC and then we have the companion Policy Guide. The Policy Guide has multiple chapters, and it has more detailed operational requirements and instructions for D-SNPs. It is posted on the DHCS website and we update it more frequently. The SMAC, we update once per year. The Policy Guide is updated more frequently, a few different times a year, and we release new chapters on a rolling basis. The 2025 Policy Guide is already posted, and you can see all the chapters there. And the 2026, we are in the process of posting updates. Next slide.

00:50:06 — Anastasia Dodson — Slide 44

An update on our 2026 Policy Guide. Next slide.

00:50:14 — Anastasia Dodson — Slide 45

We recently published the Integrated Materials and Marketing Chapter, and that has to do with the member materials that Medi-Medi Plans send out, they are integrated member materials. So, instead of having one packet or materials about their Medicare benefits and then a separate packet about Medi-Cal benefits, they're combined together so that in the Member Handbook, the Summary of Benefits, they can see in one place both sets of benefits. Each health plan customizes those materials, but it's customized based on the template that CMS, on the Medicare side, and DHCS, on the Medi-Cal side, provide to the plans. So again, there are template materials. The plans take those, they customize them, and they use them to provide information to their members. Now, the actual templates for 2026, those are not posted just yet. The plans have received them. They're working on customizing them. But we do have '25, '24 and 2023 integrated materials posted on the DHCS website. Next slide.

00:51:42 — Anastasia Dodson — Slide 46

Another piece of the Policy Guide is about Coordination with Dental Benefits. This is a really important topic. Next slide.

00:51:54 — Anastasia Dodson — Slide 47

We have a chapter in the D-SNP Policy Guide related to dental benefits, and that includes requirements for all D-SNPs to coordinate dental benefits by including language on Medi-Cal Dental benefits in the member and marketing materials. So, one thing that we have observed through the years is that some people may not know that Medi-Cal Dental benefits are available to people who are dually eligible. Having that information about Medi-Cal Dental benefits in the materials that D-SNPs use can be really important, so that when people see that language, they know they don't have to rely just on whatever supplemental benefit may be offered by the D-SNP, they know they can use their Medi-Cal Dental benefits as well. We have seen, and we're going to talk about this in the data further in the call, that there's a good increase in utilization of Medi-Cal Dental benefits among members who are in Medi-Medi Plans. Back to this Dental Benefits Chapter, there's minimal changes between 2025 and 2026, and we're going to be posting it soon. But anyway, around marketing, making sure that members know that they can use their Medi-Cal Dental benefits. Next slide.

00:53:25 — Anastasia Dodson — Slide 48

We also have a fact sheet, just a reminder, it's been posted for a while, about Medi-Cal Dental benefits and how to understand from a provider's perspective how to bill Medicare versus Medi-Cal versus supplemental benefits for dental benefits for providers. So, that's on our website. Next slide.

00:53:54 — Anastasia Dodson — Slide 49

So, we're going to go to a spotlight on data. Anything else, Cassidy, before I go ahead and hand it off to Christopher?

00:54:07 — Cassidy Acosta — Slide 49

I think we're good to pass it over to Christopher.

00:54:09 — Anastasia Dodson — Slide 49

Okay. Christopher Tolbert, going to be presenting from OMII on our data.

00:54:17 — Christopher Tolbert — Slide 49

Thank you, Anastasia. Next slide.

00:54:23 — Christopher Tolbert — Slide 50

DHCS has a number of different data sets for duals here in California and D-SNPs, information can be found on our OMII webpage. We have a BI Dashboard webpage, which I'll do a demonstration later today in the presentation. We have a Medicare

Advantage options dual webpage as well. We're going to have another D-SNP and duals data webpage with a lot of data that we've been accumulating for the past couple of years. And there's also the Open Data Portal.

What's on the OMII webpage? In terms of data, there's chart books. There are four or five chart books. One of them is about the culture and linguistic demographics of the California Medicare population, and the chronic conditions experienced by Californians with Original Medicare. The Business Intelligence Dashboard, it's an interactive dashboard. Right now, it has 2023 data; hopefully, later in the year, we can update it to 2024 data.

Then, the Medicare options webpage has enrollment for duals and the overall Medicare delivery system. It also includes PACE and other types of Medicare Advantage plans, and has the definitions of the plan types of what we've been talking about. And then, as I mentioned earlier, DHCS is working on this webpage with D-SNP and duals data that will house all the data for D-SNPs and duals. Some of that data that's going to be on that webpage, it will be fresh in the D-SNP BI Dashboard. Lastly, the Open Data Portal has several key data sets on duals, some of the information about the Medicare population, and the chronic conditions. Like I mentioned earlier, about that chart book, that Excel workbook is on the Open Data Portal. We also have the number of duals by county and by age on the Open Data Portal. Okay, next slide.

00:56:36 — Christopher Tolbert — Slide 51

I'm going to talk about Medicare enrollment for duals and for D-SNPs.

00:56:45 — Christopher Tolbert — Slide 52

These are the definitions, as I mentioned earlier. Next slide.

00:56:55 — Christopher Tolbert — Slide 53

You can see the definitions here, FIDE SNP, PACE, and other Special Needs Plans. Next slide.

00:57:08 — Christopher Tolbert — Slide 54

Okay. So, this data right here, as can see, is over the course of a year, January 2024 to January 2025. You can see the middle portion that is blue. You can see there's been consistent growth in Medi-Medi Plans over the years. And then this year, this is the first time where Medi-Medi Plans have surpassed regular MA plans in terms of enrollment in California for duals. So, we want to have more integrated care for people. And then also you can see other integrated care options such as PACE, there has been steady

enrollment over the course of the year. The little teal section, with other SNP, most of that includes C-SNPs or over 90% of total duals that are enrolled in C-SNPs. And that has really increased quite a bit over the past year. Next slide.

00:58:25 — Christopher Tolbert — Slide 55

This is overall what we're seeing, what I just talked about, where more than half are duals, and they're in Original Medicare. As I mentioned earlier on the previous slide, there's more duals in Medi-Medi Plans than there are in regular MA. But overall, D-SNPs are about 25% of duals that are in D-SNPs here in California. Next slide.

00:58:54 — Christopher Tolbert — Slide 56

Okay, so now we're going to talk about the 2024 D-SNP data highlights, including data reported by the D-SNPs to DHCS on Health Risk Assessments and ICP completion, or Individualized Care Plan completion, members who receive ECM-like services, members who receive palliative care services, and members who received a Cognitive Health Assessment.

00:59:21 — Christopher Tolbert — Slide 57

In addition to existing CMS requirements, DHCS has the D-SNPs submit state-specific requirements quarterly and annually.

At DHCS, we do a completeness review, we process the data about the D-SNPs for publication. It's going to be on our website and then also some of it'll be in the D-SNP Dashboard. The purpose of this presentation is to share updates that the D-SNPs have made for 2024 with quarterly and annual measures. Some of them will be on the interactive dashboard, and then you can find more information about these and other quality measures on the DHCS website. Okay, next slide.

01:00:13 — Christopher Tolbert — Slide 58

First, we'll take a look at the data D-SNPs submitted to DHCS for 2024 on a quarterly basis. This table outlines the Health Risk Assessment, like the completion rate within 90 days for Medi-Medi Plans, which also includes the SCAN FIDE D-SNPs and Non-EAE D-SNPs, and then also includes the Individualized Care Plans completed within 90 days of enrollment. Next slide.

01:00:47 — Christopher Tolbert — Slide 59

This slide talks about ECM-like services that members received. For ECM, it's broken out across quarters, like quarter one and quarter three. And I'll just note that our

requirements change from quarter one to quarter three for the ECM-like services. So, that's why there's such a variation in that. And then what you see for the ECM-like percentages is people who received an ECM-like service but also had an in-person engagement for that service. Something that's not mentioned on this slide, but we will post this data, is people that were identified as ECM-like eligible. 31% in Medi-Medi Plans receive an ECM-like service compared to 19% for the non-EAE D-SNPs.

Then, the palliative care measure, that's the plans that reported beneficiaries that were newly enrolled in palliative care services from Q1 to Q4. The percentages that are under the data represent the total enrollment for those plans at the end of each quarter; so, quarter one, March, etc. That's what that data represents. Next slide.

01:02:31 — Christopher Tolbert — Slide 60

This slide is about the Cognitive Health Assessment percentage. People that are age 65 and older receiving a Cognitive Health Assessment from when they're part of a Medi-Medi Plan or non-EAE D-SNP from a provider and those plans, you can see the percentage is 12% for both. This represents a remarkable increase from 2023 where it was 5% for people in Medi-Medi Plans getting their Cognitive Health Assessment versus 4% in non-EAE D-SNPs. So, it has really increased from the previous year. Next slide.

01:03:22 — Christopher Tolbert — Slide 61

Now, we're going to talk about reviewing the 2024 data that the Medi-Medi Plans submitted for long-term services and support measures. These measures report members receiving and being referred to CBAS, IHSS, MSSP and long-term care. Next slide.

01:03:44 — Christopher Tolbert — Slide 62

I also want to add that this data is reported by the plans, by the D-SNPs, to DHCS. And this table outlines members receiving and getting referred to whether it's CBAS or IHSS. We see CBAS, people receiving referral, this remains stable, but there was a big increase from quarter two to quarter three of members receiving IHSS. It also happened again in quarter four versus the previous quarters here on this slide. Next slide.

01:04:28 — Christopher Tolbert — Slide 63

And again, this slide shows MSSP, people in the Medi-Medi Plan, also enrolled in MSSP. Then, we can see the referrals, and then we see the number of people that are in long-term care, and then also receiving any referrals, with quarter three being the highest for long-term care. Next slide.

01:04:56 — Christopher Tolbert — Slide 64

Okay. Before we go to our next portion of the presentation, are there any questions, anything that was presented during this section?

01:05:06 — Cassidy Acosta — Slide 64

Thanks so much, Christopher. We do have one question in the chat specifically around looking for some clarity on how many duals currently are in Original or Fee-For-Service Medicare. I don't know if it's helpful to go back to that slide, but just to confirm whether or not 50% of California's dual eligible members are currently in Original Medicare.

01:05:25 — Christopher Tolbert — Slide 64 [Goes back to Slide 55 for reference]

If we go back to that slide. Here, in California, there's about 1.7 million duals. So, it's approximately 850,000. I think it's a little bit more than that. Soon, we'll post on one of those websites that I was talking about, the Medicare Advantage options. On that website, we'll have the actual number of duals that are enrolled in Original Medicare. I think it's around 880,000 in January. But it represents about half of all duals here in California.

01:06:07 — Cassidy Acosta — Slide 64

Great. Thanks, Christopher. I think that's the question that we have so far. So, I think we can move into our next section on our data. Oh, go for it, Anastasia.

01:06:20 — Anastasia Dodson — Slide 64

One thing I just wanted to add. Christopher, terrific job going over all this data! We really are now improving our ability to be more transparent about this data. We have a lot of data coming in and we are looking at different ways to publish the data. As Christopher said, we have our Open Data Portal, we have ways that we can put stuff on this BI that he's going to walk through. And then also even just publishing a PDF. So, if you didn't get a chance to look at every single table here, don't worry, we will definitely share the slides. But a lot of this is on our website, so we want to make sure that people can access this. I will also say that the health plan-specific information is also either posted or will be posted. A lot of the data that's been shown here is across all plans, but we have plan-specific data we are sharing. Okay, thanks Christopher. Back to you.

01:07:24 — Cassidy Acosta — Slide 64

And I think that we do have a couple of additional questions. So, Brianna, you should be able to unmute now.

01:07:30 — Brianna Moncado — Slide 64

Hi. Thanks so much. Just a quick question on the slides where it says the referral, are those referrals into the program? Like total numbers of MSSP referrals, for example, is that per quarter new? If it is, is that included in the total right above it or is that in addition to?

01:07:54 — Christopher Tolbert — Slide 64 [Goes back to slide 63 for reference]

I think those are separate because each of these are unique members. They may be included, but I'm not entirely sure because usually people receiving these services, they could have been receiving these services before they joined the Medi-Medi Plan, but they're making those referrals to those MSSP sites, CBAS, or to the IHSS county as well. So, it may be included, but it's not always the case.

01:08:32 — Brianna Moncado — Slide 63

And it could be referrals to other services, you're saying? If I were just using the MSSP one as an example, it's MSSP members that are being referred to other services, you're thinking?

01:08:43 — Christopher Tolbert — Slide 63

It's my understanding that these are people that are in the D-SNP being referred to the MSSP sites.

01:08:50 — Brianna Moncado — Slide 63

Got it. Okay. Thank you so much. And same with the long-term care, I'm guessing?

01:08:57 — Christopher Tolbert — Slide 63

That's the one where, again, plans reported data – and I'm not sure exactly how this works – of members being referred to long-term care versus receiving services. But it may include some of those people that were referred, they may be included, and those people receiving services. But generally, it's double for long-term care, and it's a wide variation for those other LTSS services.

01:09:35 — Brianna Moncado — Slide 63

Okay. Thank you so much.

01:09:41 — Cassidy Acosta — Slide 64

Great. Just in the interest of time, I think we'll move into our next presentation on the D-SNP Dental benefits data.

01:09:47 — Cassidy Acosta — Slide 65

But I do know that we have one more opportunity for questions after we get through this. I'm taking a look at the chat, and I know that we can circle back on some of those. So, Christopher, back to you.

01:09:57 — Christopher Tolbert — Slide 65

Thank you, Cassidy. So, next we'll discuss D-SNP Medi-Cal Dental benefits data in 2023, we're going to be looking at the annual visits by age group and plan type for Medi-Cal Dental. Next slide.

01:10:15 — Christopher Tolbert — Slide 66

So, as we all know, Medicare is a primary payer for duals, and it does not cover most dental services. Medi-Cal covers a variety of dental services for Medi-Cal members, including duals. Sometimes MA plans, they may offer some dental benefits which are definitely beyond what original Medicare covers, and they vary by plan. And if the Medicare Advantage plan supplemental dental benefit overlaps with the Medi-Cal Dental benefit, Medicare is always going to be the primary payer, and Medi-Cal is always going to be the payer of last resort. Next slide.

01:11:00 — Christopher Tolbert — Slide 67

As I mentioned earlier, this is Medi-Cal Dental annual visits for dual members by age group. You can see the highest age group that used Medi-Cal Dental, had an annual visit, was 45 to 64 years, 32%. Even those 75 and older, they have access to Medi-Cal, everybody that's in Medi-Cal, they all have access to Medi-Cal Dental. But we're just seeing the utilization across different age groups. But overall, 28% of duals utilize Medi-Cal Dental. Next slide.

01:11:50 — Christopher Tolbert — Slide 68

So, this is what Anastasia was talking about earlier, where having those dental benefits included in the Integrated Member materials is helpful, because we're seeing that duals that are in Medi-Medi Plans have a higher utilization of using Medi-Cal Dental benefits than duals in Original Medicare, or a regular MA plan, or non-EAE D-SNP. And then others include PACE, the SCAN FIDE D-SNP, I-SNP, and then Chronic Special Needs Plans as well. The overall utilization is 28% for duals having a Medi-Cal annual dental visit in 2023.

I don't know if, Anastasia, you have anything else to add here about Medi-Medi Plans and Dental?

01:12:50 — Anastasia Dodson — Slide 68

We're so glad to see that 32%, higher utilization among Medi-Medi Plan members. One thing that's not on this slide is supplemental dental benefits, we don't know the utilization there. That could be adding to these utilization numbers. At some point, we will get Medicare Advantage supplemental benefit utilization data, then we can add it in. But for what we see here on Medi-Cal, we think it's good to know for Medi-Medi Plans. Back to you, Christopher.

01:13:21 — Christopher Tolbert — Slide 69

Thank you. Next slide. Okay, so we're going to be talking about the ECM and Community Supports data update.

01:13:32 — Christopher Tolbert — Slide 70

DHCS publishes the ECM and Community Supports Quarterly Implementation report, it was updated in March 2025, and reflects data from January 1st, 2022, through September 30th, 2024. So, this includes a total population receiving ECM and Community Supports, and that does include duals.

At previous stakeholder meetings, and there's slides on our website, we usually share the duals data specifically for ECM and Community Supports, whether by ECM populations of focus or by Community Support. But again, we're not seeing too many changes across time when we have been sharing that data. So, that's why we're not sharing anything specific today. But there haven't really been too many changes if you look back at the data that we have posted from our previous MLTSS meetings, the data's not changing very much, which is why we don't have specific data for this meeting.

01:14:47 — Anastasia Dodson — Slide 70

Yes, and Christopher, as you have presented in prior meetings, we know that dual eligible beneficiaries have a higher proportion of participation in ECM and specific Community Supports. So, I know at first, we were all wondering, "are dual eligibles getting ECM and Community Supports?" Yes, we know they are from the data we have looked at in the past. In fact, they're over-represented because of the high rates of chronic conditions, etc. in ECM and Community Supports, particularly for people who are transitioning out of long-term care. So again, we didn't see any significant changes, we did not have the bandwidth to give the specific data this time. But there's been no drop or anything in number of duals getting those services. Back to you, Christopher.

01:15:41 — Christopher Tolbert — Slide 71

Thank you. Well, now I am going to do a presentation on the 2023 D-SNP BI Dashboard.

01:15:52 — Christopher Tolbert — Slide 72

DHCS transitioned from the Cal MediConnect Dashboard to a D-SNP Dashboard. The Cal MediConnect Dashboard was a PDF. The first few iterations of the D-SNP Dashboard we did use a PDF as well, but this is the first time where we're moving into the future here at DHCS. The D-SNP Dashboard provides select measures on key aspects of D-SNPs in California. And for those of you that are familiar with the Cal MediConnect demonstration, these are the same measures I'm about to show you, they're the same measures for the D-SNPs. So, there shouldn't be anything new. There might be some changes, but overall, it's the same.

As I mentioned, the release, we're updating from a PDF to an interactive dashboard. I don't know if any of our EDIM colleagues here at DHCS are on the call, but really appreciate working with them. So, I'll start showing you all the dashboard.

Okay. Can you see my screen?

01:17:34 — Cassidy Acosta — 2023 D-SNP BI Dashboard

Yes. Looks great.

01:17:37 — Christopher Tolbert — 2023 D-SNP BI Dashboard

Okay, good. So, this is our D-SNP Dashboard and Microsoft Power BI, Business Intelligence. So, there's 13 slides. This first one, this is just displaying enrollment, all 2023 data, and this is just displaying enrollment by EAE, which we call Medi-Medi Plans here in California and non-EAE D-SNPs. As a whole, we see the enrollment across all four quarters in 2023. So, that's the first one.

The second slide, quarter one. So, we can select the plan type, EAE or non-EAE, we could change the quarter and then we can go back and forth. So, we can see D-SNP enrollment by plan on this dashboard.

And then this is the demographics. So, D-SNP demographics enrollment by race and ethnicity, language, age, and gender. One thing that we'll see that's different between the Medi-Medi Plans and the non-EAE D-SNP is 42% people who are Hispanic, they're more in Medi-Medi Plans, but when we click on non-EAE, that changes to 28%. So, that's one key difference. It's the same thing for the language, mostly it's 59% English for non-EAE, and then it's 47% for the Medi-Medi Plans. The enrollment by age doesn't really

change much across the plan types and by quarter. And the gender, it stays the same, stays constant.

So, this portion is for members who had a Health Risk Assessment completed within 90 days of enrollment into the D-SNP. And then this yellow line is the statewide average. You can see all the plans here. So, we have all the plan information, and we have it by Medi-Medi Plan, we also have it by non-EAE, and we can change the quarters. So, it's not always the same. And then there's going to be another portion that will better represent this.

This one is for members the D-SNP was not able to locate to complete a Health Risk Assessment within 90 days. So, this is the same measure that we had in Cal MediConnect. Again, as I mentioned earlier, we can change plan type, reporting period, and you see the variation. And anything that's blank, we have suppressed. Then, if it's a zero, it just means there is just no data from the plan.

And then, this is percentage of members who had an Individualized Care Plan completed within 90 days of enrollment into the D-SNP. So, this varies by quarter. You can see the averages; they change each quarter. Same thing if I click on a non-EAE, things change over time. So that yellow line, that's the average. This is similar to the HRA, this is the ICP that the plan, they were not able to locate the member to complete the ICP within 90 days of enrollment. So, you can see averages, quarter to quarter.

We had the 2024 data that we talked about earlier, so this is the 2023 data. And the way that we're looking at this, this is on a per 100-member basis. So, when you see these numbers, think of it as a percentage. So, .10, that's .1%. So, a 10th of 1% had a referral to CBAS in that plan. And then members receiving Community-Based Adult Services per 100 members, 5.81, that represents a percentage, like 5.81%. So, that's how we read this information when we're looking at the LTSS measures.

And the next one is MSSP referrals. Like I mentioned earlier, percentages statewide, members receiving and then members residing in long-term care. Now again, it's on a per 100-members, meaning it's a percentage. So, you can see 4% for that plan. And then we can change by quarter, so this is a quarterly measure. And then this one is people referred to County IHSS. Again, quarterly measure, you see the averages per 100.

I'll go to the next one. So, this is where we can easily see the comparison between the EAE D-SNPs and the non-EAE D-SNPs. So, completing a Health Risk Assessment, we can see the comparisons across the plans. And then also for the ICP, how the plans did overall, the trend, and then this trend line, again, this is per 100, so it's a percentage. 1.1% residing in long-term care and then these are the referrals at the bottom.

01:24:19 — Anastasia Dodson — 2023 D-SNP BI Dashboard

Christopher, I'm going to jump in and say one of the things that we are thinking about at DHCS for next steps is benchmarks. So, we are thinking about if there is a minimum threshold that we want all the plans to achieve. Is there a level or upper goal, that's a goal for all the plans. We are working on that benchmark in addition to all the great work we're doing to get this data published. And I know we're about out of time. Anything else, Christopher, you want to add?

01:24:56 — Christopher Tolbert — 2023 D-SNP BI Dashboard

We have the annual data, documented discussion care goals by Medi-Medi Plan and non-EAE, the care coordination measurement ratio, and emergency room visits related to the utilization. That's all I have for today.

01:25:20 — Anastasia Dodson — Slide 73

Wonderful, Christopher, thank you so much. We've made great progress in getting this data published and we're going to continue to get more data published and work on benchmarks. So, back to you, Cassidy. Is there anything else we need to do to wrap up this meeting?

01:25:41 — Cassidy Acosta — Slide 74

I think we can move to our next slide and close out in our last minute. Just to note and say thank you to our speakers today, Anastasia, Christopher, and Dr. Miller, who had to hop, and to all of the folks on the call today for the great discussion. This is just a reminder that the next MLTSS and Duals Integration Workgroup will take place on September 24th at 12:00 PM and we'll see you all there.