

CALAIM MANAGED LONG TERM SERVICES AND SUPPORT AND DUALS INTEGRATION

Date: April 22, 2026
Time: 12:00 p.m. – 2:00 p.m.
Number of Speakers: 5
Duration: 1 hour 37 minutes

Speakers:

- » Sasha Husley
- » Lauren Solis
- » Christopher Tolbert
- » Theresa Hasbrouck

TRANSCRIPT:

00:00:00 — Sasha Husley — Slide 1

We have some great presenters with us today including Lauren Solis, Chief in the Office of Medicare Innovation and Integration at DHCS, Christopher Tolbert, Section Chief in the Office of Medicare Intervention and Integration, and Theresa Hasbrouck, Branch Chief in the Medi-Cal Eligibility Division.

A few meeting management items know before we begin. All participants will be on mute during the presentation. As a reminder, the monthly MLTSS and Duals records are -- ask questions.

We ask that the plans that join these calls hold their questions for the multiple other venues they have with the Department through the month. 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, please use the raise hand function and we will unmute you.



As a reminder, the PowerPoint slides and all meeting materials will be available on the DHCS website soon.

00:01:26 — Sasha Husley — Slide 2

At this time, we'd ask that you take a minute to add to your organization's name to your Zoom name, so it appears your name-organization. To do this click on the participants icon at the bottom of the window, hover over your name in the participants list on the right-hand side of the Zoom window, click more and select rename from the drop-down menu. And then you can enter your name and your organization as you would like it to appear.

00:01:54 — Sasha Husley — Slide 3

We have a packed Agenda for today. We will start off with some H.R. 1 updates. Next, we will discuss the 2026 Medi-Medi Plan expansion, then we will share some updates on the EAE default enrollment pilots, followed by presentations on Medicare enrollment data for Duals and 2025 D-SNP quality data.

We will then have a walk-through of the dashboard, and our last presentation will be on BridgeCare pilots for near Duals and finally we will close out with a final Q&A and some next steps.

At this point I will kick it over to Lauren to start us off.

00:02:35 — Lauren Solis — Slide 4

Thank you, Sasha. Let's go to the next slide.

Welcome everyone and welcome back to those that have joined the work group previously. We are so glad to have you here. And for those who are duly joining us, we are very happy to have you participate as well.

Hopefully everyone knows the purpose of this work group, but it essentially serves as a stakeholder collaboration hub for MLTSS and integrated care for Duals. Provides an opportunity for stakeholders to give feedback and share information including information being shared from DHCS around policy operations and strategy for Medicare Medi-Cal. Work group is open to the public as if you're interested you can take a look at the charter posted on our website.

We really value all of the participation that we have in the workgroup across the stakeholder community including plans, providers, advocates, beneficiaries, caregivers and the CMS. So again, thank you very much for joining us today and without further ado, we will shift into our first topic today, which is an update on H.R. 1 implementation.



For that I'm going to turn it over to Theresa Hasbrouck from the Medi-Cal Eligibility division.

00:03:48 — Theresa Hasbrouck — Slide 5

Thank you for inviting me to come and provide an update to all of you. As you will see from the slide, there's a pretty dense amount of information. We are not going to cover everything in it, really talk high level, but there might be details that you are interested in that we wanted to make sure you had available on your slides.

We will go ahead and go into our first slide.

00:04:15 — Theresa Hasbrouck — Slide 6

Just to walk through what changes happened in H.R. 1 that are directly related to Medi-Cal Eligibility. There are going to be some that do affect our Dual population, and I will flag those as I walk through, and then there will be other changes that are important changes that are happening but they are not going to necessarily be changes that affect eligibility and for the most part for our Duals population.

I'm going to walk you through the changes that are coming into effect. The first one is back previously there were some streamlining eligibility final rules for both Medicare and Medicaid that were making it easier for individuals particularly Duals individuals to be accessing information and services. Part of H.R. 1 actually put all of those provisions on a moratorium, meaning that they would be on hold for a significant amount of time and not move forward with the implementation of those. As soon as H.R. 1 was signed income immediately worked on anything related to those streamlining eligibility final rules did stop at that particular point.

The next thing that was changed was the amended eligibility are federally funded Medicaid. I think this is one that this group is likely interested in, and unfortunately the one that at this point we are still doodling through guidance on. So, to give an overview, what this does is it is changing who counts as a qualified immigrant for federally funded full scope coverage. There are certain immigration statuses, and we are estimating that there are about 200,000, of individuals that are in immigration status is such as refugees and asylees who today are entitled to full scope coverage and also entitled to Medicare. With this particular rule it is basically saying that this population no longer qualifies for full scope Medi-Cal and instead would only be entitled to emergency and pregnancy services only when it comes to federal funding.

DHCS and California currently have in the governor's proposed budget what will happen to this population in California as a result of this particular H.R. 1 provision, and we also



just recently received guidance from CMS through a state health operations letter that indicates some additional details about what that transition will look like.

That state health operations letter is hot off the presses and so we are working through that particular guidance right now to fully understand what that implementation will look like for our full Medi-Cal population, but also very specifically what that is going to look like for our Dual population as well, including things such as the Medicare buy-in program.

We absolutely are committed to coming back to this group to provide additional updates and clarity as we are able to fully understand everything that was in the state health operations letter and as the final budget is enacted and we know the direction that California, the final direction California will be moving in.

The next two are ones that you probably are hearing quite a bit of traffic about because it does impact a large portion of our population, and a little later in our presentation will go through them in a bit more detail, but the first one is the addition of work at community engagement requirements for certain Medi-Cal populations. We will talk about who that population is in just a second.

And very similar, that we would have an increase in renewals to six months' renewals instead of annual renewals for certain populations as well.

Just to give a timeline for all of these, the change to the amended eligibility for federally funded Medicaid will take effect on October 1 st of 2026, and the work requirements and six-month renewals will both take effect as of January 1 st 2027.

There are a few more changes unfortunately coming as well. One is reducing duplicate enrollment. This one actually will be a benefit to some degree to all of our members because what it is enforcing is the use of the national change of address database to be able to automatically update Members information based on when they report address changes to the United States Postal Service.

It also allows us to take updated contact information from third party trusted sources and what this really does is it allows us to ensure that we've got the right address and the right contact information on file remembers so that when important information, notices about changes to the benefits, or their annual renewal forms, come to them, it is going to the right address and we are able to ensure their continued coverage.

That will go into effect on January 1 st 2027, with a later additional database that CMS is creating will come into play on 10/1/2029 that will provide additional updated address information. More to come on the second piece at a later time.

The next is the deceased Member verification process. I'm not going to cover this too much because it's a process that DHCS already does where we take action once somebody is notified that they have passed away. And so, this is just streamlining the process to be a bit more efficient. That will take place on January 1st, 2027.

00:08:45 — Theresa Hasbrouck — Slide 7

The next one will also impact our Duals population, and this is the reduced time frames for retroactive coverage. Today if somebody comes in and applies for coverage and they have a past due medical bill, we allow individuals to ask for their Medi-Cal to start up to three months before their application date in order for that to have those past medical bills that they might have incurred covered if they qualify for Medi-Cal.

What this particular provision does is, instead of allowing the three-month time period, it reduces that time period to depending on what type of Medi-Cal somebody receives. If an individual receives Medi-Cal under the MAGI Adult Group, that group is the group that had Medi-Cal expanded to them as part of the Affordable Care Act. Traditionally we call this the population that was 19 to 64 that tended not to qualify for Medi-Cal before the Affordable Care Act because they didn't necessarily have a connection or a link such as being disabled or being a senior or having children, so they didn't qualify for

Medi-Cal. That particular group is referred to as the MAGI New Adult Group and we will talk about them quite a bit into just a second. That particular group will not only be entitled to one month of retroactive Medi-Cal coverage. Historically our dual-eligibility population is not included in that particular coverage group, so they won't be subject to that one-month retroactive period, but all of our other Medi-Cal coverage groups including our age, blind and disabled populations and programs will be restricted to only two months of retroactive coverage. So, it is reducing the amount of months that we can go back and provide coverage when they newly apply.

The last one is cost-sharing, and it is editing a very small co-pay amount to certain benefits, and again, this is only for that group that is part of the MAGI or Modified Adjusted Gross Income group, so that 19 to 64, very small niche group that this is referencing.

00:12:45 — Theresa Hasbrouck — Slide 8

I'm going to go ahead and move us onto the next slide, and this is where you will see me kind of cover things a bit more high-level, especially because we've only got about six minutes remaining. I think the important thing and where you will really track where the Department's act on this effort is our DHCS H.R. 1 implementation plan and our implementation plan is publicly posted or you also take a look at. It goes over



California's approach to all of the provisions, as well as some of our outreach efforts and other things that we are doing to ensure that California is ready, and we try to keep as many people on coverage as we can as we face these very challenging federal changes.

There is also a recording of a walk-through of that limitation plan that can be found at the very same location.

Key components of those plans include all of these different things that are listed here that really help keep us focused. Those include automating protect coverage, so using our system to make sure people stay in coverage, making sure that we are communicating clearly to our members, but also really importantly, to those folks that are helping our members navigate all of these major changes that we are trying to simplify the renewal process for the populations that are going to have to renew more often now. That we are educating and training Medi-Cal Members and those who serve them and so you are going to see we will be rolling out some train the trainer services, similar to what we did during the continuous coverage unwinding, and other sessions to our partners to make sure that you all are well informed about what is happening and that the message to our Members is consistent no matter who is engaging them.

And finally, it's really important we learn this lesson very valuably during the unwinding, that that timely and transparent and consistent communication with our partners is what is going to help ensure that California mitigates as many of these sort of negative things that are happening to our program as possible.

00:14:56 — Theresa Hasbrouck — Slide 9

So go ahead and moving to the next slide. I am going to talk about these super high level.

I mentioned that this is likely not going to affect your population, but I wanted to include this slide just for your awareness. Individuals that are in the MAGI New Adult Group will now be subject to renewal every six months. This is only that population that are subject to this particular renewal cycle. Individuals that are duly covered in Medi-Cal and Medi-Cal will continue with their annual enrollments. The only time we might see that change or that impact a little bit is as people are transitioning, maybe from not being in Medicare to being in Medicare as they aged into the program, there will be a little bit of overlap where the county needs to do that redetermination. So that would be the only sort of overlap with the population.

Otherwise, the other population will be subject to that new six months renewals because renewals are done at the individual level, if you have a household where one person is a MAGI New Adult version and another is in another Medi-Cal program, only the person

that is part of the MAGI New Adult Group will be subject to the renewal. If, for whatever reason, that renewal is not turned in, nothing will happen to the other person on the case. I think that's really important to note as we do have people that are mixed statuses.

00:18:29 — Theresa Hasbrouck — Slide 10

Overview of work reporting requirements. There's quite a few slides on this that is really more just for your information for you all to take back with you. Very similarly, that same MAGI New Adult population, you are beginning to see a trend, that these changes were very focused on this particular group. The MAGI New Adult Group will also be required to meet work and community engagement hours of at least 80 hours per month unless they meet an exemption.

00:19:04 – Theresa Hasbrouck – Slide 11

The great news is, even if we have a Medicare Member who happens to be stuck in the MAGI New Adult Group, which we know can sometimes happen, while the county is waiting to do that transition to another coverage group, having Medicare alone is an exemption from them having to be subject to these work at community engagement requirements. So we don't believe our Duals population will be subject to these at all, but of course, we want to make sure all of our partners have awareness about this particular piece.

00:19:35 – Theresa Hasbrouck – Slide 12

Sort of in all of the following slides after this, and we can sort of skip through them and I will talk through what information is contained there, if we go to the next one, this is just really walking through what fits in exemption, what fits in our qualifying activities, and what is allowed from a compliance perspective in order for them to meet these and at what point we have to look at them.

This is really just for information only. Certainly if you have questions on it, happy to answer them, but in the interest of time I am going to not go any deeper than just explaining the purpose of this particular piece.

The next slide is really getting into the details about those exemptions and who actually qualifies for them. Including some short term hardship exemptions. You are going to see that the Department will be doing quite a bit of education in dedicated training sessions where we will talk about the details of this and what the Department is doing to use data to help verify a lot of these exemptions so that there is no burden to our Medi-Cal Members in some of our other sessions. For the purposes of today, I just want

you to have awareness that there are exemptions for this and these are what those exemptions have, just in case you get any questions from folks or you start to hear about that so that you have understanding about what other populations might be subject to.

00:21:07 – Theresa Hasbrouck – Slide 13

I'm going to move us to the next slide.

A really important one to say that very similar to the unwinding, we had sort of a full rollout of an outreach plan and some key messaging that we passed along to our partner organizations to be able to use as well. So that when we were explaining these things, we universally were explaining these changes using the same language, using the same materials, so that our Members didn't get asked messages from us, and even beyond our Members, people who are looking to newly apply. The same thing will be true as we enter into these H.R. 1 provisions and that will be across all of the provisions that I covered in the beginning. We are having all of those materials use are tested, meaning our Members are actually looking at them and providing us feedback, and then we have some very dedicated stakeholder workgroups who work with folks that we are serving in these populations that are also providing some really important feedback to ensure that our outreach campaign and our messaging to our Members really aligns with where they are at and how they can understand it so they can know what is coming for them and their coverage.

00:22:20 – Theresa Hasbrouck – Slide 14

Lastly, I think we have some information about our coverage ambassador program, which I always make sure we promote. We know obviously you are in this meeting and hearing updates, but if you want realtime information and what access all of those outreach materials we are developing, becoming an out the worst ambassador doesn't commit you to doing anything, doesn't cost you anything but it means you're getting all that important information at your fingertips in your inbox, so I highly encourage you all to sign up if you haven't already.

Sorry for going a couple minutes over. We will now see if we have time to answer any questions.

00:22:59 – Q&A

That was some great information. We have some questions now, time for questions on H.R. 1. As a reminder, agile question to the chat or raise your hand and we



will unmute you. Susan, I will ask you to unmute now so you should be able to unmute. Go ahead.

Thank you, Sasha. Welcome to Earth Day, everyone. Theresa and Susan, wonderful presentation. I would like to ask the question of, will the Department consider having a list serve -- listserv dedicated to all of the updates so the county, the stakeholders, the providers and all of those that do see best counseling with Members would be receiving the data at the same time. Because currently it is fragmented, we don't get everything all at once. Even if we are a coverage ambassador.

I think I hear -- what I think I'm taking from you, Susan, is that you want to make sure there is a consistent channel so that when information is released, updates, stakeholder updates, outreach materials, all of those things, it is sort of blessed to everybody at the same time. Is that your ask, Susan?

It is, Theresa. And the reason I'm asking for that is starting in skilled nursing facility changes for fee-for-service, and we did not have the listserv and the plan, the providers, everyone were lost for a good year. It wasn't until the Department decided to create the listserv that we now get that information in realtime, all the various partners, including your plans and stakeholders and providers. And it makes such a tremendous difference.

Thank you so much, Susan. I really love that idea. I absolutely want to take it back.

I'm always transparent and will just say that we want to make sure that we figure out how to successfully do this without maybe taking away from the ambassador program, because we have over 8,000 organizations signed up there, so I absolutely hear the ask and I think it's an important one, and let me think about how we can make sure we accomplish that goal. I think that's important.

Thank you so much, it's always a pleasure, excellent presentation.

Thank you so much.

Thank you, Susan.

We have one in the chat that we will go to first and then we will go to you. So to clarify, Dual Members that have Medicare will not be subject to the six-month renewals.

That is correct. We would expect that they would be in a different coverage group. Now we understand there is some times where folks are transitioning, but at the point where the county does any renewal and it's time to transition that person, they will be moved out of that aid code and into a coverage group that is not subject to the renewals. So we would not expect this population to experience those increased renewals at all.



Wonderful. Thanks so much, Theresa.

Lupe, I'm going to ask you to unmutes. You should be able to unmute.

Thank you, Sasha. Hi, Theresa. Thank you for the presentation.

I had a question on the timing around the address updates. Isn't known as of yet as of how often those updates will be made or the frequency?

Yeah, excellent question.

The intent is, to obviously to get them -- to be totally honest, there isn't -- I thought there would be some sort of reconciliation that happens on a regular basis, but apparently the national change of address database does not work that way. So it's actually triggered prior to sending Members information. So to give a really good example, if it was time for my annual renewal, what would happen is, the systems would automatically take my information and compare it to the national change of address database and determine what address is on file or what's been reported. If it does not align with the address that I have on file and there's been an update since the last time they engaged the system, the system will know to automatically update the address and then send it to the correct individuals address at that point. So it is triggered directly based on when we are ready to mail something to individuals, so it's realtime.

There's a couple of different places where that will be happening, and so we believe that we will be able to naturally get those address updates throughout the year just through general mailings we have with Members.

Thanks, Theresa.

It looks like we have one more question that we will take in the chat. Would consumers who have original Medicare with Medi-Cal and an advantage plan be subject to six-month renewal of Medicare?

Nea, I don't know if you want to raise your hand and we can have you come on and clarify that as well.

Not sure if the question is specific to the Medicare side. What I will generally answer on the Medi-Cal side is that those individuals would not be subject to any renewal on the Medi-Cal side. Any impacts of H.R. 1 directly with Medicare and any of the Medicare processes -- I would have to defer to someone else, but from the Medi-Cal side, they would not be subject to its regardless of any of those pieces.

Thanks, Theresa.



And one last quick one, under the exemption for medical frailty, is HIV/AIDS consider one of the complex medical conditions?

Fantastic question. One thing I didn't get into the weeds about but I will hear about this question is to say that we in California want to try to exempt as many people as possible. We know the work and community engagement requirements are going to be a barrier to coverage, so if people fit within what we believe the CMS definition of these things are, then we are going to take full advantage of that. When we were doing that is through claims data and looking at any particular claims that we think would align with the overarching definition of medical frailty based on what we are hearing from CMS, but also current existing policies that exists out there partly.

HIV/AIDS or something our stakeholders absolutely lifted up and is part of the claims data we are looking at to do the audio exemption for.

Thanks, Theresa.

We really appreciate the extra time and the really detailed presentation. For folks as a reminder, we will be sharing the slides on the DHCS website. They have additional information.

Now I will pass it back over to Lauren for some updates on the 2026 Medi-Medi Plan expansion.

00:30:38 – Lauren Solis – Slide 15

Thank you again, Theresa; that was a wonderful presentation.

I'm now going to shift gears and talk a little bit about the expansion of Medi-Medi Plans which we just newly launched in a number of additional counties on January 1.

The slides I go through today are probably familiar, we have presented them before. For those that are seen them in the past, please bear with me. Toward the end we will go over the current status of the newly launched Medi-Medi Plans, but for those who are newly joining the watch to make sure we give them the foundational information about anybody plants and their approach.

00:31:14 – Lauren Solis – Slide 18

I'm sure everybody here knows what a dual eligible is, but is individuals who qualify for both Medi-Cal and Medicare. In those cases Medicare covers -- doctor visits, hospital stays, labs, prescription drugs and other benefits and Medicare is the secondary coverage. It pays for Medicare Part B premiums and co-pays and also provides additional services that Medicare may cover but Medi-Cal covers more generously or



covers services that Medicare does not cover. Like long term stays in -- IHSS program, transportation and other benefits.

In California we have about 1.8 million Duals, and that represents about a quarter of Medicare Members overall. Across the state about half of Duals are in original or fee-for-service Medicare and the other half are enrolled in some sort of Medicare advantage plan including integrated plans like Medi-Medi Plans which we will talk about more in a moment.

All dual eligible Members in California are enrolled in a Medi-Cal managed plan or MCP. Let's talk about Medi-Medi Plans.

00:32:33 – Lauren Solis – Slide 20

For most Duals, Medicare Medi-Cal operate separately. They are distinct programs and have different funding streams which can cause fragmentation. That can be very confusing and hard to navigate, particularly for Duals which tend to be a vulnerable population, a lot of healthcare needs, and having those two separate systems again can be challenging and may not provide person centered services.

That's where the CalAIM approach comes in. We have health plans under CalAIM required to coordinate care across Medicare Medi-Cal and these are known as Medi-Medi Plans. Previously, Medi-Medi Plans were available in 12 counties and as of January 1 of this year they launched in an additional 29 counties as well. If you are interested, you can see a list of Medi-Medi by county on our website.

00:33:29 – Lauren Solis – Slide 21

This shows a map of current Medi-Medi Plan availability. The orange color shows the counties that were previously launched, in 2023 or 2024. The darker blue shows the counties that were newly added just as of this year. The polka-dot shading shows where Medi-Medi Plan was newly added this year and there's going to be an additional Medi-Medi Plan option at a later time. And the lighter blue color indicates the counties where Medi-Medi Plans will also be phased in later. There is no availability there yet.

00:34:05 – Lauren Solis – Slide 22

So looking a little bit further into many plans, under the hood, they are a combination of a dual-eligibility plan or D-SNP plus a Medi-Cal MCP. The D-SNP is considered a type of Medicare advantage plan and it is only open to dual eligible Members. They Medi-Medi Plans operate with exclusively aligned enrollments which means that individuals can only enroll in the D-SNP if they are also enrolled or in the process of enrolling in the companion Medi-Cal MCP.



It's one parent organization that is responsible for both the D-SNP and the MCP. They are still two technically separate entities, but from the Members' perspective a look and feel like one plan. They have one set of Member materials, one phone number to call, and integrated appeals and grievance process, etc. It's much more cohesive, coordinated and person centered.

00:35:02 – Lauren Solis – Slide 23

Members who are enrolled in the Medi-Medi Plan receive coordinated care. Although again it's the D-SNP of providing them and Medicare services, the MCP is providing Medi-Cal services, it is doing so in an integrated fashion.

Important to note that although we think there is numerous benefits of joining a Medi-Medi Plan, enrollment in them is completely voluntary.

00:35:27 – Lauren Solis – Slide 24

Care coordination is really the hallmark of Medi-Medi Plans. They help Members access all of their available Medicare and Medi-Cal benefits, including those that are carved out. So across physicians, hospitals, prescriptions, labs and x-rays, transportation, DME, community support, nursing facility, dental, the Medi-Medi Plan is responsible for coordinating across all of it.

00:35:52 – Lauren Solis – Slide 25

You may have heard of the Medi-Cal enhanced ECM program under CalAIM. We have something similar in the Medi-Medi program and recall that California integrated care management instead to help distinguish from ECM. We will talk more about that in just a moment.

Again, Medi-Medi Plans are required to coordinate across all Medicare and Medi-Cal benefits, and that includes carved out benefits that the Medi-Medi Plan is not financially responsible for but they do need to help the Member access and coordinate across those benefits as well.

That includes things like IHSS, MS SP, Behavioral Health services that are provided by the county, and dental. Important to note that joining a Medi-Medi Plan does not impact its Members' IHSS benefits at all. We know that Duals tend to be high utilizers of IHSS if they join the Medi-Medi Plan they keep their IHSS providers and hours and still retain the right to hire, fire and manage their IHSS providers as well. No change there when joining a Medi-Medi Plan.

Similarly, it Members and Medi-Medi Plans also can continue to receive community supports, another initiative under CalAIM. The community supports are provided by the



Members Medi-Cal MCP and the Medi-Medi Plan is responsible for coordinating those community supports along with other Medi-Cal benefits.

00:37:21 – Lauren Solis – Slide 26

I started to talk about this a little bit, but getting a bit more in the weeds on California integrated care management or CICM, that is the ECM-like care management program that Medi-Medi Plans offer. The reason why we kind of distinguish the two is because in Medi-Medi Plans, the federal government has requirements around care coordination expectations that have to meet. In order to reduce any sort of confusion or duplication, instead of having the ECM provided by the Medi-Cal MCP, we have layered the ECM requirements on top of existing federal requirements for care coordination for the Medi-Medi Plans. Again, in order to reduce any confusion or duplication.

The care management provided by the Members D-SNP they get similar level of involvement as they would with the ECM, similar populations of focus and criteria to qualify, etc., it's just shifting the requirement over to the D-SNP side of the Medi-Medi Plan.

Another important aspect of Medi-Medi Plans is access to providers. If a Member's current provider is not in the Medi-Medi Plans network, that provider could of course seek to join the network or the Medi-Medi Plan could help the Member find a new doctor. But it's important to note that when a Member joins a Medi-Medi Plan, they are offered a continuity of care period up to 12 months. To continue to see providers that they haven't -- have an established relationship with. The provider and the Medi-Medi Plan need to agree to terms but when they come to that agreements the Member can continue to see that provider for up to 12 months with the goal that hopefully that provider will ultimately become part of the Medi-Medi Plans network.

00:39:15 – Lauren Solis – Slide 28

For those who are interested in joining. Eligibility criteria include having both Medicare Part A and B, you have to be 21 and older and then live in one of the counties that offer Medi-Medi Plans. Member enrollment in Medi-Medi Plans is voluntary, important to stress. For those that are interested in enrollments they can contact their Medi-Cal plan or 1-800-medicare.

00:39:45 – Lauren Solis – Slide 29

I won't go through all of this, but we have a number of resources for both Members and providers and other stakeholders as well. We have a fact sheet that's translated into a number of different languages. We also have the HICAP and MMLP which can help



provide support to Members as they navigate decision-making for their coverage. And we have a number of other webpages that provide more information about Medi-Medi Plans and generally. Definitely save the slide and take a look.

00:40:16 – Lauren Solis – Slide 30

Without further ado, let's talk a little bit about how the launch is going for the nine new Medi-Medi Plans that started on January 1.

As of this month, enrollment in those plans is approximately 4,000 individuals. It's relatively low number in relation to the broader Medi-Medi Plan enrollment and other more established Medi-Medi Plans across the states, but it aligns with a lot of the Medi-Medi Plans expectations, a lot of them are taking a more measured approach to their outreach to ensure that they are fully established, everything is running as it should before they are encouraging folks to come in and enroll.

As far as we have been hearing, the enrollment processes are running smoothly. We haven't had any sort of technical challenges in that space, which is really great.

We are also hearing from high cap and MMLP that they are not hearing of complaints or other issues being reported. And from the Medi-Medi Plans themselves they have not raised any significant concerns or publications with the rollout. As far as we can tell Evan he has been going very smoothly.

We are really encouraged to see the continued growth and the newly launched Medi-Medi Plans, we will talk more about that a little further in the presentation. But again, we are at 4,000, that's even an increase of what we were seeing in January, so there's a lot of month-over-month improvement already.

With that I think we can shift into any questions.

00:41:55 – Q&A

Thanks, Lauren.

As a reminder for folks, please feel free to raise your hand if you have questions on the 2026 Medi-Medi Plan, or drop it in the chat.

Thank you, Sasha. Susan La Padula. Thank you for your wonderful presentation. I have a question for you regarding the potential of the Department providing instruction for high cap counselors and stakeholders and providers on the appeal process with the Medi-Medi Plans. We are having difficulty in the field with the idea that those appeals are supposed to be consolidated and what the steps are.

LAUREN SOLIS: Thank you, Susan, for your comment.



We do educate high cap, and have shared information with them about the integrated appeals and grievance process but we are always happy to refresh. If there are additional sort of questions about how integrated appeals and grievances should work, we definitely welcome an e-mail to our inbox and we are happy to work through any considerations there.

Thanks, Lauren.

Any other questions from folks?

Seeing none, I think, Lauren, we pass it back to you for some updates on the EAE Enrollment Pilot.

00:43:44 – Lauren Solis – Slide 33

As noted, we will talk a little bit about the default enrollment pilot.

As many of you I'm sure know, we launched D-SNP default enrollment pilot back in 2024 starting with just a few select plans. How the default enrollment works is when a Member is enrolled in one of the participating MCPs, and that never becomes eligible for Medicare, either by aging in or on the basis of disability, the Member will receive two notices explaining that they will be automatically enrolled into their MCP medic -- Medi-Medi Plan unless they choose a different option for the Medicare coverage.

00:44:32 – Lauren Solis – Slide 34

It's important to note that this pilot is specific to individuals who already have Medi-Cal and they are gaining Medicare. It does not impact individuals who are already Duals, already have Medicare and Medi-Cal, or individuals who are already enrolled in Medicare and are newly gaining Medi-Cal.

So again, it's focused on the population of individuals who have Medi-Cal and gaining Medicare. Even so, the pilot impacts a very small number of Members every month. For example, in San Diego County in April this month, 110 Members were default enrolled into community health group, and then in San Mateo County, for health plan of San Mateo, this month 25 Members were default enrolled. Very small number relatively speaking.

00:44:52 – Lauren Solis – Slide 35

A little more on the participating plans. Community health plan in San Diego started sending their initial notices in June of 2024. Health plan of San Mateo started in January of 2025 and then Kaiser most recently started sending their notices in May of 2025. And all three of these plans have met with local stakeholders to discuss the pilot. DHCS is

also worked very closely with these plans on the implementation of default and overseeing the processes as well.

00:45:59 – Lauren Solis – Slide 36

A little bit on Community Health Group. Here is their default enrollment data. Starting with September of through this month. You can see in the middle column is the percent of Members who received notices and then were ultimately enrolled in the plan via default. In the last column was the percent of Members who disenrolled from the plan within 90 days of being default enrolled into the plan.

You can see relatively high percentages with pretty good consistency for Members who enrolled in the plan via default. And then in that last column the Members who left within 90 days of their enrollment is also relatively low as well. So encouraging signs for the community health data.

00:46:47 – Lauren Solis – Slide 37

We are seeing similar patterns with Health Plan of San Mateo. A little bit more variability but again a very high proportion of individuals who received the notices for default enrollments are continuing on with that process. And to get very low percentage of Members who actually disenrolled subsequent to their default enrollment.

00:47:08 – Lauren Solis – Slide 38

And lastly, here's Kaiser. You will see some variation here but pretty high numbers in the percent of Members enrolled via default including some 100 percent for certain. You will see the percent of Members that were disenrolled within 90 days, we see a lot more variation there. Really that is primarily due to the very small number of individuals who are being default enrolled into Kaiser. With a small group you see a small group ends up disenrolled if you look like a high proportion when the number overall is relatively small.

We are encouraged to see these strong numbers from individuals -- from Kaiser and individuals choosing to move forward with the default enrollment.

00:47:54 – Lauren Solis – Slide 39

So in sum, since community health started default enrollment, they have enrolled 2,150 individuals via that enrollment mechanism. HPSM has enrolled 380 Members and Kaiser has enrolled 63. So again you can see the Kaiser numbers are small boats up to the other plans and that's why we see a little more variation there.



So given the success that we have seen over the past many months, in the limitation of default, and in conversations with plans and advocates around how it's going and the Member experience, we have come to a point where we feel it is time to expand the opportunity potentially to some other EAE D-SNP to participate as well.

The policy is still in the works, but we are planning to potentially expand that opportunity to the D-SNP that meet specific performance criteria on three measures. The first would be network overlap between Medicare and Medi-Cal for primary and specialty care providers. The SNAP care management from star ratings, CMS star ratings and the rating -- we selected these measures because we really felt that they were really the most important factors to consider when evaluating a plans sort of potential to successfully implement default enrollments. For folks who are in Medi-Cal, they are seeing their Medi-Cal provider, having -- providers also participating in the Medicare network, we thought was really important so we wanted to see a high degree of overlap there. The SNAP care -- oftentimes the first meaningful touch point and a Member has with the health plan and it sets the stage for their care coordination processes to come. We felt that was important to look at as well. And lastly with the rating of health plan we wanted to look at the Member perspective of their perspective and the plan and rating of health plan a sort of broader and more all-encompassing when thinking about that Member experience. We felt that was important to include as well.

There will be much more to come on this around the details of the policy, how we will evaluate those measures and of course the timing for the implementation. Lots more to come on that soon.

I think with that we can move into any questions.

00:50:31 – Q&A

Thanks, Lauren.

Questions with the eight -- EAE default, place them in the chat. A couple of notes, a comments from Neo, it would be helpful to see the disenrollment of the waiver (Indiscernible) a comment there for DHCS. We do have question from Eve for the satisfaction measure new plans will not have a result until 2027. One will DHCS make decisions about plans ability to participate and what if the plan is too small to rate?

LAUREN SOLIS: That is something we have consecrated as well. There is a lag in reporting and we are anticipating having an avenue for plans who do not yet have reportable data because they are too new to have a vehicle to qualify. More to come on what that might look like, but what we are considering is having an element to look at



the model of care approval from NC QA. As the sort of bridge until they have the data to inform a decision on measures that I outlined.

Thanks for that question.

Any additional questions on the EAE default?

If not, thanks, Lauren. I think we will continue to move along. I know we've got a lot of updates so we will go over to Christopher for some updates on Medicare enrollment.

00:52:14 – Christopher Tolbert – Slide 43

Thank you, Sasha.

If we could go to the next slide.

We are going to talk about Medicare enrollment data for our dual eligible Members.

A little bit of level setting, for Medicare delivery services for Duals, original Medicare, Medicare providers provide free service rendered from regular managed where they can serve Dual Members and Medicare only Members and not required to have written agreements with DHCS for benefit of care coordination.

There's also these folks that we have been talking about, provide specialized care and wraparound services so Members that are dually eligible for Medicare and Medicaid and they have a state Medicaid contract with DHCS. We are talking about Medi-Medi Plans here and they have integrated coordinated care -- integrated appeals and grievances and of course membership is limited to Duals who are also enrolled in the affiliated Medi-Cal Managed Care Plan. And of course the non-EAE D-SNP, those plans do not have (Indiscernible) Medicare managed player -- we have fully integrated dual eligible specialty plan, one California operated by SCAN which provides integrated Medicare and Medi-Cal benefits to dually eligible Members.

And there's other types of special needs claims, special needs plan (Indiscernible) and of course PACE, integrated care that provides medical and long term services support to individuals age 55 and older for nursing facility care. Most who are dually-eligible in California there are a number of PACE organizations.

00:54:12 – Christopher Tolbert – Slide 46

So this is the Medicare managed care enrollment for Duals in California. We have data from October 2024 to 2025, we don't have more recent data yet for the whole system, but soon we will. As you can see, there's been a gradual increase of dual eligible Members enrolling into Medi-Medi Plans over the course of a year, and we also see there's been that gradual decrease of dual eligible Members in a regular plan. There has

been a steady decrease of Duals in the -- but there has been growth of Duals in the other special needs plans which are mostly with chronic special needs plans and also the growth in pace and the scan as well.

00:55:15 – Christopher Tolbert – Slide 47

This is just a pie chart like what we have is from October of 2025. Again, still a bit more of the Duals are in -- for this one it says 20 percent for Medi-Medi Plans but more recently is going to be a bit higher. Based on the data we have as of April. There will probably be a little bit more for scan and pace as well and maybe similar for the other SNP and I think it's going to go down for the non-EAE SNPs unless we have more available data.

00:55:56 – Christopher Tolbert – Slide 49

So next we will talk about Medi-Medi Plan enrollments. As of April 2026, and running across all Medi-Medi Plans is approximately 473,000. About 103,000 more enrollees compared to April 2025, representing an increase of nearly 28 percent. As of April 2026, enrollments in the newly launched nine Medi-Medi Plans is about 4,000.

00:56:33 – Christopher Tolbert – Slide 50

On the next slide we'll get into a bit more information, but of course enrollments will be lower compared to the existing Medi-Medi Plans because most of those plans are also participating (Indiscernible) so of course they will have higher enrollments. Overall their rate grows from January 2026 up until April 2026 is going to be almost 84 percent.

00:57:04 – Christopher Tolbert – Slide 51

This is showing more information on each Medi-Medi Plans. Central California alliance for health, community health plan of imperial valley, Contra Costa health plan, Gold Coast, health plan of San Joaquin, current family health systems, so as you can see each plan they've increased enrollment since January. They have varying growth for the plans but as you can see overall where we get that 83.7 percent they started at about 2,173 and are now about 4,000 in April. So we will continue to track this and share this data.

00:57:52 – Christopher Tolbert – Slide 52

These are the existing Medi plans, enrollment as of April '26. From Blue Cross, Blue Shield, Cal Optima, community health group, health plan of San Mateo, inland empire health plan, Kaiser, LA care, Molina, Santa Clara family health plan, scan health plan and will care. As you can see, Kaiser they have the highest enrollments of Members in Medi-Medi Plans, followed by anthem, but 101,000. And then you see like the enrollment is consistently increasing Duals and Medi-Medi Plans.



As I talked about in previous slides, there is 473,349 Duals in Medi-Medi Plans. And then there's 39,067 in non-EAE D-SNPs. So 92 percent of Duals in D-SNPs are in Medi-Medi Plans. And we got this information from CMS webpage and it will be on the slides when we posted them and they update their enrollment monthly.

Any questions?

00:59:11 – Q&A

Thanks, Christopher.

As a reminder, feel free to raise your hand or drop any questions in the chats. It looks like we do have a comments question from Meredith in the chat. Interested in learning about the ISNP enrollment as well, if those numbers are available. Christopher, is that something you can speak to?

We do have a website, Medicare advantage options for Duals, it is posted there. We do have that information where we have enrollment (Indiscernible) I'll provide the link in the chat.

Thanks, Christopher.

Question from Nea in the chat on whether there is data on what major medical providers accept Medi-Medi Plans?

I don't know if we have data on that, but I think it would be on the plans website. So you would have to check with each of the Medi-Medi Plans.

Great. Any other questions on this presentation work?

I think we can move back to you, Christopher, for some of the highlights on the 2025 D-SNP quality data.

01:00:44 – Christopher Tolbert – Slide 55

Thank you. I'm going to talk about some of the state specific measures that the D-SNP is required to report to DHCS in 2025.

In addition to the CMS Medicare Advantage requirements, DHS requires all D-SNP to submit data on a series of state specific requirements on a quarterly and annually basis. DHCS will conduct and complete this review and report it for publication on the DHS website and a D-SNP dashboard. The purpose of today's presentation is to share updates on the data submitted for 2025 quarterly and annual measures.

01:01:33 – Christopher Tolbert – Slide 56

Today we will go over these quality measures, the ICP measure which captures the number of Members with individualized care plans completed within 90 days of enrollment during the reporting quarter. The ECM measure is going to capture the number of eligible Members received ECM-like services during the quarter and the number of eligible Members who received in person ECM-like care management during the quarter. The PAL measure captures the number of Members who were newly enrolled in palliative care services within the quarter. The long term care measure captures the number of Members currently residing in long term care for more than 90 days during the quarter. And then the CHA Member -- measure captures a number of Members age 65 and older who had their cognition assessed during the year.

01:02:33 – Christopher Tolbert – Slide 57

This first slide is about the individualized care plan, with a care plan completed. Again, within 90 days of enrollments. We have the entire year for 2025, the first quarter through fourth quarter, and the Medi-Medi Plans and the SCAN FIDE-SNP plan. So as you can see, these change quarterly, completion, completion percentage, quarterly basis and of course all of these we are adding all of the data together.

01:03:21 – Christopher Tolbert – Slide 58

This one, ECM, ECM-like services, so this one is the total Members received ECM-like services. We have it for the entire quarter, but also you see that percentage there, what that indicates is the number of people that were also eligible to receive ECM-like services. So the total Members received ECM-like services and divided by the people that were eligible to receive the ECM-like services. And of course we have it for all of the Medi-Medi Plans, the non-EAE SNPs and of course we measure it out across all SNPs in each quarter.

01:04:06 – Christopher Tolbert – Slide 59

This is ECM-like services continued. This is for Members that received ECM-like services and had an in-person interaction. So like this is for all of 2025, Medi-Medi Plans, non-EAE, but when you see those percentages, that is the percentage of people that receive an in-person interaction, when they received an ECM service that had an in-person interaction. That's what that percentage means. Of those who had in-person interaction from those that received, you can see -- that's what those numbers mean.

01:04:59 – Christopher Tolbert – Slide 60

Palliative care. This is total Members newly enrolled in palliative care services. So we just track the number of people that are newly enrolled that have palliative care, so

there's not any percentages of people relative or anything like that, but it's like a total number across all of 2025.

01:05:28 – Christopher Tolbert – Slide 61

This is the long term care measure for the total Members currently residing in long term care for more than 90 days in the quarter. This one is only reported by the Medi-Medi Plans in the SCAN-FIDE SNP. It's not recorded by the non-EAE SNPs.

01:05:53 – Christopher Tolbert – Slide 62

This one is the cognitive health assessment for members 65 and older. The measure is total Members 65 and older who received a cognitive health assessments. This is an annual measure, so we are just measuring across what happened in 2023, we saw in 2024 overall, 2025 it's kind of similar but what of the things we are trying to do and see improvement in 2026, so try to make it reporting requirement worse extension 2026 so we can see improvements in this measure. We want to see improvements in this measure so we hope to dig into (Indiscernible) improve this particular measure.

Thank you so much, Christopher.

01:07:01 – Q&A

Again, if you have any questions on the 2025 quality data that Christopher presented on, please feel free to raise your hands or drop in the chat. We do have a couple questions. One is from Jennifer asking if the reference to ECM-like services is CACM, those are the same.

No, in 2025, we still called it ECM-like services, so the plans they had to choose at least to four populations of focus. For ECM-like services, whereas CACM the average was all of the population focus on ECM plus an additional measure for adults with documented dementia needs. So CACM captures all of the populations of focus, where ECM-like they had to do at least four but they didn't have to do all of them. It's similar but different. That's one of the reasons we transitioned to CACM to kind of get rid of that.

Great, thank you.

One question from Tiffany says on slide 58 there was a decline in ECM-like services in quarter four across all D-SNP and Tiffany is wondering if there's any insight into what happened.

I don't really have any insight into that because this is kind of the first year we've actually had a full year of data for ECM like. Whereas in 2024 we only had a couple of



quarters because we had to change reporting Primus, so it's hard to say why they would be a decrease in quarter four. I really don't want to speculate but it's what the plan reported. It's hard to really know without more data for future years.

LAUREN SOLIS: That's definitely something we can investigate with the plans. As Christopher noted. I don't want to speculate either. I know sometimes there can be some seasonality that occurs towards the end of the year and tending to drop off potentially, but we haven't had those conversations at. These are fresh data so we will definitely talk to the plans and see what more we can learn about what might be going on.

Thank you both.

Question in the chat from Dan. Dan is asking can you tell us what data sources are used to calculate the quality measures, and are the data coming from plans care management systems, clinical chart review or somewhere else? And Dan is particularly interested in how CHA and ECM utilization is monitored.

I'm sure the plans have some sort of tracking of this data, I'm not entirely sure. I could speak a little bit more to the health assessment Manager, (Indiscernible) American neurology -- in our policy guidebook, but that can also be reported by care managers or providers. As far as the other quality measures, I'm not entirely sure -- that's not something that we request from the plans unless there's other information. I'm hoping I answered your question.

Thanks, Dan.

Well, I think seeing no additional questions I can probably move on to the next presentation. Christopher, I know this is you on the DHCS D-SNP dashboard. We can pull down the slides and let you screen share.

Okay, let me make sure I share the correct screen. Can you see the screen, is going to be hard for me to see anything in the chat while I'm sharing.

Yes, we can.

Okay good.

01:11:39 – Christopher Tolbert – Slide 63

So this is our DHCS dashboard, the interactive DHCS dashboard. We have data updated until 2024. This first slide is about the enrollment by plan types. We have various charts, various data of -- EAE D-SNP which is the Medi-Medi Plan, the non-EAE enrollment, so this first half it shows from 2023 until 2024, two years of data, so you can

go back and forth between the years, the tab or we can swipe all of that and this is just high level and then the next one, so this is going to be enrollment by plan by enrollment quarter. This is the plan type so you can see -- and then you can see the quarters here so you can see the enrollment. You can see how they are increasing, etc. This is what this figure displays in the slide. This particular -- this enrollment demographic, the shows enrollment by racists -- race ethnicity, primary language spoken, age, enrollment by sex. As you can see, plan type EAE you see, enrollment by language, and click on non-EAE there's a difference, a noticeable difference when you toggle between the plan types. Pretty similar. You can toggle by the reporting quarters. And we have enrollments by age. You go back to the EAE, the enrollments by age I believe this is more of a static line, but again you see the differences within demographics.

This was something we talked about in some of the quality measures. This is the health risk assessment. Right now is 2024 data is quite different from 2023. The difference in 2024 data was instead of people unable to be reached or refusals, we just -- this is like a straight average of how many people were eligible for a health -- health risk assessment during the quarter. So when I click on 2023, you can see there is differences. The plans -- it's just the way that we calculated that is different from 2023 to 2024. In 2023 we took out some of those people that were unwilling to participate and to be reached, so that's why the numbers look the way that they do. Again, it's not like in the plans they can do worse, it's just how the calculations are different. This is for the health risk assessment.

This is also for the health risk assessment, people unable to be located. These are maybe similar, so as not showing the huge difference.

The next slide, talked about Members -- a bit different in 2024 because we are just asking for how many people got their ICP completed within a given quarter as in 2023, it's going to look quite a bit different. Because people that are unwilling to locate or refusals or pulled from the denominator so that's why the numbers look quite different.

And of course again, there is a toggle for each quarter and each reporting period, when you click on a certain year. So that's what that means.

And again, it's the same measure from year to year, unable to be located. So that will change from 2023 to 2024 and how it's calculated.

This shows referrals, the LDSS referral by Medi-Medi Plans. It includes CBAS, multipurpose thing (Indiscernible) IHSS and people residing in long term care longer than 90 days. So in 2024 the difference is on a per 1,000 Member basis, whereas in 2023, this (Indiscernible) there's like no differences here but it's just for the Medi-Medi



Plans. So this is the referrals, per 1,000 Members. If you go online it's always going to be these averages. You see referrals, and then this is people that refer to the county per 1,000 Members. It's like the average and then of course you can toggle these recorders to -- too.

Medi-Medi Plans only, those were the only ones we are collecting from. And then per 1,000 you can toggle within the years. And then in 2023 it was per 100 words in 2024 we did per 1,000, so there some differences. And again, this is showing the same data but kind of line graph, little different. Completion at 2024, varying rates become -- between EAE and non-EAE. To see the differences of how it was in 2024 because it's calculated differently so we have that for the HRA. Also the ICP and long term care.

And then some of these are the annual measures that we have documented Specialist care goals, so you can scroll down there's also (Indiscernible) this is also on the DHCS dashboard. And then emergency services utilization, this is annual count -- per Member months.

EAE and non-EAE, we can see that. And this is an acronym list. We use acronyms all the time, so what does this mean. This is where we would have the acronyms for the DHCS dashboard and I will stop sharing.

01:19:52 – Q&A

Okay, I will pull the slides back up, if folks have questions for Christopher on the DHCS while -- dashboard.

I see a comment saying the dashboard looks great and thanks for building out and sharing this useful tool.

Any additional questions or comments from folks as we pulled the slides back up.

I see a question from Jane.

Yes, this looks like it's about encounter records and she's asking to Medi-Medi Plans submit Member level encounter records to DHCS currently and does scan submit Medicare covered service encounter records to DHCS?

The plans they don't submit Medicare encounters to DHCS. We are going to get that information from CMS hopefully soon. So there's no requirement but we have requirements for them to submit to DHCS but we can get that encounter data from CMS. So that's we chose.

Thanks, Christopher.

Any additional questions from folks on the DHCS dashboard?



Thanks, Christopher, for sharing all of that helpful data.

Now I think we will pass it back over to Lauren for some information on the BridgeCare pilots for Near Duals.

01:21:41 – Lauren Solis – Slide 68

Thanks, Sasha.

So I wanted to talk a little bit about newly proposed initiative from DHCS to CMS as part of our CalAIM section 1115 demonstration renewal. Hopefully folks are tracking the CalAIM demonstration is set to expire at the end of this year so we are currently in process with submitting the renewal to CMS to continue on with many of the important work we been doing under CalAIM, and then adding a couple of new initiatives including what we are calling again BridgeCare pilots, which is a targeted program for the Near Dual population.

As part of the BridgeCare pilot, the goal is to support older adults, specifically Near Dual to remain in their homes and communities, prevent nursing home admission and the impoverishment that can ultimately lead to Medi-Cal enrollment, improve health outcomes and reduce avoidable healthcare spending.

Under BridgeCare, individuals will be provided with a targeted set of HC BS and caregiver supports and this is again specific to Near Duals. Which we define as Medicare Members who are aged 65 and older who have significant health needs, limited income that's just above Medi-Cal limits, and ultimately lack adequate resources for care.

Participants in BridgeCare would be required to pay cost-sharing up to a specified average care services, local entities which we envision to be counties or regions would opt in to implement the pilot in their region and importantly would support the nonfederal share of the Medicaid funding.

We are requesting federal approval if they approve this project overall to also be able to reinvest a portion of Medicare savings that would result from BridgeCare pilots in order to offset the cost of the program.

01:23:37 – Lauren Solis – Slide 69

A little bit more on the eligibility and services that we are envisioning under these pilots.

Eligibility, individuals would be age 65 or older, they would be enrolled in traditional Medicare, they would require a level of care that is typically provided in a skilled nursing facility, but live at home or in the community. And they would need to meet specific



financial eligibility criteria including having a countable income between 138 and 220 percent of the federal poverty level. It's that income group just above Medi-Cal Eligibility. And then have countable assets within medical device Medi-Cal asset limits.

For individuals who have Medi-Cal with a share of costs are also eligible if they have not met their share of costs or do not have enough medical expenses that are anticipated to meet their share of costs.

For people who are eligible, they would be given a core set of services that the local entities would provide to all participants. That would include assessments, individualized care planning, care management, personal care services, respite for caregivers, and then the CAPABLE program, which is a time-limited program in the home where an occupational therapist, a registered nurse and a handy worker team work together to improve independence and functioning in the home.

Local entities would also be able to select from a list of discretionary services that they could add on to the core menu. That would include homemaker services, adult daycare, assistive technology, communications, device and translation, interpretation, community transition services, consultants of clinical services, nutritional services, social support and transportation. So again that would be a list of optional services that local entities could elect to add on.

01:25:32 – Lauren Solis – Slide 70

And little bit more on the role of the local entities. The local entity is again a county or region that would elect to participate in the BridgeCare pilots. The local entities were designed and administered the services for eligible participants and that would include both implementing the program and funding the program as well.

In terms of implementation, they would identify eligible pilot participants, designed the service package based on that core set of services, and then adding on discretionary services as they see fit. They would administer the services, coordinate care and support evaluation activities to help us assess the success of the BridgeCare pilot program.

They would also again importantly be responsible for the funding portion. They would determine a monthly individual service budget for the pilot participants, they would administer the cost-sharing schedule that's defined by the state, provide funding for the nonfederal share for all BridgeCare services, and depending on the funds available, they may establish an enrollment cap and develop a waitlist as needed.

I open it up for any questions.



Again, this is part of the CalAIM 1115 waiver demonstration renewal request that's going to be going to CMS. We thought that this was an important project to potentially request for CMS approval to serve this population that is typically doesn't have the funds are the means or the support in order to be able to continue to live safely in their community without the impoverishment that ultimately leads to Medi-Cal enrollment.

It's a little bit of a creative solution in the current environment we are operating in, but we are hopeful that we will get some support from CMS to move down this path. With that I will stop to see if there are any questions.

01:27:31 – Q&A

Thanks so much, Lauren.

It looks like we have some questions and we will start with one in the chat from Laura. Has DHS thought about those with a share of cost to be able to access the services when the current maintenance needed still stuck at \$600?

LAUREN SOLIS: This initiative wouldn't change anything about the calculation of the share of cost. In an individual's eligibility to ultimately qualify for Medi-Cal services. This would be an additional opportunity for those individuals to have access to the HC that would be provided under the pilot. So nothing would change on the share of cost side but this individuals will still be able to access the services through BridgeCare.

Thanks, Lauren.

Eve, I will unmute you and you should be able to come off of mute.

Thanks, Lauren. Anything that addresses Near Duals and supports them is something that I'm highly in favor of. My question is, if the intent is to save money on long term care costs, and the local entity which would be the county is not at risk for long term care costs, where would the local entity get funding to provide the services? Or is the expectation that the local entity would work with others who are at risk for the long term care costs?

LAUREN SOLIS: We are at the moment -- great question -- we are leaving it to local entities to potentially structure of the program in the way that makes sense and it could include partnerships with organizations that may have more of a role in that financing space in some capacity, but I think the important thing to stress is that the local entities would be responsible for up fronting the money. However, the savings that would ultimately accrue to the Medicare program as part of our request to CMS we are asking for a share of that savings. Those savings we would pass along to local entities as well. So ultimately the program maybe able to be funded through those savings, but

obviously there is a lot of sorted details of how that would technically work that we would still need to figure out.

Thanks, Lauren. Susan, I see a hand up and a clarifying question in the chat. Local entities would be separate from existing MCPs.

LAUREN SOLIS: That's right.

Thank you.

Susan, I will go ahead and unmute you. You should be able to come off of mute now.

Thanks, Sasha.

Lauren, has the Department looked at the baby boomers as they are aging, and how that is affecting our enrollment in the Duals programs?

LAUREN SOLIS: Are you asking are we tracking changes in the number of Duals in the state court over time.

That, as well as more specific granular data such as which plans are they choosing to enroll in? Are they choosing a D-SNP, are they choosing a SCAN, a FIDE? Where are they going as we are going each year, each day actually in accruing additional elderly joining Medicare because they have aged into it. They are healthy but they are aging into Medicare.

LAUREN SOLIS: We track that very closely. Something we pay a lot of attention to. Christopher in his presentation had some graphics on Medicare enrollments. We have right now through October 2025 more to come on that, but we take a very close look for folks who are aging into Medicare or getting the care on the basis of a disability, what coverage options they are choosing. We have seen some shifts over time, which has been interesting to track and has helped inform the approach we take with Medi-Medi Plans as well.

That first link that I put, additional information on MA options for Duals, post-reports and it shows specific Medi-Medi Plans. We don't post all of the plans that they are enrolling in but we have a type of plan in those reports as well. I hope that some of that is what you were looking for.

Thank you both.

As a reminder, Christopher will put the link to the slide deck in the chat as well.

Mara, I'm going to go ahead and unmute you.

I wanted to follow up on the points about sharing costs and make sure that whoever is working on this pilot, it doesn't sound like it would change anything, and I understand how Medicare eligible he works, I'm wondering then how practically anyone with an income over 138 would be able to use and access BridgeCare pilot since most people who end up on share cost now cannot access existing HCBS programs and they also don't have access to any of the supports through managed-care. So urging the Department to think about if you are kind of thinking about this new creative pilots, that people can't live on \$600, so I don't know how that would actually change the use of HCB services for people who are slightly over the poverty level. Thank you.

LAUREN SOLIS: Thanks for your feedback.

I want to emphasize, this is a separate initiative from traditional Medi-Cal. For folks that have a share of cost and aren't reaching their share of costs in order to qualify for HCBS under the Medi-Cal program as it exists today, that would continue on. This doesn't change anything about that. This is a new program that has a separate eligibility mechanism and they would be a bit -- they would be able to access these services under BridgeCare.

Thanks, Lauren.

We have a follow-up from Tara on this question. If the local entities are separate from the existing MCP is, how would a provider who the entity is to engage contracting as a provider?

LAUREN SOLIS: There is a lot more to come in terms of program design and exactly how this would look. Again, the local entities that we are envisioning here are counties that would elect to opt in. Counties we envision we would give them a fair amount of latitude on how they would design their programs. If they want to potentially leverage existing HCBS infrastructure in the county, they could potentially opt to do that. So again, what we are envisioning is the ability for the local entities to design a program that works best in their local context, but we -- if we do get CMS approval to move forward with this there would be a lot more details we would need to work out.

I hope that answers the question. Feel free to follow up if not.

Feel free to follow up if there's anything additional from there.

Not seeing any additional questions in the chat, if folks have questions, I know we do have an open Q&A session after this so feel free to drop them in.

I think we can go ahead and look at the next slide.

01:35:45 – Open Discussion

Just a little bit of time now for open discussion with our speakers if there's any outstanding questions or comments, please feel free to put them in the chat.

We did get one from Jennifer asking if there is a time frame or the release of the 2027 D-SNP policy guide. Ever know Christopher if you have any updates on that.

LAUREN SOLIS: In prior years we are planning to have stepwise release chapter by chapter. The first chapter that will come out is the care coordination chapter, which is imminent. We are reset -- expecting to release that in the very near future.

Follow up from Tara, not sure Lauren if you can speak to this about the immigration and non-duplication of CBAS with -- new BridgeCare program.

LAUREN SOLIS: Folks who have CBAS wouldn't be eligible for BridgeCare by virtue of having Medi-Cal. This is a pilot specifically targeted at folks who do not qualify for Medi-Cal. Their income is above that 138 percent of the federal poverty level up to 220 percent.

Any additional questions from folks, feel free to raise a hand or drop them in the chat. There is a lot of information, great and helpful presentations on today's call. As a reminder, the slides and recording of the presentation will be available on the DHCS website soon so folks can look through all of the information that was shared today as well.

Christopher just dropped the link in the chat for all of that information will be posted.

I'm not seeing anything additional in terms of questions, but thanks everyone for the great participation today.

Thank you to all of our speakers for wonderful presentations.

We can go onto the next slide.

01:38:12 – Sasha Husley – Slide 73

As a reminder, the next MLTSS Duals integration workgroup meeting is scheduled for Wednesday, August 26th, at noon. Registration is available in the slides and on that webpage that Christopher just shared. There is a workgroup webpage for agendas and an archive of past meeting information as well.

Let me drop that link in the chat.

Lauren or Christopher, any final comments?



LAUREN SOLIS: Thank you, everybody for joining today for the great questions. We really appreciate your engagement.

If you have any lingering questions, comments, concerns, please always feel free to e-mail us at the inbox. Maybe Christopher, you could drop the e-mail link in the chat. We really appreciate you all and value your contributions and thank you again for joining today.

Thank you, everyone. A couple more links in the chat and a link to the inbox.

Thank you all for joining and have a great rest of your afternoon.

LAUREN SOLIS: Thanks, everybody.

Recording stopped.