

CALAIM MANAGED LONG TERM SERVICES AND SUPPORT AND DUALS INTEGRATION WORKGROUP

Date: September 24, 2025
Time: 12:00 p.m. – 2:00 p.m.
Number of Speakers: 11
Duration: 1 hour 36 minutes

Speakers:

- » Cassidy Acosta
- » Anastasia Dodson
- » Lauren Gavin Solis
- » Christopher Tolbert
- » Andrey Bodrov
- » Tyler Brennan
- » Barbra McLendon
- » Genevieve Caruncho-Simpson
- » Linda Keenan
- » Cara Rossi
- » Renee Metts



TRANSCRIPT:

00:00:00:00 — Cassidy Acosta — Slide 1

Good afternoon, and welcome to today's CalAIM Managed Long Term Services and Supports, or MLTSS, and Duals Integration Workgroup. 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 Innovation and Integration at DHCS, Tyler Brennan, Health Program Specialist in the Managed Care Quality and Monitoring Division at DHCS, Andrey Bodrov, Health Program Specialist and Eliza Rodriguez, Associate Government Analyst in the Medi-Cal Eligibility Division at DHCS, Barbara McLendon, Senior Director of Public Policy and Advocacy at Alzheimer's Los Angeles, Genevieve Caruncho-Simpson, Value-based Care Lead, and Linda Keenan, Clinical Advisor at Family Caregiver Alliance, and Cara Rossi, Senior Director of Strategic Supports, and Renee Metts, Director of Care Management at Health Net.

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 the plans that join these calls hold their questions for the multiple other workgroup venues 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 unmute you. And the PowerPoint slides and all meeting materials will be available on the DHCS website soon. We can go to our next slide.

00:01:33:08 — Cassidy Acosta — Slide 2

I'd like to ask everyone now to take a minute just to add your organization's name to your zoom name so that it appears as "your name - organization". 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 window, clicking more, and selecting rename from the dropdown menu. From there, you can enter your name and add your organization as you would like it to appear. And on our next slide we'll go through our agenda.

00:02:00:09 — Cassidy Acosta — Slide 3



For this afternoon, we'll begin today's meeting with some welcomes and introductions from OMII leadership at DHCS. Then we will share an update on the Medi-Cal asset limit policy. After that, we will receive updates on the 2026 Medi-Medi Plan expansion, which will be followed by an update to the Medi-Cal Matching Plan policy. We'll then pause for stakeholder Q&A. After, we will receive EAE Default Enrollment Pilot updates, as well as an update on the 2026 State Medicaid Agency Contract, or SMAC, and Policy Guide. Following this, we will have a duals data update on the Medicare enrollment ECM and Community Supports, which will be followed by our second stakeholder Q&A.

And finally, we will have a spotlight presentation on dementia care and caregiver supports, which will be followed by our final stakeholder Q&A. We'll end today's workgroup with some information on upcoming meetings. And I think with that, I'll transition it over to Anastasia.

00:02:56:14 — Anastasia Dodson — Slide 4

Thank you so much, Cassidy. It's great to be here this afternoon. I wanted to say a couple words. You all have heard that I'm transitioning away from my job at DHCS, but you're in good hands; Lauren Solis is here. She has tremendous experience, working at the federal government on duals policy. We're very lucky to have her expertise. And I'm gradually phasing out, to support the transition.

Christopher Tolbert is also here from the OMII team. I have a lot of confidence in Lauren and Christopher, and we're going to have a smooth handoff. You'll see me in the background here and there, but Lauren's the lead and I'm very pleased to pass the baton to her.

00:03:56:24 — Lauren Gavin Solis — Slide 4

Thank you very much, Anastasia. I'm very excited to be joining the team, and am looking forward to continuing all the wonderful work that OMII has been doing. We can go to our next slide.

00:04:11:20 — Lauren Gavin Solis — Slide 5

First off, as a reminder, the CalAIM MLTSS and Duals Integration Workgroup serves as a stakeholder collaboration hub for this effort. It includes health plans, stakeholders, and the federal Centers for Medicare and Medicaid Services, or CMS. This workgroup provides an opportunity for stakeholders to give feedback and share information about policy, operations, and strategy for the Department's transition plan for dual eligible individuals. The workgroup is open to the public, and the charter is posted to the DHCS website. There's a link on this slide.



We really value our partnerships with health plans, providers, advocates, beneficiaries, caregivers, and CMS in developing and implementing this work. So, with that, we can move to the next slide.

00:05:03:02 — Lauren Gavin Solis — Slide 6

I'm going to pass the baton to my colleagues, Andrey and Eliza for a presentation on the Medi-Cal asset limit policy update.

00:05:13:12 — Andrey Bodrov — Slide 6

Good afternoon, everyone. My name is Andrey Bodrov, and I am working in the Medi-Cal Eligibility Division within DHCS. And we'll go ahead and provide a brief update regarding the asset limit policy updates that will be occurring on January 1, 2026.

00:05:32:10 — Andrey Bodrov — Slide 7

Next slide please.

00:05:35:18 — Andrey Bodrov — Slide 8

Effective January 1, 2026, individuals eligible for Medi-Cal using the non-MAGI Medi-Cal methodology will be required to provide asset information and have assets under the asset limits of \$130,000 for single individuals, plus an additional \$65,000 for each additional household member. Existing Medi-Cal members will not be asked to provide their asset information until their annual renewal in the 2026 calendar year. And counties will attempt to verify self-attested asset information utilizing the Asset Verification Program prior to requesting verification from members. Next slide, please.

00:06:06:24 — Andrey Bodrov — Slide 9

Looking at our impacted populations, these limits will apply to non-MAGI Medi-Cal members and applicants. These are individuals who are aged 65 years old or older, individuals whose Medi-Cal eligibility is based on a disability, or individuals that are currently in nursing home facilities (their eligibility is based on their long-term care facility institutionalization). Also, individuals that are in family units that earn too much money to qualify under the federal tax rules or MAGI Medi-Cal under the Affordable Care Act will also be impacted by asset limits if their eligibility is based on that particular program. Next slide, please.

00:07:12:15 — Andrey Bodrov — Slide 10

What are asset limits? An asset limit is the most amount of countable assets that you can own and still qualify for Medi-Cal. So as a recap, starting January 1, 2026, the asset



limit for single individuals is \$130,000, and each additional individual will add \$65,000 to the family asset limit, up to a total of ten individuals in the household.

Not everyone that's living at home would count towards a family unit under non-MAGI Medi-Cal, which means that those individuals' assets will not be counted when determining the asset limit for that household. An example can include adult children that are living with an individual who's either aged or has a disability and under non-MAGI rules. Some married couples or registered domestic partners may also qualify with higher asset limits under spousal impoverishment provisions. Next slide, please.

00:08:16:19 — Andrey Bodrov — Slide 11

Next steps for members. If individuals are already enrolled in non-MAGI Medi-Cal programs as of December 31, 2025, they will not need to do anything until their first annual renewal, after January 1, 2026. Now, for any subsequent changes in assets, they would be required to report those changes to their local county Medi-Cal office after their first annual renewal. Next slide, please.

00:08:50:11 — Andrey Bodrov — Slide 12

Individuals who find themselves to be over the asset limit, or members who do not require any type of care in nursing facilities, can give away or sell their property at any time without impacting their Medi-Cal eligibility. However, individuals who are currently in nursing facilities or who may need that level of care in the next 30 months will need to spend down their assets in order to qualify for the asset limits and not lose any access to nursing facility level of care. Examples of spending down include paying for school, medical bills, car loans, or other debts, future rent or mortgage payments, buying clothes or household items, making modifications to a home, or buying any assets that don't count for Medi-Cal eligibility purposes. Next slide, please.

00:09:43:15 — Andrey Bodrov — Slide 13

DHCS has published an outreach letter and frequently asked questions document that we will be mailing out to the non-MAGI Medi-Cal members who will be impacted by the reinstatement of asset limits. A copy of the letter is available on the DHCS website, published under [MEDIL 25-23](#). There is also information regarding what are assets and the asset rules under the [MC 007](#) informational form, which is also available on the Medi-Cal DHCS website. We also created frequently asked questions. There is information for members to access on the DHCS website under the help center, and we did include links to all the resources. Once the presentation is shared, you can go ahead and navigate to those resources on the website. Next slide, please.

00:10:40:08 – Andrey Bodrov – Slide 14

For any questions regarding asset limits or the changes to asset limits, you can reach out to us directly at our asset limit changes inbox, and we'd be happy to address them. That does conclude the slides that we have. We'll go ahead and open the floor to any questions.

00:10:59:21 – Cassidy Acosta – Slide 14

Thanks so much, Andrey. I know that Eliza has been dropping in some of those links into the chat. We do have a couple of moments now for questions. We have one in the chat, and one with a hand raised. We'll take the chat and then we'll go to folks who have their hand raised. The first question here is that folks want to "confirm that asset limits apply to MSP."

00:11:24:04 – Andrey Bodrov – Slide 14

Correct. The asset limits will apply to the Medicare Savings Programs.

00:11:30:10 – Cassidy Acosta – Slide 14

Thanks, Andrey. Karli, you should be able to unmute now.

00:11:33:18 – Karli Holkko – Slide 14

Thank you so much. Andrey, you had on the slide that for married couples, domestic partners, or individuals eligible under spousal impoverishment there may be higher limits for them. Does that mean they still have to report their assets so that the county has that information to see if it fits under those levels?

00:11:24:04 – Andrey Bodrov – Slide 14

Correct. When it comes to spousal impoverishment provisions, with individuals applying, they would be required to report the asset information for both the institutionalized spouse and the community spouse so that we can determine the CSRA values, or the Community Spouse Resource Allocation, and determine if the individual is under those combined resource limits.

For individuals that are currently Medi-Cal members, we will be publishing guidance later this year regarding individuals that find themselves to be under spousal impoverishment provisions, who have not ever reported assets, and the process for reducing their assets and still retaining their Medi-Cal eligibility.

00:11:33:18 – Karli Holkko – Slide 14



Amazing, thank you for clarifying. I appreciate it.

00:12:42:13 – Andrey Bodrov – Slide 14

Thank you for the question.

00:12:44:19 – Cassidy Acosta – Slide 14

Thanks so much. I don't see any other hands raised and let's see one more question in the chat. I think this might be our last question, just in the interest of time. But a follow up about, asking about the 250% FPL.

00:13:01:17 – Andrey Bodrov – Slide 14

Yes, the 250% Working Disabled Program will be subject to the asset limits, starting from January 1st. Thank you so much for those questions. And, if you have any additional questions, we dropped our inbox in the chat as well. Thank you, everyone, for having us.

00:13:16:02 – Cassidy Acosta – Slide 14

Thanks so much, Andrey. Thanks, Eliza, for joining. With that, I'll turn it over to Lauren to kick off our next presentation.

00:13:25:01 – Lauren Gavin Solis – Slide 15

Thank you, Cassidy. We're going to dive into an update on our Medi-Medi Plan expansion in 2026. Next slide.

00:13:36:16 – Lauren Gavin Solis – Slide 16

We'll start off with an overview of Medi-Medi Plans.

00:13:45:00 – Lauren Gavin Solis – Slide 17

We'll begin by setting the stage with some quick background on dual eligible individuals. In California we have about 1.7 million duals, which represents almost a quarter of Medicare members in the state across California. Those duals are evenly split in how they receive their Medicare coverage. About half are enrolled in a Medicare Advantage plan and half are in Original Medicare (Fee-For-Service), although that split can vary in different parts of the state. For their Medi-Cal coverage, all duals are in Medi-Cal Managed Care Plans. Next slide.

00:14:23:19 – Lauren Gavin Solis – Slide 18



As you likely know, duals tend to have high rates of chronic conditions and high rates of service utilization. That means that for this population, coordinated, person-centered care is particularly important. But for most duals, their Medicare and Medi-Cal coverage is separate and can be very confusing and difficult to navigate. And that's what we're seeking to address through what we call Medi-Medi Plans.

In a nutshell, they are integrated plans that coordinate care across Medicare and Medi-Cal. Medi-Medi Plans are currently available in 12 counties, and they're going to be launching in an additional 29 counties in 2026, bringing the total to 41 counties. And we have a link in the slide to the list of Medi-Medi Plans by county. Next slide.

00:15:16:23 – Lauren Gavin Solis – Slide 19

Let's dig a little deeper into the structure of Medi-Medi Plans. Looking under the hood, Medi-Medi Plan is the term we use specifically in California for the combination of a Dual Eligible Special Needs Plan or D-SNP, which is a type of Medicare Advantage plan, plus a Medi-Cal Managed Care Plan, or MCP. The D-SNP and the Medi-Cal MCP are operated by the same organization, but under two separate contracts.

However, from the member's perspective, it looks and feels like one plan. There's one ID card, one phone number to call, one set of plan materials, and so on and so forth. And through the Medi-Medi Plan, members have coordinated access to their Medicare services, including hospitals, doctors, prescription drugs, and their Medi-Cal wrap around services like Medicare cost-sharing, Long-Term Services and Supports (LTSS), and transportation. It's really important to note that enrollment in Medi-Medi Plan is completely voluntary. Next slide.

00:16:25:22 – Lauren Gavin Solis – Slide 20

Here is a map of current and future availability of Medi-Medi Plans. The orange color represents counties where Medi-Medi Plans are currently available. That includes large counties in Southern California, some in the Central Valley, and then a couple in the Bay Area. The dark blue is where Medi-Medi Plans will be newly available starting in 2026. The polka dot is counties where at least one Medi-Medi Plan is going to be newly available, and then the lighter blue is where Medi-Medi Plans will be phased in a little later after 2026. Next slide.

00:17:06:20 – Lauren Gavin Solis – Slide 21

Care coordination is important for these health plans. It's a federal requirement that's bolstered and supported by state requirements. Care coordination needs to be across all Medicare and Medi-Cal benefits: Doctors, hospitals, prescription drugs, labs, x-rays,



transportation, durable medical equipment, Long-Term Services and Supports, nursing facilities, mental health, dental, etc. These are all of the benefits that are covered by Medicare, plus any supplemental Medicare benefits and all of the Medi-Cal covered benefits as well, whether the plan is providing it directly or it's a carved out Medi-Cal benefit. The Medi-Medi Plan is responsible for coordinating across all of it.

You've likely heard about Medi-Cal Enhanced Care Management, or ECM. It's part of the CalAIM initiative and something we're generally proud of here at DHCS. But in the context of Medi-Medi Plans, there are such rigorous care coordination standards already from the federal government that end up duplicating a lot of what's provided in ECM. We looked at the federal requirements for care coordination compared to ECM, and wherever there was any kind of gap, we added a state requirement under the umbrella of what we call California Integrated Care Management or CICM.

The bottom line is that it's the same level of care coordination that someone could get through ECM but will instead be provided through the Medi-Medi Plan under CICM. Next slide.

00:18:49:05 – Lauren Gavin Solis – Slide 22

We just talked about the importance of care coordination under these plans. But it's worth re-emphasizing that the care coordination requirements extend to all Medicare and Medi-Cal benefits, including those that are carved out. In other words, even if a plan doesn't have direct financial responsibility for these services, there is still the expectation that they need to coordinate those services.

IHSS, or In-Home Supportive Services, is a good example of that. For members in these plans, there is no change in IHSS benefits, their hours, or their ability to manage their own provider, and the county is still determining eligibility, etc. That said, there is an expectation that the health plan will be coordinating with the county. For example, if someone is being admitted to, or discharged from, a hospital, the idea is to make sure everyone is aware of what is happening and how to best support the member.

It's the same expectation with other carved out benefits like Specialty Mental Health and Substance Use Disorder Services provided by the county, Medi-Cal Dental, and MSSP. The Medi-Medi Plan is responsible for coordinating across everything. Let's go to the next slide.

00:20:05:01 – Lauren Gavin Solis – Slide 23

You may have also heard of Community Supports, which is another initiative under CalAIM for Medi-Medi Plan members. Community Supports continue to be available,

and they are provided by the Medi-Cal MCP. That is part of the Medi-Medi Plan, so, there's no change to the Community Supports benefit if someone joins the Medi-Medi Plan.

We already talked about Enhanced Care Management or ECM. But again, instead of ECM there's still a high level of care coordination that's required for Medi-Medi Plans. We've labeled it CICM for clarity. But the expectation is that it's the same level of care coordination. One key difference I would note is that under CICM, the health plan is responsible and may or may not contract out with community-based organizations or other entities as they do in ECM. But again, bottom line, the coordination is still available under these plans. Next slide.

00:21:03:00 – Lauren Gavin Solis – Slide 24

A little bit on provider networks; like virtually all managed care plans, Medi-Medi Plans have established provider networks that members will use to access their care. If a member's provider is not in the Medi-Medi Plan's network, the provider could seek to join the network, or the member could opt for a new provider.

But it's important to note that plans are also required to offer a continuity of care period, where the member could continue to see their provider for up to 12 months after enrolling in the plan. When a member's existing provider is not in-network, we strongly encourage the plan to work with that provider to establish a temporary agreement, or hopefully a long-term contracting arrangement. Because that continuity of care is important, we want people to be able to enroll in the plan even if their existing provider is not in the network, with the hope that ultimately the provider will be in-network. Let's go to the next slide.

00:22:00:07 – Lauren Gavin Solis – Slide 25

How do you join a Medi-Medi Plan. Next slide.

00:22:09:19 – Lauren Gavin Solis – Slide 26

Members can join a Medi-Medi Plan if they have Medicare Parts A and B, Medi-Cal, are 21 or older, and live in one of the counties where Medi-Medi Plans are available. And again, in 2026 that will be 41 counties in total. Enrollment in a Medi-Medi Plan is completely voluntary. If a member does want to join, they can contact the plan or call 1-800-MEDICARE to enroll. Next slide.

00:22:41:24 – Lauren Gavin Solis – Slide 27



A little bit more on the Medicare enrollment process. Medicare Open Enrollment is coming up very soon. It starts on October 15th, and it runs through December 7th. During that time, Medicare beneficiaries can make changes to their Medicare coverage. For example, moving from Original Medicare to a Medicare Advantage plan or changing their Medicare Advantage plan. And that includes Medi-Medi Plans since they are a type of Medicare Advantage plan.

Any changes made during that time period become effective January 1st, 2026. There's also a second Open Enrollment period specifically for members already in Medicare Advantage, which runs from January 1st through March 31st. During that window, anyone already in a Medicare Advantage plan can switch plans or return to Original Medicare. And those two windows aren't the only opportunities to make a change to Medicare coverage.

There are also Medicare Special Enrollment Periods, or SEPs, that allow dual eligible members to make changes at other times of the year. There are some links here on the slide with more information on that, but we'll dive a little more in on that topic on the next slide.

00:23:59:03 – Lauren Gavin Solis – Slide 28

As of this year, there are new Special Enrollment Periods, again, SEPs, for duals. There's one that allows duals to switch to Original Medicare with a stand-alone prescription drug plan once per month. And then another SEP, called an integrated care SEP, allows duals to choose a Medi-Medi Plan once per month in any month of the year.

It's important to emphasize that the monthly integrated care SEP is specific to enrolling in a Medi-Medi Plan. Duals will not be able to enroll in or change regular Medicare Advantage plans or other types of Special Needs Plans outside of Open Enrollment, unless the individual qualifies for a different SEP, like, for example, moving out of the plan's service area. Next slide.

00:24:49:01 – Lauren Gavin Solis – Slide 29

So come January 1, 2026, duals may have the following enrollment options. They can do Original Medicare and a Medi-Cal plan, a Medicare Advantage plan and a Medi-Cal plan, or a Medi-Medi Plan, which, as we've discussed, will be in 41 counties. PACE is also an option, where available, for those who specifically qualify. And as a reminder, Open Enrollment, we already mentioned this, is coming up very soon, from October 15th through December 7th. And that's the time when Medicare beneficiaries can make changes. Next slide.



00:25:26:21 – Lauren Gavin Solis – Slide 30

We're going to shift gears and talk a little bit about how we've been spreading the news on the Medi-Medi Plan expansion. Next slide.

00:25:38:06 – Lauren Gavin Solis – Slide 31

We here at DHCS have been doing a ton of outreach to help support the plans as they seek to launch Medi-Medi Plans in additional counties in 2026. That's included doing presentations like this one, to their network providers, member advisory committees, etc. And we know the plans have been doing work to outreach to individuals that are enrolled in their Medi-Cal plans to collaborate with the community, etc.

We've also shared information in this workgroup and in an All-Comer Webinar we held on July 29th for providers and stakeholders. And there's a link in the slide for those webinar materials. Finally, we've been engaging with a number of key groups, including County Behavioral Health Agencies, County Social Service Agencies, with a focus specifically on the IHSS program, Health Insurance Counseling and Advocacy Programs, or HICAPs, Home and Community-based Services, or HCBS, waiver agencies and Independent Living Centers. Next slide.

00:26:43:16 – Lauren Gavin Solis – Slide 32

On this slide, we have some links and phone numbers where members can get more information. We have a Medi-Medi Plan fact sheet translated into multiple different languages, as well as a web page devoted to Medi-Medi Plans. If members want to enroll, they can contact the health plan or call 1-800-MEDICARE. As noted here, support is also available through the HICAPs and the Medicare Medi-Cal Ombudsman program, or MMOP.

For providers, any questions should be directed to their contracted Medi-Cal plan. Additionally, providers and any other stakeholders can submit questions to DHCS by email to info@calduals.org. And then there are some helpful links to materials for providers and stakeholders on this slide as well. Next slide.

00:27:40:18 – Lauren Gavin Solis – Slide 33

We're going to transition from the update on our Medi-Medi Plan expansion to talking about the Medi-Cal Matching Plan Policy. Next slide.

00:27:55:21 – Lauren Gavin Solis – Slide 34



To set the stage, it's important to emphasize that Medicare is the primary coverage for dual eligible members. And like all Medicare beneficiaries, dual eligible members have freedom to choose how they receive their Medicare coverage. So, there are no restrictions whatsoever on Medicare choice.

For members who choose to enroll in a Medicare Advantage plan, DHCS' Medi-Cal Matching Plan Policy states that the member's Medicare Advantage choice will determine their Medi-Cal plan. In other words, we match your Medi-Cal plan to your Medicare plan when a match is available. As of 2025, the Medi-Cal Matching Plan Policy is in effect in 17 counties, including some of the largest counties in the state.

If you are a dual eligible member living in one of those 17 counties and are enrolled in a Medicare Advantage plan, you are required to enroll in the matching Medi-Cal Plan if one is available. The Matching Plan Policy ensures that members have appropriate care coordination and helps to address the challenges members may encounter when coordinating across different health plans for their Medicare and Medi-Cal coverage. Next slide.

00:29:18:07 – Lauren Gavin Solis – Slide 35

Starting in 2026, the Medi-Cal Matching Plan Policy will expand from 17 counties to all counties in California. That means regardless of where a member lives, if there's a matching Medi-Cal plan to their Medicare Advantage plan choice, they will be automatically enrolled into the matching Medi-Cal MCP. Those that are not already matched in the expansion counties will be evaluated and matched effectively as of January 2026.

Members will receive a letter from Health Care Options explaining enrollment in the matching Medi-Cal plan. It's important to note that we haven't heard about any issues coming up in the 17 counties where this policy already exists. We anticipate that the roll out to the rest of the state will go smoothly. But if there are any questions or issues, of course, please reach out to DHCS.

You can find additional details on the Medi-Cal Matching Plan Policy on the DHCS website, linked here in the slide. Next slide.

00:30:21:24 – Lauren Gavin Solis – Slide 36

With that, I'm going to transition back to Cassidy to facilitate some Q&A.

00:30:27:06 – Cassidy Acosta – Slide 36



Great. Thanks so much for that presentation, Lauren. We do have some time for Q&A. As we jump into it, I have a couple of questions in the chat. But, of course, folks, please feel free to raise your hand as well.

The first question that we have is from Eddy, and this is specifically looking at the continuity of care provisions for Medi-Medi Plans, that Lauren, you provided some information about. Could you speak to “whether or not those continuity of care provisions apply for Community Supports and ECM providers, or do they just apply for medical networks?”

00:30:58:03 – Anastasia Dodson – Slide 36

I'm going to jump in. This is Anastasia. For the Community Supports, since that's a Medi-Cal benefit, the Community Supports policy is where the continuity of care provisions are. And I know later we have Tyler Brennan, who can speak to that. But my understanding is there is a continuity of care provision around Community Supports on the Medi-Cal side, but Tyler can confirm that later. And then on the ECM, since it's not identical across ECM and the D-SNP care management requirements, the intent and the operational piece that most D-SNPs have is to provide continuity of care, but it's not as rigid because individual circumstances may be different. And, if the ECM provider is not in the D-SNPs provider network, that can cause some complications as well. Thanks.

00:32:06:15 – Cassidy Acosta – Slide 36

Thanks so much, Anastasia. I know we have another question from Eddy in the chat specifically about the “Part A Buy-in.” I don't think that we have the right folks on for that call, but Anastasia, anything that you'd like to share about that one?

00:32:19:12 – Anastasia Dodson – Slide 36

Yes, SB 315 was about the HCBA waiver, but it does look like it's about Part A Buy-in. We do have information we can put in the chat about the Part A Buy-in that we transitioned to January 1, 2025. But I'm not familiar with anything related specifically to the HCBA waiver.

00:32:46:05 – Cassidy Acosta – Slide 36

Thanks, Anastasia. I know Tatiana has also been putting some helpful resources in the chat. Any other questions around the Medi-Medi Plan expansion or the Medi-Cal Matching Plan Policy? Again, feel free to drop your question into the chat or raise your hand and we can unmute you.

Min, you should be able to unmute now.

00:33:14:02 – Min Chang – Slide 36

Great. Can you hear me?

00:33:15:13 – Cassidy Acosta – Slide 36

We can. Yes.

00:33:16:23 – Min Chang – Slide 36

My question is more on the IHSS side. So, how does this expansion impact IHSS recipients?

00:33:32:08 – Lauren Gavin Solis – Slide 36

Thanks for the question, Min. We had a slide on this, but to reiterate, there's no change to IHSS whatsoever. It continues to be a carved-out benefit. So, the Medi-Medi Plans are not financially responsible for IHSS. It continues as it exists today for the individual. The county is still making the determinations, and the individual is still able to hire, fire, etc., their providers, so there's absolutely no change to that whatsoever.

The expectation for the Medi-Medi Plan is to help coordinate with other services that the member may be receiving. I think I gave the example of, if a member is being admitted to the hospital or discharged from the hospital, the Medi-Medi Plan can be that centralized entity to help make sure that all of the member's relevant providers, including IHSS, are keyed in on that and can help really support the member during that transition.

00:34:28:21 – Cassidy Acosta – Slide 36

Thanks so much, Lauren. And Jane, you should be able to unmute now.

00:34:33:16 – Jane Ogle – Slide 36

Thank you. Just a question about Los Angeles because this came up for me yesterday. If a person is in the Matching Plan Policy, does that apply to Kaiser and Blue Cross? So, if a person is Medi-Medi do they get automatically put into Kaiser for both Medicare and Medi-Cal? Or do they stay in LA Care, for example, for the Medi-Cal work?

00:35:03:19 – Anastasia Dodson – Slide 36

Yes, I'll take that one. When there's a delegation, and Kaiser, as far as I know, is no longer delegated in LA, the prime plan is responsible for effectuating the Matching Plan Policy, as far as I know. Now, Stephanie Conde, in case she's on, can chime in if there's anything different there.

00:35:33:13 – Cassidy Acosta – Slide 36

Stephanie is on. So, Stephanie, if you have any other additional responses, feel free to jump in.

00:35:39:24 – Stephanie Conde – Slide 36

Hi, good afternoon. Anastasia has it right.

00:35:44:21 – Cassidy Acosta – Slide 36

Perfect, thanks, Anastasia. Thanks, Stephanie. I think we have another question in the chat asking about when an individual is enrolled in a dual plan under the new program. So, I believe that they're referencing the Medi-Medi Plans. "If the individual would like to remain in a Medicare Fee-For-Service, are they still allowed to do this?"

00:36:04:16 – Lauren Gavin Solis – Slide 36

Outside of the Default Enrollment Pilot that we have, specific to just three plans and three counties, there isn't any sort of automatic process for enrollment into a Medi-Medi Plan. All of the enrollment into Medi-Medi Plan is voluntary. This is even true in the Default Enrollment Pilot; individuals can always opt out of that. So, if you're happy with your Medicare coverage as it is, there's no obligation to sign up for a Medi-Medi Plan whatsoever.

00:36:36:09 – Cassidy Acosta – Slide 36

Thanks, Lauren. And I think that might be a good segue into our next presentation. I don't see any other questions in the chat, and no additional hands raised at this time. And I believe next up is our update on the EAE D-SNP Default Enrollment Pilot. So, back to you.

00:36:50:10 – Lauren Gavin Solis – Slide 37

Great segue, Cassidy. Thanks so much. So, we're going to give a brief update on the Default Enrollment Pilot and where it stands today. Let's move to the next slide.

00:37:02:16 – Lauren Gavin Solis – Slide 38

In 2024, we launched a pilot program with a small number of health plans. Under this pilot, when a dual eligible member is enrolled in one of the participating Medi-Cal plans and later becomes eligible for Medicare due to age or disability, they receive two notices before being automatically enrolled into the Medi-Medi Plan affiliated with their Medi-Cal plan.

That is unless they actively choose different Medicare coverage, so there's no obligation and they can opt out of that process. Next slide.

00:37:38:07 – Lauren Gavin Solis – Slide 39

As a reminder, the pilot does not affect dual eligible individuals who are already enrolled in Medicare or those who are enrolled in Medicare before becoming eligible for Medi-Cal. It only applies to a small number of new members each month and you can see some specific example enrollment numbers at the bottom of this slide. For example, as of this month, 97 members were default enrolled in Community Health Group, and 17 members were default enrolled in Health Plan of San Mateo: relatively small numbers. Moving to the next slide.

00:38:12:21 – Lauren Gavin Solis – Slide 40

The Default Enrollment Pilot, as I mentioned already, includes three participating plans: Community Health Group in San Diego, Health Plan of San Mateo, and Kaiser Permanente, specifically in San Mateo, as well. Community Health Group began sending its initial 60-day notices in June 2024. Health Plan of San Mateo followed in January 2025, and then Kaiser Permanente began in May 2025. Each of these plans has been engaged with local stakeholders to discuss the pilot and ensure coordination and collaboration. Let's go to the next slide.

00:38:52:15 – Lauren Gavin Solis – Slide 41

Let's review some updated enrollment data for the three participating plans. Specifically, we're going to look at the percentage of members who received a default enrollment notice and then ultimately enrolled, and then the percentage who disenrolled from the plan within 90 days, all broken down by month. This slide has the data for Community Health Group, which is the plan that's been participating in the pilot the longest.

As you can see, the percentage of members who enrolled via default increased from under 70% in July to around 80% in September. Notably, disenrollment dropped to 0% in both August and September, which is a substantial improvement from the prior months. Let's go to the next slide.

00:39:44:23 – Lauren Gavin Solis – Slide 42

Here we're showing the same breakdown of data for Health Plan of San Mateo. The percentage of members who enrolled via default decreased by about 25 percentage points from July to September, with July showing the highest enrollment rate at about



90%. Disenrollment also similarly dropped to 0% in both August and September, and overall, has remained consistently low since June. Next slide.

00:40:18:00 – Lauren Gavin Solis – Slide 43

And finally, we have the enrollment data for Kaiser. Having just launched default enrollment about three months ago, Kaiser is showing strong initial enrollment. Default enrollment decreased from 100% to about 70% in September, but there have been no disenrollments to date, which is a positive early indicator. Let's go to the next slide.

00:40:44:01 – Lauren Gavin Solis – Slide 44

We're going to shift gears a little bit and jump into some updates on the 2026 D-SNP SMAC [State Medicaid Agency Contract] and Policy Guide. Next slide please.

00:40:55:13 – Lauren Gavin Solis – Slide 45

As a reminder, all D-SNPs are required to have a State Medicaid Agency Contract, or SMAC, with DHCS. DHCS shared draft SMAC templates with plans and advocates back in February, which reflected feedback from stakeholders, advocates, and plans, and aligned with CalAIM integration goals for 2026. All plans at this point have reviewed and signed their SMAC.

If you're interested in seeing more, you can view the 2026 SMAC boilerplates for both EAE (exclusively aligned enrollment) and non-EAE D-SNPs on the DHCS website. Next slide.

00:41:37:20 – Lauren Gavin Solis – Slide 46

Both the EAE and non-EAE SMAC boilerplates reference the 2026 CalAIM D-SNP Policy Guide. Similar to the 2025 version, the 2026 D-SNP Policy Guide is structured into multiple chapters, each outlining detailed operational requirements and instructions for D-SNPs. It's important to note that each year's D-SNP Policy Guide stands alone, so plans should always be referencing the version for the current contract year.

The 2026 Policy Guide is posted on the DHCS website and available for plans, or anyone who's interested, to go and take a look. And that link is here on the slide. DHCS is going to continue to release chapters of the guide on a rolling basis throughout 2025 and will provide updates as additional chapters become available. Next slide.

00:42:39:21 – Lauren Gavin Solis – Slide 47

Speaking of releasing chapters, we just sent out the Medicare Continuity of Care and Network Guidance chapters of the Policy Guide. We did that on September 12th. Both



chapters are going to be available on the DHCS website soon for reference. But it's worth noting, no substantial revisions were made to those chapters compared to the 2025 version. Next slide.

00:43:05:00 – Lauren Gavin Solis – Slide 48

Now I'm going to pass the baton to Christopher to give us a little bit of insight into the latest data.

00:43:15:16 – Christopher Tolbert – Slide 48

Thank you, Lauren. If we can go to the next slide.

00:43:21:19 – Christopher Tolbert – Slide 49

We're going to talk about Medicare enrollment data for dual eligible members and D-SNPs.

00:43:28:00 – Christopher Tolbert – Slide 50

So, this is just a reminder on the Medicare delivery systems for dual eligible beneficiaries. Again, there's Original Medicare which is Fee-For-Service. This is the original system where Medicare pays providers for services rendered. And then there's regular Medicare Advantage, the plans that also serve both dual eligible beneficiaries and Medicare-only beneficiaries, and they're not required to have written agreements with DHCS for benefit and care coordination.

And then, D-SNPs, which are Medicare Advantage plans that provide specialized care and wrap around services for members that are dually eligible. D-SNPs have to have a State Medicaid Agency Contract, or SMAC, with the state Medicaid agency, with DHCS in California. And, we've been talking about Medi-Medi Plans, which provide integrated D-SNP care coordination requirements, integrated member materials, and integrated appeals and grievances. And membership is limited to dual eligible members who are also enrolled in a Medi-Cal Managed Care Plan that is affiliated with the D-SNP.

And then we also have non-EAE D-SNPs. These plans either have an affiliated Medi-Cal Managed Care Plan, but they're not in counties that offer Medi-Medi Plans yet or do not have an affiliated Medi-Cal Managed Care Plan. Next slide.

00:44:50:13 – Christopher Tolbert – Slide 51

There are other integrated care options. First, there is a Fully Integrated D-SNP (FIDE SNP). This is one D-SNP which is operated by SCAN that provides integrated care; Medicare and Medi-Cal benefits to dually eligible members.



And then we have the Program of All-Inclusive Care for the Elderly, which is PACE, an integrated care model that provides medical and long-term services and supports to individuals 55 and older who meet the criteria for a nursing facility level of care, most of whom are dually eligible. And California has a number of PACE organizations. And then, there's other Special Needs Plans (SNPs), which are Chronic Conditions Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPS). Next slide.

00:45:36:14 – Christopher Tolbert – Slide 52

This graph shows the enrollment for duals in Medicare managed care. There has been a steady increase of duals selecting Medi-Medi Plans in enrollment from January 2024 to January 2025. And then over that same time period there has been a significant increase of duals in other SNPs, which are mostly the Chronic Special Needs Plans (C-SNPs) since they represent more than 90% of that Other SNP total.

As of January 2025, Medi-Medi Plans had the most enrollment out of the Medicare Advantage plans, and the regular Medicare Advantage enrollment has decreased for the first time in January 2025.

00:46:28:11 – Christopher Tolbert – Slide 53

As I mentioned in the previous slide, duals and Medi-Medi Plans have surpassed Regular MA [Medicare Advantage] plans as of January of this year for the first time with 19% of duals in a Medi-Medi Plan. And about half of all dual eligible members are in Original Medicare.

00:46:52:00 – Christopher Tolbert – Slide 54

Now we're going to talk about Enhanced Care Management and Community Supports data updates. Next slide.

00:47:02:17 – Christopher Tolbert – Slide 55

The ECM and Community Supports Quarterly Implementation Report was updated in July of this year. There's a link to the report which is included in the slides. Although we will not be providing an update on dual eligible members receiving ECM during this meeting, we recommend reviewing materials from the previous presentations that have that data. However, we will be providing an update on dual eligible members receiving Community Supports next, and I'll transition to Tyler Brennan from MCQMD, for his update.

00:47:40:21 – Tyler Brennan – Slide 56

I really appreciate that, Christopher, and thank you so much to everyone here. I'm really excited to be here today to talk a little bit about Community Supports and provide my quarterly or semiannual update on dual beneficiaries' access and Community Supports. We can go into the next slide.

00:47:58:20 – Tyler Brennan – Slide 57

I'm going to give a quick recap of what Community Supports are. These services are optional. They are non-entitlement services that are available under California's CalAIM initiative. And these services are really designed to address the social determinants of health or health related social needs that our members have, such as housing, nutrition and other environmental needs.

We currently have 14 pre-approved services, although a 15th is coming up very shortly called transitional rent, that is going to be available for select populations of focus starting in January of 2026. A lot of these services include housing deposits, Medically Tailored Meals, personal care and homemaker services, asthma, sobering centers, and a number of others, including the nursing facility transitions and the community or home transition services, which are both important for this population.

These wrap around supports really aim to promote independence, prevent institutionalization, and improve the health outcomes for our vulnerable populations, including the dual eligible beneficiaries who qualify for both Medicare and Medi-Cal. Managed care plans are the ones who decide which services they'd like to offer. But all plans have opted to provide at least some, and duals are able to access those without needing to be enrolled in health care management.

I wanted to present some figures and data on the screen. You'll see the growing dual numbers over time. Starting with Q1 in 2022 when the program launched, they were very low in the 3,000s. As of Q1 of this year, we had almost 41,500 dual members cumulatively having received Community Supports. And they currently represent about 24% of the total members who are actively receiving services.

There's an age breakdown at the bottom, which I always include and have in the past. I hope this information is helpful. As Christopher referenced, we regularly publish the online ECM and Community Supports Quarterly Implementation Report. A quick Google search will get you right to it. It's available through ArcGIS story maps, if you don't want to wait for that link, and we encourage you all to peruse that at your own opportunity. Next slide, please.

00:50:18:06 – Tyler Brennan – Slide 58



I provided two different slides here. Usually, I come here quarterly for this, but I think I might have missed a quarter, so I wanted to make sure I was getting both the Q4 numbers from last year as well as the Q1 numbers from this year. Here on the screen, you can see a lot of the services broken out with the totals of duals that are accessing each, showing you the percentage makeup of the need for certain services.

You can see that dual members are high utilizers of the personal care and homemaker services, as well as the two transition services on the right, the nursing facility transition to diversion to assist living facilities and the community or home transition services. And those two services have been named interchangeably. We felt like they could use a little bit of fine tuning, so we adjusted those names to assisted living facility transitions. As I said before, community or home transition services still make up a strong part of the Medically Tailored Meals population as well. As well as the environmental accessibility adaptations, which are home modifications that are designed for members to be able to more easily live in their own homes. We can go to the next slide, please.

00:51:28:19 – Tyler Brennan – Slide 59

Here is a demographic breakdown showing what the picture looked like for Q4 2024. Again, this is a slide that we refresh for all of these meetings. And I want to make sure that we're including this in the deck for your future reference or current reference.

We've got about 11% of dual members that are receiving Community Supports also enrolled in ECM, which is important. We feel like ECM and Community Supports really go hand in hand and in an optimal way complement one another, in terms of providing the full, whole person care that that individuals might need. We can go to the next slide, please.

00:52:13:02 – Tyler Brennan – Slide 60

And as I said, these are going to be the same two slides, except this data is refreshed for Q1 of 2025. So, the numbers are a little bit higher. The percentages are a little bit different but overall general trends remain the same. The same services remain highly utilized by this population, so we wanted to communicate that. And we can go right to the next slide, please.

00:52:38:21 – Tyler Brennan – Slide 61

Again, for the demographic breakdown, remember that we had a higher percentage as of Q1 2025, with 15% of members receiving both ECM and at least one Community Support service. And these demographics are generally in line with our overall Medi-Cal population for these areas. This is an area of monitoring that we do pay attention to.



We'll have conversations with the plans if we see any gross disparities or any gross outliers. And I know that there was a question about the continuity of care protection, and I wrote that down, I just wanted to cover that quickly. We do have continuity of care protections for members receiving Community Supports.

This is to ensure minimal disruption in any of their service receipts. So, if a member switches from one managed care to another, that managed care plan has to be offering that same service, which is more common than not in today's world. But as long as that is the case, the new plan must honor any existing authorizations that have been made for that member, and they must automatically approve services by adapting to those parameters. They must also use a 90-day historical lookback period to identify any needs or engage prior providers to avoid any care gaps.

And then for services that have a lifetime or periodic maximum, say the six-month cap that has been recently put on the short-term post hospitalization housing, the recuperative care and the transitional rent, members are only able to receive a cumulative total of six months in a twelve-month rolling period for those services. We do require that the managed care plans essentially track the usage and apply continuity if those limits have not been met. If they have been met, then they still have to abide by those lifetime limits, yearly limits, or whatever they might be.

If an MCP does terminate a service, it must give at least a 30-day notice to all of its members, particularly those receiving service, and they must implement a transition plan.

For duals there are additional safeguards that include continuing Medi-Cal covered Durable Medical Equipment for at least 90 days post enrollment, and some other measures as well. I hope that helps answer and complete that part of the response to that question. But if there are any outstanding questions, please feel free to let me know in the chat and I'll try to pay attention and address those there. I really appreciate the opportunity. I believe I'm passing things off to Cassidy.

00:55:09:21 – Cassidy Acosta – Slide 62

Thanks so much, Tyler. And thank you to Christopher and Lauren as well for these presentations. We do have time for questions now. As always, feel free to drop a question into the chat or raise your hand and we can come around and unmute you. We have one in the chat from David, "Is Q1 2025 data available in the ECM and Community Supports Quarterly Implementation Report?"

00:55:34:01 – Tyler Brennan – Slide 62



That was a great question and something I absolutely meant to mention. For Q1 2025, we are in the very final stages of release. We were just finalizing the communications rollout plan and the messaging that is partnered with the release. And we anticipate that happening by the end of the month. About a week from now, the Q1 2025 refresh should happen. Please allow a few days on either end for that.

00:56:04:22 – Cassidy Acosta – Slide 62

Thanks so much, Tyler. Any other questions on Community Supports data, Medicare Enrollment data for duals?

Susan, you should be able to unmute now.

00:56:27:12 – Susan LaPadula – Slide 62

Thank you, Cassidy. Tyler, thank you for your presentation, it's always good to have you with us. On a previous meeting we spoke about expanding the possibility of the Department considering all 15 community services for all Managed Care plans statewide. How is that looking today?

00:56:54:03 – Tyler Brennan – Slide 62

It kind of cut out in the middle. Was it about transitional rent or...?

00:56:58:05 – Susan LaPadula – Slide 62

It's about all 15 service options, if that would be available in all 58 counties?

00:57:05:16 – Tyler Brennan – Slide 56

Yes, that's a great question. We also publicize a full and refreshed elections chart on our ECM and Community Supports webpage. You can also find those again through a Google search. If you type in Community Supports elections, it would likely be in the top three. But you can easily find it on the DHCS webpage. I'll drop a link in the chat after I'm done with this. But essentially twice a year, usually in June and December, and this is all based on the managed care plan submitted Model of Care process, which is a quite involved process in which they submit all their PMPs to us. They want to optionally elect one of these services and deliver it to their members.

That is available on our website. It is regularly updated. Every six months, plans can elect new services. So, every July and every January that would be when you expect to see the changes happen. We have seen a constant uptick of services, broadly speaking, across the state. And more plans have opted to elect all 14 services. We are starting to see some cost analysis and cost benefit studies on return on investment. Based on a lot of

these findings we are seeing some plans in certain areas pull back on a couple of services. This is very limited, and it doesn't affect the program overall. With these services we're already seeing very low utilization. And again, there's a number of reasons for that, largely based on their geography and areas they are in. But for the most part, we are seeing a constant uptick even this quarter for January 2026.

We know that there will be more services available than there were in July of 2025. So that trend line continues to go upwards, although there might be a couple of kinks in it. But that's to be expected, since this has been a continuation of a pilot. We're introducing a lot of these new services into Medi-Cal, into the health care system, that traditionally were not always available. But we're really excited about what we're seeing, the utilization, the stories that we're hearing from members who are able to access and benefit from these services. We think we're driving in the right direction.

00:59:41:13 – Cassidy Acosta – Slide 62

Thanks so much, Tyler. And I think that answered another question that we got in the chat as well. We do have another question from David, "Does the quarterly report data include information on dual eligible members? Is that an update that has been made to the report?"

00:59:57:24 – Tyler Brennan – Slide 62

The quarterly reports will not yet contain information on duals. This is something that was brought up at the last meeting and it's something that's in the works. We're working to add new visualizations that are specific to duals, for both ECM and Community Supports. And we hope to have that available, if not for the Q2 2025 reporting, then optimistically by Q3 of 2025.

01:00:24:07 – Cassidy Acosta – Slide 62

Thanks, Tyler. I know we have another question in the chat, from Tatiana. This is not about Community Supports or Medicare enrollment data, but Lauren and Anastasia, we welcome you to jump in here. "When a dual eligible member is enrolled in a plan that offers vision and dental, will there be any kind of coordination with the Medi-Cal plan?"

01:00:51:11 – Lauren Gavin Solis – Slide 62

I think this depends on what kind of plan the dual is enrolled in. So, if they're enrolled in a Medi-Medi Plan, if that's the nature of the question, then yes. The Medi-Medi Plan is responsible for coordinating across all services, including vision and dental. So, anything that the beneficiary is entitled to, the Medi-Medi Plan helps with that coordination. In a

type of regular Medicare Advantage plan, there isn't necessarily that same kind of expectation. And so that's one of the benefits that we see of enrollment into the Medi-Medi Plan.

01:01:25:21 – Cassidy Acosta – Slide 62

Thanks so much, Lauren. And I think we have one more question about Community Supports, and then maybe we'll move into our next section. This comes from Tiffany, "How can we cross-reference which plans are pulling back on Community Supports? Are prior Community Supports election charts still posted online?"

Tyler, do you have a response for that one or would it be helpful for DHCS to take it back?

01:02:03:16 – Tyler Brennan – Slide 62

I'm so sorry. I was reading the chat, and I completely didn't realize that was for me. I'll be happy to answer that.

01:02:11:01 – Cassidy Acosta – Slide 62

No worries at all, Tyler. This comes in from Tiffany, "How can we cross-reference which plans are pulling back on Community Supports? Are prior Community Supports election charts still posted online?"

01:02:21:07 – Tyler Brennan – Slide 62

The prior elections are not posted online. We do keep the link that I had shared in the chat evergreen. We have this link embedded in a number of our policy documents. So, it makes the most sense, for every six months, that we do not have to go in and redo all of our remediation and compliance for all of these different policy documents we share. So, no, we don't have previous versions of the election charts, but if you have any questions, we encourage you to submit those to our mailbox, which I also put that in the chat here.

And, again, it's more to come. I don't want to give any names of plans, or the areas or services right now. Just know that it's a very low number of members that will be affected by this. And a lot of the transition plans are already being operationalized to make sure that these folks continue to receive the services they need.

01:03:23:13 – Cassidy Acosta – Slide 62

Thanks so much, Tyler. I think with that, we can go into our next section on Dementia Care and Caregiver Supports. And I will pass it back over to Lauren.

01:03:34:18 – Lauren Gavin Solis – Slide 63

Thank you, Cassidy. We're excited to kick off our spotlight presentation on Dementia Care and Caregiver Supports. In this session we will provide an overview of D-SNP requirements and hear from health plans and advocacy organizations about a couple things: first, the impact of dementia on the dual eligible population, and secondly, the importance of health plan and caregiver supports in improving outcomes and quality of life for this population and their caregivers. Next slide.

01:04:09:05 – Lauren Gavin Solis – Slide 64

We'll begin with an overview of D-SNP requirements, particularly around Cognitive Health Assessment (CHA) data. Next slide.

01:04:34:12 – Cassidy Acosta – Slide 64

Apologize, I think we might be having some technical difficulties on our end.

01:04:34:12 – Cassidy Acosta – Slide 65

Let us know, we can always pull down the slides and pull them back up.

01:04:45:09 – Lauren Gavin Solis – Slide 65

No worries, we're good. So, individuals living with Alzheimer's Disease and Related Dementia, or ADRD, are a priority population for DHCS. We're committed to improving early detection, quality of care, caregiver support, and data analysis to better serve individuals with ADRD. And you can learn more about the Department's efforts to serve this population by visiting the DHCS webpage that's linked here in this slide. Next slide.

01:05:21:03 – Lauren Gavin Solis – Slide 66

D-SNP members with documented dementia needs are eligible to receive targeted support through CICM, which we talked about earlier in the presentation. And that includes access to a trained dementia care specialist as part of their care team. These dementia care specialists must meet specific qualifications and complete required trainings, which are outlined on this slide. For more detailed information, please refer to the 2026 Policy Guide, which includes the full set of CICM requirements. Next slide.

01:06:00:18 – Lauren Gavin Solis – Slide 67

I'm going to pass the torch to Christopher to dig in on some data related to this.

01:06:08:21 – Christopher Tolbert – Slide 67



Thank you, Lauren. In addition to existing CMS Medicare Advantage requirements, DHCS requires all D-SNPS to submit data on a series of state-specific requirements on a quarterly and annual basis. DHCS conducts completeness reviews and processes the data reported by the D-SNPS for publication on the Open Data Portal, and we also have an interactive D-SNP Dashboard.

You can find more information about these and other quality measures that DHCS collects from D-SNPs on the DHCS website, and I'll post a link in the chat because we have data from 2023 and 2024. Next, we will present 2023 and 2024 Cognitive Health Assessment data. This is a required reporting measure by DHCS, in which health plans report the percentage of members age 65 and older who received a cognitive assessment during the reporting period. Next slide.

01:07:14:07 – Christopher Tolbert – Slide 68

This table outlines one of the annual measures for the plans, reporting the number of members aged 65 and older who received a Cognitive Health Assessment in 2023. The percentage of members 65 and older who received a Cognitive Health Assessment was about 3% for Medi-Medi Plans and 7% for non-EAE plan members age 65 and older. Next slide.

01:07:42:15 – Christopher Tolbert – Slide 69

This table shows the same measure, the total number of members age 65 and older who received a Cognitive Health Assessment in 2024. The percentage of members 65 and older who received a Cognitive Health Assessment was about 12% for both Medi-Medi Plans and non-EAE D-SNP members. This is an increase from data reported by the plans in 2023.

When surveyed, some D-SNPs attributed low rates to lack of provider awareness of the importance of the Cognitive Health Assessment completion and underreporting due to missing claim codes. And the D-SNPs that improved on this measure attributed their success to incorporated Cognitive Health Assessments and their care management and health risk assessment interactions, and efforts to increase the number of members going to annual wellness visits.

D-SNPs are taking steps to increase provider outreach and awareness through written materials and trainings. D-SNPs also shared that they are improving data capture for this particular measure.

Now, we will transition to Barbra from Alzheimer's Los Angeles to present on dementia and the duals population in California.

01:08:57:16 – Cassidy Acosta – Slide 70

Thanks, Christopher. And thanks, Barbra. Before we jump into the presentation, since we've been having a couple of technical difficulties on our end, we're going to swap slides here. Give us just a moment as we pull them up, and then Barbra, I'll pass it over to you to get started.

01:09:12:05 – Barbra McLendon – Slide 70

No worries.

01:09:17:16 – Cassidy Acosta – Slide 70

Great. All right, Barbra, the floor is yours.

01:09:19:18 – Barbra McLendon – Slide 70

Thank you so much. Really happy to be here today and happy to be following Christopher. We love nothing more at Alzheimer's L.A. than data about what's happening in this population. I'm going to give you a very fast, high-level overview of dementia broadly in California, and then specifically within the duals population. Next slide.

01:09:40:15 – Barbra McLendon – Slide 71

I don't think it's a surprise to anyone on this webinar that the number of people living with some form of dementia is increasing in California. The number one risk factor for developing dementia is age, and the population in California is getting older. And as it does, there will be more people who are living with some form of dementia by 2040, estimates say almost 2 million. Next slide.

01:10:05:08 – Barbra McLendon – Slide 72

That's not going to be felt evenly across all our different populations because there are some communities that have a higher risk for developing some form of dementia. In the Latino community, there's a one and a half times increased risk of developing dementia. And in the African American/Black community, there's twice the risk. And we don't have time in today's webinar to unpack why, but while the number of people across all of our communities is going to be increasing, that increase is going to be higher in some communities over others. And that's something that our health plans, and our health care system in general, needs to keep in mind as it's thinking about how we can make sure that we meet the needs of everyone in California. Next slide.

01:10:55:06 – Barbra McLendon – Slide 73

Let's look specifically at the prevalence rate for cognitive impairment within the duals population. For the general population over 65, that prevalence number is about 10.7%. It's almost double that within the dually eligible population. And one of the main reasons why this is the case is because people within the duals population are coming with more comorbidities, for example, diabetes and hypertension.

These are the kinds of medical conditions that significantly increase the risk of developing some kind of dementia. These may also be people who have not had regular access to health care across the lifespan, so that is going to be another thing that puts them at higher risk. It's essential within the duals population that we are doing the very best job that we can with that dementia screening, which Christopher was referencing related to the quality measure. Next slide.

01:11:53:05 – Barbra McLendon – Slide 74

Generally speaking, what does dementia screening look like? Only 1 in 7 older adults receive any kind of regular cognitive assessment. And among the people that do get an assessment, only 45% of those people are told their diagnosis, which again we don't have time to unpack why that is the case. And frequently that diagnosis does not get documented in their electronic health record.

So that means for a population that has multiple comorbidities, they are finding themselves in various health care spaces to deal with those specific comorbidities and that dementia diagnosis. If they're fortunate enough to get it, it isn't necessarily following them into all of these health care spaces. If these other medical professionals are not aware of the presence of that cognitive impairment, it is going to significantly hinder their ability to successfully address these other chronic health conditions. So, it's essential that we do as comprehensive of a job as we can with the dementia screening. We are so pleased that the state made the choice, and it is groundbreaking. I'm not aware of any other state in the country that has anything like this dementia screening quality measure. We really are setting the standard, and that also means that we're learning as we go.

And again, we are so appreciative of the state for partnering with us in that learning. If you think back to Christopher's slides about percentages of dementia screenings that are happening, the numbers are moving in the right direction. But with the way the dementia screening measure is structured there are some populations that are automatically excluded from it. The goal we're trying to reach is 100%, so we do still have work to do. But we are at least moving in the right direction. Next slide.

01:13:57:19 – Barbra McLendon – Slide 75



I don't think this information is going to be a surprise to any of you on this webinar today either, but people who are living with a cognitive impairment are a lot more expensive to both systems. When it comes to Medicare, people with a cognitive impairment are three times as expensive. That's largely due to increased hospitalizations. In Medicaid, it's even more stark. They are about 23 times more expensive, and this is largely related to higher use of nursing homes. Next slide.

01:14:30:10 – Barbra McLendon – Slide 76

What we see as the opportunities on both the Enhanced Care Management side and the Integrated Care Management side is the opportunity to move the needle on that cost information because the improved care management, specifically with that dementia expertise, gives us the opportunity to better engage with those family caregivers and do a better job of connecting people to those community-based Long-Term Services and Supports. Particularly if the plans have contracts in place with CBOs [community-based organizations] like Alzheimer's Los Angeles, who have the expertise serving the population and have the relationships in the community so that we can do an even better job of connecting people to that full range of services and support. So not only are their medical needs being met, but all those additional wrap-around needs. And what we can do is help people not end up in the emergency room or hospitalized as frequently, and to be able to remain in the community for longer before nursing home placement. That might be something that needs to happen for the safety of that individual.

01:15:41:05 – Barbra McLendon – Slide 77

And I think that's the end of my slides. Thank you so much.

01:15:54:24 – Cassidy Acosta – Slide 77

Thanks so much, Barbra. I think with that we can pass it over to Genevieve and Linda.

01:06:01:24 – Genevieve Caruncho-Simpson – Slide 78

Thank you so much, Cassidy. Good afternoon, everyone, and thank you so much, Barbra, for a wonderful summary of how important this condition is to D-SNPs and beyond. Next slide.

01:16:17:18 – Genevieve Caruncho-Simpson – Slide 79

On behalf of the Caregiver Resource Centers, thank you so much for the opportunity. In the next few minutes, we want to give you a more human summary of what the cost of care really means to caregivers everywhere from our side of the house. Dementia care is

a daily effort; it does not ease up in a week or two. Families face profound changes in memory, mood, and behavior, and it is hard. Those with the fewest resources especially are dual eligibles and face the highest risk of avoidable hospitalizations and nursing home stays. The cost and stress is overwhelming as pointed out by Barbra. Most families cannot shoulder it alone or pay for care without the support that we provide. For over 40 years California's Caregiver Resource Centers, FCA is one, have been the state's only dementia-ready caregiver inclusive network, supporting families in every county in this state.

Our local staff meet families where they are with caregiver inclusive assessments. They offer culturally-responsive support and trusted community connections, such as with the Alzheimer's Association. This community-based infrastructure directly supports DHCS' goals of improving dementia detection, integrating caregiver supports into CICM, and strengthening outcomes for all dual eligible Californians. Now, Dr. Keenan will share how we bring this model to life. Linda, next slide.

01:17:52:21 – Linda Keenan – Slide 80

We all know that the CRCs already provide excellent resources to the caregivers - our education counseling services, the ability to provide respite and training, and the practical skills to take care of their loved one or family member or neighbor. However, the model is now evolving. We are looking, as Barbara mentioned, for the percentage of members with either Alzheimer's or a condition related to dementia to increase by 2040.

With that said, we are wanting to include the caregiver in a more meaningful way and remove caregiver burden. We're looking at a new evolving model of a dyadic care model to include dyadic care planning, one where a caregiver is involved in the care plan and has a documented area in the patient or the client's care plan.

And through that integration, this dyadic new model will evolve into a CICM compliant model and meet all the requirements of that endeavor. Next slide, please.

01:19:12:19 – Linda Keenan – Slide 81

How are we going to do this? This is a dyad model that looks at the caregiver and the client as one unit, knowing that the caregiver burden negatively impacts the outcomes for the client. With that said, we are looking at an RN (Registered Nurse) led MSW (Master of Social Work) supported care model. It is place based, geographically based, on site, and culturally tailored, with the ability to provide services not just for dementia. As Barbra mentioned, there are so many comorbid conditions that also make up the holistic view of a patient that the caregiver also has to manage. We are looking to have

all these different disciplines in this dyadic model. We have a caregiver, who is assessed as usual, and then we have the client who along with the caregiver is now going to have an Integrated Care Plan. They will have the ability for the caregiver to remove the burden of placing themselves at the forefront of having to make a referral to a community resource.

The actual dyad staff will be making those referrals and will be following up on those referrals. And a closed list referral assures a one and done outcome; success for all. Additionally, this model will be simplified by sharing the Integrated Care Plan and providing a liaison capability to the providers, to the care plans, and to other community resources. Knowing that we can share across the continuum, close gaps that exist, and remind providers that a last assessment looked like this particular client was floundering. And ask, "could there be a dementia-related diagnosis here that has not yet been documented?" and get that documented diagnosis in the EHR [electronic health record]. We are looking at providing 'eyes-on' care management, helping with their transition of care, making sure that what they found out in the hospital truly is in a home environment. We can decrease the inappropriate utilization, having it all documented so we learn from mistakes that may have been made for a certain placement. And then overall lower costs so we can provide additional care to additional members, especially duals, who have a higher propensity for dementia. And in addition, we can keep the unit and the family together longer.

01:22:17:19 – Linda Keenan – Slide 82

This is our goal. Thank you.

01:22:23:21 – Cassidy Acosta – Slide 82

Thank you both so much. And with that we can turn it to our last presenters, Cara and Renee.

01:22:34:06 – Cara Rossi – Slide 83

Hi, all. Thank you. I'm Cara. I'm here to represent Wellcare by Health Net. And we're going to give a little bit of an overview of our Caregiver Collaborations program, as well as some dementia care support programs we have within our plan. You can progress to the next slide.

01:22:54:14 – Cara Rossi – Slide 84

At a high level so everybody has some context, Wellcare is a Medi-Medi Plan in the state of California. We're in 19 counties and we cover about 54,000 members across the state.

That is to give context of where we're coming from; for the programs we speak to. You can move on to the next slide.

01:23:15:20 – Cara Rossi – Slide 85

I'm going to give an overview of our Caregiving Collaborations Program. This is a national program that we have, but I'll speak to the California nuances that we have here. You can progress to the next slide.

01:23:28:12 – Cara Rossi – Slide 86

Overall, our program has been designed to increase and improve the health and well-being of our members, while increasing the quality of life for the individuals who provide those members' caregiving support. And obviously, those caregivers can have a lot of different relationships with their members or roles that they're playing with them, just as other speakers have spoken to. Nationally, our Caregiving Collaboration Program is available to multiple different sets of populations. But specific in California, we've implemented this for the D-SNP and dementia populations. The overall program was developed, and has been implemented, through an interdisciplinary care team that our organization headed by our Clinical Innovations Program. And the team that supported it included nurses, social workers, psychologists, and a lot with a variety of different experiences, both in the caregiver space and dementia care space. And we've had some consultation from external entities as well. Overall, our strategy aligns with the RAISE Act Family Caregiving Advisory Council, and the National Strategy to Support Family Caregivers.

We're really trying to implement evidence-based practices for our care management teams to implement to serve their membership. And, specifically in California, we've provided specific ways for our care management teams to identify caregivers through our health risk assessment process, as the requirements that were referenced earlier that advised what we need to do, and other trainings on how to identify them through ongoing conversations with the membership.

We've implemented the Benjamin Rose Institute Caregiver Strain Tool as our screening and assessment tool for our caregiver support program. And from that tool, our care managers are trained on the scoring of the tool and the needs coming out of it. They'll integrate all those needs into the care plan so that they can provide resource connection to meet the specific needs coming from the assessments and things that are provided from the caregiver. And they'll make connections. For example, to address some of the SDOH concerns that they might have, education on how to approach their new identity as a caregiver if it's been a transition to them, the condition that the

member has specifically, and things like that. Some of that is provided directly and some of it might be referrals to community resources that are available within the California market. And I am going to transition it over to Renee, who's going to speak to our dementia care programs within care management.

01:26:01:19 – Renee Metts – Slide 87

Hi, good afternoon. You can move to the next slide, please.

01:26:07:00 – Renee Metts – Slide 88

For our team, for California, we developed a training for our staff. And we did that in partnership with John Hopkins University and also aligned it with the CMS guidance. With that, they had 20 hours of e-learning and some live virtual instructor-led learning courses on dementia knowledge and implementing best practices and dementia care, providing CEUs. Any of our staff that were reaching California members were required to take this training.

We have also gone back this past year, and they have taken a refresher course on it. They did not have to go through the initial 20 hours, but they did have to take a refresher. In that care management process for dementia, we speak to the member and the caregivers and do assessments so that we're able to identify the needs of that member and ensure that they are safe and taken care of.

We coordinate with the providers, specialists, and Medicaid partners: CBAS, IHSS, and the AAA. We make referrals for palliative and hospice care as needed, to help assist that member, and the caregivers to make the transition as needed. We want to help them coordinate community resources for caregiver support. We want to ensure that everyone has the support they need from the community so that they can utilize those resources. And we also facilitate coordination of assistive devices as well as home care or home modifications to mitigate safe safety risk.

Our goal is safety. We want to ensure that they are familiar with and utilize their community resources, that they are able to see their provider, that we're able to coordinate their provider visits, palliative or hospice care, and then to also make sure they have what they need to be successful at home. Any questions? I see Janine answering questions.

01:28:49:07 – Cassidy Acosta – Slide 89

Thank you guys so much. I think that that we can turn it over to our questions section. But a big thank you to Alzheimer's Los Angeles, Family Caregiver Alliance, and Health

Net for our spotlight presentations today. I know that there are a couple of questions in the chat, but as always, feel free to raise your hand as well, and we'll come around and unmute you.

Our first question around this spotlight is for our DHCS folks. So, this will be for Lauren and Christopher, and it comes from Kate in the chat. "Since one of the CICM populations of focus is adults with documented dementia needs, is there any thought to adding a D-SNP quality measure on the percentage of those with the documented dementia who are enrolled in or receive CICM services? In addition, of course, to the D-SNP dementia screening measure."

01:29:39:07 – Lauren Gavin Solis – Slide 89

I welcome Christopher and Anastasia to jump in with any background that I may not be readily aware of as I'm new to DHCS here, but it's a great question, Kate. And one I think we can certainly take back and consider. We always have to be cognizant of what we're measuring and what we're doing with that data and how it feeds into monitoring priorities. But again, great question, and it's something we're happy to take back.

01:30:06:17 – Christopher Tolbert – Slide 89

Yes, and I agree with Lauren.

01:30:10:00 – Anastasia Dodson – Slide 89

Right. I think what we need to think about is, we already know there are some limitations on the other measures that Christopher went through. And so, is it a chart review type measure? Is there a difference in plans? We would have to use the same type of codes across all the plans, but I would be curious if there might be other factors that could cause big differences by plan.

01:30:53:08 – Cassidy Acosta – Slide 89

Thanks to the DHCS team. I know that we have another question in the chat. This comes from Tatiana, and I believe that it's referencing medical providers. But I also think this might be an interesting question for Family Caregiver Alliance, as we think about caregivers. The question is, "How are providers educated on a local basis about the support services available for dementia care?"

So, I think if, Health Net, you all would like to tackle this on how you keep your providers informed, that would be great. But I also welcome Family Caregiver Alliance to weigh in and share a little bit more about how they educate caregivers on dementia care as well. And Janine, you should be able to unmute now.

01:31:39:03 – Janine Angel – Slide 89

Thank you. Hi everyone. For Wellcare and HealthNet here, we do provide our PCPs [primary care providers], specialists, and provider groups, who support our California membership, with regular trainings on the importance of understanding signs and symptoms of dementia, as well as the assessment tools that are available for them to utilize. And we have an update going out very soon, where we do one reminder a year for our standard training and our standard update reminders. So that is how we do it for our contracted providers.

01:32:24:20 – Cassidy Acosta – Slide 89

Thanks so much, Janine. And, Family Caregiver Alliance, anything you'd like to add on the caregiver perspective?

01:32:30:20 – Genevieve Caruncho-Simpson – Slide 89

Yes, from the family caregiver side, our statewide network has one network that covers every county in the state of California. We have regular meetings with our hospital and primary care providers and other specialty groups on a regular basis because we participate in a lot of models of care. And more recently, we've been having more focused conversations about this upcoming change related to contract year 2026.

Overall, we are continuing to educate our provider groups about this unique requirement that requires a differentiated, place-based care model of care, given the cost trajectory and the burden it presents to caregivers and families everywhere.

We would love to support our health plans as needed. Please reach out if there's anything we can do to support you.

01:33:29:07 – Cassidy Acosta – Slide 89

Thanks so much. Barbra, feel free to jump in.

01:33:31:19 – Barbra McLenon – Slide 89

I love touching on this question because I think this is a challenge, especially in a county like Los Angeles. At Alzheimer's Los Angeles, we are always working to try to educate this huge community that we have about what services we provide. We have a lot of relationships with our health plan; I think that we've been able to build through the advent of ECM. I think that's helping, but there are far too many provider groups and health care professionals who are not aware that we exist and the services that we



provide. That is something that we are always looking at, ways that we can make sure that this community is better educated on what resources are out there.

01:34:25:13 – Cassidy Acosta – Slide 89

Thanks so much, Barbra. Any other questions on our spotlight? I don't see any additional questions in the chat that haven't been answered, but do want to take a moment to pause and see if anyone else would like to raise their hand and come off mute before we wrap up today?

Thank you, Tatiana, for dropping resources in the chat. I'm not seeing any other questions at this time, so I think we can move on to our next steps and closing.

01:35:11:20 – Cassidy Acosta – Slide 90

I do want to just take a moment to thank all our speakers today for the wonderful presentations. Thank you so much to our spotlight speakers for coming out and talking about dementia care and caregiver support. And of course, thank you to everyone for the great discussion today. This is just a reminder that the next MLTSS and Duals Integration Workgroup will take place on Wednesday, November 19th at 12 P.M. We'll see you all there. Please have a good afternoon.