CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

CALAIM MANAGED LONG TERM SERVICES AND SUPPORT AND DUALS INTEGRATION

Date: August 26, 2026

Time: 12:00 p.m. – 2:00 p.m.

Number of Speakers: 17

Duration: 2 hours 3 minutes

Speakers:

- Cassidy
- Sasha Husley
- Lauren Solis
- Christopher Tolbert
- Theresa Hasbrouck
- Dr. Armazeo
- Lauren Gavin
- Allison Brown
- Dr. Ammazeo
- Sharon Bongolan
- Misty Dominguez
- Jamie Juarez
- John Okone
- Tyler Brennan
- Dennis Hisch
- Annette
- Eddie

00:00:00 – Cassidy — Slide 1

Good afternoon. Welcome to the CalAIM Managed Long-Term Services and Supports of medical eligibility, Tyler Brennan, John Ohkane, and Sharon, at the health clinic in San Mateo. Misty Dominguez, Dr. Armazeo will provide the stakeholders an opportunity to ask questions. We ask that any plans on the call today hold their questions for the multiple other workgroup meetings that we have with the Department throughout the month. Please feel free to submit any questions that you have. During the discussion, if you have a question, please use the raise your hand function. All reading materials will be available on the DHCS website.
If we can move to our next slide.

00:01:12 – Cassidy – Slide 2

A quick reminder on how to add your organization to your Zoom name. We ask that you take a minute now. Clicking on the participants icon at the bottom of the window, hovering over your name on the right side of the window, clicking More, and renaming the drop-down menu and writing it as you would like it to appear.
Next slide, please.

00:01:37 – Cassidy - Slide 3

We have a jam-packed agenda, and we will start with HR 1 updates, transition of UIS members to FFS impacts to D-SNP members, Medicare enrollment, data for dual-eligible members, community supports data for dual-eligible members, 2026 Q 1 D-SNP quality data highlights. And EAE deny default enrollment pilot data update, default enrollment plan presentation and discussion.
With that, I will pass it over to Lauren.

00:02:42 – Lauren Gavin- Slide 4

Hello, everyone. Just for purposes of this workgroup, it serves for CalAIM for dual-eligible members for yourselves to give feedback and information about policy operations and strategies for Medi-Cal and Medicaid. We value our partners very much,

with partners, caregivers, and CMC dropping in and engaging in this work. We appreciate it.
Back to you, Cassidy.

00:02:44 – Cassidy

Thank you, Lauren. Now we'll go to Allison.

00:03:16 – Allison Brown - Slide 5

Good afternoon, everyone. My name is Allison Brown with the Medi-Cal Division at ACS, and I will go over the main provisions of HR 1 and a little bit more information about some of our qualified non-citizen information.
Next slide, please.

00:05:23 – Allison Brown - Slide 6

So, walking through the main provisions of HR 1, the streamlining eligibility final rules moratorium. This is related to two streamlined final rules for the HR 1 air. They aim to improve notice and processing time frames for renewals and disabled and eligibility groups. With the release of HR 1, there was a moratorium placed on both of those streamlining rules effective immediately. So those two streamlining rules took effect July 20, 2026. There are purposes for eligibility for funding Medicaid and for federally funded full scope Medi-Cal. This goes into effect October 10, 2026. We'll talk about this a little bit more on the following slides. There was also a requirement for work and community engagement for a certain population of our Medi-Cal enrollees. These are referred to as federally expansion group enrollees. In California, we use the adult expansion for multiple populations.

For clarity here, this is our new adult group population in California: 19-64. This requirement is that they must either work-study or volunteer at least 80 hours per month unless they are exempt. It does go into effect January 1, 2027. Additionally, for the same population, a new requirement for adult members. Previously, all Medi-Cal members had a new requirement every year; now it's every six months.
Next slide, please.

00:05:23 – Allison Brown - Slide 7

A reduced and duplicate enrollment had two parts to it. The first part codifies the requirement for change of address or NCOA database and also return mail from the United States Postal Service starting in January of 2027. It also has a second part, effective in October of 2029; the Federal Government must establish a national database that will identify individuals who may be enrolled in Medicaid in more than one state, and states will be required to utilize that database. Similarly, for deceased member verification, it requires that states verify eligibility against the federal death master file on a quarterly basis or a successor system to identify individuals who shouldn't be on the list that goes into effect January 2027.

There is a reduction for Medi-Cal time frames for all Medi-Cal members. Currently, all Medi-Cal members are able to receive 2 months prior to their application. For new adult members, 19-64 years old that we were speaking about, they are not limited as of January 1st to only one month of retroactive coverage, with all other members eligible for two months of retroactive coverage.

Finally, the last provision we wanted to highlight today is that there is a requirement for cost-sharing new adult group members, that same population we have been talking about, which requires states to implement new payments for some services, while keeping essential care like emergency, prenatal, and health services free.
Next slide, please.

00:07:25 – Allison Brown - Slide 8

If anyone would like more information about the implementation plan of DH 1 that was implemented January 30th, you can go to our website, and these eligibility medical enrollment conversations, and I will cover key points of that plan today.

One of the key components is to do whatever we can to automate coverage and to reduce the burden on those members and eligibility workers. So an example of that is using all data we have available to us to confirm eligibility without needing to reach out and require members to provide that information.

Additionally, another key component is to communicate with clarity and connection and to provide plain language, culturally appropriate information in all threshold languages. We are working very closely with readability experts on any of the outreach materials that we are developing.

We also want to do whatever we can to simplify the renewal experience by streamlining the six-month renewal steps to help members stay enrolled. We understand that the burden is increasing with the renewals moving to six months for some of the population. It's increasing on both the members and our County eligibility workers.

So doing whatever we can to streamline that process for everyone. We have also already started to educate and train those who serve Medi-Cal members. We are going to be offering trainings and tools to both County in coverage ambassadors and will be holding these sessions throughout the year. We have already started the sessions for our counties to help prepare them for the upcoming changes.

Lastly, to provide timely and transparent communication, we have been doing everything we can to share updates early through multiple channels to both members and our community partners, so they have time to prepare for the changes that are coming.
All right.
Next slide, please.

00:09:45 – Allison Brown - Slide 9

So, from here, we'll just talk a little bit more specifically about some changes coming for our qualified and non-citizen QNCs.
Next slide, please.

00:09:56 – Allison Brown - Slide 10

So, on July 4, 2025, with the release of HR 1, which the CMS refers to as the tax cut legislation. Section 71109 of the Medi-Cal eligibility updates QNC eligibility with federal full-scope Medicaid granted through 2026. Those are lawful permanent residents who have met the five-year bar. Cuban, Haitian, and COFA migrants. If an individual does not

meet the eligibility requirements for full-scope Medicaid, federal financial participation is only available for their emergency and pregnancy-related services. Beginning October 1, 2026, California will provide full service to QNC until July 21, 2027. At which time this population will transition to restricted scope.

So effective October 1, 2026, the following QNCs will no longer qualify for federally funded full scope Medi-Cal. These are our refugees -- and those for deportation or removal or in the United States for one year or more and the parent or child of battered non-citizens.
Next slide, please.

00:011:46 – Allison Brown - Slide 11

States are required to reverify the immigration status for all Medi-Cal members who have a QNC status that is no longer eligible for federal full scope under section 71109 starting October 1, 2026. States first must attempt to read the numbers of members' status from the information on the record before contacting the member.

The electronic verification services for status include verifying lawful presence, modified adjusted gross income record, or systematic alien verification for entitlement. If the state cannot electronically verify the member's immigration status and the member remains eligible for federal full scope Medicaid, the member must be given a reasonable period to provide new immigration status information to establish a status to remain eligible for full scope Medicaid. If a person can identify a status that remains eligible for full scope Medicaid, their update must indicate full scope Medi-Cal eligibility criteria.

These changes also affect Medicare eligibility. So section 71201 implements restrictions on non-citizen eligibility for Medicare recipients as well, effective July 4, 2025, for new applicants, and the new applicants who are impacted may not enroll in Medicare, and effective January 4, 2026, existing members may be disenrolled.

The Social Security Administration is required to notify its members. The federal statute requires the Social Security Administration to complete its review and identify those impacted individuals by July 4, 2026. There are identified members then receive the formal notice from the Social Security Administration informing them that their

Medicare will be terminated effective January 4, 2027. Once the members' Medicare is discontinued.
That brings us to the end of our presentation of HR 1 and immigrant changes.

00:014:35 – Cassidy

Thank you. We have a couple of moments for some questions. I don't see any questions in the chat at this time.

All right. I see a hand raised from Jennifer. You should be able to unmute now.
Jennifer, if you are talking, we cannot hear you.
Jennifer, I'm going to try this one more time.
Unfortunately, we still can't hear you. If you don't mind dropping your question in the chat, that will be helpful.
I see a question in the chat from Eddie.
How many people will be impacted by this new immigration rule?

Currently, the budget has it estimated at 148 K for the QNC population; that includes those that are SSI and Medicare eligible who are also QNCs.

Thank you.

Where do you find the exemption form?

00:016:15 – Allison Brown
If you are able to provide more information, that would be helpful. If it's referring to exemption from work and community engagement requirements, these are efforts still underway. The exemption is for ages 19-64. I'm assuming this is the specific work community engagement requirements, and these are still details that are being worked out.

00:016:49 – Cassidy

A question from Tiffany, specifically about the number of folks impacted by the immigration rules?

00:016:58 – Jillian

Yes, I want to say it was about 25K for the SSA control records.

00:017:10 – Cassidy

Thanks, Jillian.
All right. We have a couple of questions in the chat. I'm going to pass it over to Lauren to talk about the UIS transition for fee-for-service and the impacts of DSA.

00:017:32 – Lauren Gavin Slide 12

Thank you, Cassidy.
We are going to be transitioning to a status from UIS for the fee-for-service, and we want to talk about the impact as a result of that transition.
Next slide, please.

Medi-Cal members with one satisfactory immigration status will be moved from Medi-Cal managed-care to a fee-for-service program. This change is required by new federal guidance issued by the Centers for Medicare and Medicaid Services. Approximately 2 million Medi-Cal members will be impacted by this change, and those eligible.
Next slide, please.

00:018:09 – Lauren Gavin Slide 13

Specifically, individuals who are enrolled in a Medi-Medi plan will be in the transition to the medical fee-for-service. Since the membership is limited to individuals who are also enrolled in affiliated Medi-Cal MCP, most if are not eligible for MCP will be effective January 1, 2027. So generally, the expectations and the requirements that the DHCS has for Medi-Cal MCP's as part of that transition will also apply to Medi Medi plan because it's no longer an option once the individual is disenrolled. We are exploring new areas around noticing, but by and large, the Medi-Medi plan will apply.
Next slide, please.

00:019:36 – Lauren Gavin Slide 14

If you want to learn more about the transition. General information, this can be found on the Medi-Cal Web pages. The link is there. In July, the DHCS hosted an ambassador meeting. That information is on this slide as well. Lastly, the DHCS has created a UIS transition policy guide for Medi-Cal and MCP's to support this transition. The first element of that guide was released last month in July and will continue on a slow basis. That information is on the slide as well.
It's brief, but hopefully that information is helpful, and we welcome any questions that you may have.

00:020:36 – Cassidy

Cassidy: Thanks, Lauren.
We have a couple of minutes for some questions. There is a conversation in the chat. Thank you, Julian, for responding, as well as Allison.
Any questions?

Do you know anything about the CalAIM Program?
CalAIM?

00:021:29 – Lauren Gavin

Did you have a question about CalAIM?
Yes. For Health Net, I was on a managed-care program, and now they're dropping it from my housing.

Yes, I think I know what your comment is in reference to. If you wouldn't mind, maybe holding your question. We are going to later in the conversation talk about community supports. We do have a representative from the DHCS joining and might be able to address some of the questions that you may have.
A couple of questions. When will those notifications be out?
That will be by July 2028.
Another question in the chat. For duals enrolled, what choices do they have in Medicare if they are in a managed-care plan?

Great question.
For those retaining Medicare coverage, as discussed in the prior presentation, there is also a narrowing of qualified non-citizen eligibility per HR 1. For those retaining Medicare coverage will be through original Medicare or original Medicare fee-for-service or a Medicare Advantage plan. They won't be able to join another Medi-Medi plan. Enrollment in a Medi-Medi plan is contingent upon alignment between the EAED SNP, and without that enrollment, that person is not eligible for that D-SNP.

One more question.
Can you speak to the other outreach strategies we will do with changes?
Thank you for the question.
There are notice requirements for the D-SNP population that CMS has as well. We are currently working with CMS to see if there is an opportunity to potentially make some small changes to the notice to better reflect the situation and provide information to individuals about the coverage options and where they can go for help. More to come on that, but yes, it is a requirement for D-SNP to send a notice as well.

Thank you. I'm going to Christopher to talk about enrollment tools.

00:025:29 –Christopher Tolbert – Slide 15

We are going to talk about Medicare enrollment. The original system where Medicare pays providers for each service rendered. And we have regular Medicare Advantage where plans serve both dual eligible and Medicare-only members and are not required to have written coordination.

We have the dual plans, D-SNPs that provide wrap-around care with Medicaid and Medicare. And we have the Medi-Medi plan, EAED D-SNPs. These plans meet integrated D-SNP care coordination requirements with integrated member materials and integrated appeals and grievances; membership is limited to duals who are also enrolled in the Medi-Cal management care plan.

Non-EAED D-SNP, and then we have these other special needs plans. The chronic conditions special needs plans and the institutional special needs plans and the PACE

program, which provides integrated care, medical and long-term services and supports to individuals aged 55 and older. Could be nursing facility level of care criteria; most of whom are dually eligible, California has a number of D-SNP organizations.

This is the pie chart of where dual-eligible members are in the Medicare delivery system. This data is as of January of this year. As you can see, still most duals are in original Medicare; now there is a quarter of those members in California in the Medi-Medi plans. We can see the percentage and the other SNPS and the total and 2% non-EAED SNPS. Next slide. We are going over the Medi-Medi plan enrollment.

As of August 2026, enrollment in all Medi-Medi plans is about 480,000.
It's about 95,000 more compared to last year, which is an increase of 25%. Then, the newly launched Medi-Medi plans have an enrollment is approximately 6300. And since the beginning of this year, you can see that their rate of growth is about 191%. So, as you can see, and we'll see on the next slide, the growth for these plans.
Next slide, please.

00:029:22 –Christopher Tolbert – Slide 16

So, this is from January to April. As you can see, each of the new SNP's that launched this year is growing each month. You can see Alameda Alliance for Health, Cen Cal Connect, Central California Alliance for Health, Community Health Plan of Imperial Valley.

It's consistent across the board -- from January to now, Alameda Alliance for Health, the rate of growth is 263.5%; Central California Alliance for Health, 192%. Community Health Plan, 179%; Contra Costa, 232%; Gold Coast, 173%. You can see overall is 191% for the new plans that just launched this year.
Next slide, please.

00:030:52 –Christopher Tolbert – Slide 17

Again, we just want to show the enrollment for all the other D-SNPs as well that have been existing in California for quite some time. You can see there is a variety of enrollment for each of these plans. Some of them are in multiple counties, some are

entirely throughout the state, and some are in one County. As you can see in the bottom, the total is 473, 306.
Next slide, please.

00:031:24 –Christopher Tolbert – Slide 18

The kind of looking into the numbers a little bit more. As of August, there are 479633 dual eligible members in the Medi-Medi plans. There are 36102 dual eligible members in non-EAE D SNPs, which are closed to new enrollment. 93% of dual eligible members in D-SNPs are in Medi-Medi Prance. This enrollment information is available on the website.
Are there any questions?

00:032:04 – Cassidy

Thank you so much, Christopher. We'll take a moment for questions. Raise your hand, and we'll come around to unmute you.

All right. I'm not seeing any questions. I know we have other opportunities for questions for today's presentation. I see one coming in. For those who will be affected, will the health plan, actually, this might be specific to a previous conversation. We'll hold that for the end.

With this, we can go on to our next presentation. We'll go to Tyler.

00:033:17 –Tyler Brennan – Slide 19

Good afternoon, everyone. My name is Tyler Brennan with the community supports data for dual-eligible members. I'm here to talk about community supports. We'll be Zooming in on dual members for accessing community supports on these next few slides. Some of these slides may look familiar. Really a continuation of the data to see the full picture included on each slide.

That, we can jump to the next slide.
Next slide, please.

00:034:32 –Tyler Brennan – Slide 20

We do, on a regular basis, release a new report. We just refreshed that at the beginning of July and end of June, which includes information from January 1, 2022, through December 31, 2025, summarizing total Medi-Cal members receiving ECM and community supports and key trends in enrollment, utilization, and provider capacity. Among a number of things like demographic, county statistics, etc.
Next slide, please.

00:035:57 –Tyler Brennan – Slide 21

We'll review some of the data we have recently released, and this is all going to be new to this group since the last time we came. Last time we provided information on Q1 2025 data; here we will be providing data on Q 2 through Q 42025 update. This has been approved, and we are approved to release it here. This will be incorporated in our quarterly report to be released by the end of September.
Next slide, please.

00:036:39 –Tyler Brennan – Slide 22

The annual count of dual-eligible beneficiaries receiving community supports for 2022 is current. For now, it's good to keep the running picture alive. You can see as we have moved through 2025 on the right side at the top and down to 2025 on the bottom left, we are starting to see signs of program maturation leveling off. We are updating the policy to drive it towards quality to ensure the members are receiving appropriate services and community supports. As a whole, we do see the dual eligible beneficiaries represent about 21% of the total number of members that receive community supports, and that's just measuring and looking for Q 42025 periods. I added some age groups and breakouts to see where they fall, and obviously is over age 65, which makes sense. This is the whole picture.
With that, next slide, please.

00:038:33 –Tyler Brennan – Slide 23

Zooming in on a number of our key services and highlighting the services that dual eligible is most likely to access, these are the highlights here. We have 11 of the 14 services shown on screen, including our housing try-on services at the top left, personal care and homemaker services, and caregiver respite, and showing the percentages and the dual eligible numbers receiving these actual services. You can see that homemaker and caregiver services, environmental accessibility adaptations, those are dual eligible members receiving these services. I wanted to highlight that.

Medicare tailored meals, medically supportive food 25509 dual eligible members, about 31 percent of the total. I wanted to give you a better understanding and a more accurate picture of what that looks like for those accessing Medi-Cal services and Medi-Cal.
Next slide, please.

00:039:56 –Tyler Brennan – Slide 24

Among those members on the previous page that were accessing services, this is what that demographic breakdown looks like for those members. I will hold off on reading the percentages. I'm sure they are quite apparent. We did have 15% of members who are dual also receiving ECM. Just highlighting that. I don't think there are any real surprises on the screens, but happy to answer any questions for someone looking for more specificity. With that, we can jump to the next slide.

Next speaker, please. That's the question slide.

I think the division chief might be in the wings, willing to answer questions.

00:041.32 – Cassidy

You are correct. He has joined the call. You can drop your questions in the chat or raise your hand. I do have one question in the chat from Carly.

Do you expect the numbers to shift down to go towards CICM?

That is a very specific question, but I don't feel fully equipped to answer. I will have to take that back or suggest that it be submitted to the enhancement care management box at dhcs.ca.gov.
Thank you.

Another question from Brittany:
For new organizations that are participating in ECM resources or recommendations for readiness requirements?

Yes, from the program level, we encourage close coordination and participation with the local managed-care plans. All of our services are electively covered by those who choose to offer them by the operation. The first step is to reach out to your local MCP, ask about community supports, and if you are able to join their network, we have to make sure we manage all of our managed-care plans to be sure they have training policies in place and provider education pathways so they are able to bring providers for their community supports.

Many of which are non-traditional to Medi-Cal because a lot of these services are social service-driven and touch more on areas that are historically not necessarily part of Medi-Cal. So we have on our DHCS website a host of resources page where a number of valuable resources for providers can be found. We have all of our policy guides contained there for each one of the services so you can get a much better idea of where it came from, intentions, long-term goals, and how you can participate.

Cassidy: Thank you so much, Tyler.

Another question for those in EAE or non-EAED SNP's, as well as Medicare Advantage plans?
Interesting question.

The community supports are only available in the managed-care delivery space. That is something that has been true since the beginning of the program in 2022. So, yeah, it's not available to members in fee-for-service. It's just a managed-care delivery-elected coverage benefit.

What was the other part of the question?

The other part of the question was whether or not it captured all duals, for example, those in an EAED SNP, non-EAED SNPs, someone on the Medicare Advantage plan or the Medi-Cal side?

I have to respond to that with a little ambiguity. As long as the member has the ability to access their Medi-Cal service through their managed care health plan and meets the requirements for our services, they should be able to meet that type of business as long as there is not comparable Medi-Cal as a last resort.

Anything that is existing in Medicare should not duplicate it. Any wrap-around that might be necessary for that part of it. We can provide the community supports.

Thank you so much, Tyler.
I know Christopher might have wanted to jump in. I will pause if you have anything to add.

Christopher Tolbert: I wanted to add, yes t dual members include EAED SNP or some other type of Medicare plan and can access supports through their managed-care plan.

Cassidy: Thank you for that. Another question. Could you share how many of the duals accessing community supports are enrolled in the Medi-Medi plan?

Tyler Brennan: I don't think we have that breakdown, but they all have to be enrolled in a managed-care plan. I don't have that breakdown available to us at this time. Sorry about that.

Cassidy: Thanks, Tyler.
I'm going to ask Annette to unmute. Last question for this section.

Annette: I don't think if I'm talking about the right person with the managed-care program that I was on, they are going to be eliminating that for housing?
Do you think if this is specific to a community support?

Lauren Gavin: One thing Annette might be thinking of is the Health Net transition?

Tyler Brennan: Are you currently receiving services?

Annette: Yes. I don't want to put my foot in my own mouth. I will phone a friend first before I jump into that one.

Dennis Hischier, Division chief: How can we be helpful? What questions do you have? I know there has been a lot of concern about this one. So, definitely want to be sure I answer your question appropriately.

Annette: I have been receiving that assistance for my housing. I live in assisted living. Was told as of November 11, it's going to be terminated.

Dennis Hischier: Sorry to hear that. Prior to November 11th, I'm assuming you are working with master care?

Annette: Yes.

Dennis Hischier: DHCS just issued some guidance today, and we'll definitely send you a copy. We have been tracking the situation closely. And the benefit through Health Net is covered through at least the end of this year, December 31, 2026. If you have a date that's prior to that, we would recommend calling Health Net and/or working with master care to request ongoing services.

If you are medically and clinically appropriate, meaning you meet the guidelines, which I assume you may given what you shared with me so far. Health Net does have to review that and if you are eligible, authorize you to remain through December 31. So there is a second thing at play here. There is a whole issue around master care, some of the other providers being terminated.

So like, even if master care does not end up staying with Health Net through December 31, Health Net still has to cover you through December 31 if you are eligible. The caveat here is that community support, as Tyler shared, is optional for plans to choose to opt

into, or to not offer every calendar year. Health Net is indicating they are looking to terminate and stop offering this benefit as of January 1.

So, in that case, health net's obligation to you and others in your situation is they need to sit down with you, assess, talk with you and understand what's happening and come up with a transition plan with another setting that would cover that may be look like going to a long-term care facility such as a skilled nursing facilities, that they would continue to pay for, it could also mean going home with additional benefits if you happen to have a home or family that you can stay with and there is other things such as in home support services that would be appropriate to support you there.

So every single individual's situation is different, and that is why Health Net is terminating this benefit. Or if they do decide to go ahead with terminating this benefit as of December 31, they need to be sure they appropriately sit down with every single member receiving this benefit to be sure there is an appropriate agreed-upon outcome in terms of where the member would transition.

Annette: Okay, I did call Health Net, and they said a caseworker would be assigned. I was told November 11th.

Dennis Hischier: That is incorrect information that has been shared with some individuals by, I'm not sure who told you that. I think if you are being told November 11th, you do have a right to ask to stay through at least December 31st if Health Net decides to terminate this benefit. That means you should ask your caseworker, talk to whoever told you November 11th, and say I would like to submit a request to stay until December 31st.

Annette: Okay.

Cassidy: Thanks, Annette.
Is there an email she can reach out to the DHCS for additional questions?

Dennis Hischier: Yes, we can send an email and just put out this morning a clear statement on the DHCS understanding health obligations as well as members' rights in

this situation, and happy to share with this entire group, which Tyler can pop into the chat. We would also be happy to connect with Annette if she's having challenges.

00:052:41 – Cassidy

Thank you for the presentation. In the interest of time, we are moving to the next section.
Next slide, please. Great. I will pass it over back to Christopher.

00:052:59 –Christopher Tolbert – Slide 25

Thank you, Cassidy.
We are going to talk about the report this year for SNPs' quality and data reporting. In addition to the existing CMS Medicare Advantage requirements, the DHCS requires all D-SNPs to submit data on a series of state-specific requirements on a quality and annual basis, and the DHCS completes reviews and processes data and 2026 measures.

We are going over the definitions of the quality measures. ICP measure captures the number of members with individual care plans completed within 90 days of enrollment during the quarter.
The CICM, California Integrated Care Management, captures the number of eligible members who received CICM services during the quarter and the number of eligible members who received in-person CICM care management during the quarter.

The LTC measure captures the number of members currently residing in long-term care for more than 90 days during the quarter.

The first slide, this is the individualized care plan, ICM measure, with the care plan completed. In the first quarter of this year. You can see the Medi-Medi plans; there were 31,000 care plans completed during this quarter for members that reached 90 days of enrollment.
Then, there are some non-EAED SNP's that were still open for enrollment at the end of the quarter, but as you can see, all the D-SNPs, 35339 completed during the quarter, and 67%.
Next slide, please.

00:055:50 –Christopher Tolbert – Slide 26

This is CICM: the total members that received CICM during the quarter. So, 18099 members received CICM during the quarter. 35.2% is the number of members eligible to receive CICM during the quarter. That's what that number means. The non-EAED SNP's, they have to provide CICM. A little over 2100, they were provided during the quarter. Of those eligible. 28.2%, all the D-SNPs, 20302, 34% eligible to receive D-SNPs.
Next slide, please.

00:057:29 –Christopher Tolbert – Slide 27

This is the in-person care interaction for people that received CICM services and also a person that had in-person care interactions. Over 1064, 36%, and non-EAED SNP's 782, 36%. All D-SNP 1847, 9% have this interaction. This is the long-term care measure for the members that are currently residing for more than 90 days. This measure is not reported by the non-EAD plans. Are there any questions on the data?

Are there any additional questions

We have some questions in the chat. From a lawyer, what qualifies as in person and how is this evaluated?

Christopher Tolbert: This is physically in person, but I also believe a telehealth will qualify. I have to double-check. I think it's a video as well that also qualifies. I have to be absolutely sure.

Cassidy: I'm not seeing any other questions in the chat. I can pause to see if anyone raises their hand.
All right. I think we can move into our next slide.
I'm going to pass it over to Lauren for our enrollment pilot update.

00:059:13 –Lauren Gavin – Slide 28
Thank you, Cassidy.

I'm going to provide a status on our enrollment pilot update. A little bit of background. Next slide, please.

We launched the plan in 2024 for Medi-Medi plans. When a member enrolled in one of the pilot MCPs becomes eligible for Medicare, due to age or disability, the member will receive two notices and will be automatically enrolled into the MCP's Medi-Medi plan unless the member chooses a different Medicare option. It is not a requirement for them to enroll in the Medi-Medi plan, but it makes it the automatic choice. If an individual does not want that choice, they are free to select a different coverage option for the benefits.

It's important the pilot does not impact dual enrollment for Medicare and does not cover individuals. The pilot does not impact dual eligible members who are already enrolled in Medicare or individuals already enrolled.

This pilot impacts a small number of members of each month.
This is just a little bit more information on when each of the three participating plans started their default enrollment practice. Community health groups sent their notices in June 2024; the health plan of San Mateo started sending their notices in January 2025; and also in San Mateo County, Kaiser Permanente, prior to 2025. And all the plans met with local stakeholders to discuss.
Next slide, please.

01:02:25 –Lauren Gavin – Slide 29

Digging into the data: community health group default enrollment data.
From January 2026. The second column shows those default enrolled into the plan. The last column shows who disenrolled within 90 days. You can see for the community health group, their numbers have a little bit of fluctuation and are still pretty large, ranging from 68% to a high of almost 82 percent. And then for the members who disenrolled within 90 days of enrollment, pretty low numbers. Sometimes 0, highest 9.4; overall, most individuals are choosing to stay in the plan for the first three months.
Next slide, please.

01:04:56 –Lauren Gavin – Slide 30

Okay, we see similar numbers for the health plan of San Mateo; their range is looking for the past several months from about 73-74%, up to a high of 90% for members who were enrolled via default, and similarly a little bit of a range in the number of members who are disenrolling within 90 days, from very low numbers of 6%. A good education -- indication that members are choosing to stay in the plan.
Next slide, please.

01:05:46 –Lauren Gavin – Slide 31

This Kaiser Permanente, by and large, most choose to enroll in that mechanism. The percentage that are disenrolling. Wide variation there, and I would caution some of the interpretation of this data. The last number that Kaiser Permanente is default enrolling is very small. If you look in March of 2026 and there is 57%, that can be due if you are looking at a handful of people that were default enrolled, and one or two choose to leave the plan, that can look like a pretty high proportion. So, there you have it. Those are all three of the plans, and the overarching takeaway for individuals that are eligible for default enrollment, the majority are choosing to go through with it and enroll in the plan for Medicare benefits as well, and in most cases the majority are choosing to stick with the plan for the 90 days post-enrollment.
Next slide, please.

01:06:49 –Lauren Gavin – Slide 32

This is a summary of overall, since the pilot was launched for each of the three plans, how many have ultimately been enrolled via default. For the community health group, about 2600 members were enrolled by default, health plan San Mateo, 460 members, Kaiser Permanente, 86 members.
Next slide, please.

01:08:02 –Lauren Gavin – Slide 33

We have a lot of experience under our belt with default enrollment, and it seems to be going smoothly; that includes member satisfaction and helping members with the plans as they are gaining Medicare. As a result, we are planning to expand the opportunity to

other EAED SNP's to prepare for default enrollment. In order to be able to qualify, they need to meet specific performance criteria, and one is Medi-Cal. A health risk assessment completion and rating a health plan, which is a survey measure. So a response in the plan of providing their rating of the health plan on a scale of 0-10678 is also a CMS measure. We are working on designing how this approach would look for EAED SNPs to raise their hand and indicate an interest in participate negative default, and looking at the criteria and evaluating. Details on what that will look like in the policies and implementation will be released soon.
Next slide, please.

01:09:27 –Lauren Gavin – Slide 34

With that, I'm very excited to welcome Health Plan of San Mateo to give an overview of their experience in the implementation of default enrollment.
Next slide, please.

I'm going to pass it to John. From San Mateo and excited to learn about the plan's perspective on how default enrollment has been going.

01:10:40 –John Okone – Slide 35
Thank you. Default enrollment. We are presenting -- our enrollment Sharon Bongolan, enrollment disenrollment supervisor.

All right. This is the agenda for today. We'll give you our story in three major buckets, as to how, why. And what?
Next slide, please.

01:12:02 –John Okone – Slide 36

Care Advantage is the name of our line of business. We have been in the managed population for some time, around 20 years. Care Advantage was developed as a result of the Medicare Modernization Act of 2003. We have been margin dual eligible for some time and part of the Connect program as well. We are currently about 8500 total members, and I put some statistics there to give you a quick profile of the members. At

the end day, our focus is to help our members to coordinate their members to receive services as they receive benefits and take care of themselves.
Next slide, please.

01:13:51 –John Okone – Slide 37

Why did we foster default enrollment?
Next slide, please.

01:14:00 –John Okone – Slide 38

It comes down to a few things. When we have the projects, we look at trying to connect them back to our strategy objectives. We look at member experience, clinical health outcomes, and product sustainability, and streamline the process for our members, especially when they are going through a major transition in their life. In terms of clinical health outcomes, default enrollments, because of our 100% coverage between Medicare and Medicaid, can continue to receive their care, and providers can continue to provide the healthcare in the coordinated plan.
I want to call your attention to this plan. At the end of the day, what is the impact of this enrollment?
Next slide, please.

01:15:39 –John Okone – Slide 39

Here, we put some numbers together to show the impact on overall enrollment. As you can see on your left. Default enrollment is increased by 20% of all enrollment. As Lauren mentioned, members are choosing to stay with retention rates on average. Something else I wanted to call out. In 2025, we experienced something unique. As you can see on the bottom right-hand side, in 2025, we experienced 12 consecutive months of part enrollment. That is one measure we look at every single month to see, based on the total enrollments, how many we have. Total enrollment minus total disenrollments. At the end of the day, we try to break even. That's just one statistic. But it was interesting to see that in our 20-something years, 2025 was one of the years where we saw a positive enrollment. Definitely there are some other factors, but the positive enrollment was one of the factors to support these results.

Next slide, please.

01:16:54 –John Okone – Slide 40

So Lauren also talked about Medicare measures and looking at the HPSM care management. We also look at and try to understand the retention rates and experience as well using our stars measure. These are two measures that came to our mind. One is those who choose to leave the plan, and you can see from the stars; we will continue to track to be sure we stay at five stars, and also complaints. The number of complaints that members submit to 1-800 Medicare, and we keep track of that, and you can see they are very low. From a perspective, you can see how a member is experiencing default enrollment and enrollment in general with HPSM.

Now, Sharon is going to talk about how we prepare members for default enrollment.

01:18:07 –Sharon Bongolan – Slide 41

Good afternoon, everybody. I'm the care advantage enrollment disenrollment supervisor. I will give you a high-level overview timeline and key steps involved in preparing our members for the enrollment pilot. We start with the DHGS 834 file, the monthly 834 file, use to conduct an eligibility batch query and additional eligibility verification for eligibility requirements, and they receive a notice.

The notice includes PCP information, opt out form. On the same day the notice is mailed, we will also submit an enrollment transaction to CMS. Two weeks after the 60-day notice is mailed, our Care Advantage navigators will conduct outbound calls to eligible members, and during these calls, they will provide information about the default enrollment and answer any questions the members may have regarding their automatic enrollment into Care Advantage.

Next, we will send a 30-day notice prior to the default enrollment effective date. The 30-day notice contains the same information as the 60-day notice. Around that time, we will also mail the Care Advantage welcome packet and ID cards to members who remain eligible. As a side note, before we send out a 230-day notice to members, our team will

perform another eligibility verification to make sure that members are still eligible for enrollment.

Then, approximately about three weeks before the default enrollment effective date, our Care Advantage navigators will conduct welcome calls. The purpose of this call is to confirm that the members have received their welcome packet and ID cards and to address any questions they may have at that point.

Finally, if the members do not opt out or cancel their enrollment, they will be automatically enrolled into Care Advantage on the date of enrollment effective date. Next slide, please.

01:21:22 –Sharon Bongolan – Slide 42

In addition to what I mentioned, this will include the following components. First is the coverage overview, which explains the upcoming transition and available Medicare coverage for our members. And then continuity of care shows that members can continue seeing their current primary care providers. Meaning, since they already have one medical provider, they can continue to see that doctor. Lastly, we have answers to common questions. That's to address common concerns about their Medicare choice, in-home support services program, pharmacy benefits with co-pay, and supplemental benefits. That's all. Back to John.

01:22:47 –John Okone – Slide 43

John Okome: Thank you, Sharon.
We have the engagement following default enrollment. It's a little bit busy. If we can go to the next slide.

Please click through to the end. In terms of after enrollment, you do the welcome call. Once that is done, within 90 days, you complete your health risk assessment. You have the risk score; information from the health risk assessment is also used to create an individualized care plan, and we have access to the claims utilization history and look at that to learn more about the health of the members.

High-risk members have the opportunity to participate in an interdisciplinary team, and members can participate in this call and meeting. And that BCP can participate as well. We also drew members to the extended care team to help them to be able to navigate the healthcare system and provide them with pharmacy information and preventive care services that we provide, introduce them to chronic condition management t diabetes prevention program.

Once they go through the enrollment program, we make sure we connect them with all the services possible. We ensure we look at the member as a whole and connect them to wraparound services. We have social isolation programs that we make available to our members.

We connect them to IHSS and make sure they know about the benefits and that they are actually using the benefits. At the end of the day, what comes out of these ecosystems is an enhanced experience for the member for the providers improve population of total cost reduction and total cost of care for our members.

We see all of these things connected: enhanced experience from improved population health. This is how we stay engaged with our members. We wanted to share that. It's not just about the enrollment number, but also, what happens after the enrollment as well.

Now, I believe I'm going to hand it to Sharon to talk about what we -- learned from our pilot.

01:25:53 –Sharon Bongolan – Slide 44

Lessons learned.
Overall, the experience on the benefits and continued coverage supplemental benefits. Also, members are happy because they don't need to complete any forms. Of course, there are lessons we need to learn. These are the top 33 that we learned since we started the default enrollment pilot.

The first one is that members need reassurance. Not another marketing solicitation. So our response to that is we repeatedly reinforce that this is an important Medicare

transition, not a sales campaign, by using multiple communications, local outreach, and consistent messaging. And the second is the pharmacy benefits prescription. We require clear communication as a medical 0 co-pay. This is maybe the issue that we encounter because before, when they had San Mateo, they did not have co-pays, but now that they are eligible for Medicare, they now have a co-pay for their Part D Medicare. That mirrors Part D from Medi-Cal. They have extra help, which is why their co-payments are really low.

Also, we answered questions through our Care Advantage Navigator's first call resolution. Lastly, we refer our members to HICAP, the Health Insurance Counseling Advocacy Program, if they prefer to go to another plan. We focused on a conversation on continuity of care, coordinating benefits, the HBSM community-based approach, and comparing plans and the highlights for them since they are getting extra benefits in addition to the benefits that they already have.
I think that's all for me. Back to you, John.

01:28:57 –John Okone – Slide 45

Thank you for the participation here today, and also thank you to HPSM for providing the resource to deploy this project. The last thing that stuck with me when we were preparing for this presentation if that in the default room did not succeed not because members automatically enrolled, and we support them before, during, and after the room. They feel that we are there to support them. They love the questions, FAQ's, we are very transparent and always willing to answer their calls whenever they call.
Thank you so much.

Cassidy: Thanks, John.
We have a couple more questions. Feel free to raise your hand or drop a question in the chat.

Thank you for the great presentation. As mentioned, you reached out to advocates in your community. I'm wondering if you had any lessons learned or if lessons learned were shared that were related to that, and what barriers did the advocacy face in doing default enrollment.

John: I don't recall any major barriers from many of the applicants. It's been some time. You need to look at my notes to see. If there was something significant, it would be top of mind right now. I would say something that I heard directly from a member, and this is a member speaking directly to me, and her comment was in the default room that makes sense because you don't have to get bogged down by the material that comes to them. So hearing that directly from members, that the process is definitely good feedback. Let me go back to check my notes to see if there is anything directly from the applicants.

Cassidy: Thanks, John. There are a couple of comments in the chat as well telling you thank you for the great information and insight today.

In the interest of time, I will keep us moving. We have an opportunity for any final questions from the stakeholders on the call today. Feel free to drop questions on the call to the San Mateo team. We'll go to the next slide and pass it back to Lauren.

01:32:02 –Lauren Gavin – Slide 46

Thank you, Cassidy. We have another health plan, California healthcare is going to talk about implementation of CICM. First, I wanted to provide a very brief overview of expectations around CICM.

Okay. Broadly speaking on the overall coordination approaches, I'm sure many of you are familiar with what we call enhanced care management, a program under CalAIM ECM, provided through Medi-Cal managed-care plans and providers to select Medi-Cal members with complex needs. Due to significant overlap across the federal D-SNP model of care and Medi-Cal ECM, the members in D-SNP don't receive Medi-Cal from ECM and MCP. Instead, they receive Cal ECM, which is similar to Medi-Cal ECM. Those not in D-SNP will not change. There is no change for those individuals.

01:33:31 –Lauren Gavin – Slide 47

Next slide, please. Okay. A little bit deeper dive into the requirements for CICM. Again, it refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by the D-SNP. According to federal guidance,

D-SNPs have to provide robust coordination to all of their members. The CICM expectations are layered on top of those requirements by the Federal Government for D-SNPs.

This year, CICM has a new care management provider. Similarly, the policy continues to apply to members who are eligible to receive Medi-Cal ECM. Instead of getting ECM from the MCP, they now get CICM from the D-SNP. But the population of focus for ECM is to address additional vulnerable adult populations with documented dementia needs.

In summary, CICM includes three major elements, the populations, they reflect Medi-Cal, ECM, populations, addition to that other population adults documented dementia needs that specific, in terms of contracting recommend don't require that D-SNP contract with to provide care management to specific CICM for in person engagement populations don't require the plans to provide care management to CICM populations primarily persons interactions and those experiencing homelessness CICM population and individuals D-SNP are required to provide in person care.
Next slide, please.

01:36:16 –Lauren Gavin – Slide 48

We have a continuity of care provisions for those already receiving Medi-Cal and ECM from their M cP. In those cases, D-SNP will provide continuity of care with existing Medi-Cal ECM when it's possible. Up to 12 months.

Now we'll shift gears into a presentation for Kern Family Healthcare.
Next slide, please. I believe we are joined by Misty Dominguez.

01:37:07 –Misty Dominguez– Slide 49
Thank you, Lauren. Next slide, please.

Tagging along with what Lauren initially covered is a high-level overview of what CICM is. CICM stands for California Integrated Care Management, California's enhanced care management approach for certain dual-eligible special needs plan members who have complex medical, behavioral health, functional, or social needs, designed to provide whole-person integrated care coordination by bringing together medical care,

behavioral health services, long-term services and supports, and community-based resources. We must provide care management to all the members that qualify for the enhanced care management on the Medi-Cal side; they are not disadvantaged for the care as we would through the D-SNP.

Reviewing the requirements in the policy guide, core requirements we had to make sure were included in the model of care management and how we are going to provide efficient care management services that were equivalent to exceeding that care that they were providing to its members. Their model of care requirements that we must incorporate into our model of care, community-based organizations are critical. A continuity of care for those receiving services and those who choose to submit to the plan, and in-person engagement.
As often as possible, but definitely for those who are homeless.
Next slide, please.

01:39:40 –Misty Dominguez– Slide 50

So, just a reminder for everyone, there are eight populations of focus: homeless members, two at risk for hospital and emergency visits, mental health issues, substance disorders, transitioning from incarceration, those living in the community but high risk for long-term care institutionalization. And racial or ethnic disparities, and those who have delivered, and the last population of focus, which are members with documented dementia needs.

Next slide, please.

01:40:32 –Misty Dominguez– Slide 51

In our model of care, we strategized around the guidance and how we are going to meet the needs of our members. We decided to extend continuity of care to all of our members who identified as enrolled in ECM participants when they signed up for the plan. It's automatically granted to them. In order to identify these folks, we leverage multiple needs through data exchange, and for anybody who may qualify for services. The first being actively enrolled in CICM.
Next slide, please.

01:41:10 –Misty Dominguez– Slide 52

So, this is going through again different ways that we have identified CICM eligible in a population. We use a roster of our active D-SNP enrollment and around population focused to identify members that may be at risk. We use state and data files, data shared by our partners, primary care, FQ, claims information, hospital records, referrals from providers, and community partners.

So, going back to how we chose to approach CICM for our members, we work very closely and have a program on the Medi-Cal side of the house. So we actively go through enrollments. We identify folks that are actively participating in ECM, and we make sure it's guaranteed for them for 12 months, making sure there is no gaps. Changes in service. Meanwhile, we reach out and engage with those members and invite them into the plan, explaining the plan to them. Offering them the option to stay with their ECM program, or they can opt to go into ECM with the care manager and find success with that, and members are welcoming this instead of ECM.

So, I wanted to give a little bit of background. When we wrote our model of care, we were foreshadowing what our population would look like and using our Medi-Cal data and statistics from our community and getting an idea of what our population may look like with D-SNP. We anticipated that 27% of our enrollment could be qualified. With the focus, we stratified into that, with one of our highest population focuses being our homeless members; almost 30% that qualified, 12 percent would need intensive in-person services, adults with SMI, SUD needs, were stratified. The percentage of what we thought our population would look like.
Next slide, please.

01:43:49 –Misty Dominguez– Slide 53

What we did find, just looking at this slide, looks at just our CICM eligible population. We are on target with 12% enrollment of total members eligible for CICM that are already ECM participating. We found that 12%, reaching out to all of them, total membership 1349, all eligible.

This is giving more information. CICM enrollment: out of 100%, this is the population that chose to migrate to CICM. We have had a 65% success rate of members opting to choose their CICM provider. Only 40% chose to stay with their provider. One member declined to participate at all. There is that out there, and a small percent we are reaching out to make contact while they are being granted services and propose that to them if they would like to move over.

So there is another population for non-ECM enrolled folks. We did identify 12% that were ECM enrolled; there is another group out there. In order to identify those folks, we embedded some key streams, and we are looking for folks, like detective work with our care management team on who may be eligible for additional services.

We have identified folks through our ICT, part of our inpatient rounds, data that we share with our administrative partner, and those validating the information that is gathered to the HRA historical needs and to all members that qualify. Making in-person visits to all members identified as homeless, and also episodes where our ECM team is at hospitals and meeting with people in the community when it's difficult to reach them. We are linking homeless members and the street medicine providers to establish care for them as well.

So this is folks that are eligible for CICM but may not be already enrolled in ECM. This is kind of a graphic that shows that. 34% of those eligible for CICM were not affiliated with a provider at all. We have enrolled those, and folks are staying engaged and happy. Next slide, please.

01:46:50 –Misty Dominguez– Slide 54

So, I would like to invite Dr. Ammazio, CMO, Jamie Juarez, case manager and Mendoza on the line to give an overview of a case study and remind us all of why we do what we do and how it benefits the members in the end. Ladies, would you like to take over the presentation?

01:47:05 –Dr. Ammazio– Slide 55

Good afternoon. I'm doctor Armezio, overseeing the Department. And I have Jamie Juarez,
who will speak about her experience with a member

01:47:23 –Jamie Juarez

Hi, everybody. A member enrolled and presented a decent plan as an agent member. His member history was severe for pulmonary supplemental oxygen, and shortly he lost his housing and was living in his vehicle with his significant other and without access to services; he relied on a portable oxygen tank. Once we became aware of their living situation, we could not provide an oxygen tank to help with his needs, and he made frequent ED visits. The member was not enrolled in ECM. He was identified as ineligible due to his homelessness and social conflicts and at risk for hospital utilization with ten ED visits.

The care team and I provided in-person contact and conducted a comprehensive assessment of his social and environmental barriers to care. The team partnered with community-based organizations and resources and developed an individualized plan to address his housing and oxygen needs.

The Department was actively engaged with developing solutions aligned with his goals and preferences and approaching and being collaborative as his circumstances evolved. The outcome was a success, and we secured stable housing. Now, he has reliable support for supplemental oxygen and has had no emergency department visits, and his long-term care continues to evolve, with coordination of his services and utilization. This case demonstrates the value of the intersection of complex medical conditions and social determinants of health. By combining intensive care coordination and targeted resource navigation, the care team established a meaningful reduction in acute care utilization.

Misty: I think the team would agree that although this case was successful, it was iterative, and the management care team worked with him- sometimes very compliant, typical of the population; other days not as receptive and continued to reassess what his current needs are through the iterative process. Thank you to the team for the care overview. Was there anything else you would like to share around this case?

Yes, super briefly. Basically underscoring what you just said. I was actually talking with the team, specifically to Jamie, saying this is not a fairytale. It doesn't end with they live happily ever after. It is ongoing, it is active. I think Jamie's ability to engage the member and go out of her way to earn his trust and that's how she ends up with a successful story.

Misty: Absolutely. Thank you for your efforts and connecting with this member. Sometimes it shows that Medi-Cal resources are available, and partnering with the care management team, we were able to utilize the resources to get this gentleman out of his car. It was a real situation. He had the potential to further decompensate and have further medical concerns. We are at 100 degrees now, several days out of the month, and it's not an easy situation. Kudos to the team for engaging with him and identifying his challenges and finding a solution. Good job, guys. Thank you.
Next slide, please.

01:52:26 –Dr. Ammazio– Slide 56

We also wanted to share, just briefly, some of the CICM pain points that we are experiencing. As Dr. Matthew stated, not everything is Rosie all the time, and we wanted to share things that we are seeing and maybe not be as positive around CICM. We find that ECM is a program that providers are compensated for. From an enrollment perspective, we are finding ECM providers are just waiting for individuals to enroll in a decent plan because they will lose them on the ECM side. That's a challenge for us and getting members to choose our decent plan.

For members that were enrolled fast and were delivering effective services, and knowing who was in and out and how we are going to manage all of that. It should be smooth and seamless; however, there are barriers, and there is bifurcation when you layer the components.

There are two planned care management teams, and making sure the care is coordinated through the guidelines and the ECM providers working to meet their needs causes an unintentional bifurcation in care management. Even if you are trying to manage care with each other, there is a lot that gets caught in the middle. Also, when a

member enrolls in select, they must disenroll in the plan to revert back to ECM. Going backwards is difficult. Talking about solutions and talking with providers, looking at other programs that work.

One of our ECM leads was talking about post-institutional members. There is a payment bundle set up that incentivizes ECM providers to complete warm Handoffs and transition members, and if we adopted or considered adopting something similar in the D-SNP, it might be very helpful to have folks transition to care management services over to CICM services, which may be a little bit more holistic and broader approach and broader visual ability member. I think it would promote improved perceived understanding and satisfaction. I would like to see the plan provide a whole comprehensive care management to all of our enrollees.
Any questions?

01:55:39 – Cassidy

Thank you so much for that lovely presentation. We have a question in the chat. I will make a plug here that if folks have questions for either of our health plans, raise your hand and we'll unmute you.

The first question is: how did you reach out potentially for Jamie and Dr. Armazeo?
Is there a specific timeframe?

I can let them speak to you on this specific scenario; we have a contact with that member. Within that first 90 days of the plan, get that started, and that is within the first 90 days, and we do our best. One of the strategies we employed was at the time of enrollment. Sometimes that may be the only time you can brief someone and get them in front of you. You do it as much as you can and in groups. That was our strategy.

Would you like to speak to this individual member and how you reached out to him?

Universal healthcare: Actually, this person was presented to me when he had difficulty obtaining DME. The grievance was filed and given to me. I was able to coordinate his care and get him enrolled for further care coordination to figure out what we needed to do.

Misty: If we relied on the paperwork, everything looked good on paper. But it came through I think it was fear that caused the member to reach out to member services and file a grievance because he didn't know what to do. Jamie took that grievance and as she started to dig, found the social dynamics and the impacts that were causing negative health outcomes for this member, and that's when she took action and intervened. She did a great job with this member.
Any questions?

Not any other questions at this time for Kern, but feel free to drop them in the chat.

I'm going to ask San Mateo, John, if you are still on the line. A question on the default. What percentage opted out prior to their effective date?

Looking for that, for last year, is really low, about 4% last year.

Sharon: Roughly maybe 4-5 percent, including this year. Really a low number.
Thanks, Sharon.

All right.

I don't see any other questions at the moment. I'm going to move us to our next slide. We have some time for questions in the last couple of minutes. If you have any questions. Please raise your hand. We'll give it about 30 seconds in case folks have anything they would like to add.

Eddie: Thank you for this opportunity. My question is a follow-up for Dennis, who joined the call. In regard to what's going on with the miscommunication and things that are happening on the ground for folks that are receiving community supports and are already in Health Net.

My first and foremost question is what are the continuity of care provisions for folks that have been approved for this benefit and if health net should not offer it at the end of the year and appreciate that we have a little bit more understanding on the member should expect but on the ground the communication miscommunication on how the

providers will continue to receive payment because a lot of them have different dates of when they are cancelling their contract with health net.

So how are these members going to continue to receive these benefits, and how are these facilities going to get paid for those services?

Thank you for the question. I think Dennis had to hop off, but Tyler, can you get back to this?

Tyler Brennan: We are having regular meetings with them. I know the provider termination notices have already been sent out. We have put some processes in place to prevent additional ones from going out until the processes are clear. The benefits are going to be allowed up through December 31, 2026.

So there may be some sort of corrective notices that they have sent out with that information, and we are finalizing those with them right now. In terms of the providers being paid, it's what providers should be working with Health Net and continue to receive payments through, including the end of the year. This is a living situation. We are still meeting with Health Net. We are encouraging them to go back to take another look at their calculus regarding this selection, but we are proceeding. We have to proceed with the understanding that it's possible this might happen. So really, we are making sure that we are working with Health Net to be sure they have a transition plan for their members and will continue to be doing in the next few weeks. I would encourage you if you have any questions about your facility or provider situation, please submit those to our mailbox at community supports at DHCS .gov, and we'll get back to you with a response.

I will say specifically, thank you, Tyler.

Dennis Hisch: That providers should be following extensions with health net in terms of behalf of members can request through health net service if there are any problems and advocates should be filing grievance with health net if you receive an adverse benefit negotiation determination or notice of action, NOAA, file a timely appeal if you believe that health net is changing or terminating your benefit, shortening the duration or send a notice of action anytime they make any changes or deny.

Thank you for answering that question.

We are almost out of time. We'll give it another opportunity in case anyone has any additional questions before we wrap up.

Annette?

Yes, you mentioned that you had my email. The gentleman that just spoke? He was going to send something through an email earlier.

Dennis: If you can share your email, we'll be happy to send it. I put it in the document in the chat. If we have your email if you are able to share it, we are happy to send you a document that we issued.

Okay, I will put it in the chat.
That would be great.
Thank you so much, Dennis.

Cassidy: Any final questions from the group?

Dennis: I see a comment in the chat on who to submit questions to.

Cassidy: If you raise your hand. You should be able to unmute if you want to address that question.

Eddiey: Can you hear me?
Yes.

I transferred to my car.

Dennis: You put the comment in the chat that you had emailed questions but didn't receive a response. I wanted to ask for some follow-up and clarification on who you submitted the questions to?

You are right, I looked back. It was to the Managed Long-Term Services and Supports MLTSS) in-box, but it looks like you have a different community support in-box. I didn't get a response because I have been helping folks from Medi-Cal get this benefit and now in danger of losing the benefits. I'm not getting direct answers from either Health Net or the Department of Health Services. I'm glad you said you put something in the box to get answers from that. Nobody is really giving great communication, and misinformation is coming from the facilities, boarding care, assisting living facilities. If we can get some clarity on what's going on and specifically continuity of care provisions and benefits for these folks.

Dennis: In terms of continuity of care, it's a concept used widely. This is a benefit through December 31st. So that means anybody who is eligible for it, Health Net has to assess them if they are eligible and cover the benefit through December 31st.

Because this is overall an optional benefit, in terms of the benefits package, after December 31st, if health net decide to terminate the benefit, then there is no continue nutrient of protection of staying in CFE or ALF, if the member remain a health net member, health net has an obligation to safely and in coordination with the member or their family transfer them to an appropriate level of care that is our skilled nursing facility, home with support or some other facility that is appropriate. I think hopefully that answers your question because there are two things happening: pre-December 31st termination, where the member is entitled to receive services to December 31st, but if they terminate the benefit, asking Health Net not to, but if they proceed with that decision, there is the health obligation to be sure the member is transitioned into an appropriate level of care. There is no continuity in that sense after December 31st to stay in the ALF or RCFE or boarding care. Hopefully that's clear.

Thank you, Dennis. I know we are over our time. We are going to move to the next slide to close out today's meeting.
Next slide, please.

02:02:24 – Cassidy

Great. A couple of next steps. Thank you to our speakers for today's presentations and able to hop on and answer question an thanks everyone on the call for the discussion.

The next meeting is scheduled for Wednesday, December 9, 2026 at 12:00 p.m. Registration is on the slide as well as the DHCS website. Please visit the group page for information as well. With that, I will pass it to Lauren for any final comments.

Lauren Gavin: Thank you for joining us today and for the excellent questions in the conversation. We appreciate all that you do in partnership and in support of our duals approach. Thank you for joining us, and hope to see you all again on December 9th. Thank you, everyone. Have a great afternoon.

[End of Realtime Captioning]