AMERICA'S PHYSICIAN GROUPS

Physician Organizations and Successful CalAIM D-SNP Implementation

Insights and Considerations for California Policymakers

AN AMERICA'S PHYSICIAN GROUPS ISSUE BRIEF | AUGUST 2025

Physicians and physician organizations are the backbone of California's health care system. As the state continues to transform care delivery for its most vulnerable older adults and people with disabilities through the California Advancing and Innovating Medi-Cal initiative (CalAIM), provider organizations that can assume financial risk and accountably manage the health of duals will be critical to the success of these efforts.

Many duals opt to receive coordinated Medicare and Medi-Cal benefits through a Dual Eligible Special Needs Plan (D-SNP). As specialized Medicare Advantage (MA) managed care plans that also hold a State Medicaid Agency Contract (SMAC), D-SNPs are better positioned to provide care coordination and wraparound services than standard MA plans. In 2026, the California Department of Health Care Services (DHCS), through CalAIM, will expand the implementation of Exclusively Aligned Enrollment D-SNPs (EAE D-SNPs) by Medi-Cal managed care plans (MCPs).[1] Duals enrolled in EAE D-SNPs will also be enrolled in the MCP affiliated with the D-SNP, thus enabling coordinated benefits and coverage, similar to their experience under Cal MediConnect plans that were previously implemented through California's Coordinated Care Initiative (CCI).

If implemented effectively, EAE D-SNPs have the potential to ensure that duals receive highly integrated care that enhances their health outcomes and care experience. These aligned plans can also help advance California's integration of select Medi-Cal Long-Term Services and Supports into managed care by aligning incentives and improving access to supports that help duals live independently and avoid institutional care. Successful EAE D-SNP implementation could thus reduce Medi-Cal costs for this growing population.

Snapshot of Duals in California[2-6]

- More than 1.7 million Californians are "duals" — people eligible for health care benefits under both Medicare and Medicaid (known as Medi-Cal in California)
- The number of duals in California has grown by 17% since 2020
- Duals comprise 11% of the Medi-Cal population but account for 32% of Medi-Cal expenditures
- As of January 2025, most duals in California were enrolled in Original Medicare (50%), followed by EAE D-SNP (19%), regular MA (18%), non-EAE D-SNP (6%), and Other SNPs (6%)

America's Physician Groups (APG) is the leading national association representing approximately 340 physician groups committed to the transition to value, with more than 260,000 physicians and other clinicians serving nearly 90 million patients — roughly 1 in 4 Americans — across 49 states, the District of Columbia, and the U.S. territory of Puerto Rico. APG members focus on delivering clinically integrated, coordinated, patient-centered care that is accountable for both costs and quality. In California, APG's more than 180 members consist of capitated, delegated, or risk-bearing organizations that include medical groups, medical foundation entities, Independent Practice Associations (IPAs), Federally Qualified Health Centers, and Accountable Care Organizations.

Why the Participation of Capitated and Delegated Medical Providers in CalAIM's Aligned D-SNPs Matters

Capitated and Delegated Medical Providers (CDMPs) are uniquely positioned to help drive successful EAE D-SNP implementation. California's earlier efforts to integrate care for duals through CCI showed that robust care networks of providers and provider organizations with established patient relationships are crucial to building enrollment in integrated plans. Beyond enrollment, CDMP engagement directly impacts Medicare quality Star Ratings and ultimately, the long-term financial sustainability of EAE D-SNPs.

In California, CDMPs currently serve roughly 2.8 million MA enrollees, many of whom are duals. They also provide care for a significant portion of the state's 14 million Medi-Cal managed care enrollees.[7,8] **CDMPs therefore already play a central role in managing duals' health care,** and with aligned reimbursement and incentives, some are ready to take on advanced risk arrangements with DSNPs. It is therefore important to understand the CDMP perspective on EAE D-SNP implementation.

> Capitated and Delegated Medical Providers are physicians or physician organizations that assume capitation payments, delegated responsibilities, or financial risk for health care services in California.

This issue brief outlines CDMPs' experiences with CalAIM EAE D-SNP implementation, and offers insights for DHCS and policymakers to foster provider participation. Findings are based on a series of focus groups and key informant interviews conducted from September 2024 to January 2025 with 20 APG member organizations serving over 200,000 duals in California.

OPPORTUNITY #1:
Proactively Engage and Communicate with CDMPs on D-SNP Requirements

Providers are struggling to stay informed about DHCS policy requirements for EAE D-SNPs, including timelines, implementation steps, and the phase-out of non-aligned D-SNPs and lookalike plans. The volume and complexity of annual policy changes can be overwhelming. One key challenge is understanding the eligibility requirements and distinguishing features of the various care coordination and care management services available to duals, including Enhanced Care Management (ECM), California Integrated Care Management (CICM) services,[9] Community Health Worker (CHW) services, and Community Supports.

> DHCS meetings are very helpful. During these sessions, DHCS explains their rationale and invites plans and other stakeholders to participate, which helps us understand their perspective. This way, we're not just left interpreting a dry policy guide. We hear directly from them about why these changes are important.
>
> *—Senior Director, Northern and Central California Medical Group*

Strategies to Improve Engagement and Communication:

1. **Host regular D-SNP webinars with plans and their providers** to review DHCS policy updates, answer questions, and discuss any CMS regulatory changes that impact California D-SNPs.
2. **Clarify eligibility criteria for D-SNP care coordination services,** CICM, ECM, and CHW offerings, and highlight key differences.
3. **Review proposed network overlap requirements** and the ongoing applicability of current reporting metrics, emphasizing the state's policy goals and objectives related to any network overlap criteria.[10]
4. **Allow sufficient ramp-up time and transition for implementing new policies** to enable effective design and adjustment in provider operations.
5. **Develop tailored FAQs addressing key implementation topics,** such as Individualized Care Plan development, Interdisciplinary Care Team roles, and SMAC implementation priorities.
6. **Create fact sheets to help providers and members distinguish between covered benefits and eligibility for services** when duals are enrolled in traditional Medicare, MA-only managed care, versus integrated managed care with a D-SNP.
7. **Provide clear timelines** for MCPs' required EAE D-SNP launches and policy activation dates.
8. **Develop consolidated reference guides on CMS and DHCS D-SNP care coordination requirements.**
9. **Share oversight resources,** including escalation contacts for SMAC and D-SNP Policy Guide compliance.

OPPORTUNITY #2:
Strengthen Partnerships and Collaboration Between CDMPs and Plans

If appropriately reimbursed, CDMPs are eager to expand D-SNP contracts and support duals' care, including assuming two-sided global risk for Medicare managed care. Recognizing that care coordination and care management — particularly for duals with complex health conditions — are most effective at the point of care, some CDMPs seek greater delegation of these specific responsibilities, including CICM services. Moreover, they are well-positioned to identify CICM-eligible members and have the experience and capabilities to integrate care coordination and care management services into primary care.

CDMPs also expressed a desire for greater involvement in D-SNP MOC development to help align health plan and DHCS expectations with operational realities. They noted that some MCPs lack dedicated Medicare teams, which can lead to inconsistent implementation of D-SNPs. Improved collaboration and communication between D-SNPs' Medi-Cal and Medicare teams and clear definitions of roles, responsibilities, and oversight are needed.

Strategies to Support Stronger Partnerships:

1. **Promote standardized contracts and delegation agreements,** including coded Division of Financial Responsibility templates.[11]

2. **Tie member incentives to achievement of key care milestones** (e.g., completion of initial PCP visits or preventive care activities) that lead to improved outcomes.

3. **Encourage plan-provider collaboration in MOC development** and future MOC updates.

4. **Consider allowing mid-cycle MOC enhancements** to support continuous improvement and tests of change that optimize care and outcomes.

5. **Clarify SMAC flexibilities that permit delegation of care coordination responsibilities to CDMPs,** bringing care coordination as close as possible to the point of care and avoiding service duplication.

6. **Adapt CICM** to (a) align with ECM eligibility and ease transitions, (b) support standardized and streamlined referrals, (c) enable D-SNP contracting with duals' primary care medical homes, and (d) facilitate data sharing among plans, medical providers, and other CICM service providers.

> My wish list would include more value-based arrangements with the providers rather than having the D-SNP plans manage all the risk. Instead of doing fee-for-service or pay-for-performance, it would work better if the health plan delegated more responsibilities to the provider organizations and let them manage it.
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> *—Northern California Executive Leader, West Coast Regional Health Care System*

OPPORTUNITY #3:
Support Data Sharing for Identification, Engagement, and Care Coordination of Duals

Accurate contact information is critical to improving care for duals. Gaps in this data can significantly hinder care delivery. CDMPs noted that health plans' provider portals and member lists often differ in format and content, and they can lag in flagging changes to members' coverage and contact information. At times, when transmitting monthly member attribution files, health plans have unknowingly overridden member contact details that providers updated. Although DHCS enrollment reports, ECM Member Information Files, and county eligibility data offer additional sources of member information, inconsistencies limit effective initial identification and engagement of duals.

Medical providers and care teams also lack connections with care coordinators and information on services provided by third-party ECM, CICM, CHW, and Community Supports personnel who may be working in tandem with their patients. This lack of contact can lead to care duplication, service gaps, and confusion about who should lead on providing assistance.

> There are no D-SNP regulations that say the plans must share with provider groups their members who are enrolled in case management and who the case manager is at the plan.
>
> *—-Executive Leader, IPA*

Strategies to Improve Identification, Engagement, and Care Coordination:

1. **Enable provider use of AI or other tools in the Automated Eligibility Verification System (AEVS)** to streamline member identification and batch Medi-Cal eligibility verification.
2. **Develop a centralized, real-time database for MCPs, medical providers, community-based ECM and Community Supports providers, and members** to verify and update member contact details. This system could leverage evolving technology in DHCS' Population Health Management initiative.[12]
3. **Support the development of D-SNP reports for medical providers that list assigned care coordinators;** third-party CICM, CHW, or Community Supports services providers; and any 1915(c) Home and Community-Based Services care coordination providers.
4. **Consider monthly or quarterly reports on CICM-eligible members,** including any plan preauthorizations or presumptive authorizations, to support proactive member outreach and engagement.

LOOKING AHEAD

Aligned D-SNPs hold significant promise for improving care integration for duals. CDMPs are key to realizing this potential and are aligned with the state's vision for EAE D-SNPs. Accountable providers' buy-in and participation are essential for building robust care networks and preventing gaps in care delivery. Early and intentional inclusion of CDMPs in the EAE D-SNP implementation process can enhance enrollment, reduce provider and member frustration, and strengthen plan-provider partnerships that improve the access, quality, and cost-effectiveness of care for duals in California.

Additional Resources

The following APG issue briefs in this series also offer recommendations and strategies to support health plans and physician organizations in effective CalAIM D-SNP implementation:

- **Physician Organizations and Successful CalAIM D-SNP Implementation:** Insights and Considerations for Health Plans
- **Partnering for Successful CalAIM D-SNP Implementation:** Insights and Considerations for Capitated and Delegated Medical Providers

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APG is the leading national association representing physician groups engaged in value-based payment models. APG's motto, 'Taking Responsibility for America's Health,' represents its member groups' commitment to providing high-quality, accountable care.

Transform Health is a mission-driven, nationally certified women- and minority-owned health policy consulting firm that drives systems change to build healthy communities.

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ENDNOTES

[1] Exclusively Aligned Enrollment Dual Special Needs Plans (EAE D-SNPs) are also referred to by DHCS as Medicare Medi-Cal Plans (MMPs).

[2] "Medicare Monthly Enrollment Data File, California Duals." *CMS*, Updated March 2025, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data. Accessed April 22, 2025.

[3] "Medi-Cal and Seniors." *California Health Care Foundation*, April 2025, https://www.chcf.org/wp-content/uploads/2025/04/MediCalSeniors_PolicyAtAGlance.pdf

[4] "Profile of the California Medicare Population." *DHCS*, February 2022, https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook-February-2022.pdf

[5] Justice in Aging. "A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care." *California Health Care Foundation*, September 2020, https://www.chcf.org/resource/primer-dual-eligible-californians/

[6] "CalAIM Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup, June 25, 2025." *DHCS*, June 25, 2025. https://www.dhcs.ca.gov/provgovpart/Documents/June-MLTSS-and-Duals-Integration-Workgroup.pdf

[7] 2025 Financial Solvency Standards Board. "Health Plan Quarterly Update" and "Provider Solvency Quarterly Update." *California Department of Managed Health Care (DMHC)*, May 28, 2025, https://dmhc.ca.gov/Portals/0/Docs/DO/FSSBMay2025/AgendaItem8_HealthPlanQuarterlyUpdate.pdf and https://dmhc.ca.gov/Portals/0/Docs/DO/FSSBMay2025/AgendaItem7_ProviderSolvencyQuarterlyUpdate.pdf

[8] "Medi-Cal Monthly Eligible Fast Facts, April 2025 (Date Represented: January 2025)." *DHCS*, April 2025, https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-January2025.pdf

[9] Beginning January 1, 2024, all D-SNPs must provide sufficient care management ("ECM-like services") to D-SNP members to ensure that members who would otherwise qualify for Medi-Cal Enhanced Care Management (ECM) are not adversely impacted by receiving care management exclusively through their D-SNP. Starting in 2026, "ECM-like" services will transition to California Integrated Care Management (CICM). CICM layers state-specific requirements on top of federal D-SNP requirements.

For more information on CICM, see "CalAIM Dual Eligible Special Needs Plan Policy Guide–Contract Year 2026." *DHCS*, June 2025, https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-CalAIM-D-SNP-Policy-Guide-2026.pdf

[10] For more information on building successful networks for duals in D-SNPs, see the RAND Report. "Building Provider Networks for Enrollees in Both Medicare and Medi-Cal." *California Health Care Foundation*, January 2025, https://www.chcf.org/resource/building-provider-networks-for-enrollees-medicare-medi-cal/. Accessed February 15, 2025.

[11] APG and the Health Industry Collaboration Effort (HICE) have collaborated on standardized, coded DOFR templates to support value-based contracting and delegation. HICE's annual release of coded DOFRs currently covers Commercial and Medicare lines of business. The HICE Medi-Cal DOFR template is under development. To access HICE's current DOFR templates, see: https://www.iceforhealth.org/messagedetail.asp?mid=11839

[12] For more information, see "CalAIM Population Health Management Initiative." *DHCS*, https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx. Accessed May 1, 2025.