AMERICA'S PHYSICIAN GROUPS

Physician Organizations and Successful CalAIM D-SNP Implementation

Insights and Considerations for Health Plans

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 contract, 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 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 increasing access to supports that help duals live independently and avoid institutional care. Successful EAE D-SNP implementation could thus also help 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 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 also directly impacts Medicare quality Star Ratings, risk adjustment, and ultimately, the long-term financial sustainability of EAE D-SNPs.

> 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.

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 the health care of duals and of Medi-Cal beneficiaries who may transition into dual eligibility. Many of these providers have extensive experience in MA full or global risk contracts and are well positioned to take on advanced risk arrangements caring for duals. It is therefore important for health plans implementing EAE D-SNPs to understand CDMPs' experiences and perspectives.

This issue brief offers insights on how plans — especially MCPs new to Medicare — can successfully engage CDMPs in EAE D-SNP implementation. The brief highlights findings from a series of focus groups and key informant interviews conducted from September 2024 to January 2025 with 20 APG member organizations serving more than 200,000 duals in California.

OPPORTUNITY #1:
Inclusion of CDMPs in EAE D-SNP Networks

In caring for duals, CDMPs emphasized the value of shared financial accountability and aligned incentives among health plans, hospital systems, and provider groups. When adequately reimbursed, many provider groups are willing and equipped to take on greater delegated responsibilities, including two-sided global risk. Aligned accountabilities support prioritization and investment in preventative care, population health management, and interventions that improve health outcomes and reduce avoidable costs.

> For Medicare full risk, we are willing to take it, and most plans are willing to offer it. However, the question becomes, are you willing to reimburse us enough to survive? If we are paid appropriately, we will take full risk.
>
> *—Executive Leader*
> *Northern California Medical Group*

Given their existing patient relationships and expertise managing complex care, some CDMPs seek greater delegation of D-SNP care coordination and California Integrated Care Management (CICM) services.[9] These providers are well-positioned to identify CICM-eligible members and have the experience and capacity to integrate care coordination and care management services into primary care.

FQHCs face unique challenges: Health centers' participation in D-SNP or MA contracts may require additional billing and reconciliation processes that can complicate or delay full wraparound payments under the FQHC Prospective Payment System (PPS). Reimbursement delays, along with any D-SNP to PPS rate differences, can disincentivize FQHC participation in D-SNPs. These are significant concerns because health centers are important care providers for duals.

Strategies to Support CDMP Contracting:

1. **Initiate early and consistent EAE D-SNP contracting discussions** that align on capacity, rates, and responsibilities.
2. **Prioritize CDMPs offering high-value care,** including those seeking full or global risk arrangements. With appropriate reimbursement and aligned incentives, MCPs new to Medicare can rely on these CDMPs as experienced partners to enhance member outreach, improve quality performance, optimize chronic condition capture, and strengthen network development and compliance with D-SNP requirements.
3. **Utilize standardized delegation agreements, including coded Division of Financial Responsibilities (DOFR) templates,** that specify both CMS and DHCS care coordination requirements.[10]
4. **Minimize service duplication and gaps by prioritizing CICM provider contracting with members' medical homes** to leverage existing care coordination infrastructure and proximity to care.

OPPORTUNITY #2:
Collaborate on Care Delivery Design

CDMPs prioritize patient-centered, evidence-based care and want deeper collaboration with D-SNPs to shape care delivery models and Models of Care (MOCs) submissions. These co-development partnerships can ensure realistic expectations and foster innovation between MOC approval cycles. Greater collaboration between providers and plans throughout the MOC design process can also strengthen mutual understanding of D-SNP requirements and each partner's responsibilities.

> Transparency from the beginning about the Model of Care construct is crucial. We need to understand whether we can deliver on what is being promised.
>
> *—Executive Leader*
> *Southern California Medical Group*

CDMPs struggle to understand the multitude of care coordination and care management services available to duals, such as CICM, Enhanced Care Management (ECM), Community Health Workers (CHWs), and Community Supports. Not only are they challenged with navigating different eligibility requirements for these services, they also often lack line-of-sight to health plan-based care coordinators, CICM providers, and other plan-contracted service providers. This lack of contact can lead to care duplication, service gaps, and confusion about who should lead on providing needed assistance to shared members. Enhanced collaboration can address these issues and help develop solutions to improve access, benefits navigation, and care coordination.

Strategies to Strengthen Collaboration:

1. **Solicit provider input on draft MOCs prior to submission.** Emphasize MOCs that enhance primary care investments and prioritize care activities that improve health outcomes.
2. **Co-design solutions to meet D-SNP requirements and address priority needs, including:**
   - Coordinated member materials and audit compliance protocols.
   - Member incentives and supplemental benefits that encourage participation in essential care activities (e.g., primary care visits and closing care gaps) that have measurable impact.
   - Member engagement strategies that incorporate culturally competent and linguistically concordant patient liaisons and CHWs.
   - Best practices educating and supporting members in navigating their benefits.
   - Enhanced care access through transportation or home-based supports.
   - Expanded access to specialty care by leveraging incentives, targeted provider outreach, and telehealth or e-consult strategies.[11]
3. **Facilitate regular joint operating meetings to clarify expectations, responsibilities, compliance obligations** (e.g., Interdisciplinary Care Teams, Individualized Care Plans, and SMAC compliance), **and EAE D-SNP implementation progress**. These meetings can foster mutual understanding, define points of contact, enhance compliance, and provide a consistent platform for communications between the plans and their networks.
4. **Share up-to-date contact information for plan-based care coordinators and third-party service providers** working with duals enrolled in D-SNPs. This includes D-SNP care coordinators, any CICM or ECM care managers, CHWs, Community Supports providers, and 1915(c) Home and Community Based Services providers.

OPPORTUNITY #3:

Enhance Data Sharing to Optimize Member Identification and Engagement

Identifying and engaging duals are foundational to delivering quality care. Addressing gaps in contact information is a crucial first step to ensuring duals receive appropriate care. Yet, provider organizations often experience gaps in DHCS, county, and health plan data. Provider portals may lack real-time eligibility updates with changes in member status not always flagged, and contact information can be outdated or inconsistent. At times, when transmitting monthly member attribution files, health plans have unknowingly overridden member contact details that providers updated. Another missed opportunity to exchange up to date member information occurs when providers lack information on which plan-based coordinators, CICM service providers, or other community-based supports are working with their members. To address these challenges, CDMPs often rely on imperfect workarounds, such as leveraging brokers or utilizing emergency room face sheets.

> You can have a housing navigation organization supporting a member for 7-8 months and no information will be shared with the provider group. Who is connecting to the point of care for the member? These support organizations aren't required to be part of any kind of portal or system. This is a missed opportunity.
>
> *—-Executive Leader, IPA*

Strategies to Improve Data Sharing:

1. **Share standardized eligibility files that include Dual status flags with coverage type and benefit codes.**
2. **Establish protocols for medical and other service providers to share and update member contact information** in the provider portal or through other mechanisms that ensure retention of the most current and accurate data.
3. **Provide regular updates on assigned care coordinators and related service providers,** including CICM, ECM, CHW, Community Supports, and 1915(c) HCBS care coordination providers.
4. **Share periodic reports identifying members who are eligible for CICM services** as well as related preauthorization or presumptive authorization details.

LOOKING AHEAD

The expansion of EAE D-SNPs presents a critical opportunity to improve care integration and benefits coordination for California's duals. Health plans' ability to align incentives, strengthen partnerships, and draw on the expertise of CDMPs can significantly impact provider participation and the success and sustainability of EAE D-SNP implementations. By engaging and working collaboratively with CDMPs, aligned D-SNPs can boost beneficiary enrollment, optimize care networks and value, and significantly improve care experience and outcomes for duals in California.

Additional Resources

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

- **Physician Organizations and Successful CalAIM D-SNP Implementation:** Insights and Considerations for California Policymakers
- **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 the DHCS D-SNP Policy Guide for CY 2026.

[10] 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

[11] For more information on building successful networks for duals in D-SNPs, see Building Provider Networks for Enrollees in Both Medicare and Medi-Cal, RAND for the California Health Care Foundation, January 2025.