AMERICA'S PHYSICIAN GROUPS

Partnering in Successful CalAIM D-SNP Implementations

Insights and Considerations for Capitated and Delegated Medical Providers

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 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 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.

About this Issue Brief

Capitated and Delegated Medical Providers (CDMPs) are uniquely positioned to support statewide implementation of EAE D-SNPs. This issue brief highlights findings from focus groups and key informant interviews conducted between September 2024 to January 2025 with 20 APG member organizations serving more than 200,000 duals in California. APG groups shared their experiences caring for duals and identified specific collaboration opportunities with health plans implementing 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.

Why Participation of Capitated and Delegated Medical Providers in CalAIM D-SNPs Matters

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.** Furthermore, 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. With the right financial alignment and support, CDMPs are uniquely positioned to drive successful EAE D-SNP implementation.

In conjunction, engagement in EAE D-SNP implementation offers multiple benefits for CDMPs:

1. **Increased Revenue Opportunities**
   Compared to standalone MCPs or MA-only plans, EAE D-SNPs offer more streamlined and coordinated reimbursements for Medicare and Medi-Cal covered services. Additional income opportunities include quality bonuses (e.g., linked to Medicare Star ratings), care coordination incentives, delegated California Integrated Care Management (CICM)[9] and other service contracts.

2. **Better Patient Alignment and Retention**
   Participation in EAE D-SNP networks allows CDMPs to retain their members and serve established duals as well as new duals when Medi-Cal members transition into Medicare.

3. **Improved Health Outcomes through Integrated Care**
   Through CalAIM's integrated D-SNP benefits and services that bridge physical, behavioral, and long-term care services, CDMPs can invest in population health strategies for duals that span the care continuum and care settings.

4. **Influence Over Whole-Person Care**
   EAE D-SNP participation enables CDMPs to innovate care for high-risk populations and incorporate upstream services and supports such as CICM, Community Supports, and other community-based services available to duals.

5. **D-SNPs are the Future of Health Care Coverage for Duals in California**
   D-SNP enrollment in California has grown by 260% since 2020.[10] DHCS is phasing out enrollment in non-aligned D-SNPs, and CMS is discontinuing D-SNP look-alike plans.[11] By 2027, EAE D-SNPs will therefore serve as an even more significant coverage option for duals in California. DHCS is also piloting default enrollment into EAE D-SNPs in two counties for Medi-Cal members who become eligible for Medicare due to age or disability. Although DHCS has not communicated any intent to expand default enrollment, experiences from the pilot may inform future planning.[12]

WHAT WE LEARNED:
Partnership, Contracting, and Delegation with D-SNPs

If reimbursement and incentives are aligned, APG's CDMPs shared that they are willing to serve more duals and assume greater risk, including two-sided global risk. Some groups seek expanded delegation of care coordination and care management responsibilities–including CICM–because these are important care components for complex populations like duals. CDMPs are also eager for greater involvement in D-SNP Model of Care (MOC) development to help align care delivery expectations, share best practices, and innovate care solutions for duals.

> 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*

However, an array of factors affects CDMPs' interests in participating in D-SNP contracts. Payment alignment across provider types and hospital systems, as well as adequate rates for preventive and primary care, remain key challenges. FQHCs face unique concerns because their 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). This reimbursement delay, along with any D-SNP to PPS rate differences, can disincentivize FQHC participation despite their importance as care providers for duals.

Finally, CDMPs expressed concern that health plans new to Medicare may lack the experience or specialized infrastructure to manage proactive member outreach, accurate and timely risk adjustments, and Medicare quality Star Rating performance. These plans need collaborative CDMP partners, especially those with experience in advanced Medicare risk arrangements, to ensure successful EAE D-SNP implementations.

Promising Practices:

- Seek collaboration with plans on MOC development and updates.
- Collaborate on implementation strategies that enhance member outreach, improve quality performance, optimize chronic conditions capture, and strengthen network development.
- Leverage a standardized Division of Financial Responsibility (DOFR) template that includes Medicare and Medi-Cal services and care coordination requirements. APG and the Health Industry Collaboration Effort (HICE) have collaborated on standardized, coded DOFR templates to support value-based contracting and delegation.[13]
- Prioritize delegation for care coordination and care management, including responsibilities for individual care plans, interdisciplinary care teams, and CICM services. Establish connections with plan-based staff and third-party service partners.
- Establish regular joint operating meetings with plans on execution of D-SNP policy and MOC requirements.
- Explore co-design of member incentives and supplemental benefits that encourage participation in essential care activities with measurable impact (e.g., completing the initial primary care visit or Medicare Annual Wellness Visit and addressing care gaps)
- Coordinate development of member materials and member engagement strategies, including the use of culturally competent and linguistically concordant patient liaisons or community health workers (CHWs).
- Share best practices in educating and supporting members to navigate their benefits.

WHAT WE LEARNED:
Experience with DHCS Policy Guidance

Although the CDMPs that participated in APG focus groups and interviews support DHCS' vision for integrated care with implementation of EAE D-SNPs, they are challenged by the fast pace, volume, and complexity of evolving policies. They encounter difficulties understanding the eligibility and service distinctions among the multitude of care coordination and care management services available to duals, such as plan-based care coordination, Enhanced Care Management (ECM), CICM, CHW services, and Community Supports.

Promising Practice:

- To stay informed and voice implementation concerns, allocate dedicated staff and time to review DHCS D-SNP policy guidance and participate in stakeholder workgroups, including quarterly CalAIM Managed Long-Term Services and Supports and Duals Integration Workgroup meetings.[14]

> Monthly 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*

WHAT WE LEARNED:
Data Sharing and Member Identification

Although duals' current overage status and member contact information are essential for effective care delivery, accurate and timely information is often lacking in provider portals and attribution files. At times, when transmitting monthly member files, health plans unknowingly override 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 identification and engagement of duals. To address these challenges, CDMPs often rely on imperfect workarounds such as leveraging brokers or utilizing emergency room face sheets to access up-to-date member contact information.

> 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*

Medical providers also often lack line-of-sight to plan-based care coordinators and care managers, as well as third-party CICM, ECM, CHW, and Community Supports providers serving their members. This lack of contact can lead to care duplication, service gaps, and confusion about who should lead on providing needed assistance to shared members.

Promising Practices:

- Establish protocols with health plans for real-time updates to member contact data.
- Request periodic contact lists for assigned care coordinators, care managers, and service providers, including the member's assigned D-SNP care coordinator and any CICM care managers, CHWs, Community Supports providers, and 1915(c) Home and Community Based Services care coordination providers.
- Work with plans to develop periodic reports identifying members eligible for CICM services as well as related preauthorization or presumptive authorization details.

WHAT WE LEARNED:
Access to Care

For duals, language, culture, and transportation pose significant barriers in access to care. Regardless of region, CDMPs reported that duals struggle with navigating the logistics of MCP transportation benefits. Besides obtaining appropriate authorization, duals often need to use a smart device to schedule rides in

advance and plan their rides with distance, timing, and location restrictions in mind. To improve access to care, provider organizations are increasingly leveraging non-traditional delivery models, including home-based care, mobile urgent care, and virtual visits.

Inadequate access to specialty care networks for duals was another priority concern, and some specialties were in particularly short supply in certain areas. In general, specialty care availability and timely access have been exacerbated by broader physician shortages, fewer physicians opting for independent practice, and health system consolidations.

Northern California provider groups noted a critical shortage of custodial long-term care (LTC) capacity in skilled nursing facilities. However, through CalAIM Community Supports, MCPs can now help members needing LTC remain in independent community living through a variety of mechanisms, including home-based services, respite care, or transition to and ongoing services in an assisted living facility.[15]

Promising Practices:

- Among duals, using language and culturally concordant care managers can significantly improve preventive care engagement and outcomes such as colonoscopy screening rates.
- Collaborate with MCPs to understand and leverage Medi-Cal Community Supports for duals to avoid or delay transition to institutional LTC.

WHAT WE LEARNED:
Outreach and Engagement

Provider organizations are trusted sources for health care information in the community but need support from plans and policymakers to effectively disseminate EAE D-SNP information and educate their patients. Outreach staff and materials must be coordinated to avoid confusing or overwhelming members. CDMPs have expanded linguistically and culturally concordant services and personnel in their outreach efforts, including the use of CHWs. Some have found that in-person CHW connections in rural areas have resulted in better member engagement than phone or media campaigns. They have also had success deploying CHWs with mobile clinics that provide health screenings, eligibility reviews, application assistance, care gaps closure, and care transitions follow-up.

> There is no perfect solution for outreach and engagement, but trust remains the foundation of our work. Language barriers add another layer of difficulty. It is not just about speaking the language but about offering culturally relevant services in ways that truly resonate with the community.
>
> *—-Physician Executive, Southern California Region of National Medical Group and IPA*

Promising Practice:

- Outreach and engagement strategies such as texting, in-home visits, and bilingual patient liaisons and CHWs can effectively reach duals.

LOOKING AHEAD

Aligned D-SNPs have enormous potential to transform care for California's duals, but their success depends on strong collaboration and coordinated execution between health plans and provider organizations. By actively participating in EAE D-SNP implementation and strengthening partnerships with health plans, CDMPs have important new opportunities to increase revenue and member retention, drive improved health outcomes, and promote whole-person care for duals in California. As EAE D-SNP implementation expands across the state in 2026, it is critical that CDMPs are at the table and have a voice in care delivery design and policy changes affecting this complex population. APG will continue to amplify the perspectives of accountable physician groups and facilitate collaboration and understanding between CDMPs, health plans, and policymakers in California.

Additional Resources

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

- **Physician Organizations and Successful CalAIM D-SNP Implementation:** Insights and Considerations for California Policymakers
- **Physician Organizations and Successful CalAIM D-SNP Implementation:** Insights and Considerations for Health Plans

Acknowledgements

This issue brief series was developed by America's Physician Groups with assistance from Transform Health, LLC, and through support from the California Health Care Foundation.

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] "Special Needs Plan (SNP) Data: SNP Comprehensive Reports - January 2020 and January 2025." *CMS*, https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/special-needs-plan-snp-data

[11] "Medicare Advantage D-SNP Look-Alike Plans." *DHCS*, https://www.dhcs.ca.gov/Pages/MA-D-SNP-Look-Alike-Plans.aspx#:~:text=Because%20look%2Dalike%20plans%20target,contracts%20effective%20January%201%2C%202023. Accessed April 29, 2025.

[12] "Medi-Medi Plan (EAE D-SNP) Default Enrollment Pilot." *DHCS*, https://www.dhcs.ca.gov/Pages/MMP-Default-Enrollment.aspx. Accessed April 29, 2025.

[13] 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

[14] DHCS CalAIM Managed Long-Term Services and Supports and Duals Integration Workgroup meeting dates, registration links, and materials are available at https://www.dhcs.ca.gov/provgovpart/Pages/MLTSS-Workgroup.aspx

[15] Detailed information on Medi-Cal Community Supports that support community transitions is available in the DHCS Community Policy Guide Volume 1