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FCA Family Caregiver Alliance®

Dementia and D-SNPs in 2026

How California Is Setting the Standard—and What Care Teams Need to Know

Speakers:
Genevieve Caruncho-Simpson, MPA
Senior Advisor at Family Caregiver Alliance

Linda M Keenan, PhD, MPA, BSN, RN-BC, NMCC
Clinical Advisor at Family Caregiver Alliance

Anna Chodos, MD, MPH
Executive Director at Dementia Care Aware, Division of Geriatrics, UCSF

Outline

- General Logistics
- Content:
    1. The clinical imperative
    2. The policy landscape
    3. Care model evolution
- Complete registration, course evaluation and claim CE

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Logistics

Please use the chat and Q&A functions to enter your questions throughout.

A recording and materials will be available on **DementiaCareAware.org** at the end of this webinar.

CE/CME information will be available at the end of the hour.

Today's speakers

Presenter
Genevieve Caruncho-Simpson, MPA
Senior Advisor
Family Caregiver Alliance

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Linda M. Keenan,
PhD, MPA, BSN, RN-BC, NMCC
Clinical Advisor
Family Caregiver Alliance

Moderator
Anna Chodos, MD, MPH
Executive Director,
Dementia Care Aware
Division of Geriatrics, UCSF

Quick review: Dementia Care Aware

DEMENTIA Care Aware ALZHEIMER'S ASSOCIATION

Training and Support at Dementia Care Aware

Education and Training:

- Core: CHA training
- More online training modules
- Bi-Monthly Webinars and Podcasts

Warmline:

1-800-933-1789

A provider support and consultation service staffed by Dementia Care Aware experts

Practice change support:

- Alzheimer's Association Health Systems team
- Implementation guide

DementiaCareAware.org DCA@ucsf.edu

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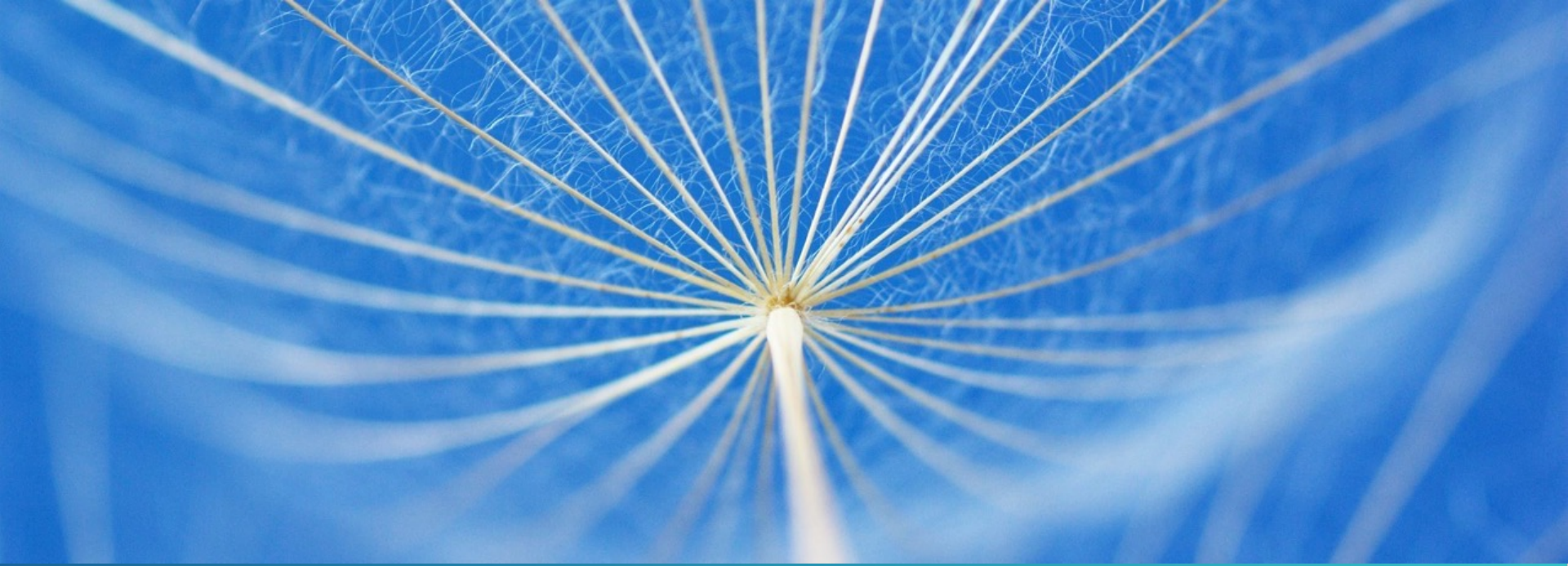

The Cognitive Health Assessment

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The Cognitive Health Assessment

- Annual screen
- A quick check on **cognitive** and **functional** symptoms and an assessment of the person's support system
- **The start** of a diagnostic assessment
- A jump start on a brain health plan

Various team members can do all or parts, but it needs to be reviewed by the billing provider.

Screening for Dementia: The Cognitive Health Assessment

Part 1

Take a Brief Patient History

Part 2

Use Screening Tools

Part 3

Document Care Partner Information

Goal: screen patients 65 and older annually (who do not already have a diagnosis of dementia)

Use Screening Tools. *You Have a Toolbox!*

	Administered to the patient:	Administered to the care partner:
Cognitive Screening Tools	GP-COG: Part 1: General Practitioner assessment of Cognition (for the patient) Mini-Cog	Short IQ-CODE: Short Informant Questionnaire on Cognitive Decline in the Elderly AD-8: Eight-Item Informant Interview to Differentiate Aging and Dementia
Functional Screening Tools	ADLs/IADLs: Activities of Daily Living and Instrumental Activities of Daily Living	GP-COG Part 2: General Practitioner Assessment of Cognition (for the informant) FAQ: Functional Activities Questionnaire

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Learning Objectives

After this webinar, you will be able to:

1. Describe the current state of cognitive screening and the clinical, financial, and access challenges for dementia patients and their families

2. Explain how D-SNPs, Medicare Advantage, and ACO policy changes are creating new care coordination infrastructure

3. Apply the "dyadic" approach—assessing both patient AND caregiver—to improve dementia outcomes

Part 1

The Clinical Imperative

Anna Chodos, MD, MPH

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California's Screening Gap

DHCS and CMS D-SNP Quality Reporting, September 2025

12%

of D-SNP members 65+ received a Cognitive Health Assessment (CHA) in 2024

California DHCS MLTSS & Duals Integration Workgroup (Sept 2025)

1 in 5

older adults receive regular cognitive assessments

PMC National Health Study (2025)

>75%

of people with dementia are told of their diagnosis

HHS ASPE (2020), Journal of General Internal Medicine (2025)

3-4x

Higher dementia rates within the dual-eligible Medicare-Medicaid population vs. Medicare only

KFF (2025)

California's Dementia Trajectory

866,000 Californians with Alzheimer's in 2025 → 1,965,820 by 2040 (127% increase)

Screening is growing (3% → 12% in CA Medicare/Medicaid members) but most patients aren't being assessed.

Early detection enables planning before crises—but only if there's somewhere to refer them.

The Problem—From Every Angle

Why dementia care is broken—and why it matters for your practice

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Clinical

No "dementia specialist" to refer to

Screen → diagnose → then what?

Patients return in crisis

Experience

Families navigate alone

Providers feel helpless

70% of caregivers report declining health

Finance

$360B annual cost (2024)

State budgets squeezed by Medicaid LTSS

Providers under-reimbursed

Access

Care happens at home—not clinic

Community services fragmented

No interoperability or coordination

Technology

EHRs don't capture complexity

SDoH invisible

No shared care plans

What You See in Your Practice

Patient scores positive • Exhausted family member in the room • Complex meds, questionable adherence • "We're managing" (but clearly struggling) • No clear next step after diagnosis • You have 15 minutes

After they leave:
Family tries to figure it out alone → caregiver health declines → missed doses → crisis → ED → hospitalization → you get the discharge summary.

Part 2

The Policy Landscape

Genevieve Caruncho-Simpson, MPA

The information presented is for educational purposes only and does not constitute legal, regulatory, or medical advice. Policy requirements and guidance may change. Consult official CMS and DHCS sources for current requirements.

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2026 Dementia Policy Changes

Quick Provider Reference

Program	What's Changing in 2026	Why It Matters for Providers
Traditional Medicare (FFS → ACOs)	• Greater emphasis on **cognitive screening & documentation** at AWV • Expansion of care coordination expectations including **caregiver involvement** • GUIDE Model paying for dementia navigation • ACO LEAD Model (2027+) signals shift toward **advanced ACOs for dementia + complex patients**	➢ Clear, specific documentation of dementia becomes essential ➢ Providers must incorporate caregiver engagement + shared care planning ➢ Practices aligned with dementia-capable workflows will be preferred partners for ACOs
Medicare Advantage (MA)	• **New Dementia-Focused Stars Quality Measures (2027 Star Ratings, Measurement Year 2025)**—plans graded on cognitive screening, accurate diagnosis, care plans, medication mgmt, caregiver engagement • **Rising importance of behavioral health, transitions, opioid/benzo safety, HRSN, whole-person outcomes** • Greater scrutiny on polypharmacy and psychotropic use in dementia	➢ 2027 Advance Notice: Audio-only HCC removals and unlinked chart review eliminations ➢ Plans will push providers to complete dementia assessments consistently and document cleanly ➢ Providers who deliver reliable dementia care become high-value partners for MA networks
Dual-Eligible SNPs (D-SNP)	• **Full rollout of CICM requirements for dementia**—including dyadic assessments (patient + caregiver) • **Mandatory caregiver identification and caregiver strain measurement** • **Care plans must reflect cognitive status, functional abilities, safety risks, caregiver needs, and HRSN** • CA aligning D-SNP with ECM and community partnerships	➢ Providers expected to share info on caregiver needs, functional status, HRSNs, and transitions ➢ More expectations for warm handoffs, post-hospital follow-up, and coordinated care planning ➢ Expect more communication from care managers—need workflows that support dyadic care

Bottom line: Dementia care coordination is becoming a quality requirement across ALL Medicare pathways.

What Is a D-SNP?

Dual Eligible Special Needs Plan (D-SNP): A Medicare Advantage plan for people with **both Medicare AND Medi-Cal**. These plans coordinate care across both programs with extra benefits and care coordination.

New in 2026: D-SNPs must use dyadic care planning and caregiver assessment for members with dementia.

For Patients & Families

- One plan for both programs
- Care manager assigned
- Extra benefits (dental, vision)
- Caregiver support required (new!)

For Providers

- Care managers to call
- Required CBO connections
- Dementia specialists on team
- Updates back to you

California Scale (2026)

- 1.7M dual eligibles in CA
- 330K in Medi-Medi Plans
- Expanding to 29+ counties
- Matching plan policy statewide

Why States Are Pushing Medicare-Medicaid Integration

State budgets are under pressure from Medicaid LTSS costs for older adults and complex care populations. Integration shifts coordination to Medicare while improving outcomes. California's Medi-Medi expansion is a model other states are watching.

California D-SNP
2026 Requirements

What plans must do—and what it means for referrals

✓ Ask if members have a caregiver and assess caregiver needs	*Caregiver burnout drives patient decline*
✓ Include caregivers in care planning for members with dementia	*Caregivers execute the care plan at home*
✓ Include trained dementia care specialists in care teams	*Specialized coordination for ADRD*
✓ Connect members to community services (CRCs, AAAs, CBOs)	*Home/community care—not just clinical*
✓ Coordinate all Medicare and Medi-Cal benefits including IHSS	*Integration reduces fragmentation*
✓ Share information across providers via interoperability	*Complete picture of member needs*

In 2026, dementia-capable coordination is not optional for D-SNPs. In a consolidating MA market, D-SNPs that invest in dementia infrastructure now will have strategic differentiation in Star rating, able to reduce avoidable costs + improve margin predictability, attract high-performing provider networks. *At FCA, in partnerships with California Caregiver Resource Centers (CRCs), we're developing infrastructure to support this.*

Part 3

Care Model Evolution

Linda Keenan, PhD, RN-BC

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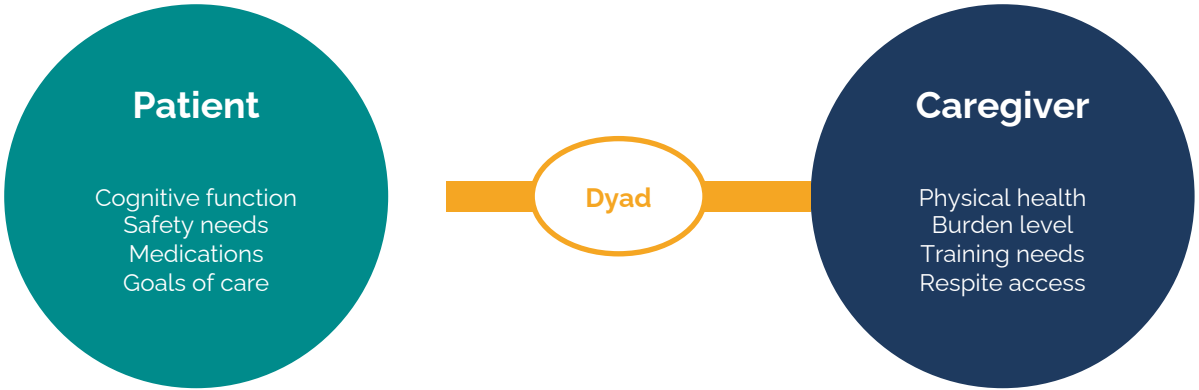
Why Assess Both?

The Dyad Model for Dementia Care

Often cognitive decline is non-linear. The caregiver relationship is the actual unit of care. And cultural context shapes everything from medication adherence to end-of-life preferences.



The Clinical Logic

The caregiver is your patient's care delivery system at home. They manage medications, notice changes, respond to crises, decide when to call.

Overwhelmed caregiver → missed doses, missed symptoms, falls, ER visits. **Supported caregiver** → stable patient, adherence, fewer crises, longer time at home.

How It Works

Screen → Refer → Home & Community Coordination Partner

You Screen
CHA at AWV or care transition

→

You Identify
Positive screen + caregiver present?

→

You Refer
To D-SNP care manager

→

Community Partner
CRC + D-SNP assess & support

Your Role

- Screen with CHA
- Ask: "Who helps you at home?"
- Document caregiver in chart
- Refer to D-SNP care manager
- Continue managing medical care

What Place-Based D-SNP Care Managers

- ✓ Create dyadic care plan
- ✓ Assess patient AND caregiver
- ✓ Connect to community resources
- ✓ Coordinate across providers
- ✓ Send updates back to you

You identify and refer. Your place-based CM coordinates. You stay informed. This is a new type of teamwork.

Community resources: Respite • Support groups • Home safety • Adult day • IHSS • Medication mgmt • Transportation

Dyadic Case

Maria and Isabela

Maria, 82, at her AWV. Daughter **Isabela, 56**, accompanies her. Maria screens positive. Isabela looks exhausted. Maria is in a D-SNP.

Before

- Document cognitive impairment
- Suggest "look into resources"
- Family goes home overwhelmed
- 3 months: fall → ER → hospitalization

After

- Document CHA + Isabela as caregiver
- Refer to D-SNP care manager
- CRC contacts Isabela; support + respite
- You see Maria for routine follow-up

6-Month Outcome

Maria: Stable at home. Zero ER visits. Medications managed. Advance directive completed.
Isabela: Getting respite, peer support, knows the plan if Maria declines.

By documenting the caregiver and referring, you activated a support system that kept both healthy.

What You Can Do Now

1. **Screen routinely** (<5 minutes per visit)
   CHA at AWV and care transitions for patients 65+
2. **Ask about caregivers**
   "Who helps you at home?" Document name and relationship. Add to intake and EHR workflow.
3. **Refer to D-SNP**
   Positive screen + caregiver identified → contact the member's care manager
4. **Request updates**
   Ask for care plan updates (quarterly) — you're still the medical home
5. **Complete DCA training**
   Free CE/CME at dementiacareaware.org (~90 minutes)

You identify and refer. Partner to coordinate. Your systems reflect the complexity you're managing—with appropriate reimbursement as quality measures tighten.

Key Takeaways

Screening is growing but still low—and early detection only matters if there's somewhere to refer

D-SNP CHA rates went from 3% to 12%—but most patients still aren't being screened. Policy is now creating the referral infrastructure that was missing.

Medicare is moving toward outcomes—and dementia is a priority condition across all pathways

D-SNPs, MA Stars, ACOs all increasingly require CBO partnerships and caregiver support. Practices that build these workflows now will be positioned for quality performance and reimbursement.

CRCs and CBOs are your partners—not just referral destinations

Dementia care happens at home. You screen, document, refer. Select aging networks are beginning to coordinate with D-SNPs and support families. Interoperability + partnership ensures your practice isn't overwhelmed while capturing the complexity.

DementiaCareAware.org | Caregiver.org

Questions?

Enter your questions in the Zoom Q&A panel

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Why Home & Community Partnership Matters

Dementia care happens at home—that's why CBO partnerships are essential.

What Clinical Care Can't Do Alone

- Can't train caregivers on daily management
- Can't provide respite when caregivers are exhausted
- Can't coordinate IHSS, benefits, housing
- Can't offer peer support groups
- Can't do home safety evaluations
- Can't be available 24/7 for family questions

What CRCs & CBOs Provide

- Caregiver assessment and care planning
- Skills training for dementia behaviors
- Respite coordination (61% of respite to duals)
- Benefits counseling (IHSS, Medi-Cal)
- Support groups—in-person and virtual
- Crisis intervention and ongoing support

Why Partnership—Not Referral—Matters

As interoperability improves, you'll see more of your patients' SDoH and complexity. CBOs like CRCs ensure your practice isn't overwhelmed—while your systems can reflect the true coordination you're performing. High-performing CBOs are gearing up for managed care contracts. Try to partner now.

FCA and the 11 CRCs are California's statewide infrastructure for this—40,000+ caregivers annually, specialized in dementia.

✓ *61% of respite hours for duals already come through CRC networks.*

Thank You

For Clinicians

dementiacareaware.org
Free CHA training (1.5 CE/CME)
Monthly webinars + resources
dca@ucsf.edu

For Questions about D-SNP and Caregiver-Inclusive Models of Care

caregiver.org
Family Caregiver Alliance
Part of the 11 California CRCs / Aging Network
gcaruncho@caregiver.org

Complete the course evaluation to receive your 1 CE/CME credit

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Education and implementation support resources for dementia screening and care planning.

DementiaCareAware.org
dca@ucsf.edu

Clarity

Free 50-state tool developed to help patients and their caregivers navigate legal and financial planning.

PlanForClarity.org
peterselizabeth@uclawsf.edu

FREE CE/CME

Caregivers As Partners in Care Teams

A national training program that provides health care teams with the skills & confidence to include caregivers in a patient's care journey.

CarePartners.ucsf.edu
capct@ucsf.edu

ALZHEIMER'S ASSOCIATION

QI project support for health systems and education and support groups for persons living with dementia and their caregivers.

alz.org
avalenzuela@alz.org

Enroll in the IHI 2026 Action Community

- Begins **March 2026**
- 7-month, virtual community
- Monthly webinars about the 4Ms
- Community of testers and learners
- Learn more in the Action Community Flyer

Register Here
https://bit.ly/IHIAC2026