CALAIM DUAL ELIGIBLE SPECIAL NEEDS PLANS REPORTING REQUIREMENTS TECHNICAL SPECIFICATIONS

Contract Year 2025

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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INTRODUCTION

The following document contains technical specifications for the 2025 Reporting Requirements and Quality Measures for Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs, also called Medicare Medi-Cal Plans), SCAN's Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), as well as non-EAE D-SNPs. Additional information from DHCS is available on the DHCS D-SNP Quality and Data Reporting webpage.

The majority of definitions are pulled from existing materials, including:

- CY 2025 Core Reporting Requirements (as of 11/01/2024)
- CY 2022 California-Specific Reporting Requirements (as of 02/28/2022)
- American Academy of Neurology Mild Cognitive Impairment Quality Measurement Set (as of 03/25/2019)

Please note, additional information is included in the 2025 D-SNP Policy Guide, as well as the 2025 D-SNP Reporting Templates. The latest version of D-SNP Reporting Templates are available upon request via email to info@calduals.org.

DHCS is requiring D-SNPs to stratify reporting requirements by race/ethnicity according to NCQA standards for select measures (ED BH, CHA, ICP, PAL, and data element B for ECM). Plans will submit stratified data via the 2025 D-SNP Reporting Templates. Please see the 2025 D-SNP Policy Guide for additional information. In addition, plans are **required** to identify the data source used to identify race/ethnicity by entering the data source within the space indicated on the "Comments" tab in the D-SNP Reporting Template. If plans do not include race/ethnicity data source in a report submission, the data source included in the most recent previous report submission will be assumed to apply to the latest submission. Detailed instructions are available in the D-SNP Reporting Templates.

SUMMARY OF UPDATES AND KEY CHANGES

Date	Chapter/Section	Update/Change
4/16/25	All	Initial Release

DEFINITIONS

All definitions for terms defined in this section and throughout this Technical Specifications document apply whenever the term is used, unless otherwise noted.

Calendar Year: All annual measures are reported on a calendar year basis. For example, Calendar Year (CY) 2025 represents January 1, 2025 through December 31, 2025.

Calendar Quarter: The four calendar quarters of each calendar year will be as follows:

- Quarter one (Q1): January 1 to March 31, 2025
- Quarter two (Q2): April 1 to June 30, 2025
- Quarter three (Q3): July 1 to September 30, 2025
- Quarter four (Q4): October 1 to December 31, 2025.

Enhanced Care Management (**ECM**): ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. (From the ECM Policy Guide, updated August 2024)

Some D-SNP Members needing care management services through D-SNPs may also meet the criteria for ECM populations of focus. However, there is significant overlap across the D-SNP model of care and ECM requirements, which could result in duplication and confusion for Members and care teams if a Member receives care management from both programs. Member care management, as well as coordination across Medicare and Medi-Cal benefits, is a primary function of D-SNPs. D-SNPs must provide sufficient care management to Members to ensure that Members who would otherwise qualify for Medi-Cal ECM are not adversely impacted by receiving care management exclusively through their D-SNP.

D-SNPs should review the ECM populations of focus per the ECM Policy Guide. D-SNPs in California must include, in addition to any other sub-populations determined by the D-SNP, four or more populations of focus from the Medi-Cal Enhanced Care Management program. More information is available in the 2025 D-SNP Policy Guide.

Please note that CY 2026 California Integrated Care Management (CICM) requirements replace the CY 2024 and CY 2025 "ECM-like care management" requirements for D-SNPs. ECM-like services are still a requirement for the 2025 reporting year.

Individualized Care Plan (**ICP or Care Plan**): The plan of care developed by an Enrollee and/or an Enrollee's Interdisciplinary Care Team or health plan.

Palliative Care: Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and suffering of the illness and can be provided along with curative treatment. The goal is to improve the quality of life for both the Member and the family.

Palliative care is provided by a specially trained team of doctors, nurses, and other specialists who work together with a Member's other doctors to provide an extra layer of support. Qualified providers must be used based on the setting and needs of a Member. Palliative care can be provided in a variety of settings, including, but not limited to, inpatient, outpatient, and community or home-based settings. Palliative care is based on the needs of the Member, not on the Member's prognosis. It is appropriate at any age and any stage in a serious illness.

Since 2018, Medi-Cal Managed Care Plans have been required to offer palliative care to Medi-Cal Members under All Plan Letter (APL) 18-020. DHCS requires all D-SNPs to offer palliative care services to dually eligible Members. Requirements for D-SNPs around palliative care are in the 2025 D-SNP Policy Guide. (From the D-SNP Palliative Care Fact Sheet)

ED BH – EMERGENCY DEPARTMENT (ED) BEHAVIORAL HEALTH SERVICES UTILIZATION

Reporting Frequency	Reporting Level	Reporting Period	Due Date	Plan Types Required to Report
Annually	H-Contract, broken out by EAE and non-EAE	Calendar Year	By the end of the second month following the last day of the reporting period.	EAE and non-EAE D-SNPs; FIDE SNP

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values	Tab in Reporting Template
A.	Total number of ED visits with a principal diagnosis related to behavioral health.	Total number of ED visits with a principal diagnosis related to behavioral health during the reporting period. Refer to 2025 Core Value Sets Workbook for Core Measure 9.1.	Field Type: Numeric	Tab 1 – ED BH in the 2025 D-SNP Annual Reporting Template

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- DHCS will perform an outlier analysis as needed.
- As data are received from D-SNPs over time, DHCS may apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.

- N/A.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored.
   - DHCS will use enrollment data to evaluate the total number of ED visits with a principal diagnosis related to behavioral health per 10,000 member months during the reporting period.
     - Rate = (A / Total Member Months) * 10,000

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

   Data Element A

   - D-SNPs should include all ED visits with a principal diagnosis related to behavioral health for Members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all Members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
   - D-SNPs should use the ED value set to identify ED visits. D-SNPs should use facility claims to identify ED visits.
   - D-SNPs should use the Mental Health Diagnosis value set to identify a behavioral health diagnosis.
   - If there are two different ED visits with the same date of service within the reporting period (and there are two separate, adjudicated claims), then both ED visits should be reported in data element A. Adjudicated claims refers to claims that are in final status, including paid claims and denied claims. Pending claims should not be included.
   - D-SNPs should refer to "2025 Core Value Sets Workbook for Core Measure 9.1" for a list of diagnosis codes, linked on the CMS website: https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-reporting-requirements

   Data Element A Exclusion

   - D-SNPs should exclude ED visits followed by admission to an acute or nonacute inpatient care setting (same or different facility as ED visit) on the date of the ED visit. To identify admissions to an acute or nonacute inpatient care setting:
     - Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
     - Identify the admission date for the stay
   - An ED visit billed on the same claim as an inpatient stay is considered a visit that

resulted in an inpatient stay and should be excluded from data element A.

F. Data Submission – how D-SNPs will submit data collected to DHCS.

- D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

CCMR – CARE COORDINATOR TO MEMBER RATIO

Reporting Frequency	Reporting Level	Reporting Period	Due Date	Plan Types Required to Report
Annually	H-Contract, broken out by EAE and non-EAE	Calendar Year	By the end of the second month following the last day of the reporting period	EAE and non-EAE D-SNPs; FIDE SNP

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values	Tab in Reporting Template
A.	Total number of full time equivalent (FTE) care coordinators working at the D-SNP.	Total number of FTE care coordinators working at the D-SNP as of the last day of the reporting period.	Field Type: Numeric	Tab 2 – CCMR in the 2025 D-SNP Annual Reporting Template

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- DHCS will perform an outlier analysis. However, all D-SNPs must internally validate all data and quality measures submitted to DHCS according to their usual processes.
- As data are received from D-SNPs over time, DHCS will apply threshold checks.

C. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored.

Note: This measure is not adjusted for case mix, and care coordination will vary for each D-SNP's care plan model structure. Therefore, this measure will be used solely to track care coordination investments and changes in each D-SNP's care coordinator to Member ratio longitudinally.

DHCS will:

- Use enrollment data to evaluate the number of Members per FTE care coordinator.
    - Rate = (Total Members Enrolled / A)

D. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- D-SNPs should refer to the 2025 D-SNP Policy Guide for the definition of care coordinator.
- FTE is defined as full time equivalent.

General Guidance

- To calculate the number of FTE care coordinators, add up all of the care coordinators' work hours during the reporting period and divide this value by the number of normal working hours for one full-time employee that occurred during the reporting period.
    - In instances where care coordinators support multiple lines of business, include only the time associated with the D-SNP.
- For all data elements, FTE reported values should be rounded to the nearest positive integer.
- All part-time and full-time care coordinators will be counted, regardless of whether they are subcontracted or employed directly by the D-SNP.

E. Data Submission – how D-SNPs will submit data collected to DHCS.

- D-SNPs will submit data collected for this measure through the DHCS D-SNP Reporting Template.

CHA – ANNUAL COGNITIVE HEALTH ASSESSMENT FOR PATIENTS 65 YEARS AND OLDER

Technical specifications for the state-specific D-SNP reporting requirement CHA refer to the measure specifications for the Annual Cognitive Health Assessment for Patients 65 Years and Older measure as published in the American Academy of Neurology's Mild Cognitive Impairment Quality Measurement Set.

Reporting Frequency	Reporting Period	Due Date	Plan Types Required to Report	Tab in Reporting Template
Annually	Calendar Year	By the end of the second month following the last day of the reporting period	EAE and non-EAE D-SNPs; FIDE SNP	Tab 3 – CHA in the 2025 D-SNP Annual Reporting Template

Measure Title

- Annual Cognitive Health Assessment for Patients 65 years and Older

Measurement Period

- Calendar Year (e.g., January 1, 2025 to December 31, 2025)

Eligible Population

Eligible Providers

- Medical Doctor (MD), Doctor of Osteopathy (DO), Neuropsychologist (PhD, PsyD), Psychologist (PhD, PsyD), Physician Assistant (PA), Advanced Practice Registered Nurse (APRN)

Care Setting(s)

- Outpatient Care

Ages

- Age 65 and older

Event

- Office visit

Diagnosis

- All patients

Data Collection

D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

Denominator

Patients aged 65 and older

Numerator

- Patients who had cognition assessed* within the measurement period.
- Patients who had cognition assessed* at least once during the measurement period.

*Cognition assessed is defined as use of one of the following validated objective tools (Users are encouraged to review possible copyright and use requirements prior to administration, as well as, ability to have the informant(s) potentially complete the validated tool. The tools are not necessarily equal and interchangeable. Clinician judgment is needed in selecting and interpreting the appropriate tool.):

  - Montreal Cognitive Assessment (MoCA)(1),
  - Mini-Mental State Examination (MMSE)(1-2),
  - Memory Impairment Screen (MIS)(1),
  - Saint Louis University Mental Status examination (SLUMS)(3),
  - Mini-Cog©(4),
  - Clinical Dementia Rating (CDR)(5),
  - Self-Administered Gerocognitive Examination (SAGE)(6),
  - Cognitive Health Assessment (CHA), or
  - Neuropsychological assessment results.

- To perform well on this measure, the following key phrases are suggested for collection in a registry. These key phrases should be recorded within the measurement period:
- "Order for referral for neuropsychological assessment",
- "Neuropsychological results discussed/counseled/reviewed with patient",
- "MoCA [OR SLUMS, MMSE, MIS, CDR, Mini-Cog, SAGE, CHA, or neuropsychological] results reviewed", OR
- "MoCA [OR SLUMS, MMSE, MIS, CDR, SAGE, Mini-Cog] results" followed by numerical score
- Presence of CPT code on encounter date or within the measurement period for neuropsychological testing would meet the measure: 96116, 96136, 96138, 96146

Required Exclusions

- Prior diagnosis of Mild Cognitive Impairment
- Prior diagnosis of dementia

Allowable Exclusions

- Patient declines cognitive health assessment on date of encounter
- On date of encounter, patient is not able to participate in a cognitive health assessment, including non-verbal patients, delirious, comatose, severely aphasic, severely developmentally delayed, severe visual or hearing impairment and for those patients, no knowledgeable informant available.
- Patient previously had a cognitive assessment in the measurement period and prior results noted.
- To perform well on this measure, we suggest using key phrases for collection in a registry. These key phrases should be recorded on the encounter date:
  - "Patient unable to communicate, no informant present"
  - "Patient unable to understand task"
  - "Patient declines cognitive assessment tool"
  - "Informant declines cognitive assessment"
  - "Patient refuses cognitive assessment tool"
  - "Informant refuses cognitive assessment"
  - "Care partner [OR spouse, informant, caregiver] declines cognitive assessment"

- "Patient screened and results noted."
- "Patient previously assessed for cognitive impairment and results present."

Allowable Exclusion Inclusion Logic

Allowable exclusions can only help measure performance. If a patient has an allowable exclusion but is found to meet the numerator that patient is included in the count to meet the measure. This logic applies to the allowable exclusions noted above.

Exclusion Logic

Patients with prior diagnoses of MCI and dementia are excluded from the measure to prevent duplicative measurement in the calendar year. These patients are subject to other screening and assessment measures. (See Harmonization with Existing Measures below.) Patients or informants need to be able and willing to complete assessment for the assessment results to be valid. Additionally, patients previously assessed in the measurement period may be excluded if prior results are noted to reduce duplicative assessments.

Measure Scoring

Percentage

Interpretation of Score

Higher Score Indicates Better Quality

Measure Type

Process

Level of Measurement

Provider

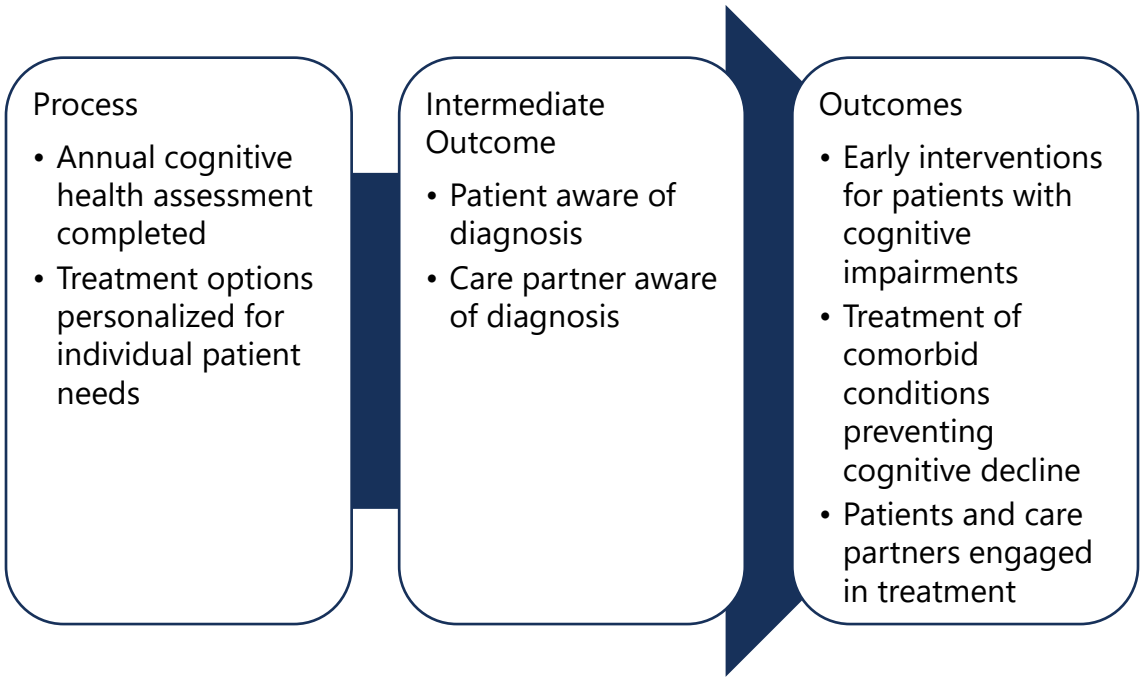
Risk Adjustment

Not applicable for process measure.

For Process Measures Relationship to Desired Outcome

From American Academy of Neurology MCI Guideline: "Clinicians should assess for MCI with validated tools in appropriate scenarios (Level B). Clinicians should evaluate patients with MCI for modifiable risk factors, assess for functional impairment, and assess for and treat behavioral/neuropsychiatric symptoms (Level B)."[7]

» The Alzheimer's Association notes, "Informal observation alone by a physician is not sufficient (i.e., observation without a specific cognitive evaluation."[8]



Opportunity to Improve Gap in Care

Opportunity exists to improve the recognition of MCI through routine screening of cognitive health in older adults who because of their age are at high risk[8,9]. The work group restricted the measure to patients over the age of 65, but encourages clinicians to screen all at-risk patients for MCI. The work group also notes an informant may help in identification of at-risk patients along with thorough cognitive assessment.

Physicians fail to recognize about 50% of patients in their practice with significant cognitive deficits, missing an opportunity to offer appropriate evaluation and treatment[10]. Depending solely on a complaint is insufficient because patients may not recognize or report worsening memory problems to their physicians[11]. Although, there is conflicting evidence on the benefits of cognitive impairment screening for older adults, there is growing support for the assessment of patients over the age of 65 years old and the benefits of this screening[12-13].

Harmonization with Existing Measures

Although numerous cognitive screening measures exist for disease- specific conditions (such as multiple sclerosis, Parkinson's disease, dementia, and stroke), a cross-cutting

measure is needed for all patients over the age of 65 years old for baseline assessment for MCI. Current measures focused on cognitive screening are listed below for clinician consideration when identifying the best measure to meet your population needs:

- Percentage of actively enrolled home-based primary care and palliative care patients who received an assessment of their cognitive ability.
- Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.
- Cognitive Assessment for patients with MS
- Cognitive impairment following a stroke
- PD Cognitive Impairment or Dysfunction

References

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3. Feliciano L, Horning SM, Klebe KJ, et al. Utility of the SLUMS as a cognitive screening tool among a nonveteran sample of older adults. Am J Geriatr Psychiatry. 2013; 21(7):623-630.
4. Borson S, Scanlan JM, Chen P, Ganguli M. The Mini-Cog as a screen for dementia: validation in a population-based sample. Journal of the American Geriatrics Society. 2003;51(10):1451– 1454.
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7. Petersen RC, Lopez O, Armstrong MJ, et al. Practice guideline update summary: Mild cognitive impairment. Neurology. 2018;90(3):126-135.
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10. Boustani M, Peterson B, Hanson L, et al. Screening for Dementia in Primary Care: A summary of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 2003: 138:927-937.
11. Vannini P, Hanseeuw B, Munro CE, et al. Anosognosia for memory deficits in mild cognitive impairment: Insight into the neuroal mechanism using functional and molecular imaging. Neuroimage Clin 2017; 15:408-414.
12. Tong T, Thokala P, McMillan B, et al. Cost effectiveness of using cognitive screening tests for detecting dementia and mild cognitive impairment in primary care. Int J Geriatr Psychiatry. 2017; 32:1392-1400.
13. U.S. Preventive Services Task Force. Final Recommendation Statement: Cognitive Impairment in Older Adults: Screening. December 2016. Available at: https://www.uspreventiveservicestaskforce.org/Page/Documen t/RecommendationStatementFinal/cognitive-impairment-in-older-adults-screening Accessed on July 31, 2018.

Code System	Code	Code Description
		Age 65 and older
		AND
CPT	99201-99205	Office or Other Outpatient Visit – New Patient (E/M Codes)
CPT	99212-99215	Office or Other Outpatient Visit – Established Patient (E/M Codes)
CPT	99241-99245	Office or Other Outpatient Visit – New or Established Patient
CPT	99483	Cognitive Impairment and Care Plan Assessment
		AND
ICD-9		All
ICD-10		All

ICP – MEMBERS WITH A CARE PLAN COMPLETED WITHIN 90 DAYS OF ENROLLMENT

Reporting Frequency	Reporting Level	Reporting Periods	Due Date	Plan Types Required to Report
Quarterly	H-Contract, broken out by EAE and non-EAE	Calendar Quarters: Q1: 1/1 – 3/31 Q2: 4/1 – 6/30 Q3: 7/1 – 9/30 Q4: 10/1 – 12/31	By the end of the second month following the last day of the reporting period Exception: Quarter one is due by 6/30/25	EAE and non-EAE D-SNPs; FIDE SNP

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values	Tab in Reporting Template
A.	Total number of Members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Total number of Members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Field type: Numeric	Tab 1 – ICP in the 2025 D-SNP Quarterly Reporting Template

Element Letter	Element Name	Definition	Allowable Values	Tab in Reporting Template
B.	Total number of Members with a care plan completed within 90 days of enrollment.	Of the total reported in A, the number of Members with a care plan completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Completed care plans must be clearly documented.	Tab 1 – ICP in the 2025 D-SNP Quarterly Reporting Template

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
   - » DHCS will perform an outlier analysis as needed. However, all D-SNPs must internally validate all data and quality measures submitted to DHCS according to their usual processes.
   - » As data are received from D-SNPs over time, DHCS may apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.
   - » D-SNPs should validate that the sum of data elements B is less than or equal to data element A.
   - » D-SNPs should validate that Members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
   - » D-SNPs should validate that Members included in data element A were enrolled as of the last day of the reporting period.
   - » D-SNPs should validate that Members included in data element B were included in data element A.
   - » D-SNPs should validate that Members reported in data element B had a completed care plan clearly documented within 90 days of enrollment.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored. DHCS will evaluate the percentage of Members who:

- Had a care plan completed within 90 days of enrollment.
  - Percentage = (B / A) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- D-SNPs should refer to state regulations for the definition of authorized representative.

Data Element A

- D-SNPs should only include those Members who are currently enrolled as of the last day of the reporting period, including deceased Members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported Members must be enrolled in the D-SNP.
- The 90th day of enrollment should be based on each Member's most recent effective enrollment date in the D-SNP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a Member's effective enrollment date.
  - When reporting quarterly results, D-SNPs should report all Members who reached their 90th day of enrollment at any point during the three months included in the quarter reporting period. (e.g., Members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these Members should be included in reporting for the third quarter as long as they were still enrolled on the last day of the reporting period).
  - Note for quarter one 2024: Members with an effective date in November and December 2024 should be included in quarter one Q1 2025 data for ICP, as they reached their 90th day of enrollment during Q1 2025.

Data Element B

- The care plan should meet state-specific criteria and include the appropriate domains as determined by the state in the 2025 D-SNP Policy Guide.
- If a Member's care plan is in progress, but is not completed within 90 days of enrollment, then the care plan should not be considered completed, and therefore, the Member should not be counted in data element B.
- D-SNPs should only report completed care plans where the Member or the Member's authorized representative was involved in the development of the care plan.
- If a Member initially refused to complete a care plan or could not be reached after three outreach attempts, but then subsequently completes a care plan, within 90 days of enrollment, the Member should be classified in data element B.

General Guidance

- Members reported in data element B must also be reported in data element A since it is a subset of data element A.
- D-SNPs should only report Members with an initial care plan for this measure.

F. Data Submission – D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template

ECM – ECM-LIKE SERVICES

D-SNPs should refer to the Care Coordination chapter and the state-specific D-SNP Model of Care (MOC) matrix in the 2025 D-SNP Policy Guide for guidelines on providing ECM-like services (or ECM-like care management) to Members. Additional guidance is also available in the CalAIM ECM Policy Guide.

Note: For data element D, DHCS is requesting a narrative description of any assumptions the plan is using in reporting data in this report. This narrative is meant to supplement the data reported by summarizing the plan's ECM-like services reporting and providing background on a D-SNP's assumptions made when compiling data. DHCS intends to publish this description along with the accompanying data.

DHCS requires data element B to be reported with stratification by race and ethnicity according to NCQA standards, as noted in the 2025 D-SNP Reporting Template. DHCS does not require data elements A or C to be reported with stratification by race and ethnicity.

Reporting Frequency	Reporting Level	Reporting Period	Due Date	Plan Types Required to Report
Quarterly	H-Contract, broken out by EAE and non-EAE	Calendar Quarters: Q1: 1/1 – 3/31 Q2: 4/1 – 6/30 Q3: 7/1 – 9/30 Q4: 10/1 – 12/31	By the end of the second month following the last day of the reporting period Exception: Quarter one is due by 6/30/25	EAE and non-EAE D-SNPs; FIDE SNP

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values	Tab in Reporting Template
A.	Total unique Members who were identified as eligible for ECM-like services during the reporting period	Total number of unique Members who were currently enrolled in the D-SNP at the end of the reporting period and were identified as eligible for ECM-like services during the reporting period. D-SNPs must exclude any Members currently enrolled in ECM through their Medi-Cal Managed Care Plan (MCP). This data element does not need to be reported with race/ethnicity stratification.	Field type: Numeric	Tab 2 – ECM Total Members in the 2025 D-SNP Quarterly Reporting Template
B.	Total unique Members who received ECM-like services during the reporting period	Of the Members reported in A, total number of unique Members who were currently enrolled in the D-SNP at the end of the reporting period and received ECM-like services	Field type: Numeric Note: Is a subset of A.	Tab 2 – ECM Total Members in the 2025 D-SNP Quarterly Reporting Template

Element Letter	Element Name	Definition	Allowable Values	Tab in Reporting Template
		during the reporting period. This data element must be reported with race/ethnicity stratification.		
C.	Total unique Members who received an in-person ECM-like care management interaction	Of the Members reported in B, number of unique Members who received an in-person care management interaction for ECM-like services during the reporting period. This data element does not need to be reported with race/ethnicity stratification.	Field type: Numeric Note: Is a subset of B.	Tab 2 – ECM Total Members in the 2025 D-SNP Quarterly Reporting Template
D.	Narrative summary of ECM-like services reporting	Please describe your plan's assumptions and process around reporting Members eligible for and receiving ECM-like services. This must include descriptions of the following: • How your plan identifies	Field type: Text	Tab 3 – ECM Narrative in the 2025 D-SNP Quarterly Reporting Template

Element Letter	Element Name	Definition	Allowable Values	Tab in Reporting Template
		Members who are eligible to receive ECM-like services. • How your plan identifies Members who received ECM-like services. • Any additional information on your plan's approach to ECM-like services and assumptions used when reporting data.		

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

   » DHCS will perform an outlier analysis as needed. However, all D-SNPs must internally validate all data and quality measures submitted to DHCS according to their usual processes.

   » As data are received from D-SNPs over time, DHCS may apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.

   » D-SNPs should validate that Members included in data element A were enrolled in the D-SNP as of the last day of the reporting period.

   » D-SNPs should validate that Members included in data element B were included in data element A.

- » D-SNPs should validate that Members included in data element C were included in data element B.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored. DHCS will evaluate the percentage of Members who:

- » Were identified as eligible for ECM-like services and received ECM-like services across all ECM POFs.
  - o Percentage = (B / A) * 100
- » Received ECM-like services and had an in-person ECM-like care management interaction during the reporting period across all ECM POFs.
  - o Percentage = (C / B) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Element A: Total unique Members who were identified as eligible for ECM-like services during the reporting period

To identify total unique Members who were eligible for ECM-like services, plans must identify Members across all D-SNP enrollment who meet the Medi-Cal criteria for one or more ECM POFs discussed in the D-SNP's CY 2025 MOC. For additional details, D-SNPs should review the ECM POFs described in the CalAIM ECM Policy Guide:

1. Adult – Individuals Experiencing Homeless
2. Adult - Families Experiencing Homelessness
3. Adult - Avoidable Hospital or Emergency Department (ED) Utilization
4. Adult – Serious Mental Illness (SMI) or Substance Use Disorder (SUD)
5. Adult - Transitioning from Incarceration
6. Adult - at Risk for Long Term Care (LTC) Institutionalization
7. Adult – Nursing Facility (NF) Transitioning to Community
8. Adult - Birth Equity

Element B: Total unique Members who received ECM-like services during the reporting period

Of Members identified in element A, plans must report Members who received at least one instance of an ECM-like service. ECM-like services refer to the seven core services described in the CalAIM ECM Policy Guide:

1. Outreach and Engagement

2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

Note, supports and services provided to Members vary based on the needs of the Member. Some Members may receive multiple services or fall under multiple POFs – data elements A through C should only include a count of unique Members across all four or more ECM POFs that the plan included in their CY 2025 state-specific MOC.

Element C: Total unique Members who received an in-person ECM-like care management interaction

Of all Members reported in element B who received ECM-like services (as defined by the seven core services described in the CalAIM ECM Policy Guide), plans must report the number of Members who received ECM-like services in-person. Per the CY 2025 state-specific D-SNP MOC matrix, D-SNPs must engage with each Member who would otherwise qualify for Medi-Cal ECM to receive D-SNP ECM-like care management primarily through in-person contact.

General Guidance

a. D-SNPs should only include Members who are currently enrolled in the plan as of the last day of the reporting period, including deceased Members who were enrolled in the plan through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported Members must be enrolled in the D-SNP.
b. Members reported in data elements B and C must also be reported in data element A since these data elements are subsets of data element A. Members reported in data element C must also be reported in data element B since these data elements are subsets of data element B.
c. Members who are unable to be contacted or declined services may be reported under data elements A, but should not be reported in other data elements.

F. Data Submission – D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

PAL – PALLIATIVE CARE

D-SNPs should refer to the 2025 D-SNP Policy Guide Care Coordination chapter for guidelines on providing and coordinating palliative care for Members.

Reporting Frequency	Reporting Level	Reporting Periods	Due Date	Plan Types Required to Report
Quarterly	H-Contract, broken out by EAE and non-EAE	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period Exception: Quarter one is due by 6/30/25	EAE and non-EAE D-SNPs; FIDE SNP

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values	Tab in Reporting Template
A.	Number of New Enrollees	Report the total number of unique Members newly enrolled in palliative care services within the reporting period.	Field type: Numeric	Tab 4 – Palliative Care in the 2025 D-SNP Quarterly Reporting Template

B. Quality Assurance (QA) Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
    - » DHCS will perform an outlier analysis as needed. However, all D-SNPs must internally validate all data and quality measures submitted to DHCS according to their usual processes.
    - » As data are received from D-SNPs over time, DHCS may apply threshold checks.
C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.
    - » D-SNPs should check that the NPI numbers provided for data element A are valid, and does not include duplicated providers.
D. Data Submission – D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

FREQUENTLY ASKED QUESTIONS (FAQS)

Cognitive Health Assessment (CHA) Measure

1. **For the CHA measure, can plans include assessments completed by health plan staff and assessments completed by a provider?**

   Yes, assessments may be completed by either health plan staff (including case managers) or providers.

2. **For the CHA measure, does this include patients 65 and older as of December 31 of the reporting year?**

   Yes, per guidance in the American Academy of Neurology (AAN), the measure indicates patients 65 and older who had cognition assessed during the entire reporting period (January 1, 2025 through December 31, 2025). This means that if a person turns 65 during the reporting period, they should be included in the measure.

3. **For the CHA measure, what tools can be used to assess patient cognition?**

   Per guidance in AAN, cognition assessed is defined as use of one of the following validated objective tools:

   - Montreal Cognitive Assessment (MoCA),
   - Mini-Mental State Examination (MMSE),
   - Memory Impairment Screen (MIS),
   - Saint Louis University Mental Status examination (SLUMS),
   - Mini-Cog©,
   - Clinical Dementia Rating (CDR),
   - Self-Administered Gerocognitive Examination (SAGE),
   - Cognitive Health Assessment (CHA), or
   - Neuropsychological assessment results.

   The AD8 Dementia Screening Interview is also an acceptable tool for screening.

   Note: Users are encouraged to review possible copyright and use requirements prior to administration, as well as, ability to have the informant(s) potentially complete the validated tool. The tools are not necessarily equal and interchangeable. Clinician judgment is needed in selecting and interpreting the appropriate tool.

Plans are encouraged to reference and direct providers to the Dementia Care Aware website and associated resources, available here: https://www.dementiacareaware.org/.

4. **For the CHA measure, does Column F refer to the total number of patients age 65 and older as of December 31 of each reporting year?**

   Per guidance in AAN, patients should be reported for the reporting period (January 1, 2024 through December 31, 2024). This means that if a person turns 65 during the reporting period, they should be included.

5. **For the CHA measure, are telephonic screenings conducted by D-SNP nurses allowed to be reported?**

   Telephonic screenings conducted by D-SNP nurses are allowed to be reported for this measure.

6. **For the CHA measure, how should D-SNPs report Members based on the list of CPT, ICD-9, and ICD-10 codes provided?**

   D-SNPs should refer to the list of CPT, ICD-9, and ICD-10 codes for inclusion in the denominator of the measure. D-SNPs must report Members age 65 years or older with the presence of one of the listed CPT codes and an ICD-9 or ICD-10 code on the encounter date or during the measurement period.

Palliative Care

1. **Are there CPT codes that plans should be using to report the Palliative Care measure?**

   There are no CPT codes required for the Palliative Care measure. Plans should report Members in the palliative care measure based on Members enrolled in palliative care services per provider/organization that the plan is currently contracted with during the reporting period.

Additional Questions

1. **Should EAE D-SNPs report Members in the Medi-Cal Managed Care Accountability Sets (MCAS) measures?**

   Yes, Medi-Cal MCPs should include EAE D-SNP Members in MCAS reporting. Medi-Cal MCPs are required to submit MCAS reports to DHCS annually. These reports apply to all Members enrolled in the MCP, which includes dual eligible Members who are also enrolled in the EAE D-SNP of the MCP's parent organization.

2. **Will D-SNP reporting timelines align with the MCAS templates and EQRO timelines?**

   D-SNP reporting requirements and timelines are separate from MCAS templates and timelines. MCAS reporting are due on an annual basis and are required for Medi-Cal MCPs. More information about MCAS reporting is available on the DHCS website.