CALAIM DUAL ELIGIBLE SPECIAL NEEDS PLANS REPORTING REQUIREMENTS TECHNICAL SPECIFICATIONS

Contract Year 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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INTRODUCTION

The following document contains technical specifications for the 2026 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.

Please note, additional information is included in the 2026 D-SNP Policy Guide, as well as the 2026 D-SNP Reporting Templates. The latest versions of the D-SNP Reporting Templates are available upon request via email to info@calduals.org.

DHCS requires 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 CICM). Plans will submit stratified data via the 2026 D-SNP Reporting Templates. Please see the 2026 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
2/20/26	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) 2026 represents January 1, 2026 through December 31, 2026.

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

- Quarter one (Q1): January 1 to March 31, 2026
- Quarter two (Q2): April 1 to June 30, 2026
- Quarter three (Q3): July 1 to September 30, 2026
- Quarter four (Q4): October 1 to December 31, 2026.

California Integrated Care Management (CICM): The California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to Members. CICM layers state-specific requirements on top of federal D-SNP requirements. CY 2026 CICM requirements replace the CY 2024 and CY 2025 "ECM-like care management" requirements for D-SNPs.

DHCS acknowledges there is significant overlap across the D-SNP MOC and Medi-Cal Enhanced Care Management (ECM) requirements, which could result in duplication and confusion for Members and care teams if a Member receives care management from both programs. To avoid confusion and align with federal care management policy for D-SNPs, DHCS policy for CY 2026 continues to be that D-SNPs (rather than Medi-Cal MCPs) are responsible for care management for Members that may qualify for ECM. 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.

CICM policy applies to Members who may be eligible to receive ECM from their MCP. CICM requirements also address an additional vulnerable population: Members with Documented Dementia Needs. Criteria for each vulnerable population included in CICM can be found in Appendix B of the 2026 D-SNP Policy Guide.

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 2026 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.	Field Type: Numeric	Tab 1 – ED BH in the 2026 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 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 develop their own code value sets for identifying ED visits and 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.

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
  - 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 2026 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 data are received from D-SNPs over time, DHCS will 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.

- 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)

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

Definitions

- D-SNPs should refer to the 2026 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.

F. 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 MEMBERS 65 YEARS AND OLDER

Technical specifications for the state-specific D-SNP reporting requirement CHA are based on 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 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 Members aged 65 and older.	Total number of Members aged 65 and older as of the last day of the reporting period.	Field Type: Numeric	Tab 3 – CHA in the 2026 D-SNP Annual Reporting Template
B.	Total number of Members who had cognition assessed at least once during the reporting period.	Of the total reported in A, the number of Members who had cognition assessed at least once during the reporting period.	Field Type: Numeric Note: Is a subset of A	Tab 3 – CHA in the 2026 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 data are received from D-SNPs over time, DHCS will 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 data element B is less than or equal to data element A.

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 aged 65 and older who had cognition assessed at least once during the reporting period.
     - Percentage = (B / A) * 100

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

   <u>Data Element A</u>

   - For data element A, exclude Members who meet one of the following required exclusions:
     - Member has prior diagnosis of mild cognitive impairment; or
     - Member has prior diagnosis of dementia.
   - For data element A, D-SNPs may elect to exclude Members who meet one of the following allowable exclusions:
     - Member declines cognitive health assessment and does not complete a cognitive health assessment during the reporting period; or
     - Member is unable to participate in a cognitive health assessment during the reporting period – including non-verbal patients, delirious, comatose, severely aphasic, severely developmentally delayed, severe visual or hearing impairment – and for those Members, no knowledgeable informant available.

   <u>Data Element B</u>

   - For data element B, "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),
- AD8 Dementia Screening Interview, or
- Neuropsychological assessment results.

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

» Members with multiple cognition assessments in the reporting period should be counted only once in data element B.

General Guidance

» Additional information about this measure, including suggested strategies to improve performance, can be found in the measure specifications for the Annual Cognitive Health Assessment for Patients 65 Years and Older measure published in the American Academy of Neurology's Mild Cognitive Impairment Quality Measurement Set.

F. 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.

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[1] Tsoi KK, Chan JY, Hirai HW, et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Internal Medicine. 2015;175:1450-1458.
[2] Creavin ST, Wisniewski S, Noel-Storr AH, et al. Mini-Mental State Examination (MMSE) for the detection of dementia in clinically unevaluated people aged 65 and over in community and primary care populations. Cochrane Database Syst Rev. 2016;(1):CD011145.
[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.
[5] Morris JC. The Clinical Dementia Rating (CDR): current version and scoring rules. Neurology. 1993;43:2412–2414.
[6] Scharre DW, Chang SI, Murden RA, et al. Self-administered Gerocognitive Examination (SAGE): a brief cognitive assessment instrument for mild cognitive impairment (MCI) and early dementia. Alzheimer Dis Assoc Disord. 2010; 24(1):64-71.

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	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 2026 D-SNP Quarterly 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.	Tab 1 – ICP in the 2026 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 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 data element 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.

<u>Definitions</u>

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

<u>Data Element A</u>

- 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 2026: Members with an effective date in November and December 2025 should be included in quarter one Q1 2026 data for ICP, as they reached their 90th day of enrollment during Q1 2026.

Data Element B

- The care plan should meet state-specific criteria and include the appropriate domains as determined by the state in the 2026 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 initially could not be reached to complete a care plan, 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 – 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.

CICM – CALIFORNIA INTEGRATED CARE MANAGEMENT

D-SNPs should refer to the Care Coordination chapter and the state-specific D-SNP Model of Care (MOC) matrix in the 2026 D-SNP Policy Guide for guidelines on providing CICM to Members. When reporting this measure, D-SNPs should only include Members that meet criteria for the specific CICM populations of focus (POFs). Eligibility criteria for each CICM POF can be found in Appendix B of the 2026 D-SNP 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 measure. This narrative is meant to supplement the data reported by summarizing the plan's CICM 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 2026 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	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 unique Members who were identified as eligible for CICM 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 CICM services during the reporting period. This data element does not need to be reported with race/ethnicity stratification.	Field type: Numeric	Tab 2 – CICM Total Members in the 2026 D-SNP Quarterly Reporting Template
B.	Total number of unique Members who received CICM services during the reporting period.	Of the total reported in A, the number of unique Members who received CICM services during the reporting period. This data element must be reported with race/ethnicity stratification.	Field type: Numeric Note: Is a subset of A.	Tab 2 – CICM Total Members in the 2026 D-SNP Quarterly Reporting Template
C.	Total number of unique Members who received an in-person CICM care management interaction.	Of the total reported in B, the number of unique Members who received an in-person care management interaction for CICM 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 – CICM Total Members in the 2026 D-SNP Quarterly Reporting Template

Element Letter	Element Name	Definition	Allowable Values	Tab in Reporting Template
D.	Narrative summary of CICM services reporting.	Please describe your plan's assumptions and process around reporting Members eligible for and receiving CICM services. This must include descriptions of the following: • How your plan identifies Members who are eligible to receive CICM services, based on the criteria for each CICM population in Appendix B of the 2026 D-SNP Policy Guide. • How your plan identifies Members who received CICM services. • Any additional information on your plan's approach to CICM services and assumptions used when reporting data.	Field type: Text	Tab 3 – CICM Narrative in the 2026 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 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 data element B is less than or equal to data element A.
- D-SNPs should validate that Members included in data element B were included in data element A.
- D-SNPs should validate that data element C is less than or equal to data element B.
- 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 CICM services and received CICM services.
  - Percentage = (B / A) * 100
- Received CICM services and had an in-person CICM care management interaction during the reporting period.
  - Percentage = (C / B) * 100

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

Data Element A

- To identify the total number of unique Members who were eligible for CICM services, plans must identify Members who meet the criteria for one or more CICM populations of focus (POFs). The specific criteria for the CICM POFs are listed in Appendix B of the 2026 D-SNP Policy Guide. The CICM POFs include:
  - Adults Experiencing Homelessness
  - Adults at Risk for Avoidable Hospital or Emergency Department (ED) Utilization
  - Adult with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
  - Adults Transitioning from Incarceration
  - Adults Living in the Community and at Risk for Long Term Care (LTC) Institutionalization
  - Adult Nursing Facility Residents Transitioning to the Community

- Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities
- Adults with Documented Dementia Needs

Data Element B

- For data element B, plans must report Members who were eligible for CICM and received at least one CICM service. CICM services refer to the seven core services described in the CalAIM ECM Policy Guide:
  - Outreach and Engagement
  - Comprehensive Assessment and Care Management Plan
  - Enhanced Coordination of Care
  - Health Promotion
  - Comprehensive Transitional Care
  - Member and Family Supports
  - Coordination of and Referral to Community and Social Support Services

Data Element C

- For data element C, plans must report the number of Members who received CICM services in-person. Per the CY 2026 D-SNP Policy Guide, D-SNPs are encouraged to provide CICM primarily either in-person or through an interactive telehealth encounter. D-SNPs must use alternate methods (including telehealth) when in-person communication is unavailable or does not meet the needs of the Member. However, only in-person interactions should be counted under data element C.

General Guidance

- 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.
- Members reported in data element B must also be reported in data element A since this data element is a subset of data element A. Members reported in data element C must also be reported in data element B since this data element is a subset of data element B.

- Some Members may qualify for and receive services under more than one CICM POF. Such members should be counted only once when reporting this measure (i.e., plans must report unduplicated counts of members within each data element).
- Members who are unable to be contacted or declined services must be reported under data element A, but cannot be reported in data elements B or C.

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.

PAL – PALLIATIVE CARE

D-SNPs should refer to the 2026 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	Calendar Quarters: 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	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 newly enrolled in palliative care services.	Total number of unique Members newly enrolled in palliative care services within the reporting period.	Field type: Numeric	Tab 4 – PAL in the 2026 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 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 percentage of Members who are newly enrolled in palliative care services within the reporting period.
     - Percentage = (A / Total Enrollment) * 100

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

   Data Element A

   - Plans should develop their own reporting logic to identify members that are eligible for inclusion in 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.

LTC – LONG-TERM CARE

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: 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	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 residing in LTC for more than 90 days.	Total number of Members currently residing in LTC for more than 90 days during the reporting period	Field type: Numeric	Tab 5 – LTC in the 2026 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 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 Members residing in LTC for more than 90 days during the reporting period per 1,000 Members.
  - Rate = (A / Total Enrollment) * 1,000

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

Data Element A

- Plans should develop their own reporting logic to identify members that are eligible for inclusion in 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.

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. D-SNPs may use a combination of claims and administrative data when reporting the measure.

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, 2026 through December 31, 2026). This means that if a person turns 65 at any point 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?**

   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),
   - AD8 Dementia Screening Interview, or
   - Neuropsychological assessment results.

   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, 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.

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.