# CALAIM DUAL ELIGIBLE SPECIAL NEEDS PLANS REPORTING REQUIREMENTS TECHNICAL SPECIFICATIONS

*Contract Year 2024*

**December 2024**

DHCS

CALIFORNIA DEPARTMENT OF
**HEALTH CARE SERVICES**

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# INTRODUCTION

The following document contains technical specifications for the 2024 Reporting Requirements and Quality Measures for Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs, also called Medicare Medi-Cal Plans), as well as non-EAE D-SNPs. Additional information from DHCS is available here: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.

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

» CY 2024 Core Reporting Requirements (as of 11/01/2023)

» 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 2024 D-SNP Policy Guide, as well as the D-SNP Reporting Templates. The D-SNP Reporting Requirements chapter in the 2024 D-SNP Policy Guide includes information on the Healthcare Effectiveness Data and Information Set (HEDIS) for both EAE and non-EAE D-SNPs and Long-Term Services and Supports (LTSS) reporting requirements for EAE D-SNPs.

Beginning in 2024, DHCS is requiring D-SNPs to stratify reporting requirements by race/ethnicity according to NCQA standards. Plans will submit stratified data via the 2024 D-SNP Reporting Templates. Please see the 2024 D-SNP Policy Guide for additional information.

# SUMMARY OF UPDATES AND KEY CHANGES

| Date | Chapter/Section | Update/Change |
|---|---|---|
| 12/19/24 | ECM-like Services | Revised guidance for the ECM-like Services measure |
| 8/23/24 | Frequently Asked Questions | Added FAQs on palliative care and additional questions related to alignment with Medi-Cal measures |
| 1/23/24 | Frequently Asked Questions (FAQs) | Updated answer to question 3 under CHA to specify that the AD8 is an acceptable tool for the CHA measure. |
| 12/27/23 | 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 Quarter**: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: January 1 to March 31, April 1 to June 30, July 1 to September 30, and October 1 to December 31.

**Calendar Year**: All annual measures are reported on a calendar year basis. For example, Calendar Year (CY) 2024 represents January 1, 2024 through December 31, 2024.

**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 September 2023)

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 2024 D-SNP Policy Guide.

**In-Home Supportive Services (IHSS)**: Pursuant to Article 7 of the California Welfare and Institutions Code (WIC) (commencing with Section 12300) of Chapter 3, and WIC Sections 14132.95, 14132.952, and 14132.956, IHSS is a California program that provides in-home care for people who cannot safely remain in their own homes without assistance. To qualify for IHSS, an Enrollee must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program. IHSS includes the Community First Choice Option (CFCO), Personal Care Services Program (PCSP), and IHSS-Plus Option (IPO).

**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.

**Long Term Services and Supports (LTSS)**: A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following:

1. IHSS (carved out of Medi-Cal managed care);
2. Community-Based Adult Services (CBAS);
3. Multipurpose Senior Services Program (MSSP) services (carved out of Medi-Cal managed care); and
4. Skilled nursing facility (SNF) services and subacute care services.

**Multipurpose Senior Services Program (MSSP):** The MSSP waiver provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. The MSSP waiver allows the individuals to remain safely in their homes.

**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. Beginning in 2024, DHCS requires all D-SNPs to offer palliative care services to dually eligible members. Requirements for

D-SNPs around palliative care are in the [2024 D-SNP Policy Guide](). (From the [D-SNP Palliative Care Fact Sheet]())

**Primary Care Provider** (**PCP**): A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

# ASSESSMENT

## HRA1 – Members with an Assessment Completed within 90 Days of Enrollment. (Previously Core 2.1)

| Reporting Frequency | Reporting Level | Reporting Periods | Due Date | Plan Types Required to Report |
|---|---|---|---|---|
| Quarterly | PBP | Current Calendar Quarter Ex:<br><br>1/1-3/31<br><br>4/1-6/30<br><br>7/1-9/30<br><br>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 |

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 |
|---|---|---|---|
| A. | Total number of members whose 90$^{th}$ 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 90$^{th}$ day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period. | Field type: Numeric |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| B. | Total number of members who were documented as unwilling to participate in the assessment within 90 days of enrollment. | Of the total reported in A, the number of members who were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment. | Field Type: Numeric<br><br>Note: Is a subset of A.<br><br>Unwillingness to participate must be clearly documented. |
| C. | Total number of members the D-SNP was unable to reach, following three documented outreach attempts, to participate in the assessment within 90 days of enrollment. | Of the total reported in A, the number of members the D-SNP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment. | Field type: Numeric<br><br>Note: Is a subset of A.<br><br>Three outreach attempts must be clearly documented. |
| D. | Total number of members with an assessment completed within 90 days of enrollment. | Of the total reported in A, the number of members with an assessment completed within 90 days of enrollment. | Field type: Numeric<br><br>Note: Is a subset of A.<br><br>Completed assessments must be clearly documented. |

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.

» 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, C, and D 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 included in data element C were included in data element A.

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

» D-SNPs should validate that members reported in data element B were not reported in data elements C or D.

» D-SNPs should validate that members reported in data element C were not reported in data elements B or D.

» D-SNPs should validate that members reported in data element D were not reported in data elements B or C.

» D-SNPs should validate that members reported in data element B were clearly documented as unwilling to participate in the assessment within 90 days of enrollment.

» D-SNPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.

» D-SNPs should validate that members reported in data element D had a completed assessment 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:

- » Were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
  - o Percentage = (B / A) * 100
- » The D-SNP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
  - o Percentage = (C / A) * 100
- » Had an assessment completed within 90 days of enrollment.
  - o Percentage = (D / A) * 100
- » Were willing to participate and who could be reached who had an assessment completed within 90 days of enrollment.
  - o Percentage = (D / (A – B – C)) * 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 90$^{th}$ 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 90$^{th}$ 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 for reporting periods, D-SNPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (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 2023 should be included in quarter one 2023 data for HRA1, as they reached their 90th day of enrollment during quarter one 2024.

## Data Element B

» For data element B, D-SNPs should report the number of members who were documented as unwilling to participate in the assessment if a member (or the member's authorized representative):

- Affirmatively declines to participate in the assessment, affirmatively declines care management activities overall, or refuses any contact with the D-SNP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the D-SNP.

- Expresses willingness to complete the assessment but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 days). Discussions with the member must be documented by the D-SNP.

- Schedules an appointment to complete the assessment but cancels or is a no-show and then is subsequently non-responsive to additional outreach attempts by the D-SNP. All attempts to contact the member must be documented by the D-SNP.

- Initially agrees to complete the assessment, but then declines to answer a sufficient number of questions in the assessment, as determined by the D-SNP. The declination must be documented by the D-SNP.

- If a member was not reached after three outreach attempts, but then subsequently is reached and refuses the assessment within 90 days of enrollment, the member should be classified in data element B.

## Data Element C

»   For data element C, D-SNPs should report the number of members the D-SNP was unable to reach after three documented attempts to contact the member. D-SNPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email). If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.

»   There may be instances when the D-SNP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the D-SNP's outreach efforts. So long as the D-SNP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

Data Element D

»   The assessment for this measure should be the health risk assessment as included in the 2024 D-SNP Policy Guide.

»   If a member's assessment is in progress, but is not completed within 90 days of enrollment, then the assessment should not be considered completed, and therefore, the member should not be counted in data element D.

»   If a member initially refused the assessment or could not be reached after three outreach attempts, but then subsequently completes the assessment within 90 days of enrollment, the member should be classified in data element D.

General Guidance

»   Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).

»   D-SNPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to HRA2.

»   There may be certain circumstances that make it impossible or inappropriate to complete an assessment within the required timeframe. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, D-SNPs should not include such members in the counts for data elements B or C.

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

# HRA2 – Members with an Annual Reassessment. (Previously Core 2.3)

| Reporting Frequency | Reporting Level | Reporting Period | Due Date | Plan Types Required to Report |
|---|---|---|---|---|
| Annually | PBP | Calendar Year | By the end of the second month following the last day of the reporting period | EAE and non-EAE D-SNPs |

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 |
|---|---|---|---|
| A. | Total number of members enrolled as of the last day of the current reporting period. | Total number of members enrolled as of the last day of the current reporting period. | Field Type: Numeric |
| B. | Total number of members who had an assessment completed during the previous reporting period. | Of the total reported in A, the number of members who had an assessment completed during the previous reporting period. | Field Type: Numeric<br><br>Note: Is a subset of A. |
| C. | Total number of members with a reassessment completed during the current reporting period. | Of the total reported in B, the number of members who had a reassessment completed during the current reporting period. | Field Type: Numeric<br><br>Note: Is a subset of B. |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| D. | Total number of members with a reassessment completed within 365 days of the most recent assessment completed. | Of the total reported in C, the number of members with a reassessment completed during the current reporting period that occurred within 365 days of the most recent assessment completed during the previous reporting period. | Field Type: Numeric<br><br>Note: Is a subset of C. |
| E. | Total number of members who did not have an assessment completed during the previous reporting period. | Of the total reported in A, the number of members enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period. | Field Type: Numeric<br><br>Note: Is a subset of A. |
| F. | Total number of members with an assessment completed during the current reporting period. | Of the total reported in E, the number of members who had an assessment completed during the current reporting period. | Field Type: Numeric<br><br>Note: Is a subset of E. |

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

   » DHCS may 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 elements B and E are less than or equal to 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 data element D is less than or equal to data element C.

» D-SNPs should validate that data element F is less than or equal to data element E.

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 an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period.

o Percentage = (C / B) * 100

» Had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period that was within 365 days of the most recent assessment completed during the previous reporting period.

o Percentage = (D / B) * 100

» Were enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period but had an assessment completed during the current reporting period.

o Percentage = (F / E) * 100

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

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.

Data Element B

» For reporting data element B, include all members who were enrolled as of the last day of the current reporting period who received an assessment (initial or reassessment) during the previous reporting period.

Data Element C

» For reporting data element C, include all members reported in data element B who had a reassessment completed at any time during the current reporting period.

Data Element D

» For reporting data element D, include all members reported in data element C who had a reassessment completed during the current reporting period that was completed within 365 days of the date of the member's most recent assessment (initial or reassessment) completed during the previous reporting period.

  o For example, if a member was assessed twice during CY 2023 (previous reporting period), first on May 15, 2023 and again on October 15, 2023, count 365 days continuously from October 15, 2023 to determine if a reassessment occurred within 365 days.

  o In this example, if the member completes a reassessment on September 15, 2024, they would be included in data element D for CY 2024 reporting. Conversely, if the member's reassessment was not completed until November 15, 2024, they would not be included in data element D for CY 2024 reporting. In either case, the member would be captured in data element C.

» For members who disenroll and reenroll in the D-SNP, D-SNPs should count 365 days continuously from the member's most recent assessment date within the previous reporting period, even if that assessment was conducted during the member's prior enrollment period.

Data Element E

» For reporting data element E, include all members who were enrolled as of the last day of the current reporting period, who were enrolled for at least 90 continuous days during the previous reporting period who did not receive an assessment (initial or reassessment) during the previous reporting period.

- o For members who disenroll and reenroll in the D-SNP, D-SNPs should include members who had any continuous enrollment of 90 days or more in the previous year, even if that enrollment preceded a break in coverage by the D-SNP.

- o 90 days of enrollment will be equivalent to three full calendar months.

Data Element F

» For reporting data element F, include all members reported in data element E who had an assessment completed at any time during the current reporting period.

General Guidance

» The assessment for this measure should be the health risk assessment as applicable per the 2024 D-SNP Policy Guide.

» For reporting all data elements, D-SNPs should report unduplicated counts of members meeting the criteria for each data element. Members with more than one assessment or reassessment completed during a reporting period should be reported only once in the relevant data elements.

» In certain circumstances, a member with a break in coverage who reenrolls in the D-SNP and has an assessment completed upon reenrollment during the current reporting period may be reported under both HRA1 and HRA2.

- o For example, consider a member that was previously assessed on June 15, 2023, subsequently disenrolled on October 1, 2023, reenrolled on January 1, 2024, assessed again on February 15, 2024, and remained enrolled as of December 31, 2024. The member would be counted in Quarter 1 2024 reporting for HRA1 (data elements A and D) and in CY 2024 reporting for HRA2 (data elements A, B, C, and D).

» The term "current reporting period" in data elements A, C, D, and F refers to the current calendar year. The term "previous reporting period" in data elements B, D, and E refers to the prior calendar year.

» This measure is reported starting with the D-SNP's second year of operation (i.e., Calendar Year 2). All D-SNPs that have operated for at least two years must report the measure. CMC plans that transitioned to D-SNPs would be considered to have operated for at least two years.

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

# CARE COORDINATION

## ICP1 – Members with a Care Plan Completed within 90 Days of Enrollment. (Previously Core 3.2)

| Reporting Frequency | Reporting Level | Reporting Periods | Due Date | Plan Types Required to Report |
|---|---|---|---|---|
| Quarterly | PBP | Current Calendar Quarter Ex:<br><br>1/1-3/31<br><br>4/1-6/30<br><br>7/1-9/30<br><br>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 |

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 |
|---|---|---|---|
| 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 |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| B. | Total number of members who were documented as unwilling to complete a care plan within 90 days of enrollment. | Of the total reported in A, the number of members who were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment. | Field Type: Numeric<br><br>Note: Is a subset of A.<br><br>Unwillingness to participate must be clearly documented. |
| C. | Total number of members the D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan within 90 days of enrollment. | Of the total reported in A, the number of members the D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment. | Field type: Numeric<br><br>Note: Is a subset of A.<br><br>Three outreach attempts must be clearly documented. |
| D. | 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<br><br>Note: Is a subset of A.<br><br>Completed care plans must be clearly documented. |

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.

» D-SNPs should validate that the sum of data elements B, C, and D 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 90<sup>th</sup> 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 included in data element C were included in data element A.

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

» D-SNPs should validate that members reported in data element B were not reported in data elements C or D.

» D-SNPs should validate that members reported in data element C were not reported in data elements B or D.

» D-SNPs should validate that members reported in data element D were not reported in data elements B or C.

» D-SNPs should validate that members reported in data element B were clearly documented as unwilling to complete the care plan within 90 days of enrollment.

» D-SNPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.

» D-SNPs should validate that members reported in data element D 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:

» Were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment.

- o   Percentage = (B / A) * 100

» The D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment.

- o   Percentage = (C / A) * 100

» Had a care plan completed within 90 days of enrollment.

- o   Percentage = (D / A) * 100

» Were willing to participate and who could be reached who had a care plan completed within 90 days of enrollment.

- o   Percentage = (D / (A − B − C)) * 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.

- o   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 (e.g., members enrolled on May 1, June 1, and July 1

reached their 90<sup>th</sup> 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).

- o Note for quarter one 2024: Members with an effective date in November and December 2023 should be included in quarter one 2023 data for ICP1, as they reached their 90<sup>th</sup> day of enrollment during quarter one 2024.

Data Element B

» For data element B, D-SNPs should report the number of members who were documented as unwilling to complete a care plan if a member (or the member's authorized representative):

- o Affirmatively declines to complete the care plan, affirmatively declines care management activities overall, or refuses any contact with the D-SNP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the D-SNP.

    - • Note that declination or refusal to participate in the assessment does not also count as declination to complete the care plan. The member must affirmatively decline to complete the care plan in order to be included in ICP1 data element B.

- o Expresses willingness to complete the care plan but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the care plan within 90 days). Discussions with the member must be documented by the D-SNP.

- o Schedules an appointment to complete the care plan but cancels or is a no-show and then is subsequently non-responsive to additional outreach attempts by the D-SNP. All attempts to contact the member must be documented by the D-SNP.

- o Initially agrees to complete the care plan, but then declines to participate in the development of the care plan. The declination must be documented by the D-SNP.

» If a member could not be reached after three outreach attempts, but then subsequently is reached and refuses to complete a care plan within 90 days of enrollment, the member should be classified in data element B.

Data Element C

»   For data element C, D-SNPs should report the number of members the D-SNP was unable to reach after three documented attempts to contact the member. The three documented outreach attempts to contact the member must be for the purpose of completing the care plan.

   o   If a D-SNP was <u>able</u> to reach a member for the purpose of completing only an assessment, at least three new and distinct outreach attempts for the purpose of completing the care plan must be made and documented.

   o   However, if a D-SNP was <u>unable</u> to reach a member for the purpose of completing both an assessment and a care plan, and has documented three unsuccessful outreach attempts, the D-SNP is not expected to make additional outreach attempts about the completion of a care plan. The D-SNP would report this member in data element C.

»   D-SNPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email), as DHCS may validate this number. If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.

»   There may be instances when the D-SNP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the D-SNP's outreach efforts. So long as the D-SNP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

<u>Data Element D</u>

»   The care plan should meet state-specific criteria and include the appropriate domains as determined by the state in the 2024 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 D.

»   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 D.

<u>General Guidance</u>

» Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).

» D-SNPs should only report members with an initial care plan for this measure.

» There may be certain circumstances that make it impossible or inappropriate to complete a care plan within the required timeframe. For example, a member may be medically unable to participate and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a care plan. However, D-SNPs should <u>not</u> include such members in the counts for data elements B or C.

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

# ICP2 – Members with a Current Care Plan (Created or Updated in the Last Year). (Previously CA 1.5)

Note: ICP2 (previously CA 1.5) was not required in 2023. However, the technical specifications for this measure have been updated as part of 2024 D-SNP Reporting Requirements.

| Reporting Frequency | Reporting Level | Reporting Periods | Due Date | Plan Types Required to Report |
|---|---|---|---|---|
| Annually | PBP | Calendar Year | By the end of the second month following the last day of the reporting period | EAE and non-EAE D-SNPs |

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 |
|---|---|---|---|
| A. | Total number of members enrolled as of the last day of the current reporting period. | Total number of members enrolled as of the last day of the current reporting period. | Field Type: Numeric |
| B. | Total number of members who had a care plan updated/completed during the previous reporting period. | Of the total reported in A, the number of members who had a care plan updated/completed during the previous reporting period. | Field Type: Numeric<br><br>Note: Is a subset of A. |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| C. | Total number of members with a care plan updated/completed during the current reporting period. | Of the total reported in B, the number of members who had a care plan updated/completed during the current reporting period. | Field Type: Numeric<br><br>Note: Is a subset of B. |
| D. | Total number of members with a care plan updated/completed within 365 days of the most recent care plan. | Of the total reported in C, the number of members with a care plan updated/completed during the current reporting period that occurred within 365 days of the most recent care plan. | Field Type: Numeric<br><br>Note: Is a subset of C. |
| E. | Total number of members who did not have a care plan updated/completed during the previous reporting period. | Of the total reported in A, the number of members enrolled for at least 90 continuous days during the previous reporting period who did not have a care plan updated/completed during the previous reporting period. | Field Type: Numeric<br><br>Note: Is a subset of A. |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| F. | Total number of members with a care plan updated/completed during the current reporting period. | Of the total reported in E, the number of members who had a care plan updated/completed during the current reporting period. | Field Type: Numeric<br><br>Note: Is a subset of E. |

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.

   » D-SNPs should validate that data elements B and E are less than or equal to 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 data element D is less than or equal to data element C.

   » D-SNPs should validate that data element F is less than or equal to data element E.

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 during the previous reporting period who had a care plan updated during the current reporting period.

      o Percentage = (C / B) * 100

   » Had a care plan during the previous reporting period who had a care plan updated during the current reporting period that was within 365 days of the most recent care plan completed during the previous reporting period.

      o Percentage = (D / B) * 100

» Were enrolled for at least 90 continuous days during the previous reporting period who did not have a care plan during the previous reporting period but had a care plan completed during the current reporting period.

   o Percentage = (F / E) * 100

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

Data Element A

» D-SNPs should only include 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.

Data Element B

» For reporting data element B, include all members who were enrolled as of the last day of the current reporting period who had a care plan during the previous reporting period.

» The care plan should meet state-specific criteria and include the appropriate domains as determined by the state in the D-SNP Policy Guide.

» If a member's care plan update is in progress, but is not completed by the last day of the previous reporting period, then the care plan update 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.

Data Element C

» For reporting data element C, include all members reported in data element B who had a care plan completed/updated at any time during the current reporting period.

Data Element D

» For reporting data element D, include all members reported in data element C who had a care plan updated/completed during the current reporting period that was updated/completed within 365 days of the date of the member's most recent

care plan (initial or updated care plan) completed during the previous reporting period.

- o For example, if a member had two updates to their care plan during CY 2023 (previous reporting period), first on May 15, 2023 and again on October 15, 2023, count 365 days continuously from October 15, 2023 to determine if the care plan was updated within 365 days.

- o In this example, if the member had an update to their care plan on September 15, 2024, they would be included in data element D for CY 2024 reporting. Conversely, if the member's care plan update was not completed until November 15, 2024, they would not be included in data element D for CY 2024 reporting. In either case, the member would be captured in data element C.

» For members who disenroll and reenroll in the D-SNP, D-SNPs should count 365 days continuously from the member's most recent care plan completion/update date within the previous reporting period, even if that care plan was completed/updated during the member's prior enrollment period.

Data Element E

» For reporting data element E, include all members who were enrolled as of the last day of the current reporting period, who were enrolled for at least 90 continuous days during the previous reporting period who did not have a completed care plan during the previous reporting period.

- o For members who disenroll and reenroll in the D-SNP, D-SNPs should include members who had any continuous enrollment of 90 days or more in the previous year, even if that enrollment preceded a break in coverage by the D-SNP.

- o 90 days of enrollment will be equivalent to three full calendar months.

Data Element F

» For reporting data element F, include all members reported in data element E who had a care plan updated/completed at any time during the current reporting period.

General Guidance

» For reporting all data elements, D-SNPs should report unduplicated counts of members meeting the criteria for each data element. Members with more than

one care plan completed/updated during a reporting period should be reported only once in the relevant data elements.

» In certain circumstances, a member with a break in coverage who reenrolls in the D-SNP and has a care plan completed upon reenrollment during the current reporting period may be reported under both ICP1 and ICP2.

o For example, consider a member with a care plan completed on June 15, 2023, subsequently disenrolled on October 1, 2023, reenrolled on January 1, 2024, and completes a care plan on February 15, 2024, and remained enrolled as of December 31, 2024. The member would be counted in Quarter 1 2024 reporting for ICP1 (data elements A and D) and in CY 2024 reporting for ICP2 (data elements A, B, C, and D).

» The term "current reporting period" in data elements A, C, D, and F refers to the current calendar year. The term "previous reporting period" in data elements B, D, and E refers to the prior calendar year.

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

# GOC Members with Documented Discussions of Care Goals. (Previously CA 1.6)

| Reporting Frequency | Reporting Level | Reporting Period | Due Date | Plan Types Required to Report |
|---|---|---|---|---|
| Annually | PBP | Calendar Year | By the end of the second month following the last day of the reporting period | EAE and non-EAE D-SNPs |

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 |
|---|---|---|---|
| A. | Total number of members with an initial Individualized Care Plan (ICP) completed. | Total number of members with an initial ICP completed during the reporting period. | Field Type: Numeric |
| B. | Total number of members sampled that met inclusion criteria. | Of the total reported in A, the number of members sampled that met inclusion criteria. | Field type: Numeric<br><br>Note: Is a subset of A. |
| C. | Total number of members with at least one documented discussion of care goals in the initial ICP. | Of the total reported in B, the number of members with at least one documented discussion of care goals in the initial ICP. | Field Type: Numeric<br><br>Note: Is a subset of B. |
| D. | Total number of existing ICPs revised. | Total number of existing ICPs revised during the reporting period. | Field Type: Numeric |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| E. | Total number of revised ICPs sampled that met inclusion criteria. | Of the total reported in D, the number of revised ICPs sampled that met inclusion criteria. | Field Type: Numeric<br><br>Note: Is a subset of D. |
| F. | Total number of revised ICPs with at least one documented discussion of new or existing care goals. | Of the total reported in E, the number of revised ICPs with at least one documented discussion of new or existing care goals. | Field Type: Numeric<br><br>Note: Is a subset of E. |

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

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 data element C is less than or equal to data element B.

   » D-SNPs should validate that data element E is less than or equal to data element D.

   » D-SNPs should validate that data element F is less than or equal to data element E.

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 with an initial ICP completed during the reporting period who had evidence of creation of at least one care goal documented in the initial ICP.

      o Percentage = (C / B) * 100

   » Existing ICPs revised during the reporting period that had at least one documented discussion of new or existing care goals.

      o Percentage = (F / E) * 100

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

Data Element A

»   D-SNPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

»   Data element A should include all members with ICPs that were completed for the first time during the reporting period (i.e., the member did not previously have an ICP completed prior to the start of the reporting period). There can be no more than one initial ICP completed per member.

»   Only ICPs that included participation from the member (or the member's authorized representative) in the completion of the ICP should be reported.

Data Elements B and E

»   For reporting, the D-SNPs may elect to sample since this measure may require documentation review to identify data elements C and F.

»   If a D-SNP does not elect to sample, data element B should be equal to data element A and data element E should be equal to data element D.

»   For D-SNPs that elect to sample, the sample size should be 411, plus additional records should be oversampled to allow for substitution. Sampling should be systematic to ensure that all individuals eligible for a measure have an equal chance of inclusion. D-SNPs that elect to sample should complete the following steps:

  o  **Step 1:** Determine the eligible population. Create a list of eligible members, including full name, date of birth, and event (if applicable).

  o  **Step 2**: Determine the final sample size. The final sample size will be 411 unless the eligible population is less than 411. If the eligible population is less than 411, follow Step 5 to determine the final sample size.

  o  **Step 3**: Determine the oversample which should include an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20

percent. If oversampling, round up to the next whole number when determining the oversample.

- **Step 4**: If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 6. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 5.

- **Step 5**: If the eligible population is less than or equal to the final sample size as determined in Step 2, the sample size can be reduced from 411 cases to a reduced final sample size by using the following formula:

$$Reduced\ Final\ Sample\ Size = \frac{Original\ Final\ Sample\ Size}{1 + \left(\frac{Original\ Final\ Sample\ Size}{Eligible\ Population}\right)}$$

  - Where the Original Final Sample Size is the number derived from Step 2, and the Eligible Population is the number derived from Step 1.

- **Step 6**: Sort the list of eligible members in alphabetical order by last name, first name, date of birth, and event (if applicable). Sort this list by last name from A to Z during even reporting periods and from Z to A in odd reporting periods (i.e., name will be sorted from A to Z in 2024 and from Z to A in 2023).

  - Note: Sort order applies to all components. For example, for reporting period 2024, the last name, first name, date of birth, and events will be ascending.

- **Step 7**: Calculate N, which will determine which member will start your sample. Round down to the nearest whole number.

$$N = \frac{Eligible\ Population}{Final\ Sample\ Size}$$

  - Where the Eligible Population is the number derived from Step 1. The Final Sample Size is either:

  - The number derived from Step 2, for instances in which the eligible population exceeds the final sample size as determined in Step 2. OR

  - The number derived in Step 5, for instances in which the eligible population was less than or equal to the number derived from Step 2.

- o **Step 8**: Randomly select starting point, K, by choosing a number between one and N using a table of random numbers or a computer-generated random number.
- o **Step 9**: Select every Kth record thereafter until the selection of the sample size is completed.

Data Element C

» The D-SNP should only count members in data element C when the discussion of care goals with the member (or the member's authorized representative) is clearly documented in the member's initial ICP.

Data Element D

» D-SNPs should include all ICPs for members who meet the criteria outlined in data element D, regardless of whether the members are disenrolled as of the end of the reporting period (i.e., include all ICPs regardless of whether the members are currently enrolled or disenrolled as of the last day of the reporting period).

» Data element D should include all existing ICPs that were revised during the reporting period. D-SNPs should refer to the 2024 D-SNP Policy Guide for specific requirements pertaining to updating the ICP.

» Only ICPs that included participation from the member (or the member's authorized representative) in the revision to the ICP should be reported.

» If a member's ICP is revised multiple times during the same reporting period, each revision should be reported in data element D.

- o For example, if a member's ICP is revised twice during the same reporting period, two ICPs should be counted in data element D.

Data Element F

» D-SNPs should only include ICPs in data element F when a new or previously documented care goal is discussed with the member (or the member's authorized representative) and is clearly documented in the member's revised ICP.

» If the initial ICP clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the ICP, then that ICP should not be reported in data element F.

General Guidance

» If a member has an initial ICP completed during the reporting period, and has their ICP revised during the same reporting period, then the member's initial ICP should be reported in data element A and the member's revised ICP should be reported in data element D.

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

# ORGANIZATIONAL STRUCTURE AND STAFFING

## CCMR – Care Coordinator to Member Ratio. (Previously Core 5.1)

| Reporting Frequency | Reporting Level | Reporting Period | Due Date | Plan Types Required to Report |
|---|---|---|---|---|
| Annually | PBP | Calendar Year | By the end of the second month following the last day of the reporting period | EAE and non-EAE D-SNPs |

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 |
|---|---|---|---|
| A. | Total number of full time equivalent (FTE) care coordinators working on the D-SNP. | Total number of FTE care coordinators working on the D-SNP as of the last day of the reporting period. | Field Type: Numeric |
| B. | Total number of FTE care coordinators assigned to care management and conducting assessments. | Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period. | Field Type: Numeric<br><br>Note: Is a subset of A. |
| C. | Total number of FTE care coordinators that left the D-SNP. | Total number of FTE care coordinators that left the D-SNP during the reporting period. | Field type: Numeric |

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.

   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.

      o Rate = (Total Members Enrolled / A)

   » Evaluate the percentage of FTE care coordinators who were assigned to care management and conducting assessments.

      o Percentage = (B / A) * 100

   » Evaluate the percentage of FTE care coordinators that left the D-SNP during the reporting period.

      o Percentage = (C / (C + A)) * 100

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

   Definitions

   » D-SNPs should refer to their 2024 D-SNP Policy Guide for the definition of care coordinator.

   » FTE is defined as full time equivalent.

   Data Element C

» Data element C includes care coordinators who are assigned to a different role within the D-SNP.

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.

  o 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 Requirements template.

# ANNUAL COGNITIVE HEALTH ASSESSMENT FOR PATIENTS 65 YEARS AND OLDER (CHA)

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](#).

## Measure Title

» Annual Cognitive Health Assessment for Patients 65 years and Older

## Measurement Period

» Calendar Year (e.g., January 1, 2024 to December 31, 2024)

## 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.):

- o Montreal Cognitive Assessment (MoCA)(1),
- o Mini-Mental State Examination (MMSE)(1-2),
- o Memory Impairment Screen (MIS)(1),
- o Saint Louis University Mental Status examination (SLUMS)(3),
- o Mini-Cog©(4),
- o Clinical Dementia Rating (CDR)(5),
- o Self-Administered Gerocognitive Examination (SAGE)(6),
- o Cognitive Health Assessment (CHA), or
- o Neuropsychological assessment results.
- o 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:
- o "Order for referral for neuropsychological assessment",
- o "Neuropsychological results discussed/counseled/reviewed with patient",
- o "MoCA [OR SLUMS, MMSE, MIS, CDR, Mini-Cog, SAGE, CHA, or neuropsychological] results reviewed", OR
- o "MoCA [OR SLUMS, MMSE, MIS, CDR, SAGE, Mini-Cog] results" followed by numerical score
- o 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:
>> o "Patient unable to communicate, no informant present"
>> o "Patient unable to understand task"
>> o "Patient declines cognitive assessment tool"
>> o "Informant declines cognitive assessment"
>> o "Patient refuses cognitive assessment tool"
>> o "Informant refuses cognitive assessment"
>> o "Care partner [OR spouse, informant, caregiver] declines cognitive assessment"
>> o "Patient screened and results noted."
>> o "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

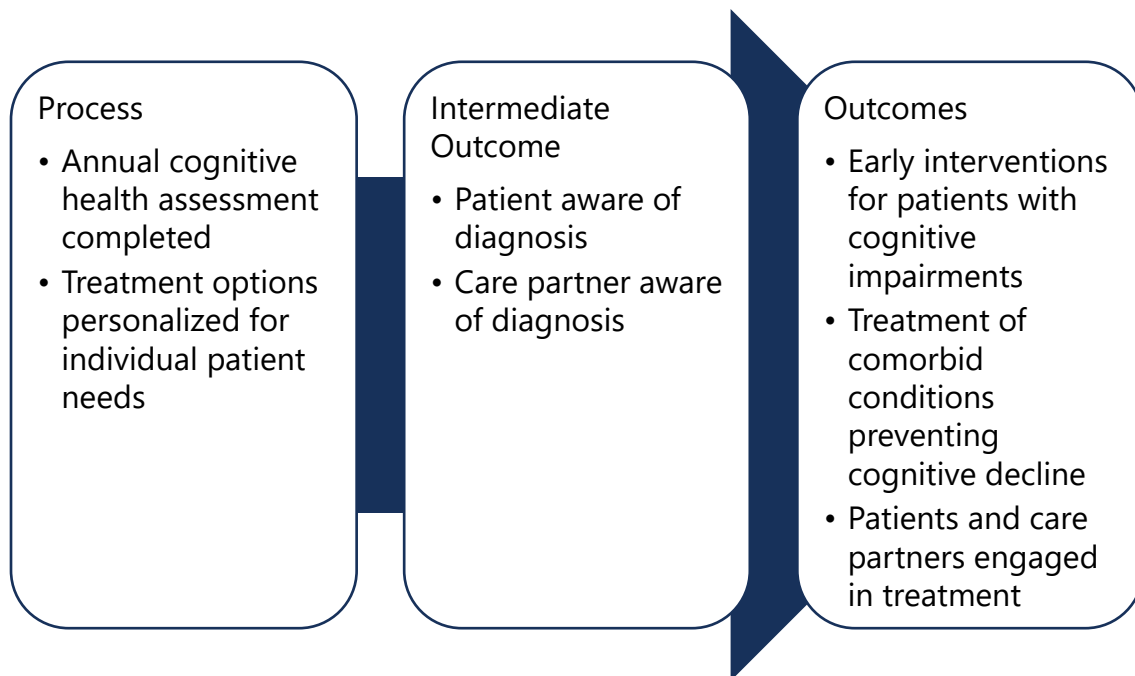## Level of Measurement

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]

| Process | Intermediate Outcome | Outcomes |
|---|---|---|
| • Annual cognitive health assessment completed<br>• Treatment options personalized for individual patient needs | • Patient aware of diagnosis<br>• Care partner aware of diagnosis | • Early interventions for patients with cognitive impairments<br>• Treatment of comorbid conditions preventing cognitive decline<br>• Patients and care partners engaged in treatment |

## 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: https://www.aan.com/siteassets/home-page/policy-and-guidelines/quality/quality- measures/17mscognitive_impairement_pg.pdf
- » Cognitive impairment following a stroke: https://www.aan.com/siteassets/home-page/policy-and- guidelines/quality/quality-measures/17srcognitiveimpairement_pg.pdf
- » PD Cognitive Impairment or Dysfunction: https://www.aan.com/siteassets/home-page/policy-and- guidelines/quality/quality-measures/17pdcognitiveimpairement_pg.pdf

## References

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| 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 |

# UTILIZATION

## ED BH – Emergency Department (ED) Behavioral Health Services Utilization. (Previously Core 9.1)

| Reporting Frequency | Reporting Level | Reporting Period | Due Date | Plan Types Required to Report |
|---|---|---|---|---|
| Annually | PBP | Calendar Year | By the end of the second month following the last day of the reporting period. | EAE and non-EAE D-SNPs |

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 |
|---|---|---|---|
| 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 2024 Core Value Sets Workbook for Core Measure 9.1. | Field Type: Numeric |

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.

    o 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 "2024 Core Value Sets Workbook for Core Measure 9.1" for a list of diagnosis codes, linked on the DHCS Quality and Data Reporting webpage: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

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:

- o Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
- o 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.

# ECM-LIKE SERVICES (ECM)

D-SNPs should refer to the Care Coordination chapter and the state-specific D-SNP Model of Care (MOC) matrix in the [CY2024 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: The ECM-like Services measure has been updated as of 12/19/2024. DHCS added new data elements A, C, D, and E while removing data elements on population of focus (POF) data. For data element E, 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 2024 D-SNP reporting template. DHCS does not require data elements A, C, or D to be reported with stratification by race and ethnicity.

These updates are effective for quarter three 2024 reporting for the ECM-like Services measure, due to DHCS on **January 24, 2025**. DHCS will not require D-SNPs to submit data for the ECM-like Services measure for quarter two and quarter four 2024.

| Reporting Frequency | Reporting Level | Reporting Period | Due Date | Plan Types Required to Report |
|---|---|---|---|---|
| Quarterly | PBP | Current Calendar Quarter: Q1: 1/1-3/31 Q2: 4/1-6/30 (Plans not required to report) Q3: 7/1-9/30 Q4: 10/1-12/31 (Plans not required to report) | By the end of the second month following the last day of the reporting period; Q3 data is due **January 24, 2025** | EAE and non-EAE D-SNPs |

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 | Field type: Numeric | Tab 7 – ECM Total Members |

| Element Letter | Element Name | Definition | Allowable Values | Tab in Reporting Template |
|---|---|---|---|---|
| | | 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. | | |
| 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 during the reporting period. This data element must be | Field type: Numeric Note: Is a subset of A. | Tab 7 – ECM Total Members |

| Element Letter | Element Name | Definition | Allowable Values | Tab in Reporting Template |
|---|---|---|---|---|
| | | 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.<br><br>This data element does not need to be reported with race/ethnicity stratification. | Field type: Numeric<br><br>Note: Is a subset of B. | Tab 7 – ECM Total Members |
| D | Total unique members with initial outreach attempt during the reporting period | Of the members reported in A, number of unique members identified as eligible for ECM-like services during the reporting period.<br><br>This data element does not need to be | Note: Is a subset of A. | Tab 7 – ECM Total Members |

| Element Letter | Element Name | Definition | Allowable Values | Tab in Reporting Template |
|---|---|---|---|---|
| | | reported with race/ethnicity stratification. | | |
| E. | 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:<br><br>• How your plan identifies members who are eligible to receive ECM-like services.<br><br>• How your plan identifies members who received ECM-like services.<br><br>• Any | Field type: Text | Tab 8 – ECM Narrative |

| Element Letter | Element Name | Definition | Allowable Values | Tab in Reporting Template |
|---|---|---|---|---|
| | | 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.

  » 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-SNPs should validate that members included in data element D were included in 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 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
- » Were identified as eligible for ECM-like services and received an initial outreach attempt across all ECM POFs .
  - o Percentage = (D / A) * 100

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

[New] 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 CY2024 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 D should only include a count of unique members across all four or more ECM POFs that the plan included in their CY2024 MOC.

[New] 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 CY2024 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.

[New] Element D: Total unique members with initial outreach attempt during the reporting period

Of the members reported in element D, plans must report number of members who received an initial outreach attempt from the plan for ECM-like services. This number should only include members who have received their initial outreach attempt for ECM-like services during the reporting period and should not have received outreach before. ECM-like services include any of the seven core services.

An "outreach attempt" is defined as an in-person or telephonic/electronic attempt to connect with an individual member for the purpose of enrolling the member in the ECM-like services. Outreach attempts from all entities (providers, office staff, D-SNP staff) are applicable in this reporting.

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, C, and D 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. Members reported in element D must also be reported in element A.

c. Members who are unable to be contacted or declined services may be reported under data elements A and D, 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.

# PALLIATIVE CARE (PAL)

D-SNPs should refer to the 2024 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 | PBP | 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 | EAE and non- EAE D-SNPs |

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 |
|---|---|---|---|
| A. | Palliative Care Provider National Provider Identifier (NPI) | For each palliative care provider/provider organization that the plan is currently contracted with during the reporting period, report the 10-digit organization NPI. If the contracted provider is an individual provider, plans may report | Field type: Numeric |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| | | the provider's individual NPI. | |
| B. | Number of New Enrollees | For each provider/provider organization reported in element A, report the total number of unique members newly enrolled in palliative care services within the reporting period. | Field type: Numeric |

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.

» 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**)

## Care Coordination

1. **For HRA1 and HRA2, can D-SNPs report HRAs completed prior to a member's effective date?**

   D-SNPs must align with [Medicare Part C Reporting Requirements](#). D-SNPs may include HRAs completed 90 days prior to the member's effective date.

## Organizational Structure and Staffing

1. **Is CCMR, Care Coordinator to Member Ratio, reported on a quarterly or annual basis?**

   CCMR is reported on an annual basis. The measure has been added to the Annual Reporting template.

## 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, 2024 through December 31, 2024). 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.