CalAIM
Dual Eligible Special Needs Plans
Policy Guide

Contract Year 2023

November 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Table Of Contents

Introduction

This California Advancing and Innovating Medi-Cal initiative (CalAIM) Dual Eligible Special Needs Plan (D-SNP) Policy Guide is intended to serve as a resource for D-SNPs in California, including both exclusively aligned enrollment (EAE) D-SNPs and non-EAE D-SNPs.

D-SNPs are Medicare Advantage (MA) plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi-Cal, and offer care coordination and wrap-around services. Medicare Medi-Cal Plan, or MMP, is the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs). All D-SNPs in California must have executed contracts with the Department of Health Care Services (DHCS), the state Medicaid agency. These contracts, referred to as the State Medicaid Agency Contract (SMAC) or Medicare Improvements for Patients and Providers Act (MIPPA) contract, must meet a number of requirements, including Medicare-Medicaid integration requirements. DHCS developed two SMAC templates for 2023: the first for EAE-SNPs and the second for non-EAE D-SNPs. DHCS maintains the authority to contract or not to contract with D-SNPs.

As part of the CalAIM initiative, DHCS is leveraging the lessons and success of the Cal MediConnect (CMC) Financial Alignment Initiative to launch EAE D-SNPs, effective January 1, 2023, in the seven counties where the Coordinated Care Initiative (CCI) was implemented: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. EAE D-SNPs are D-SNPs where enrollment is limited to D-SNP members who are also enrolled in the affiliated Medi-Cal managed care plan.

This CalAIM D-SNP Policy Guide is intended to serve as a resource for all D-SNPs, beginning in Contract Year (CY) 2023, by providing additional details to supplement the 2023 SMAC. The Policy Guide provisions that apply to all D-SNPs, and those that apply only to EAE D-SNPs, are indicated at the beginning of each section. The provisions of this Policy Guide will be part of the DHCS SMAC requirements for 2023. Updates will be published as guidance is added.

Summary of Updates and Key Changes

Date	Chapter/Section	Update/Change	Notes
11/17/2023	VI. Quality and Reporting Requirements	• Added clarifications on Core 2.1 and Core 3.2 • Removed reporting requirement for CA 1.5	
6/29/2023	I. Care Coordination Requirements	• Added language regarding Care Coordination Contact List for D-SNPs and MCPs • Added language regarding federal authority for information sharing between health plans, including county mental health plans, MCPs, and D-SNPs	
6/28/2023	VI. Quality and Reporting Requirements	• Added Core 9.1 for EAE and non-EAE D-SNPs	
3/6/2023	III. Network Guidance for EAE D-SNPs	• Updated report submission instructions	
1/30/2023	III. Network Guidance for EAE D-SNPs	• Updated report timing	
1/3/2023	VIII. Integrated Appeals and Grievances Requirements for EAE D-SNPs	• Clarified integrated appeals and grievances noticing and definitions	
12/30/22	VI. Quality and Reporting Requirements	• Updated reporting requirements for clarity • Added Core 2.1 and Core 2.3 for EAE and non-EAE D-SNPs	
12/7/22	III. Network Guidance for EAE D-SNPs	• Initial Release	

12/7/22	VIII. Integrated Appeals and Grievances Requirements for EAE D-SNPs	• Initial Release	
11/14/22	All	• Formatting adjustments	
10/5/22	II. Information Sharing	• Initial Release	
8/19/22	IV. Enrollment and Disenrollment	• Initial Release	
8/1/22	VI. Quality and Reporting Requirements	• Initial Release	
8/19/22	VII. Integrated Materials	• Initial Release	
6/30/22	I. Care Coordination	• Specified language regarding training content for dementia care specialists	
6/30/22	Appendix A	• Revised formatting of LTSS questions for HRA	
6/9/22	I. Care Coordination	• Updated language regarding training content for dementia care specialists • Added language regarding ECM benefit for Duals	
6/9/22	V. Continuity of Care	• Initial Release	
12/30/21	I. Care Coordination	• Initial Release	

I. Care Coordination Requirements

The purpose of this section is to provide state-specific care coordination requirements to health plans intending to operate EAE D-SNPs in California, beginning January 1, 2023. These requirements are specific to EAE D-SNPs, however non-EAE D-SNPs are welcome to adopt this approach.

The state requirements described in this section are in addition to all existing Medicare D-SNP Model of Care requirements outlined in 42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual. They are similar to requirements included in the CMC three-way contract, and will be included in California's SMAC for EAE D-SNPs in 2023. DHCS intends to build on these requirements to continue to enhance integrated care for dually eligible beneficiaries in future years.

New EAE D-SNPs must reflect these state requirements in their Model of Care narratives for 2023, using the provided CalAIM EAE D-SNP components template (Appendix C). Existing D-SNPs, that will become EAE D-SNPs in 2023, which are not required to resubmit their Models of Care in February 2022 for CY 2023, should consider whether an off-cycle Model of Care update would be needed to accurately reflect their care coordination process as a result of implementing the state requirements. All EAE D-SNPs should submit their Models of Care to DHCS by 8pm Pacific Time on February 16, 2022, on a file and use basis. Should DHCS identify any concerns with a plan's Model of Care, the department will contact the plan for further information.

Risk Stratification

D-SNP risk stratification of enrollees must account for identified member needs covered by Medi-Cal. At a minimum, this process must include a review of:

- Any available utilization data, including Medicaid utilization data available through the aligned Medi-Cal managed care plan (including long-term care utilization) and utilization data from the member's CMC plan (for members transitioning from the CMC to the D-SNP in 2023);
- Any other relevant and available data from delivery systems outside of the managed care plans such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and home-and community-based waiver programs, behavioral health (both mental health and substance use disorder data, if available), and pharmacy data;
- The results of previously administered CMC or Medi-Cal Health Risk Assessments (HRAs), if available; and
- Any data and risk stratification available through the DHCS Population Health Management Platform (when it becomes available).

Additional technical guidance on how to access Medi-Cal data not otherwise available from the aligned Medi-Cal managed care plan will be forthcoming.

Health Risk Assessment (HRA)

To the extent possible, while still meeting both Medicare and Medi-Cal requirements, the D-SNP should work with the aligned Medi-Cal managed care plan to create efficiencies in their respective HRA tools and processes to minimize the burden on members. Plans must make best efforts to create a single, unified HRA to meet the requirements for both the D-SNP and Medi-Cal managed care plans. Plans have flexibility in the design of their HRA tools as long as the content specified below is included. Plans should rely on Medicare timeframes for the completion of initial and annual HRAs. To the extent that Medi-Cal and Medicare guidance for HRAs conflict, plans should follow Medicare guidance.

D-SNPs must ensure their HRA identifies the following elements:

(1) Medi-Cal services the member currently accesses.
(2) Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in Appendix A or similar questions. If a plan intends to use a variation of the LTSS questions provided, the question must be reviewed and approved by DHCS. Plans may incorporate the questions into their HRA in any order.
(3) Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease.

If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the D-SNPs assessment process. HRAs must directly inform the development of member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.

Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs)

Both the ICP and ICT meeting should include, to the extent possible, services and providers from the Medi-Cal managed care and carved-out delivery systems, as appropriate for the member and consistent with their preferences. Plans must encourage participation of both members and primary care providers in development of the ICP and ICT activities.

The ICP should be person-centered and informed by the member's HRA and past utilization of both Medicare and Medi-Cal services. One ICP should be used to meet both Medicare and Medi-Cal ICP requirements. To the extent that Medi-Cal and Medicare guidance for ICPs conflict, plans should follow Medicare guidance.

The ICP must identify any carved-out services the member needs and how the D-SNP will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to:

- Community Based Organizations such as those serving members with disabilities (e.g. independent living centers) and those serving members with dementia (e.g. Alzheimer's organizations)
- County mental health and substance use disorder services
- Housing and homelessness providers
- Community Supports (formerly ILOS) providers in the aligned MCP network
- 1915(c) waiver programs, including MSSP
- LTSS programs, including IHSS and Community-Based Adult Services (CBAS)
- Medi-Cal transportation to access Medicare and Medi-Cal services

D-SNP care coordinators/managers participating in the ICT must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS programs, including home- and community-based services and long-term institutional care. The ICT should include providers of any Medi-Cal services the member is receiving, including LTSS and Community Supports.

Irrespective of having a formal Alzheimer's or dementia diagnosis, if the member has documented dementia care needs, including but not limited to: wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, and/or inability to manage ADLs/IADLS, the ICT must include the member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the member's preferences. Dementia care specialists must be trained in: understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees and caregivers. D-SNPs should leverage available training content from community-based organizations with expertise in serving people with dementia when developing training content for dementia care specialists.

These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.

Care Transitions

D-SNPs must identify individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules. Health plan social services staff serving as liaisons for the LTSS

provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. D-SNPs must identify these individuals and their contact information in materials for providers and beneficiaries.

Care Coordination Contact List for D-SNPs and MCPs

D-SNPs are required by state and federal contract language to coordinate all Medicare and Medi-Cal services for their dual members. All D-SNPs and Managed Care Plans (MCPs) in California are required to enter a care coordination point of contact for other health plans to use when a member dually eligible for Medicare and Medi-Cal is enrolled in a Medicare D-SNP with a different plan organization than the member's MCP. For members that need care coordination across Medi-Cal managed care benefits, D-SNPs must use the MCP enrollment information retrieved from the Automated Eligibility Verification System (AEVS), and the *D-SNP MCP Coordination Contact List* on Microsoft Teams to identify the point of contact in the MCP for coordination of Medi-Cal managed care benefits. For D-SNPs that need access to the Microsoft Teams channel for care coordination please contact: OMII@dhcs.ca.gov. As a reminder, D-SNPs and MCPs should **not** use the information in the *D-SNP MCP Coordination Contact List* managed by DHCS to share ADT files.

Federal Authority for Information Sharing Between Health Plans, Including County Mental Health Plans (MHPs), MCPs and D-SNPs, Without a Business Associate Agreement

Under the Health Insurance Portability and Accountability Act (HIPAA), the exchange of protected health information (PHI) data between County MHPs, MCPs, and D-SNPs for the purpose of care coordination and case management is permitted, without requiring a Business Associate Agreement. This exchange is allowable under the health care operations of both parties, as long as they have a relationship with the Medi-Cal member whose information is being shared (45 CFR §§ 164.502(a)(1)(ii) and 164.506(c)(4)). Additionally, the transfer of member PHI as part of a referral for services or treatment to a Medi-Cal member is allowed under HIPAA for the member's treatment purposes (45 CFR §§ 164.502(a)(1)(ii), and 164.506(c)(1), (2)).

Medi-Cal Enhanced Care Management (ECM) and Dual Eligible Beneficiaries

From January 2022 to July 2024, DHCS will implement the Medi-Cal ECM requirement for MCPs throughout the state. DHCS' requirements for MCPs to implement ECM are contained in the CalAIM ECM Policy Guide, ECM and ILOS Contract Template (ECM and ILOS Contract A), which will become part of the MCPs' contract with DHCS, and the DHCS' ECM and ILOS Standard Provider Terms and Conditions. The Medi-Cal ECM benefit represents an opportunity for MCPs to work with providers, counties and community-based organizations (CBOs) to deliver a strong set of integrated supports for those who need them most, including dual eligible beneficiaries.

Some EAE D-SNP members needing care management services through EAE 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. Since member care management, as well as coordination across Medicare and Medi-Cal benefits, is a primary function of D-SNPs, DHCS intends for EAE D-SNPs to provide sufficient care management to members so that those members that would otherwise qualify for Medi-Cal ECM are not adversely impacted by receiving care management exclusively through their D-SNP. For 2023, DHCS guidance for EAE D-SNPs is to provide integrated care management across Medicare and Medi-Cal benefits with the intent that beneficiaries will receive any ECM-like services they may need through the D-SNP. For members already receiving Medi-Cal ECM from their MCP, D-SNPs shall provide ongoing continuity of care with existing ECM providers when possible, until the member graduates from ECM.

<table>
<tr><th></th><th>2022</th><th>2023</th><th>2024</th></tr>
<tr><td>Most Dual Eligible MCP Enrollees
In MA or Medicare FFS</td><td colspan="3">• ECM provided by their MCP
• Member must meet Population of Focus (POF) requirements</td></tr>
<tr><td>Non-EAE D-SNP Enrollees</td><td>• Same as above</td><td>• Same as above</td><td rowspan="2">• ECM-like care management provided through D-SNP
• Requirements to be outlined in D-SNP Policy Guide</td></tr>
<tr><td>EAE D-SNP Enrollees</td><td>• ECM-like care management provided by Cal MediConnect Plan</td><td>• ECM-like care management provided by EAE D-SNP</td></tr>
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II. Information Sharing Policy

Background

This section provides state-specific information sharing requirements to health plans operating D-SNPs in California, beginning January 1, 2023. These requirements are applicable to both exclusively aligned enrollment D-SNPs (EAE D-SNPs) and non-EAE D-SNPs. DHCS intends to build on these requirements to continue to enhance integrated care for dually eligible beneficiaries in future years.

Policy

For 2023, the information sharing policy is specified in the D-SNP State Medicaid Agency Contracts (SMACs), and that language is provided below. Additional details on the policy beyond the contract is noted in italics below.

1. D-SNP Contractor is responsible for complying with State policy implementing federal information sharing requirements for D-SNPs (42 CFR 422.107(d)(1)), for the purpose of coordinating Medicare and Medi-Cal covered services between settings of care. This State policy is in addition to federal requirements for hospitals for electronic notifications listed in 42 CFR 482.24(d). The goal of the information sharing policy is for D-SNP contractor, either directly or through contracted providers or other entities, to timely notify the Member's Medi-Cal Managed Care Plan (MCP) of hospital and SNF admissions, particularly if the MCP is a different organization than the D-SNP. Timely notification supports the coordination of and referrals to Medicare and Medi-Cal covered services, including home and community based services.
2.
    a) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted hospitals to use secure email, data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform the D-SNP and the Member's MCP of any hospital admission for all Members. D-SNP Contractor will require their contracted hospitals to make this notification either immediately prior to, or at the time of, the Member's discharge or transfer from the hospital's inpatient services (if applicable).
    b) As an alternative to the hospital's notification to the Member's MCP, the D-SNP Contractor may notify the Member's MCP, in the same timeframe and method referenced in paragraph a, of any hospital admission for all Members. The D-SNP must coordinate any necessary Medicare and Medi-Cal services for the Member with the MCP.

c) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted Skilled Nursing Facilities (SNFs) to use secure email, data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform the D-SNP and the member's MCP of any SNF admission, discharge, or transfer for all Members. For SNF admissions, D-SNP Contractor will require their contracted SNFs to make this notification within 48 hours after any SNF admission. For SNF discharges or transfers, D-SNP Contractor will require their contracted SNFs to make this notification in advance if at all possible, or at the time of, the Member's discharge or transfer from the SNF.

d) As an alternative to the SNF's notification to the Member's MCP, the D-SNP Contractor may notify the Member's MCP, in the same timeframe and method referenced in paragraph c, of any SNF admission, discharge, or transfer for all Members. The D-SNP must coordinate any necessary Medicare and Medi-Cal services for the Member with the MCP.

e) In the event that the D-SNP Contractor authorizes another entity or entities to perform these notifications, D-SNP Contractor must retain responsibility for complying with this requirement. The D-SNP Contractor ultimately retains the responsibility for the notification requirements that are delegated to its contracted hospitals and SNFs.

f) For the first six months of 2023, DHCS may permit D-SNP contractor to propose and implement an alternate approach and compliance plan to meet federal information sharing requirements. *If there are extenuating circumstances and no other process identified above is available, including secure e-mail, then secure eFax is permitted, subject to DHCS review and approval.*

3. D-SNP Contractor will coordinate care management for their Members and facilitate Member access to needed Long-Term Services and Supports to support care transitions.

Submission of Alternate Approaches

D-SNPs intending to propose and implement an alternate approach, as defined in paragraph f above, should submit a proposal that includes, at a minimum, the following information to DSNPSubmissions@dhcs.ca.gov:

- *How the proposal meets the state and federal requirements and*
- *What the process will transition to after the first six months of 2023, if known.*

III. Network Guidance for EAE D-SNPs

The purpose of this section is to provide state-specific network requirements to health plans intending to operate EAE D-SNPs in California beginning January 1, 2023. These requirements are in addition to any existing federal Medicare Advantage network requirements and have been developed per Welfare and Institutions Code (WIC) Section 14184.208:

> "(e) Beginning in contract year 2023, the department shall include requirements for network adequacy, aligned networks, and continuity of care in the SMAC. The requirements shall be developed in consultation with affected stakeholders."

These requirements are included in California's State Medicaid Agency Contract (SMAC) for EAE D-SNPs in 2023. DHCS intends to build on these requirements to continue to enhance integrated care for dually eligible beneficiaries in future years.

Network Adequacy
Existing Medicare and Medi-Cal network adequacy requirements will be sufficient to meet WIC Section 14184.208(e).

Aligned Networks
The goal of aligned networks is to ensure continuity of access to providers across Medi-Cal and Medicare. For contract year 2023, DHCS intends to solicit information from EAE D-SNPs about the extent to which their networks are aligned and will be providing subsequent guidance on aligned network requirements.

To ensure network alignment, EAE D-SNPs must report to DHCS the percent and number of contracted Medi-Cal physicians for the D-SNP's aligned Medi-Cal managed care plan who are also contracted Medicare physicians and hospitals with the exclusively aligned enrollment D-SNP. The Medi-Cal managed care plan network used for this calculation should be just for the plan aligned with the EAE D-SNP parent company. If the MCP is a prime or delegate plan, the calculation should only reflect the prime or delegate plan, not both plans.

DHCS has provided a report template for the EAE D-SNPs to complete and submit through the Secure File Transfer Protocol (SFTP) site in the MCP's specific Provider Network File subfolder. This data should be reported at the county level. For the purposes of this report, Medicare and Medi-Cal providers reported should include the following provider types and be consistent in classification by using the DHCS Taxonomy Crosswalk. In order to classify the provider types, the most recent version of the DHCS Taxonomy Crosswalk must be utilized. The current DHCS Taxonomy Crosswalk is available on the DHCS Dual Special Needs Plans Contract and Policy Guide web page.

- Primary Care category:
  - Combine General Practice & Family Practice
  - Combine Internal Medicine & Preventative Medicine
  - Include Geriatric
  - Exclude Pediatrics and non-physician practitioners
- Specialty Care category:
  - Include Welfare and Institutions Code (WIC) 14917 Core Specialists and OB/GYN
  - Exclude Genetics, Maternal/Fetal Medicine, Pediatric Subspecialties,Pediatric Surgery, Vascular Surgery, and Chiropractor
- Facility category:
  - Include Acute Inpatient Hospitals
  - Include Long Term Care Facilities: Skilled Nursing, Subacute, and Intermediate Care
  - Include Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Care Providers (IHCP)

In future years, DHCS will require EAE D-SNPs to meet a minimum percentage of aligned networks and report on priority provider types, as noted above. Future report timing will be issued later in 2023. DHCS will continue to work towards requiring EAE D-SNPs to have integrated provider networks, including integrated benefit determinations and integrated provider directories.

Additionally, EAE D-SNPs must assess alignment in geographic location and language capabilities between their Medicare and Medi-Cal networks. These assessments must be submitted to DHCS with the network alignment report and must note what steps are being taken to improve the overlap in these areas.

> *Medi-Cal Provider Network Reporting Requirements*
> DHCS will use the D-SNP's submission of the existing 274 monthly provider file on their Medi-Cal provider network for the Service Area to confirm what was noted in the network alignment template. The 274 monthly provider file must be completed utilizing the most current of the Companion Guide. To request the current Companion Guide, email MCQMDProviderData@DHCS.ca.gov

To assist with network building, plans can obtain information about Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. The California Health and Human Services Open Data Portal can be found at:https://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider.

Any D-SNPs affiliated with a companion Medi-Cal MCP can obtain the file from the affiliated Medi-Cal plan.

Report Type	Purpose	Frequency/Timing	Reporting Period
EAE D-SNPs			
Aligned Networks: Percentage of aligned networks	Plans to submit alignment percentage by county per specialty type utilizing the provided template titled "2023 Network Guidance for EAE DSNPs - Template".	February 2023	Must be submitted on the Secure File Transfer Protocol (SFTP) site in the MCP's specific Provider Network File subfolder by **4/28/2023**

Aligned Network Geographic Overlap Assessment	Plans to create and submit a geographic access map for each service area showing provider coverage of Medi-Cal and Medicare physicians. The geographic access map should include the following: • Entire service area, which delineates boundaries and ZIP codes. • Pins indicating providers that are both Medi-Cal and Medicare physicians across the service area • Key/Legend if applicable	February 2023	Must be submitted on the Secure File Transfer Protocol (SFTP) site in the MCP's specific Provider Network File subfolder by **4/28/2023**
Aligned Network Language Overlap Gap Assessment	Plans to submit a narrative assessment of the overlap gaps in language capabilities and geographic location in the county.	February 2023	Must be submitted on the Secure File Transfer Protocol (SFTP) site in the MCP's specific Provider Network File subfolder by **4/28/2023**

IV. Enrollment and Disenrollment

D-SNP shall implement and maintain procedures to ensure that all Members requesting enrollment, disenrollment, or information regarding the disenrollment process are provided relevant information about their choices and Medicare rules and that their enrollment choices are appropriately processed. D-SNPs must adhere to all existing Medicare and Medi-Cal rules on noticing; these are additional scenarios that apply to the new EAE environment.

Special Enrollment Periods

1. The intent of this language is to help ensure that members are able to disenroll from a D-SNP and enroll in another Medicare Advantage plan using the same Special Enrollment Period (SEP).

    a. D-SNP must inform Members about the rules guiding Medicare SEPs if they request disenrollment, including any information they may need to appropriately execute enrollment into another Medicare Advantage plan.
        i. Beneficiaries should be encouraged to proactively enroll in the plan of their choice, during a valid period, which will automatically disenroll them from their current plan.
        ii. This will avoid confusion related to returning to fee-for-service Medicare, potentially needing to wait three months to join a new Medicare Advantage plan, or any Part D issues that would arise when disenrolling through their current plan directly.

MMP and Medicare Eligibility

1. Eligibility Age
    a. EAE D-SNPs may only enroll beneficiaries 21 years of age or older.
2. In cases where a member loses Medicare eligibility but remains in the Medi-Cal Managed Care Plan, the D-SNP must send a disenrollment notice.

V. Medicare Continuity of Care Guidance for All D-SNPs

The purpose of this section is to provide state-specific Medicare continuity of care requirements to dual eligible special needs plans (D-SNPs) in California, beginning January 1, 2023. These requirements are in addition to any existing federal Medicare Advantage (MA) requirements. These requirements are in accordance with Assembly Bill 133 (Chapter 143, Statutes of 2021), the Health Omnibus Budget Trailer Bill, Welfare and Institutions Code Section 14184.208:

> "(e) Beginning in contract year 2023, the department shall include requirements for network adequacy, aligned networks, and continuity of care in the SMAC. The requirements shall be developed in consultation with affected stakeholders."

The intent of these state-specific Medicare continuity of care requirements for D-SNPs is to ensure continued access to Medicare providers and covered services for members joining the D-SNP. These requirements are for Medicare providers and Medicare covered services and are similar to requirements included in the Cal MediConnect (CMC) three-way contract, and are included in California's State Medicaid Agency Contract (SMAC) for all D-SNPs in 2023.

Continuity of care requirements for Medi-Cal providers and Medi-Cal covered services can be found in All Plan Letter 18-008.

Additional network requirements are covered in the Network Guidance chapter of this policy guide. The network requirements are designed to ensure overall network adequacy as well as to support continued access to existing providers for Medi-Cal only beneficiaries transitioning to dual eligible status and enrolling in a D-SNP.

Continuity of Care for Medicare Primary and Specialty Providers

Upon member request, or request by other authorized person as noted below, D-SNPs must offer continuity of care with out-of-network Medicare providers to all members if all of the following circumstances exist:

- A member has an existing relationship with a primary or specialty care provider. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or a specialty care provider at least once during the 12 months prior to the date of their initial enrollment in the D-SNP for a non-emergency visit;
- The provider is willing to accept, at a minimum, payment from the D-SNP based on the current Medicare fee schedule, as applicable; and

- The provider does not have any documented quality of care concerns that would cause the D-SNP to exclude the provider from its network.

If the member leaves the D-SNP and later rejoins the D-SNP, then the D-SNP must offer the member a 12-month continuity of care period based on the date of re-enrollment, regardless of whether the member received continuity of care in the past. If a member changes D-SNPs, the continuity of care period may start over one time. If the member changes D-SNPs a second time (or more), the continuity of care period does not start over, meaning the D-SNP is not required to offer the member a new 12-month period.

Requirements Regarding Primary Care Providers and Delegated Entities

When a member transitions into a D-SNP, and has an existing relationship with a PCP that is in the D-SNP's network, as determined through 1) the HRA process; 2) review of prior utilization data; or 3) member request, the D-SNP must assign the member to the PCP, unless the member chooses a different PCP. If the D-SNP contracts with delegated entities, it must assign the member to a delegated entity that has the member's preferred PCP in its network.

When a member transitions into a D-SNP, has an existing relationship with a PCP and at least one specialist that is in the D-SNP's network, and the member wishes to continue to seek treatment from each of these providers, the D-SNP must allow the member to continue treatment with each of these providers for the continuity of care period. This is regardless of whether these providers are, or are not, in the network of the primary plan's delegated entity to which the member is assigned, as long as the continuity of care requirements are met.

For example, if a member has an existing relationship with a PCP and a specialist with the assigned Independent Physicians Association #1 (IPA #1) as well as a specialist in another IPA (IPA #2), where both IPAs are delegated entities of the same D-SNP, the D-SNP must assign the member to IPA #1 and allow the member to continue treatment with both specialists. The continuity of care agreement for the specialist in IPA #2 would last for up to 12 months.

D-SNPs are required to notify their delegated entities of these requirements and the delegated entities are also required to provide continuity of care to their assigned members.

Procedures for Requesting Continuity of Care

Members, their authorized representatives, or their providers, may make a direct request to a D-SNP for continuity of care. Only those providers who treat members who are eligible for continuity of care, as noted above, may make a request to the D-SNP for continuity of care.

D-SNPs must, at a minimum, accept requests for continuity of care over the telephone, according to the requestor's preference, and cannot require the requester to complete and submit a paper or computer form. To complete a telephone request, the D-SNP may take any necessary information from the requester over the telephone.

D-SNPs must accept and approve retroactive requests for continuity of care and pay claims that meet all continuity of care requirements noted above, with the exception of the requirement to abide by the D-SNP's utilization management policies. The services that are the subject of the request must have occurred after the member's enrollment into the D-SNP, and the D-SNP may require the member, their authorized representative, or their provider to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into the D-SNP. D-SNPs must approve any retroactive requests that:

- Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
- Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested or denial from another entity when the claim was incorrectly submitted.

The D-SNP must accept retroactive requests that are submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity. Examples include, but are not limited to, situations where the provider sent the claim to CMS (as a Medicare Fee-for-Service (FFS) claim), an MA plan, another D-SNP, or the primary plan instead of the delegate.

When a request for continuity of care is made, the D-SNP must process the request within five working days after receipt of the request. However, as noted below, the request must be completed in three calendar days if there is a risk of harm to the member. The continuity of care process begins when the D-SNP starts the process to determine if there is a pre-existing relationship and enters into an agreement with the provider.

A member or their provider may provide information to the D-SNP that demonstrates a pre-existing relationship with a provider. A member or provider may not attest to a pre-existing relationship (instead, actual documentation must be provided) unless the D-SNP makes this option available to them.

Following identification of a pre-existing relationship, the D-SNP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement or other form of agreement in order to establish a continuity of care relationship for the member.

Request Completion Timeline

Each continuity of care request must be completed within:

- 30 calendar days from the date the D-SNP receives the request;
- 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- Three calendar days if there is risk of harm to the member.

A continuity of care request is considered completed when:

- The member is informed of their right to continued access or if the D-SNP and the out-of-network provider are unable to agree to terms;
- The D-SNP has documented quality of care issues with the provider; or
- The D-SNP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

Requirements after the Request Process is Completed

If a D-SNP and the out-of-network FFS or prior plan provider are unable to reach an agreement because they cannot agree to terms or a reimbursement rate, or the D-SNP has documented quality of care issues with the provider, the D-SNP must offer the member an in-network alternative. If the member does not make a choice, the member will be assigned to an in-network provider. Members maintain the right to pursue an appeal or grievance through the Medicare process.

If an out-of-network provider meets all of the necessary requirements, including entering into a contract, letter of agreement, single-case agreement, or other form of agreement with the D-SNP, the D-SNP must allow the member to have access to that provider for the length of the continuity of care period unless the provider is only

willing to work with the D-SNP for a shorter timeframe. In this case, the D-SNP must allow the member to have access to that provider for the shorter period of time.

At any time, a member may change providers regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the D-SNP must work with the out-of-network provider to establish a care plan for the member.

Upon completion of a continuity of care request, D-SNPs must notify members of the following within seven calendar days:

- The request approval or denial, and if denied, the member's appeal and grievance rights;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period; and
- The member's right to choose a different provider from the D-SNP's provider network.

D-SNPs must also notify members 30 calendar days before the end of the continuity of care period about the process that will occur to transition the member's care at the end of the continuity of care period. This process must include engaging with the member and out-of-network provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

D-SNP Extended Continuity of Care Option

D-SNPs may choose to work with a member's out-of-network provider past the continuity of care period, but D-SNPs are not required to do so.

Continuity of Care for Medicare Durable Medical Equipment and Medical Supply Providers

Additionally, D-SNPs must ensure members have access to medically necessary Medicare-covered Durable Medical Equipment (DME) and medical supplies. In addition to complying with Medicare continuity of care requirements for these services and providers as outlined in 42 CFR 422.100(l)(2)(iii), D-SNPs must comply with the following requirements.

- Members joining a D-SNP with existing DME rentals must be allowed to keep their existing rental equipment until the D-SNP can evaluate the member, equipment is in the possession of the member, and ready for use.
    - After 90 days (per 42 CFR 422.100(l)(2)(iii)) and when the D-SNP is able to reassess the member, and, if medically necessary, authorize a new rental and have an in-network provider deliver the medically necessary rental.
- Members joining a D-SNP that have an open authorization to receive Medicare-covered medical supplies may continue to use their existing provider:
    - For 90 days per 42 CFR 422.100(l)(2)(iii); and
    - Until the D-SNP is able to reassess the member, and, if medically necessary, authorize supplies and have an in-network provider deliver the medically necessary supplies.

Member and Provider Outreach and Education

D-SNPs must inform members, or their authorized representatives, of continuity of care protections within 30 days of enrollment, and must include information about these protections in member information materials and handbooks. This information must include how a member and provider initiate a continuity of care request with the D-SNP. These documents must be translated into threshold languages and must be made available in alternative formats in compliance with Medi-Cal requirements, currently in APL 21-0004. D-SNPs must provide training to call center and other staff who come into regular contact with members about continuity of care protections.

VI. Quality and Reporting Requirements

The purpose of this section is to provide state-specific Medicare and Medi-Cal quality and reporting requirement metrics to EAE and non-EAE D-SNPs in California, beginning January 1, 2023. These requirements are in addition to existing federal Medicare Advantage (MA) requirements. Further information is provided in the Technical Specifications available here: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.

Background

State-specific reporting requirements for D-SNPs are part of a larger quality strategy within DHCS, including a focus on the Comprehensive Quality Strategy focused on dual eligible individuals, the Long-Term Services and Supports (LTSS) dashboard, and the Master Plan for Aging.

D-SNPs have robust reporting requirements for both Medi-Cal and Medicare. DHCS monitors the quality of care and health equity provided to members in Medi-Cal through various reporting requirements, as detailed in the 2022 DHCS Comprehensive Quality Strategy and Medi-Cal contracts.

DHCS built upon promising practices and quality reporting metrics from Cal MediConnect (CMC) plans, particularly as statewide and plan-specific performance has been a helpful benchmark to evaluate members' experiences in CMC plans.

In developing the state-specific quality and reporting requirements for D-SNPs, DHCS considered:

1) Overall quality and integrated care goals for D-SNPs.
2) Clinical value, and alignment with Medicare and Medi-Cal goals and measures.
3) Existing data sent to CMS that DHCS can receive.
4) Existing DHCS data that can be analyzed.
5) CMC measures to maintain for initial enrollment transition monitoring.

State-Specific Quality and Reporting Requirements

In addition to all federally required reporting requirements, D-SNPs must submit the following measures to the state at the PBP level. D-SNPs must submit the data to DHCS according to the reporting schedule listed below in an SFTP determined by the state.

D-SNPs must internally validate all data and quality measures submitted to DHCS according to their usual processes.

Additionally, for the Healthcare Effectiveness Data and Information Set (HEDIS) measures listed below, the D-SNP performance rates must be validated by an external entity (e.g., the National Committee for Quality Assurance, NCQA) prior to submission to DHCS.

When available, D-SNPs must consult the data measure steward for any technical questions (e.g., the NCQA for HEDIS measures). Please send questions to QualityandHealthEquityDiv@dhcs.ca.gov. Please see below for a list of the state-specific quality and reporting requirements. More information, including Technical Specifications for the measures, is available on the DHCS webpage here: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.

Access/Availability of Care

I. HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)[1]

Effectiveness of Care

II. HEDIS Controlling High Blood Pressure (CBP)[1]

III. HEDIS Poor HbA1c Control (>9.0%) (HBD-H9)[1]

IV. HEDIS Follow-Up After Emergency Department Visit for Mental Illness (FUM)[1]

Utilization and Risk Adjusted Utilization

V. HEDIS Plan All-Cause Readmissions (PCR)[1]

VI. Emergency Department (ED) Behavioral Health Services Utilization (Core 9.1)

[1] Measures selected for race/ethnicity stratification by NCQA. D-SNPs will be required to report race/ethnicity stratifications, per HEDIS General Guidelines, to DHCS.

Care Coordination

VII. Members with an assessment completed within 90 days of enrollment (Core 2.1)

VIII. Members with an annual reassessment (Core 2.3)

IX. Members With a Care Plan Completed Within 90 Days of Enrollment (Core 3.2)

X. Members with an Individualized Care Plan (ICP) Completed (CA 1.5) – no longer required for 2023 reporting as of November 2023

XI. Members with Documented Discussions of Care Goals (CA 1.6)

Organizational Structure and Staffing

XII. Care Coordinator to Member Ratio (Core 5.1)

XIII. Care Coordinator Training for Supporting Self-Direction (CA 3.2)

Medi-Cal Long-Term Services and Supports

XIV. Community-Based Adult Services (CBAS)

XV. In-Home Supportive Services (IHSS)

XVI. Multipurpose Senior Services Program (MSSP)

XVII. Long-Term Care (LTC)

Alzheimer's/Dementia Quality of Care

XVIII. Cognitive Health Assessment

Summary of 2023 State-Specific D-SNP Reporting Requirements

All plans must report measures at the Plan Benefit Package (PBP) level.

Measure	Name	Reporting Frequency	Plan Types Required to Report
Access/Availability of Care			
I.	HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)	Annually	All D-SNPs
Effectiveness of Care			
II.	HEDIS Controlling High Blood Pressure (CBP)	Annually	All D-SNPs
III.	HEDIS Poor HbA1c Control (>9.0%) (HBD-H9)	Annually	All D-SNPs
IV.	HEDIS Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Annually	All D-SNPs
Utilization and Risk Adjusted Utilization			
V.	HEDIS Plan All-Cause Readmissions (PCR)	Annually	All D-SNPs
VI.	Emergency Department (ED) Behavioral Health Services Utilization (Core 9.1)	Annually	All D-SNPs
Care Coordination			
VII.	Members with an assessment completed within 90 days of enrollment (Core 2.1)	Quarterly	All D-SNPs

Measure	Name	Reporting Frequency	Plan Types Required to Report
VIII.	Members with an annual reassessment (Core 2.3)	Annually	All D-SNPs
IX.	Members With a Care Plan Completed Within 90 Days of Enrollment (Core 3.2)	Quarterly	All D-SNPs
X.	Members with an Individualized Care Plan (ICP) Completed (CA 1.5) Note: As of November 2023, CA 1.5 is no longer required for 2023 reporting.	Quarterly Note: As of November 2023, CA 1.5 is no longer required for 2023 reporting.	All D-SNPs Note: As of November 2023, CA 1.5 is no longer required for 2023 reporting.
XI.	Members with Documented Discussions of Care Goals (CA 1.6)	Annually	All D-SNPs
Organizational Structure and Staffing			
XII.	Care Coordinator to Member Ratio (Core 5.1)	Annually	All D-SNPs
XIII.	Care Coordinator Training for Supporting Self-Direction (CA 3.2)	Annually	All D-SNPs
Medi-Cal Long-Term Services and Supports			
XIV.	Community-Based Adult Services (CBAS)	Quarterly	EAE D-SNPs
XV.	In-Home Supportive Services (IHSS)	Quarterly	EAE D-SNPs

Measure	Name	Reporting Frequency	Plan Types Required to Report
XVI.	Multipurpose Senior Services Program (MSSP)	Quarterly	EAE D-SNPs
XVII.	Long-Term Care (LTC)	Quarterly	EAE D-SNPs
Alzheimer's/Dementia Quality of Care			
XVIII.	Cognitive Health Assessment	Annually	All D-SNPs

State-Specific Guidance for Quality Measures

HEDIS Measures (I, II, III, IV, V):

- EAE and non-EAE D-SNPs must prepare and submit validated state-specific and D-SNP-specific Medicare HEDIS measures directly to the state, with EAE D-SNP results separate from non EAE D-SNP results if the organization has both. MA (non-D-SNP PBPs) results should be excluded if the plan has both MA and D-SNP PBPs.
- HEDIS measures should be submitted annually to DHCS, based on the submission schedule provided by NCQA.
- Plans should refer to "HEDIS Volume 2: Technical Specifications for Health Plans" for detailed information on complete technical specifications for each measure.
- Note: The target population for each HEDIS measure should be EAE and non-EAE D-SNP members at the PBP level.

Race/Ethnicity Stratification for HEDIS Measures

DHCS is committed to working to eliminate disparities in health care, and, as part of these efforts, is working to publicly report program-specific health disparity measures. In support of this vision, DHCS is requiring D-SNPs to report race/ethnicity stratifications, per HEDIS General Guidelines, for all HEDIS measures (including AAP, CBP, HBD-H9, FUM, and PCR). As stated in guidance, HEDIS measures report race and ethnicity data according to the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

Continued Core Reporting Requirements (VI, VII, VIII, IX, and XII)

- EAE and non-EAE D-SNPs must prepare and submit internally validated state-specific and D-SNP-specific measures directly to the state, with EAE D-SNP results separate from non-EAE D-SNP results if the organization has both. MA results should be excluded if the plan has both MA and D-SNP PBPs.
- Core measures 2.1 and 3.2 must be reported on a quarterly basis to DHCS. Care plans and care plan completeness should be defined as written in Technical Specifications.
- Core measures 2.3, 5.1, and 9.1 must be reported on an annual basis to DHCS.

Continued California-Specific Reporting Requirements (X, XI and XIII)

- EAE and non-EAE D-SNPs must prepare and submit internally validated state-specific and D-SNP-specific measures directly to the state, with EAE D-SNP results separate from non EAE D-SNP results if the organization has both. MA results should be excluded if the plan has both MA and D-SNP PBPs.
- CA 1.5 is no longer required for quarterly reporting to DHCS.
- CA 3.2 and CA 1.6 must be reported on an annual basis to DHCS.

Long Term Services and Supports (XIV, XV, XVI and XVII)

- EAE D-SNPs must prepare and submit internally validated state-specific and D-SNP-specific measures directly to the state, with EAE D-SNP results separate from non EAE D-SNP results if the organization has both. MA results should be excluded if the plan has both MA and D-SNP PBPs.
- Non-EAE D-SNPs are not required to report these measures.
- Medi-Cal long-term services and supports measures must be reported on a quarterly basis to DHCS.

New Alzheimer's/Dementia Quality of Care Measure (XVIII): Annual Cognitive Health Assessment for Patients 65 years and Older

- In recognition of the significant prevalence of Alzheimer's and related dementias among dually eligible beneficiaries, and the Department's Dementia Aware initiative, DHCS will require plans to report this measure. Similar to other measures, this should be reported to DHCS internally validated and at a state-

specific and D-SNP PBP specific level, with EAE D-SNP results separate from non-EAE D-SNP results if the organization has both. MA results should be excluded if the plan has both MA and D-SNP PBPs.

- This measure must be reported on an annual basis to DHCS, for the reporting period January 1, 2023 to December 31, 2023, no later than June 1, 2024.

Additional detail and reference materials for each measure is provided below.

I. HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/
- The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

II. HEDIS Controlling High Blood Pressure (CBP)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/
- Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

III. HEDIS Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c Poor Control (>9.0%)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/
- Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).

IV. HEDIS Follow-Up After Emergency Department Visit for Mental Illness (FUM)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/
- Assesses emergency department (ED) visits for adults and children 6 years of age and older with a principal diagnosis of mental illness or intentional self-

harm and who received a follow-up visit for mental illness. Two rates are reported:

- ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

V. HEDIS Plan All-Cause Readmissions (PCR)

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/
- For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

VI. Emergency Department (ED) Behavioral Health Services Utilization (Core 9.1)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of ED visits with a principal diagnosis related to behavioral health.

VII. Members with an Assessment Completed within 90 Days of Enrollment (Core 2.1)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

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.

- Note for quarter one 2023: Members who were cross-walked from a CMC plan to a D-SNP within the Medicare Advantage Organization (MAO) must **not** be included in Core 2.1. Only members with a CMC effective date in November and December 2022 who were cross-walked to a D-SNP within the MAO should be included in quarter one 2023 data, as they reached their 90th day of enrollment during quarter one 2023.

B. Total number of members who were documented as unwilling to participate in the assessment within 90 days of enrollment.

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.

D. Total number of members with an assessment completed within 90 days of enrollment.

E. 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. Percentage = (B / A) * 100

F. Percentage 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. Percentage = (C / A) * 100

G. Percentage who had an assessment completed within 90 days of enrollment. Percentage = (D / A) * 100

H. Percentage who were willing to participate and who could be reached who had an assessment completed within 90 days of enrollment. Percentage = (D / (A – B – C)) * 100

VIII. Members with an Annual Reassessment (Core 2.3)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of members enrolled as of the last day of the current reporting period.

B. Total number of members who had an assessment completed during the previous reporting period.

C. Total number of members with a reassessment completed during the current reporting period.

D. Total number of members with a reassessment completed within 365 days of the most recent assessment completed.

E. Total number of members who did not have an assessment completed during the previous reporting period.

F. Total number of members with an assessment completed during the current reporting period.

G. Percentage who had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period. Percentage = (C / B) * 100

H. Percentage who 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. Percentage = (D / B) * 100

I. Percentage who 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. Percentage = (F / E) * 100

IX. Members With a Care Plan Completed Within 90 Days of Enrollment (Core 3.2)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

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.

   a. Note for quarter one 2023: Members who were cross-walked from a CMC plan to a D-SNP within the MAO must **not** be included in Core 3.2. Only members with a CMC effective date in November and December 2022 who were cross-walked to a D-SNP within the MAO should be included in quarter one 2023 data for Core 3.2, as they reached their 90th day of enrollment during quarter one 2023.

B. 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. Unwillingness to participate must be clearly documented.

C. 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. Three outreach attempts must be clearly documented.

D. Of the total reported in A, the number of members with a care plan completed within 90 days of enrollment. Completed care plans must be clearly documented.

E. 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. Percentage = (B / A) * 100

F. Percentage 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. Percentage = (C / A) * 100

G. Percentage of members who had a care plan completed within 90 days of enrollment. Percentage = (D / A) * 100

H. Percentage of members who were willing to participate and who could be reached who had a care plan completed within 90 days of enrollment. Percentage = (D / (A – B – C)) * 100

X. Members with an Individualized Care Plan (ICP) Completed (CA 1.5)

- Note: D-SNPs are no longer required to report CA 1.5 for 2023. Reporting requirements below are for reference only.
- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of high-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.

B. Of the total reported in A, the number of high-risk members who had an initial ICP completed as of the end of the reporting period.

C. Total number of low-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.

D. Of the total reported in C, the number of low-risk members who had an initial ICP completed as of the end of the reporting period.

E. Percentage of high-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period. Percentage = (B / A) * 100

F. Percentage of low-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period. Percentage = (D / C) * 100

XI. Members with Documented Discussions of Care Goals (CA 1.6)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of members with an initial ICP completed during the reporting period.

B. Of the total reported in A, the number of members sampled that met inclusion criteria.

C. Of the total reported in B, the number of members with at least one documented discussion of care goals in the initial ICP.

D. Total number of existing ICPs revised during the reporting period.

E. Of the total reported in D, the number of revised ICPs sampled that met inclusion criteria.

F. Of the total reported in E, the number of revised ICPs with at least one documented discussion of new or existing care goals.

G. 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. Percentage = (C / B) * 100

H. Percentage of existing ICPs revised during the reporting period that had at least one documented discussion of new or existing care goals. Percentage = (F / E) * 100

XII. Care Coordinator to Member Ratio (Core 5.1)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Total number of FTE care coordinators working in the D-SNP as of the last day of the reporting period.

B. Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period.

C. Total number of FTE care coordinators that left the D-SNP during the reporting period.

D. Number of members per FTE care coordinator. Rate = (Total Members Enrolled / A)

E. Percentage of FTE care coordinators who were assigned to care management and conducting assessments. Percentage = (B / A) * 100

F. Percentage of FTE care coordinators that left the D-SNP during the reporting period. Percentage = (C / (C + A)) * 100

XIII. Care Coordinator Training for Supporting Self-Direction (CA 3.2)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.

A. Total number of full-time and part-time care coordinators who have been employed by the D-SNP for at least 30 days at any point during the reporting period.

B. Of the total reported in A, the number of care coordinators who have undergone training for supporting self-direction within the reporting period.

C. Percentage of full-time and part-time care coordinators who have undergone training for supporting self-direction within the reporting period. Percentage = (B / A) * 100

XIV. Community-Based Adult Services (CBAS)

A. Enter the total number of members currently receiving services during the reporting quarter.

B. Total number of referrals made for CBAS services for the reporting period.

C. Total number of initial member assessments completed by the CBAS centers for the reporting quarter. CBAS Eligibility Determination Tools (CEDTs) do not qualify as an initial assessment and should not be included.

D. Enter the total number of initial members approved for services for the reporting period.

E. Enter the total number of member reassessments completed by the D-SNP for the reporting period. Per Medi-Cal Managed Care boilerplate contract

requirements (Exhibit A, Attachment 19), beneficiaries are required to be reassessed every six months to determine their eligibility for CBAS services.

F. Enter the total number of member reassessments that were approved by the D-SNP for the reporting quarter.

G. Enter the total number of members denied for CBAS services for the reporting quarter. Select only one of the 5 denial options for each member denial (Not Medically Necessary, Incomplete Assessment, Member Refused Service, Transition to Other Program or Setting, Other Reason).

XV. In-Home Supportive Services (IHSS)

A. Enter the total number of ICTs w/ county social worker (county DPSS liaison) participation for the reporting quarter.

B. Enter the number of members referred to county for IHSS for the reporting period.

C. Enter the total number of member referrals received for IHSS for the reporting quarter.

XVI. Multipurpose Senior Services Program (MSSP)

A. Total number of ICTs w/ MSSP Care Manager participation for the reporting period.

B. Total number of members receiving MSSP during the reporting period.

C. Total number of member referrals made for MSSP for the reporting period.

XVII. Long-Term Care (LTC)

A. Total number of members currently residing in LTC for >90 days during the reporting period.

B. Total number of member referrals received for LTC stays >90 days the reporting quarter. This column is for members being referred to LTC for a stay anticipated to be >90 days for the first time during the reporting period.

C. Enter the total number of initial member assessments for LTC stay >90 days completed for the reporting quarter. This column is for members being assessed for LTC for the first time during the reporting period.

D. Total number of members initially approved for LTC stay >90 days for the reporting quarter. This column is for members being approved for LTC stay for the first time during the reporting period.

E. Total number of members reassessed for LTC stay >90 days for the reporting quarter. This column is for members being reassessed for LTC for the first time during the reporting period.

F. Total number of member reassessment approved for LTC stay >90 days for the reporting quarter. This column is for members being reapproved for LTC stay for the first time during the reporting period.

G. Total number of members denied for LTC services for the reporting quarter. Use only one of the 5 denial options for each member denial (Not Medically Necessary, Incomplete Assessment, Member Refused Service, Transition to Other Program or Setting, Other Reason).

XVIII. Annual Cognitive Assessment for Patients 65 Years and Older

- Additional information from the American Academy of Neurology (page 8): https://www.aan.com/siteassets/home-page/policy-and-guidelines/quality/quality-measures/2019.03.25-mci-measures.pdf
- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

A. Percentage of patients aged 65 and older who had cognition assessed within the measurement period.

D-SNP Reporting Requirements Clarifications

- Note: As of November 2023, D-SNPs are no longer required to report CA 1.5.
- D-SNPs are not required to submit state-specific measures at the county level. Reporting will be done at the PBP level.
- EAE and non-EAE D-SNPs must submit state-specific data, disaggregated by EAE and non-EAE D-SNP (if the organization has both) and excluding non-D-SNP PBPs.
- EAE D-SNPs are required to report on LTSS measures. Non-EAE D-SNPs are not required to report on LTSS measures. The LTSS reporting for EAE D-SNPs includes MCP values (that excludes EAE D-SNP values). This is in addition to Medi-Cal only reporting done by MCPs, and will be a subset of the Medi-Cal reporting.

- DHCS provided a reporting template for plans to use to submit non-HEDIS measures. Plans should submit the HEDIS measures (stratified by race and ethnicity), certified via their usual EQRO process, prior to submission to DHCS.
- D-SNPs should use the DHCS Technical Specifications available here: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.
- D-SNPs should refer to the American Academy of Neurology Mild Cognitive Impairment Quality Measurement Set for acceptable validated tools to assess patient cognition. Plans are encouraged to reference and direct providers to the Dementia Care Aware website and associated resources, available here: https://www.dementiacareaware.org/

VII. Integrated Materials for EAE D-SNPs

The purpose of this section is to provide state-specific integrated Member materials requirements for exclusively aligned enrollment (EAE) dual eligible special needs plans (D-SNPs) in California. The state requirements described in this section are in addition to all existing Medicare marketing and communications requirements outlined in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V and as described in the Medicare Communications and Marketing Guidelines (MCMG)[2]. These requirements are also included in California's SMAC for EAE D-SNPs in 2023.

EAE D-SNPs are responsible for providing integrated materials to Members. Required integrated Member materials include:

- Annual Notice of Change (ANOC)
- ANOC Coversheet
- Member Handbook/Evidence of Coverage (EOC)
- Summary of Benefits
- Member Identification (ID) Card
- Provider/Pharmacy Directory
- List of Covered Drugs (Formulary)

Integrated appeals and grievances materials will be detailed in a separate D-SNP policy guide chapter.

Program Name
The California-specific program name for EAE D-SNPs is Medicare Medi-Cal Plans (MMPs or Medi-Medi plans). The goal of this branded program name is to describe the type of plan and differentiate EAE D-SNPs from Medi-Cal plans, regular Medicare Advantage plans, unaligned D-SNPs, or PACE products. DHCS will also use this name for Health Care Options (HCO) and on the DHCS website. Though not required, DHCS recommends plans leverage the following naming convention:

First reference in each section or chapter: <Mandatory Plan Name> (Plan Type), a Medicare Medi-Cal Plan

[2] See https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.

Provider Directory

Plans must comply with existing federal and state guidelines regulating print and online provider directories. DHCS expects that print and online directories for EAE D-SNPs will reflect all contracted and in-network providers for D-SNP members, effective January 1, 2023, and be updated regularly through December 31, 2023. The intent of the provider directories is to show the providers that are in the D-SNP Medicare and/or Medi-Cal networks in a clear manner for D-SNP members. Plans are not required to indicate whether the provider is contracted on the D-SNP or Medi-Cal side, to avoid member confusion.

Translation

EAE D-SNPs are required to make all integrated materials available in the threshold languages for their aligned managed care plan (MCP) Service Area. Threshold languages are defined as those languages that meet the more stringent of either:

- Medicare's five percent (5%) threshold for language translation[3]; or
- DHCS' prevalent language requirements (the DHCS threshold and concentration standard languages), as specified in annual guidance to Contractors on specific translation requirements for their Service Areas, currently found in APL 21-004.

EAE D-SNPs must have a process for ensuring that enrollees can make a standing request to receive materials in alternate formats and in all non-English languages, at the time of request and on an ongoing basis thereafter. The process should include how the plan will keep a record of the member's information and utilize it as an ongoing standing request so the member does not need to make a separate request for each material and how a member can change a standing request for preferred language and/or format. EAE D-SNPs may refer to Cal MediConnect marketing guidance for additional instruction on material formats and translations.

Submission and Review Process

DHCS will release templates for the required integrated Member materials to all EAE D-SNP plans in Q2, annually. In addition to the Integrated Member Materials, plans will

[3] Pursuant to 42 C.F.R. §§ 422.2268(a)(7) and 423.2268(a)(7), Medicare Part C plans and Part D sponsors (Sponsors) are required to translate vital materials into any non-English language that is the primary language of at least five (5) percent of the individuals in a plan benefit package (PBP) service area. The Sponsors that have service areas that meet the five (5) percent threshold must provide these translated materials on their websites and in hardcopy upon beneficiary request.

receive the Department of Managed Health Care's (DMHC) filing checklist that includes the requirements for the filing that must be submitted to the DMHC.

Upon completing the templates, EAE D-SNPs are required to submit their completed integrated material templates to DMHC and DHCS for review and approval by close of business on the dates listed below. Plans must simultaneously submit their completed materials to DMHC through the DMHC portal and to the DHCS inbox 2PlanDeliverables@dhcs.ca.gov. The filings/submissions should include clean and redlined copies of each document. Plans should direct questions relating to DMHC materials approval to the assigned licensing reviewer. Note: The processes may change for CY2024 materials.

The Provider/Pharmacy Directory should be submitted with variable language populated, however it is not necessary for provider and pharmacy content to be added at the point of submission.

After approval from both DHCS and DMHC, the ANOC, Member Handbook/EOC, and Summary of Benefits should be submitted as file and use in HPMS a minimum of five (5) days prior to their use as described at 42 CFR section 422.2261(b)(3). The Member ID Card, Formulary, and Provider/Pharmacy Directory will not need to uploaded to HPMS.

Beneficiary Material	Deadline to Submit to DHCS and DMHC	Estimated State Approval Date	Date Materials to be Uploaded to HPMS	Due to Current Enrollees
Annual Notice of Change (ANOC)	July 20, 2022	August 31, 2022	September 30, 2022	September 30, 2022
Member Handbook/ Evidence of Coverage (EOC)	July 21, 2022	September 9, 2022	October 15, 2022	October 15, 2022
Summary of Benefits	August 1, 2022	August 31, 2022	October 15, 2022	October 15, 2022
Member ID Card	August 1, 2022	August 31, 2022	N/A	Within 10 days of when plan receives enrollment in their system (early November 2022)

Beneficiary Material	Deadline to Submit to DHCS and DMHC	Estimated State Approval Date	Date Materials to be Uploaded to HPMS	Due to Current Enrollees
Formulary	August 1, 2022	August 31, 2022	N/A	October 15, 2022
Provider and Pharmacy Directory	August 1, 2022	August 31, 2022	N/A	October 15, 2022

VIII. Integrated Appeals and Grievances Requirements for EAE D-SNPs

Introduction

The purpose of this section is to provide state-specific integrated appeals and grievances requirements to exclusively aligned enrollment (EAE) dual eligible special needs plans (D-SNPs) in California, beginning January 1, 2023.

The requirements are in accordance with 42 CFR § 422.629-634:

> "(e) General process. An applicable integrated plan must create integrated processes for Enrollees for integrated grievances, integrated organization determinations, and integrated reconsiderations."

As EAE D-SNPs in 2023 qualify as applicable integrated plans (AIP), the intent of this state-specific guidance is to ensure integrated processes for grievances, organization determinations, and reconsiderations for Enrollees. These requirements are similar to requirements included in the Cal MediConnect (CMC) three-way contract and are included in California's State Medicaid Agency Contract (SMAC) for EAE D-SNPs in 2023. These requirements are in accordance with federal and state requirements, whereby the state requirements may be more protective for Enrollees. Some differentiation is noted for plans with Knox-Keene licenses.

Grievance and appeal requirements for Medi-Cal managed care plans (MCP) can be found in All Plan Letter 21-011. Additional requirements are provided in Health and Safety Code (HSC) §§ 1367 and 1368.

While state regulations do not specifically distinguish "grievances" from "appeals," federal regulations define "grievance and appeal system" to mean the processes the plan implements to handle grievances and appeals, with the terms "grievance" and "appeal" each separately defined. Due to distinct processes delineated for the handling of each, EAE D-SNPs must adopt the federal definition but also incorporate applicable sections of the existing state definition that do not pose conflicts.

The following individuals or entities can request an integrated grievance, integrated organization determination, and integrated reconsideration:

- The Enrollee or Enrollee's representative
- An assignee or the Enrollee
- The legal representative of a deceased Enrollee's estate
- Any provider that furnishes, or intends to furnish, services to the Enrollee

In the case of a provider who is providing treatment to the Enrollee, that provider may, upon providing notice to the Enrollee, request a standard or expedited pre-service integrated reconsideration on behalf of an Enrollee.

EAE D-SNPs must establish, implement, maintain, and oversee an integrated grievance and appeal system to ensure the receipt, review, and resolution of integrated grievances and appeals.

Integrated Grievances

A **grievance** (or complaint) is any expression of dissatisfaction about any matter other than an adverse benefit determination. If the EAE D-SNP is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.[4]

An Enrollee may file a grievance at any time. Expedited grievances must be made available to the Enrollee. Expedited grievances are defined as:

1) A case involving an imminent and serious threat to the health of a patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function;[5]
2) A decision to invoke an extension relating to an integrated organization determination or integrated reconsideration; or
3) Refusal to grant an Enrollee's request for an expedited integrated organization determination under 42 CFR § 422.631 or expedited integrated reconsideration under 42 CFR § 422.633.[6]

Upon receipt of the grievance, EAE D-SNPs must send a written acknowledgement of the grievance that is dated and postmarked within five (5) calendar days of receipt.[7] EAE D-SNPs must resolve standard grievances and send written resolution to the Enrollee as expeditiously as the Enrollee's health condition requires, but no later than 30 calendar days from receipt of the grievance. Expedited grievances must be resolved in 24 hours.[8]

Written notice of determination does not apply to grievances that were received by telephone, facsimile, email, or online through the plan's internet website, that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the next business day. However, there are exceptions, and a written notice of determination is required if

[4] An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other D-SNP processes.
[5] Health and Safety Code (HSC) § 1368.01(b); 28 CCR § 1300.68.01.
[6] 42 CFR § 422.630.
[7] HSC § 1368(a)(4)(A); 28 CCR § 1300.68(d)(1).
[8] 42 CFR § 422.630.

the Enrollee requests a written response, if the grievance is related to quality of care, coverage disputes, or disputed health care services involving medical necessity or experimental investigational treatment, regardless of how the grievance is filed and when it is resolved.[9] Plans must log and report all grievances.

Integrated Organization Determinations

EAE D-SNPs must consider both Medicare and Medi-Cal coverage criteria and make a determination as to a full or partial denial of an integrated organization determination.

EAE D-SNPs must provide notice of standard integrated organization determinations as expeditiously as the Enrollee's health condition requires, and no later than 14 calendar days from when it receives the request. For Knox-Keene licensed plans, standard organizational determinations (also referred to as utilization management [UM] decisions) are to be made within five (5) business days from the plan's receipt of information reasonably necessary to make the determination and no later than 14 calendar days from when it receives the request.[10]

In the case of expedited integrated organizational determinations, EAE D-SNPs must provide notice as expeditiously as the Enrollee's health condition requires and no later than 72 hours from when it receives the request.[11]

EAE D-SNPs may not extend the deadlines for integrated organization determinations.

Prior to terminating, suspending, or reducing a previously approved item or service, EAE D-SNPs must provide Enrollees with an integrated coverage determination at least ten (10) calendar days in advance of the effective date of the adverse organizational determination. In the event of the adverse organizational determination, the Enrollee must request continuation of benefits for the previously approved Medicare and/or Medicaid benefit(s) that the plan is terminating, suspending, or reducing within ten (10) calendar days of the notice's postmark date or by the intended effective date of the action, whichever is later.

Integrated Appeals/Reconsiderations

An **appeal** is federally defined as a review by the plan of an adverse benefit determination. EAE D-SNPs must use the federal definition of appeal and comply with

[9] 42 CFR § 422.630.
[10] 42 CFR §422.631(d)(2)(i)(B); HSC § 1367.01(h)(1).
[11] 42 CFR § 422.631(d)(2)(iv); HSC § 1367.01(h)(2).

all existing state regulations as they pertain to the handling of appeals. Additional definitions can be found in the All Plan Letter linked above.

An Enrollee must file an integrated reconsideration (appeal) within 60 calendar days from the date of the integrated Coverage Decision Letter. EAE D-SNPs must send each Enrollee written acknowledgement of receipt of all appeals within five (5) calendar days.[12]

The Medicaid External Appeals processes are to be in accordance with the Department of Managed Health Care's (DMHC's) Independent Medical Review (IMR) System set forth in Article 5.55 of the Knox-Keene Act and the regulations promulgated thereunder for Medicare second level appeals.

EAE D-SNPs must resolve standard integrated reconsiderations (appeals) as expeditiously as the Enrollee's health condition requires but not exceeding 30 calendar days from the date of receipt of the request for the integrated reconsideration (appeal); expedited integrated reconsiderations (appeals) must be resolved within 72 hours of receipt of the request.[13] D-SNPs may not extend timeframes for integrated reconsiderations (appeals) of Medicare and Medicaid services, per APL 21-011.

Plans need to ensure they are obtaining all relevant information needed to make a decision within the required timeframes.

Notices

Integrated Organization Determinations[14]

EAE D-SNPs must provide an integrated Coverage Decision Letter within the required timeframes for all fully or partially denied integrated organization determinations and provide notice to Enrollees of their appeal and State fair hearing rights.

All EAE D-SNPs must attach to the integrated Coverage Decision Letter a separate notice informing Enrollees of their right to a State fair hearing after the plan's appeal process has been exhausted and include the most current State fair hearing form with this notice when the following requirements are met:

[12] 42 CFR § 422.629(g); HSC § 1368(a)(4)(A).
[13] 42 CFR § 422.633(f)
[14] Integrated organization determinations are similar to adverse benefit determinations explained in APL 21-011. As such, the noticing requirements for an integrated Coverage Decision Letter are consistent with DHCS' Notice of Action noticing requirements. EAE D-SNPs must follow all applicable requirements accordingly.

1) The denied integrated organization determination is not for a Medicare only service or benefit; and
2) The integrated organization determination is relating to a denial, in whole or in part, of a Medi-Cal service/benefit, including cases where there is an overlap of Medicare/Medi-Cal.

For Knox-Keene licensed plans, EAE D-SNPs must also inform Enrollees of their rights to an IMR and include the verbatim language required by HSC § 1368.02(b), the most recent IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

1) The denied integrated organization determination is for experimental or investigational therapy, or is a denial of urgent care or emergency service; and
2) The denied integrated organization determination is not for a Medicare only service or benefit; and
3) The integrated organization determination is relating to a denial, in whole or in part, of a Medi-Cal service/benefit, including cases where there is an overlap of Medicare/Medi-Cal.[15]

In summary, EAE D-SNPs that are not Knox-Keene licensed are required to send State Fair hearing information only. All Knox-Keene licensed EAE D-SNPs must send both State fair hearing information and IMR information, when the above requirements are met.

Plans may refer to DHCS' "Your Rights" template for notices of action and modify the template language as necessary to inform Enrollees of their right to a State fair hearing and IMR.[16]

Integrated Appeals/Reconsiderations[17]

All EAE D-SNPs must provide Enrollees notice of its integrated reconsideration (appeal) decision within the required timeframes and inform Enrollees of their rights to a State

[15] 28 CCR § 1300.70.4; HSC § 1368.03.
[16] DHCS' "Your Rights" template for notices of action is available here: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/NOA-Your-Rights-Knox-Keene.pdf
[17] Integrated appeals/reconsiderations are similar to appeals explained in APL 21-011. As such, the noticing requirements for an integrated appeals decision letter are consistent with DHCS' Notice of Appeal Resolution noticing requirements. EAE D-SNPs must follow all applicable requirements accordingly.

fair hearing and include the most current State fair hearing form when the following requirements are met:

1) The denied integrated reconsideration (appeal) decision is not for a Medicare only service or benefit; and
2) The integrated reconsideration (appeal) is relating to a denial, in whole or in part, of a Medi-Cal service/benefit, including cases where there is an overlap of Medicare/Medi-Cal.

Additionally when the above requirements are met, Knox-Keene licensed plans must also inform Enrollees of their right to request an IMR and include the verbatim language required by HSC § 1368.02(b), the most recent IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.

In summary, EAE D-SNPs that are not Knox-Keene licensed are required to send only State fair hearing information with the Enrollee's notice of its integrated reconsideration (appeal) decision. Knox-Keene licensed EAE D-SNPs must send both State fair hearing information and IMR information with the Enrollee's notice of its integrated reconsideration (appeal) decision.

In addition to the Coverage Decision Letters, additional model notices that meet federal requirements are available online: [18]

- Letter about Your Right to Make a Fast Complaint
    - This notice is used when the plan makes a decision on or after January 1, 2021, to 1) extend the timeframe for deciding an integrated organization determination or integrated reconsideration, or 2) deny a request for an expedited integrated organization determination or integrated reconsideration.
- Appeal Decision Letter
    - This notice explains the Enrollee's further appeal rights under both Medicare and the Medi-Cal program.
    - Plans must modify this notice to inform Enrollees of their right to a State fair hearing and for Knox-Keene licensed plans, also inform Enrollees of their right to an IMR. Plans may refer to DHCS' "Your Rights" template for

[18] The model notices "The Letter about Your Right to Make a Fast Complaint" and "Appeal Decision Letter" are not required but meet the requirements of 42 CFR §§ 422.631 and 422.633.

notices of appeal resolution and modify the template language as necessary.[19]

Out-of-network providers may use the integrated appeals process on their own behalf for claims for services provided to Enrollees of D-SNPs and must complete a Waiver of Liability when requesting an integrated appeal. [20]

Reversal of decisions

If an EAE D-SNP reverses its decision to deny, limit, or delay services that were not provided while the appeal was pending, EAE D-SNP must authorize or provide the service under dispute:

- As expeditiously as the Enrollee's health condition requires and within 72 hours of the date it reverses its determination; or
- With the exception of a Medicare Part B drug, 30 calendar days after the date the applicable EAE D-SNP receives the request for the integrated reconsideration (or no later than upon expiration of an extension described in 42 CFR § 422.633(f); or
- For a Medicare Part B drug, seven (7) calendar days after the date the EAE D-SNP receives the request for the integrated reconsideration.

If a State fair hearing officer reverses an EAE D-SNP's integrated appeal decision to deny, limit, or delay services that were not provided while the appeal was pending, the EAE D-SNP must authorize or provide the disrupted service(s) as expeditiously as the Enrollee's health condition requires but no later than 72 hours of the date it receives notice reversing the determination.

If the Part C independent review entity, an administrative law judge or attorney adjudicator at the Office of Medicare Hearings and Appeals, or the Medicare Appeals Council reverses the decision it must be effectuated under same timelines applicable to other Medicare Advantage plans as specified in §§ 422.618 and 422.619. Upon receiving the decision of an IMR that a disputed health care service is medically necessary, Knox-Keene licensed plans must promptly implement the decision.[21]

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[19] The "Your Rights" template for notices of appeal resolution is available here: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/NAR-Your-Rights-Knox-Keene.pdf

[20] The Waiver of Liability form is available here: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.

[21] HSC §1374.34.

In the event that a case is dismissed for being late without good cause, EAE D-SNPs do not automatically forward cases to the Integrated Administrative Hearing Officer (IAHO) and instead must notify Enrollees of appeal rights.

Quality Improvement Organization Program

The Medicare Quality Improvement Organization (QIO) Program exists to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries; this includes the requirement that the QIO expeditiously addresses individual complaints, such as Enrollee complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

Considerations for EAE D-SNPs

EAE D-SNPs must provide information about the integrated grievance and integrated appeal system to all providers and subcontractors at the time they enter into a contract, including, at a minimum, information on integrated grievance, integrated reconsideration, and State fair hearing procedures and timeframes, as applicable.

EAE D-SNPs must maintain records of the integrated grievances, integrated organization determinations and integrated appeals, whereby MCPs must review the Medicaid related information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy. The record of each integrated grievance, integrated organization determination or integrated appeal must be accurately maintained in a manner accessible to the state and available upon request to CMS.

General Medicare Advantage Medicare Part B drug regulations apply for authorization requests and appeals.

Medicare Part D process and timing are not included in the integrated grievances, integrated organization determinations and integrated appeals for EAE D-SNPs; therefore, plans should follow all existing Medicare Part D requirements related to appeals and grievances.

A comparison of the requirements under the Integrated Appeals and Grievance regulations (42 CFR §§ 422.629-634, Cal MediConnect, Medicare Advantage, and Medi-Cal) are available on the CalAIM D-SNP Contract and Policy Guide website.

Additional Guidance

Medicare Parts C & D guidance:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

Applicable Integrated Plan D-SNP guidance:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs

IX. Appendices

Appendix A: LTSS Questions for Inclusion in EAE D-SNP HRA

The questions are organized in the following two tiers and EAE D-SNPs must take a holistic view of questions in both tiers to identify beneficiaries in need of follow-up assessments:

- Tier 1 contains questions directly related to LTSS eligibility criteria, and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
- Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.

The headings in bold are not part of the questions, but provide the intent of the questions.

Tier 1 LTSS Questions:
Activities of Daily Living Functional Limitations / Instrumental Activities of Daily Living

Limitations / Functional Supports (Functional Capacity Risk Factor)
Question 1: Do you need help with any of these actions? (Yes/No to each individual action)
a) Taking a bath or shower
b) Going up stairs
c) Eating
d) Getting Dressed
e) Brushing teeth, brushing hair, shaving
f) Making meals or cooking
g) Getting out of a bed or a chair
h) Shopping and getting food
i) Using the toilet
j) Walking
k) Washing dishes or clothes
l) Writing checks or keeping track of money
m) Getting a ride to the doctor or to see your friends
n) Doing house or yard work

o) Going out to visit family or friends
p) Using the phone
q) Keeping track of appointments

If yes, are you getting all the help you need with these actions?

Housing Environment / Functional Supports (Social Determinants Risk Factor)

Question 2: Can you live safely and move easily around in your home? (Yes/No)
If no, does the place where you live have: (Yes/No to each individual item)
a) Good lighting
b) Good heating
c) Good cooling
d) Rails for any stairs or ramps
e) Hot water
f) Indoor toilet
g) A door to the outside that locks
h) Stairs to get into your home or stairs inside your home
i) Elevator
j) Space to use a wheelchair
k) Clear ways to exit your home

Low Health Literacy (Social Determinants Risk Factor)

Question 3: "I would like to ask you about how you think you are managing your health conditions"
a) Do you need help taking your medicines? (Yes/No)
b) Do you need help filling out health forms? (Yes/No)
c) Do you need help answering questions during a doctor's visit? (Yes/No)

Caregiver Stress (Social Determinants Risk Factor)

Question 4: Do you have family members or others willing and able to help you when you need it? (Yes/No)

Question 5: Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)

Abuse and Neglect (Social Determinants Risk Factor)

Question 6a: Are you afraid of anyone or is anyone hurting you? (Yes/No)
Question 6b: Is anyone using your money without your ok? (Yes/No)

Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)
Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No)

Tier 2 LTSS Questions:
Fall Risk (Functional Capacity Risk Factor)
Question 8a: Have you fallen in the last month? (Yes/No)
Question 8b: Are you afraid of falling? (Yes/No)

Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)

Isolation (Social Determinants Risk Factor)
Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one)
None – I never feel lonely
Less than 5 days
More than half the days (more than 15)
Most days – I always feel lonely

Appendix B: 2023 CalAIM EAE D-SNP Components Template

Please complete and submit this document with the 2023 EAE D-SNP Model of Care to your DHCS contract manager by 8pm Pacific Time on February 16, 2022

Applicant's Contract Name (as provided in HPMS):	
Applicant's CMS Contract Number:	

DHCS issued state-specific care coordination requirements to health plans intending to operate EAE D-SNPs in California, beginning January 1, 2023 through the D-SNP Policy Guide, December 2021

The state requirements described in the policy guide are in addition to all existing Medicare D-SNP Model of Care requirements outlined in 42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual.

Please populate the table below to indicate the location of the state-specific requirements in the 2023 D-SNP Model of Care.

MOC 2: Care Coordination	
Requirement	**Corresponding Document Section and Page Number**
Risk Stratification D-SNP risk stratification of enrollees must account for identified member needs covered by Medi-Cal. At a minimum, this process must include a review of: • Any available utilization data, including Medicaid utilization data available through the aligned Medi-Cal managed care plan (including long-term care utilization) and utilization data from the member's CMC plan (for members transitioning from the CMC to the D-SNP in 2023); • Any other relevant and available data from delivery systems outside of the managed care plans such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and home-and community-based waiver programs, behavioral health (both mental health and substance use disorder data, if available), and pharmacy data; • The results of previously administered CMC or Medi-Cal Health Risk Assessments (HRAs), if	

available; and • Any data and risk stratification available through the DHCS Population Health Management Platform (when it becomes available).	
Health Risk Assessment (HRA) To the extent possible, while still meeting both Medicare and Medi-Cal requirements, the D-SNP should work with the aligned Medi-Cal managed care plan to create efficiencies in their respective HRA tools and processes to minimize the burden on members. Plans must make best efforts to create a single, unified HRA to meet the requirements for both the D-SNP and Medi-Cal managed care plans. Plans have flexibility in the design of their HRA tools as long the content specified below is included. Plans should rely on Medicare timeframes for the completion of initial and annual HRAs. To the extent that Medi-Cal and Medicare guidance for HRAs conflict, plans should follow Medicare guidance. D-SNPs must ensure their HRA identifies the following elements: 1. Medi-Cal services the member currently accesses. 2. Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in Appendix A or similar questions. If a plan intends to use a variation on the LTSS questions provided, the question must be reviewed and approved by DHCS. Plans may incorporate the questions into their HRA in any order. 3. Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease. If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the D-SNPs assessment process. HRAs must directly inform the development of member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.	

Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs) Both the ICP and ICT meeting should include, to the extent possible, services and providers from the Medi-Cal managed care and carved-out delivery systems, as appropriate for the member and consistent with their preferences. Plans must encourage participation of both members and primary care providers in development of the ICP and ICT activities. The ICP should be person-centered and informed by the member's HRA and past utilization of both Medicare and Medi-Cal services. One ICP should be used to meet both Medicare and Medi-Cal ICP requirements. To the extent that Medi-Cal and Medicare guidance for ICPs conflict, plans should follow Medicare guidance. The ICP must identify any carved-out services the member needs and how the D-SNP will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to: o Community Based Organizations such as those serving members with disabilities (e.g. independent living centers) and those serving members with dementia (e.g. Alzheimer's organizations) o County mental health and substance use disorder services o Housing and homelessness providers o Enhanced Care Management (ECM) and Community Supports (formerly ILOS) providers in the aligned MCP network o 1915(c) waiver programs, including MSSP o LTSS programs, including IHSS and Community-Based Adult Services (CBAS) o Medi-Cal transportation to access Medicare and Medi-Cal services D-SNP care coordinators/managers participating in the ICT must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS programs, including	

home- and community-based services and long-term institutional care. The ICT should include providers of any Medi-Cal services the member is receiving, including LTSS and Community Supports. Irrespective of having a formal Alzheimer's or dementia diagnosis, if the member has documented dementia care needs, including but not limited to: wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, and/or inability to manage ADLs/IADLS, the ICT must include the member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the member's preferences. Dementia care specialists must be trained in: understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees and caregivers. These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.	
Care Transitions D-SNPs must identify individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules. Health plan social services staff serving as liaisons for the LTSS provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. D-SNPs must identify these individuals and their contact information in materials for providers and beneficiaries.	