CALAIM DUAL ELIGIBLE SPECIAL NEEDS PLANS POLICY GUIDE

Contract Year 2024

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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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. 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 maintains the authority to contract or not to contract with D-SNPs.

As part of the CalAIM initiative, DHCS launched EAE D-SNPs, effective January 1, 2023, in the seven counties where the Coordinated Care Initiative and Cal MediConnect Plans were 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. Medicare Medi-Cal Plans, or MMPs, is the California-specific program name for EAE D-SNPs.

This CalAIM D-SNP Policy Guide is intended to serve as a resource for all D-SNPs in Contract Year (CY) 2024, by providing additional details to supplement the 2024 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 2024. Updates will be published as guidance is added.

SUMMARY OF UPDATES AND KEY CHANGES

Date	Chapter/Section	Update/Change
1/23/24	IX. Appendix D	Initial Release of Appendix D
1/23/24	I. Care Coordination	Revised ECM continuity of care section
12/27/23	IV. Quality and Reporting Requirements	Initial Release
12/11/23	IV. Medicare Continuity of Care Guidance for All D-SNPs	Initial Release
11/28/23	III. Network Guidance	Initial Release
9/27/23	I. Care Coordination	Revised citations; updated language for consistency with 2024 SMAC
9/27/23	VII. Dental Benefits	Included integrated appeals and grievances section
9/27/23	IX. Appendix B	Updated Appendix B to include previously distributed 2024 MOC CA Specific Matrix
9/27/23	IX. Appendix C	Initial Release of Appendix C
7/31/23	VII. Dental Benefits	Initial Release
6/9/23	II. Integrated Materials for EAE D-SNPs	Updated Medicare requirements and submission instructions
5/26/23	II. Integrated Materials for EAE D-SNPs	Initial Release
1/24/23	I. Care Coordination	Updated formatting in the disease specific criteria palliative care section
1/19/23	I. Care Coordination	Updated MOC submission instructions
1/11/23	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 and non-EAE D-SNPs in California for contract year (CY) 2024.

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. These state requirements are part of the DHCS SMAC requirements for CY 2024.

D-SNPs that are required by CMS to submit a new Model of Care or re-submit a Model of Care for CY 2024, including those with a new D-SNP only H contract for CY 2024, must reflect these state requirements and populate and submit the California Specific Model of Care Matrix Document to DHCS email box DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager by February 15, 2023. D-SNPs should submit both the MOC and state-specific matrix to DHCS. DHCS recommends that D-SNPs submit the same MOC to both CMS and DHCS. D-SNPs are not required to submit the state-specific matrix to CMS.

For all D-SNPs in CY 2024, these requirements should be incorporated into Models of Care and implemented, regardless of prior Model of Care approval. D-SNPs that are not required by CMS to submit a Model of Care for CY 2024 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 and submit that off-cycle Model of Care update to DHCS email box DHCS_DSNP@dhcs.ca.gov, with cc to DHCS contract manager, by March 31, 2023. DHCS recommends that plans submitting off-cycle submission to DHCS also submit to CMS during NCQA off-cycle submission window. DHCS recommends that D-SNPs submit the same MOC to both CMS and DHCS. D-SNPs are not required to submit the state-specific matrix to CMS.

DHCS may provide feedback on MOC submissions, and DHCS requests any needed updated MOCs be provided to DHCS within 30 days of DHCS feedback to the plans.

Care Coordination Contact List for D-SNPs and MCPs

D-SNPs are required by state and federal regulations to coordinate all Medicare and Medi-Cal services for Members. All D-SNPs and Medi-Cal 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 is enrolled in a D-SNP with a different plan parent organization than the Member's MCP. For Members that require care coordination across Medi-Cal managed care benefits, D-SNPs must use MCP enrollment information 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 D-SNPs that need access to the Microsoft Teams channel for the *D-SNP MCP Coordination Contact List*, 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)).

Risk Stratification

D-SNP risk stratification of Members 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);

- 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 Medicare 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 identify 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.

Non-EAE D-SNPs should coordinate with unaligned MCPs for Member care, including sharing copies of their mutual Member's completed HRA.

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

- Medi-Cal services the Member currently accesses.
- 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.
- Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease. Plans should leverage Dementia Care Aware resources.

Consistent with 42 CFR § 422.101(f)(1)(i), D-SNPs must include at least one question from a list of screening instruments specified by CMS in sub-regulatory guidance on each of three domains (housing stability, food security, and access to transportation).

If a Member identifies a caregiver, assessment of caregiver support needs should be included as part of the D-SNPs assessment process. D-SNPs should use validated caregiver assessment tools, such as the Benjamin Rose Caregiver Strain Instrument, Caregiver Self-Assessment Questionnaire, and REACH II Risk Appraisal. HRAs must directly inform the development of Member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.

Face-to-Face Encounters

Regulations at 42 CFR §422.101(f)(1)(iv) require that all SNPs must provide, on at least an annual basis, beginning within the first 12 months of enrollment, as feasible and with the enrollee's consent, face-to-face encounters for the delivery of health care or care management or care coordination services and be between each enrollee and a Member of the enrollee's ICT or the plan's case management and coordination staff, or contracted plan healthcare providers. A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter. DHCS requires D-SNPs to provide the equivalent of Medi-Cal Enhanced Care Management (ECM) primarily through in-person contact. D-SNPs must use alternate methods (including telehealth) when in-person communication is unavailable or does not meet the needs of the Member, to provide culturally appropriate and accessible communication in accordance with Member choice.

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. If cognitive impairment is present, caregivers should also be involved. For Members with serious illness participating in a palliative care program, the D-SNP must use a palliative care ICT.

The ICP should be person-centered and, when cognitive impairment is present, family-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 should be developed and updated by, and/or shared with the Member's palliative care team, as appropriate.

Non-EAE D-SNPs should coordinate with unaligned MCPs for Member care, including sharing copies of their mutual Member's completed ICP and participating in the ICT.

For Non-EAE D-SNP Members, there must be established connections between the D-SNP and the MCP to coordinate care. The D-SNP is responsible for coordinating with the MCP and ensuring care managers are exchanging information to update the Member's care plan and engage providers in care plan development and care team meetings. DHCS maintains the *D-SNP MCP Coordination Contact List* for MCPs and D-SNPs. MCP and care coordinator contact information must be included in the D-SNP care plan.

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 providers in the 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
- Medi-Cal dental benefits

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. Non-EAE D-SNPs should work with unaligned MCPs to engage Medi-Cal providers in the ICT.

Dementia/Alzheimer's Care

The Dementia Care Aware training and resources may be used to support D-SNP providers when detecting cognitive impairment for D-SNP Members.

Plans should encourage any providers to leverage Dementia Care Aware resources for any primary care visit to detect cognitive impairment. When detected, a full diagnostic workup should be conducted. Providers can leverage tools presented in the California Alzheimer's Disease Centers' "Assessment of Cognitive Complaints Toolkit for Alzheimer's Disease."

Note that Medicare covers an additional Cognitive Assessment when cognitive impairment is detected. Any clinician eligible to report evaluation and management services can offer a 50-minute cognitive assessment service.

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.

D-SNPs must have trained dementia care specialists on ICTs for Members living with dementia who also have: two or more co-existing conditions, or moderate to severe behavioral issues or high utilization or live alone or lack adequate caregiver support or moderate to severe functional impairment. 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 Members and caregivers. D-SNPs should leverage available training content from organizations such as Alzheimer's Los Angeles, Alzheimer's Orange County, or similar organizations when developing training content for dementia care specialists.

Dementia care specialists 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 institutional long-term 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.

D-SNPs must have care transition protocols that include coordination with Medi-Cal plans for non-EAE D-SNPs. D-SNPs must have care transition protocols that reflect the State Medicaid Agency Contract and Policy Guide requirements for Information Sharing.

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

DHCS' requirements for MCPs to implement ECM are contained in the ECM All Plan Letter (APL), 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 (more information and links available on the DHCS ECM and Community Supports webpage).

Some D-SNP Members needing care management services through D-SNPs may also meet the criteria for ECM populations of focus. However, there is significant overlap across the D-SNP model of care and ECM requirements, which could result in duplication and confusion for Members and care teams if a Member receives care management from both programs. Member care management, as well as coordination across Medicare and Medi-Cal benefits, is a primary function of D-SNPs. Beginning on 1/1/2024, all D-SNPs must provide sufficient care management ("ECM-like care management") to Members to ensure that Members who would otherwise qualify for Medi-Cal ECM are not adversely impacted by receiving care management exclusively through their D-SNP.

For Members who did not have an active authorization for ECM on or prior to 12/31/2023, ECM-like care management may be provided to eligible Members through the EAE or non-EAE D-SNP. For Members who did have an active authorization for ECM on or prior to 12/31/2023, see the ECM Continuity of Care section below.

ECM Continuity of Care

DHCS is committed to helping to ensure dual eligible Members with authorizations to receive ECM from their Medi-Cal MCP do not experience disruptions to their ECM authorizations, provider relationships, or services. The ECM continuity of care policies outlined below aim to provide clarification for Members transitioning between health plans, including newly enrolling in EAE D-SNPs, and other transitions such as the 2024 Medi-Cal MCP Transition on 1/1/2024.

For Members Enrolled in EAE D-SNPs (as of 1/1/2024):

Beginning on 1/1/2024, for new EAE D-SNP Members (enrolled in the EAE D-SNP as of 1/1/2024) already receiving Medi-Cal ECM from their MCP, EAE D-SNPs shall provide ongoing continuity of care with the existing ECM providers, when possible, until the Member graduates from ECM.

For Members Enrolled in Non-EAE D-SNPs (as of 1/1/2024):

Beginning on 1/1/2024, non-EAE D-SNP Members (enrolled in the non-EAE D-SNP on or before 1/1/2024) enrolled in a Medi-Cal MCP who have active authorization to receive Medi-Cal ECM on or prior to 12/31/2023 will continue to receive ECM from their MCP for a period of up to 12 months or until the Member meets the criteria for discontinuing ECM as outlined in Section VIII of the ECM Policy Guide.

- For Members who are enrolled in a non-EAE D-SNP who have an active authorization to receive ECM from their MCP on or prior to 12/31/2023 and who reside in counties impacted by the MCP transition, the receiving MCP will also be subject to preexisting CoC requirements as established in the MCP Transition Policy Guide. It is also the responsibility of the MCP to notify the ECM Provider and the D-SNP when ECM has been discontinued. Plans should use the *D-SNP MCP Coordination Contact List* to identify the correct D-SNP point of contact.
- Members who have a continuing authorization to receive ECM through their MCP at the end of 2024 will transition to receiving ECM-like care management through the D-SNP beginning on 1/1/2025. Additional guidance on this will be provided by DHCS at a future date.

For Members Impacted by the Medi-Cal Matching Plan Policy:

Beginning on 1/1/2024, there will be 5 new counties (Kings, Madera, Orange, San Mateo, and Tulare) impacted by the Medi-Cal Matching Plan Policy[1], totaling 17 counties across the state. For new EAE or non-EAE D-SNP Members (as of 1/1/2024)

[1] Medi-Cal Matching Plan Policy: If a Member joins a Medicare Advantage plan and there is a Medi-Cal plan that matches with that plan, the Member must choose that Medi-Cal plan. This policy does not change or affect a Member's choice of a Medicare plan. The matching policy applies to the following counties in 2024: Alameda, Contra Costa, Fresno, Kern, Kings, Madera, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Stanislaus, and Tulare.

already receiving Medi-Cal ECM from their MCP (on or prior to 12/31/2023) whose MCP changes due to the Medi-Cal Matching Plan Policy, the D-SNP shall provide ongoing continuity of care with the existing ECM providers, when possible, until the Member graduates from ECM.

Additional information on Member-specific scenarios and operational guidance for D-SNPs and MCPs is available in Appendix D of this Policy Guide.

Dual Eligible Enrollee Type	2023	2024	2025
Most Dual Eligible Enrollees in MA or Medicare FFS	» ECM provided by the Member's Medi-Cal MCP » Member must meet Population of Focus (PoF) requirements	Same as 2023	Same as 2023
Non-EAE D-SNP Enrollees	» ECM provided by the Member's Medi-Cal MCP » Member must meet Population of Focus (PoF) requirements	» *Members who do **not** have an active authorization for ECM by the end of 2023:* ECM-like care management may be provided to eligible members through the non-EAE D-SNP. » *Members who have an active authorization for ECM at the end of 2023 and who remain in the same MCP in 2024:* ECM will	» ECM-like care management provided by D-SNP to eligible members. » Members in non-EAE D-SNPs who received ECM CoC provided by Medi-Cal MCP throughout 2024 will transition on 1/1/2025 to ECM-like care management provided by D-SNPs.

Dual Eligible Enrollee Type	2023	2024	2025
Non-EAE D-SNP Enrollees		continue to be provided by the Medi-Cal MCP for up to 12 months or until member meets criteria for discontinuing ECM. » *Members who have an active authorization for ECM at the end of 2023 and whose MCP changes in 2024 due to the Medi-Cal Matching Plan Policy:* ECM-like care management may be provided to eligible members through the non-EAE D-SNP. » *Members who have an active authorization for ECM at the end of 2023 and whose MCP changes in 2024 due to the Medi-Cal MCP Transition:* The receiving MCP will be subject to	

Dual Eligible Enrollee Type	2023	2024	2025
Non-EAE D-SNP Enrollees		preexisting CoC requirements as established in the MCP Transition Policy Guide.	
EAE D-SNP Enrollees	» ECM-like care management will be provided by EAE D-SNP to eligible members.	» Same as 2023	» Same as 2023

ECM-like Care Management Requirements for D-SNPs

D-SNPs should review the ECM populations of focus per the ECM policy guide. D-SNPs in California must include, in addition to any other sub-populations determined by the D-SNP, four or more populations of focus from the Medi-Cal Enhanced Care Management program.

EAE and Non-EAE D-SNPs must demonstrate in the state-specific Model of Care matrix how the plan's D-SNP model of care includes and reflects the delivery of the seven ECM core services, as outlined below and in the ECM Policy Guide:

- Outreach and Engagement
- Comprehensive Assessment and Care Management Plan
    - D-SNPs must engage with each Member who would otherwise qualify for ECM to receive care management primarily through in-person contact.
    - When in-person communication is unavailable or does not meet the needs of the Member, the D-SNP must use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
- Enhanced Coordination of Care
- Health Promotion
- Comprehensive Transitional Care

- Member and Family Supports; and
- Coordination of and Referral to Community and Social Support Services

Care Coordination Requirements for Palliative Care

Palliative Care Overview

All D-SNPs are responsible for providing and coordinating inpatient and outpatient/community-based palliative care referrals and services for dual eligible Members with serious illnesses that meet current Medi-Cal criteria for palliative care, including both general and disease specific criteria, or an alternate set of criteria for palliative care referral that is no more restrictive than the Medi-Cal criteria, as described in All Plan Letter (APL) 18-020 and the SB 1004 Medi-Cal Palliative Care Policy. Both EAE and non-EAE D-SNPs must leverage the Medi-Cal palliative care approach and bundle of services for their Members.

D-SNP Sub-populations of most vulnerable enrollees must include Members with serious illness eligible for palliative care referral.

Referral to and effective coordination of palliative care services should be a priority for D-SNPs. D-SNP care plans should reflect any changes resulting from palliative care consultation. Members of the palliative care team should be included in the Member's care team meetings and the palliative care coordinator should serve as lead care manager for the Member. For Members with serious illness participating in a palliative care program, the D-SNP must use a palliative care ICT. D-SNPs should ensure that the provider network includes sufficient palliative care providers and home- or community-based organizations offering palliative care services.

The DHCS Medi-Cal Palliative Care Policy specifies the minimum types of palliative care services that must be authorized when medically necessary for Members who meet the eligibility criteria.[2] D-SNPs must either adopt the DHCS minimum eligibility criteria for palliative care, or they may submit broader eligibility criteria to DHCS for approval.

Palliative Care Eligibility Criteria

Members are eligible to receive palliative care services if they meet all of the

[2] DHCS' SB 1004 Medi-Cal Palliative Care Policy, dated November 2017, is available at: http://www.dhcs.ca.gov/provgovpart/Documents/SB1004PalliativeCarePolicyDoc11282017.pdf

criteria outlined in the General Eligibility Criteria below, and at least one of the four requirements outlined in the Disease-Specific Eligibility Criteria.

General Eligibility Criteria:

1. The Member is likely to, or has started to, use the hospital or emergency department as a means to manage the Member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The Member has an advanced illness, as defined in section I.B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The Member's death within a year would not be unexpected based on clinical status.
4. The Member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The Member is not in reversible acute decompensation.
5. The Member and, if applicable, the family/Member-designated support person, agrees to:
    a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    b. Participate in Advance Care Planning discussions.

Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The Member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or

higher;[3] and

b. The Member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)
    a. The Member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    b. The Member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.
3. Advanced Cancer: Must meet (a) and (b)
    a. The Member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    b. The Member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver Disease: Must meet (a) and (b) combined or (c) alone
    a. The Member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    b. The Member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    c. The Member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.[4]

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[3] NYHA classifications are available at: http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.WefN7rpFxxo

[4] The MELD score calculator is available at: https://optn.transplant.hrsa.gov/resources/allocation- calculators/meld-calculator

If the Member continues to meet the above minimum eligibility criteria palliative care eligibility criteria, the Member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.[5]

D-SNPs must have a process to identify Members who are eligible for palliative care, including a provider referral process.[6] D-SNPs must periodically assess the Member for changes in the Member's condition or palliative care needs. D-SNPs may discontinue palliative care that is no longer medically necessary or no longer reasonable.

Palliative Care Services

When a Member meets the minimum eligibility criteria for palliative care, D-SNPs must authorize palliative care. Palliative care must include, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

A. Advance Care Planning: Advance care planning for Members enrolled in palliative care includes documented discussions between a physician or other qualified healthcare professional and a patient, family Member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

B. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:

   - Treatment plans, including palliative care and curative care
   - Pain and medicine side effects

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[5] CMS Letter #10-018 is available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10018.pdf

[6] D-SNPs may receive referrals from in-network or out-of-network providers, such as primary care providers, specialty providers, and Specialty Care Centers. D-SNPs must review all referrals received to make medical necessity determinations for palliative care services.

- Emotional and social challenges
- Spiritual concerns
- Patient goals
- Advance directives, including POLST forms
- Legally-recognized decision maker

C. Plan of Care: A plan of care should be developed with the engagement of the Member and/or the Member's representative(s) in its design. If a Member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A Member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care.

D. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a Member and of the Member's family and are able to assist in identifying the Member's sources of pain and discomfort. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team Members must provide all authorized palliative care. DHCS recommends that the palliative care team include, but is not limited to the following team Members: a doctor of medicine or osteopathy (Primary Care Provider if MD or DO); a registered nurse; a licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP); and a social worker. DHCS also recommends that D-SNPs provide access to chaplain services as part of the palliative care team.

E. Care Coordination: A Member of the palliative care team must provide coordination of care, ensure continuous assessment of the Member's needs, and implement the plan of care.

F. Pain and Symptom Management: The Member's plan of care must include all services authorized for pain and symptom management. Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address a Member's

pain and other symptoms.

G. Mental Health and Medical Social Services: Counseling and social services must be available to the Member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate.

D-SNPs must have a process to determine the type of palliative care that is medically necessary or reasonable for eligible Members. D-SNPs must have an adequate network of palliative care providers to meet the needs of their Members.

D-SNPs may authorize additional palliative care not described above, at the plan's discretion. Examples of additional services offered by many community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/7 days a week.

Palliative Care Providers

D-SNPs may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings. D-SNPs must utilize qualified providers for palliative care based on the setting and needs of a Member. DHCS recommends that D-SNPs use providers who possess current palliative care training and/or certification to conduct palliative care consultations or assessments.

D-SNPs may contract with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care. D-SNPs may contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services facilities may be considered palliative care partners for facilitating advance care planning or palliative care referrals. Palliative care provided in a Member's home must comply with existing requirements for in-home providers, services, and authorization, such as physician assessments and care plans. D-SNPs must inform and educate providers regarding availability of palliative care.

II. 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)[7]. These requirements are also included in California's SMAC for EAE D-SNPs in 2024.

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

- Annual Notice of Change (ANOC)
- Member Handbook
- Summary of Benefits
- Member Identification (ID) Card
- Provider and Pharmacy Directory
- List of Covered Drugs (Formulary)

Additional notes and requirements:

- Integrated appeals and grievances materials are detailed in the SMAC for EAE D-SNPs.
- Due to integrated Member materials containing both Medicare and Medi-Cal information, plans must suppress Medi-Cal welcome packages as they would be duplicative and unnecessary.
- Plans are required to use the CMS Multilanguage Insert (MLI) language and DHCS tagline language in their Member Handbook and applicable integrated materials.
- Member Handbook:
    - Plans must use the DHCS tagline in Chapter 1 of the Member Handbook.

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

- In Chapter 2 of the Member Handbook, plans may exclude some of the contact information (e.g., email) if that information is not available or provided anywhere for some entities.

» For Medi-Cal Rx references in integrated Member materials, plans may refer Members to the Medi-Cal Rx website and customer service number for questions.

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

DHCS does not plan on creating a logo for EAE D-SNPs at this time and does not have additional guidance on co-branding for delegated or primary Plans. Plans have discretion on co-branding, but must comply with all Medicare co-branding requirements found in 42 CFR 422 Subpart V.

Translation

EAE D-SNPs will be required to make all integrated Member materials available in the threshold languages for their aligned MCP Service Area. Threshold languages include both:

a) Medicare's five percent (5%) threshold for language translation as outlined in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V; and

b) DHCS' prevalent language requirements (the DHCS threshold and concentration standard languages), as specified in APL 21-004 or subsequent iterations guidance to Contractors on specific translation requirements for their Service Areas.

Alternate Formats

All D-SNPs[8] must provide materials[9] and Individualized Care Plans (ICPs) to Members on a standing basis in alternate formats and in any non-English language[10] , upon receiving a request for materials or otherwise learning of the Member's primary language and/or need for an alternate format. Instances where the D-SNP may learn of a Member's need for materials in a non-English language and/or alternate format include: by member request, during a Health Risk Assessment (HRA), or other touch point. The process[11] must 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.

Application Programming Interface

EAE D-SNPs are required to have a single Application Programming Interface (API) for Members to access both Medicare and Medi-Cal information. Contractor shall implement and maintain a publicly accessible, standards-based Patient Access API, and a provider directory API, as described in 42 CFR sections 431.60 and 431.70, and in APL

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[8] Pursuant to 42 C.F.R. §§ 422.2267(a)(3) and 423.2267(a)(3), MA organizations, cost plans, and Part D sponsors must provide materials to enrollees on a standing basis in any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package service area or accessible format upon receiving a request for the materials or otherwise learning of the enrollee's primary language and/or need for an accessible format. This requirement also applies to individualized plans of care described in 42 C.F.R. § 422.101(f)(1)(ii) for special needs plan enrollees.

[9] Required materials are described under 42 C.F.R. §§ 422.2267(e).

[10] Any non-English language as identified in 42 C.F.R 422.2267(a)(2) and 422.2267(a)(4) or the DHCS threshold and concentration standard languages as identified in APL 21-004 or subsequent iterations, whichever is more stringent.

[11] D-SNPs may refer to APL 22-002 or subsequent iterations for information about DHCS' processes to ensure effective communication with Members with visual impairments or other disabilities requiring the provision of written materials in alternative formats, by tracking Members' alternative format selections (AFS).

22-026. Contractor must operate the API in the manner specified in 45 CFR section 170.215 and include information per 42 CFR section 438.242(b)(5) and (6).

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

Upon completing the templates, EAE D-SNPs are required to submit their completed integrated Member 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 DHCS via the Health Plan Management System (HPMS). When submitting via HPMS plans should be selecting their DHCS Contract Manager as the reviewer. Please see the table below for list of materials. 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. The Member ID Card, Formulary and Provider and Pharmacy Directory should only be sent for DHCS' review and approval. Note: The processes may change for CY 2025 integrated Member materials.

The Provider and 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.

Beneficiary Material	Deadline to Submit to DHCS and DMHC	Estimated State Approval Date	Due to Current Enrollees
Annual Notice of Change (ANOC)	July 17, 2023	August 8, 2023	September 30, 2023
Member Handbook	July 24, 2023	August 25, 2023	October 15, 2023
Summary of Benefits	July 24, 2023	August 31, 2023	October 15, 2023
Member ID Card	August 1, 2023	August 31, 2023	Within 10 days of when plan receives enrollment in their system (early

Beneficiary Material	Deadline to Submit to DHCS and DMHC	Estimated State Approval Date	Due to Current Enrollees
			November 2023)
Formulary	August 1, 2023	August 31, 2023	October 15, 2023
Provider and Pharmacy Directory	August 1, 2023	August 31, 2023	October 15, 2023

**Note: The approval dates are subject to change based on reviewer's findings.*

Other Marketing Materials

For all other plan marketing materials not included in the list of integrated materials, there will not be state-specific marketing guidance for EAE D-SNPs.

EAE D-SNPs must follow existing CMS requirements with respect to marketing and beneficiary communications outlined in regulations at 42 CFR Subpart V, provider directory requirements at 42 CFR § 422.111(b)(3) and additional guidance in the Marketing Communications and Marketing Guidelines.[12]

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

III. NETWORK GUIDANCE FOR D-SNPS

The purpose of this section is to provide state-specific provider network guidance to all D-SNPs operating in California beginning January 1, 2024. 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 Contracts (SMACs) for EAE and Non-EAE D-SNPs in 2024. This chapter includes the following requirements for D-SNPs:

- Aligned Networks (EAE)
  - Medi-Cal Provider Network Existing Submission Requirements (EAE)
- Aligned Networks - Language Gap Assessment (EAE)
- Medicare Provider Network File Submission (EAE and Non-EAE)

Additional details on submission requirements and timelines are available at the end of this chapter. Requirements for EAE D-SNPs that offer Dental Supplemental Benefits to report to DHCS on the level of overlap for their Medicare dental network and the Medi-Cal Dental network (per CY 2024 SMAC) will be outlined in a subsequent release. Additional details, reporting submission timeline, and requirements will be released at a later date.

Network Adequacy

Medicare network adequacy requirements for D-SNPs are monitored by CMS in accordance with 42 CFR 422.116. Medi-Cal network adequacy requirements for MCPs are monitored by DHCS in accordance with Title 42 of the Code of Federal Regulations (CFR) sections 438.68, 438.206, and 438.207, and Welfare and Institutions Code (WIC) section 14197, and compliance is assessed via the annual network certification in accordance with All Plan Letter (APL) 23-001. These combined Medicare and Medi-Cal requirements and the assessments performed by Medicare and DHCS to assess compliance with said requirements are sufficient to meet the network adequacy requirements referenced in 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 Members transitioning from Medi-Cal only to dual eligibility for Medicare and Medi-Cal. For contract year 2023, DHCS solicited information from EAE D-SNPs about the extent to which their networks are aligned. Contract year 2024 guidance has been adjusted based on lessons learned from the 2023 reporting.

EAE D-SNPs must report to DHCS the percent and number of contracted Medi-Cal physicians and facilities for the D-SNPs aligned Medi-Cal managed care plan (MCP) that are also contracted Medicare physicians and facilities with the EAE D-SNP. The MCP network used for this calculation should just be for the plan aligned with the EAE D-SNP parent company. If the MCP is a prime plan, the calculation should reflect the prime plan's network. If the MCP is a delegate plan, the calculation should only reflect the delegate plan network.

DHCS has provided a reporting 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
  - Include Vascular Surgery
  - Exclude Genetics, Maternal/Fetal Medicine, Pediatric Subspecialties, Pediatric Surgery and Chiropractor
- Ancillary Provider and 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)
  - Include Dialysis Centers

For contract year 2024, DHCS recommends EAE D-SNPs meet a minimum network overlap percentage of:

- 90%: Primary Care category
- 90%: Specialty Care category

I. Medi-Cal Provider Network Existing Submission Requirements

DHCS will use the D-SNP's companion MCP 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 version of the Companion Guide. To request the current Companion Guide, email MCQMDProviderData@DHCS.ca.gov.

To assist with network building, D-SNPs 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.

Aligned Networks - Language Gap Assessment

For contract year 2024, EAE D-SNPs will be required to analyze their linguistic services, which includes languages offered (American Sign Language inclusive) by the Plan or by a skilled medical interpreter at the provider's office. This analysis should be with respect

to differences between Medicare network providers and the specified Medi-Cal network providers. To demonstrate compliance with these requirements, Plans must submit the Language Gap Assessment Deliverable including the following:

- A description of the gap analysis process
- The languages for the service area
- The specific languages offered by the Plan for each service area
- The plan for addressing the gaps in language services, by service area, including target dates for closing the gaps

The Language Gap Assessment deliverable must be submitted by the MCP compliance officer via the Secure File Transfer Protocol (SFTP) site in the MCP's Provider Network File Subfolder to DHCS.

Medicare Provider Network File Submission

For contract year 2024, all D-SNPs (EAE and Non-EAE) must submit a file with their contracted Medicare provider network to DHCS. DHCS has provided a reporting template for D-SNPs to complete. EAE D-SNPs must submit through Secure File Transfer Protocol (SFTP) site in the MCP's specific Provider Network File subfolder, and Non-EAE D-SNPs must submit to DHCS via email. Instructions are provided in the table below.

Report Type	Purpose	Reporting Period	Frequency/Timing
EAE D-SNPs			
Aligned Networks: Percentage of aligned networks	Plans to submit alignment percentage by county per specialty type utilizing the provided template titled "2024 Network Guidance for EAE DSNPs – Template."	February of the contract year	Must be submitted on the SFTP site in the MCP's specific Provider Network File subfolder by March 15th of the contract year. Plans are also required to send notification the submission has been completed to DHCS_DSNP@dhcs.ca.gov
Aligned Network Language Gap Assessment	Plans are required to analyze their linguistic services	February of the contract year	Must be submitted on the SFTP site in the MCP's specific Provider Network

Report Type	Purpose	Reporting Period	Frequency/Timing
	annually and work with DHCS to address any gaps identified.		File subfolder by March 15th of the contract year. Plans are also required to send notification the submission has been completed to DHCS_DSNP@dhcs.ca.gov
Medicare Provider Network File	Plans to submit a file listing their contracted Medicare providers utilizing the template titled "2024 D-SNP Medicare Network -Template."	February of the contract year	Must be submitted on the SFTP site in the MCP's specific Provider Network File subfolder by March 15th of the contract year. Plans are also required to send notification the submission has been completed to DHCS_DSNP@dhcs.ca.gov
Non EAE D-SNPs			
Medicare Provider Network File	Plans to submit a file listing their contracted Medicare providers utilizing the template titled "2024 D-SNP Medicare Network -Template."	February of the contract year	Must be submitted via email to DHCS_DSNP@dhcs.ca.gov by March 15th of the contract year.

IV. 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, 2024. These requirements are in addition to any existing federal Medicare Advantage (MA) requirements, including 42 CFR § 422.112(b). 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 a D-SNP. These requirements are for Medicare providers and Medicare covered services and are included in California's State Medicaid Agency Contract (SMAC) for all D-SNPs in 2024.

Continuity of care requirements for Medi-Cal providers and Medi-Cal covered services can be found in All Plan Letter 23-022, as well as any subsequent All Plan Letters on this topic.

For Medi-Cal Enhanced Care Management (ECM) Continuity of Care policy, please see the Care Coordination chapter of the 2024 CalAIM D-SNP Policy Guide. That chapter includes more information about continuity of care provisions for dual eligible beneficiaries receiving Medi-Cal Enhanced Care Management (ECM).

Continuity of Care for Medicare Primary and Specialty Providers

Upon a Member, authorized representative, or provider's request, 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.

I. 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.

II. 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 must not require the requester to complete and submit a paper or computer form. To complete a telephone request, the D-SNP must 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.

III. Requests 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.

IV. 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 provider alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider. Members in EAE D-SNPs maintain the right to pursue an appeal or grievance through the integrated appeals and grievances process, as described in the CY2024 SMAC. Members in non-EAE D-SNPs 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.

V. D-SNP Extended Continuity of Care Options

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 All Plan Letter 21-004. D-SNPs must provide training to call centers and other staff who come into regular contact with Members about continuity of care protections.

V. COORDINATION WITH DENTAL BENEFITS

The purpose of this section is to provide state-specific guidance for all D-SNPs regarding the coordination of dental benefits. D-SNP Members may have dental benefits from both their D-SNP and from Medi-Cal, and all D-SNPs are required to coordinate these benefits for their Members. These requirements are outlined in the 2024 SMACs for exclusively aligned enrollment (EAE) dual eligible special needs plans (D-SNPs, also referred to as Medicare Medi-Cal Plans or MMPs) and non-EAE D-SNPs. The state requirements described in this section are in addition to all existing federal Medicare Advantage (MA) requirements detailed in 42 CFR Part 422 Subpart C and Subpart V and as described in the Medicare Communications and Marketing Guidelines (MCMG)[13].

Requirements for EAE D-SNPs to report on Medicare and Medi-Cal Dental provider network overlap will be detailed in the Network Guidance D-SNP Policy Guide chapter.

Overview: Coordinating Dental Benefits Across Medicare and Medi-Cal

D-SNPs are required to coordinate all Medicare and Medi-Cal benefits, including dental benefits. If a D-SNP offers Supplemental Dental Benefits, those services should be coordinated to ensure the D-SNP tracks Member use of Supplemental Dental Benefits and exhausts the Supplemental Dental Benefits prior to or concurrent with authorization of or referral for Medi-Cal Dental benefits.

D-SNPs will contact the DHCS Dental Administrative Service Organization (ASO) or Fiscal Intermediary - Dental Business Organization (DBO) for provider information and the coordination of dental benefits for Members enrolled in Medi-Cal Dental fee-for-service. For Members enrolled in Medi-Cal Dental Managed Care (Sacramento and Los Angeles counties), D-SNPs will contact the Medi-Cal Dental Managed Care Plan for provider information and to coordinate Medi-Cal Dental benefits. Medi-Cal Dental Fee-for-Service contact information as well as Medi-Cal Dental Managed Care contact information can be found online.

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[13] See https://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/FinalPartCMarketingGuidelines

Integrated Appeals and Grievances for Dental Benefits

Integrated appeals and grievances procedures apply to all benefits offered under an EAE D-SNP including optional supplemental benefits. For benefits that are carved out, such as Medi-Cal Dental, EAE D-SNPs must also follow the regulations at §§ 422.562(a)(5) and 422.629(e) that require EAE D-SNPs to provide Members reasonable assistance completing forms and taking other procedural steps to assist Members with appeals and grievances. This includes offering to assist Members with obtaining Medi-Cal covered services and navigating Medi-Cal appeals and grievances in connection with the Member's own Medi-Cal coverage, regardless of whether such coverage is in Medi-Cal fee-for-service or a separate Medi-Cal Dental Managed Care Plan. If the Member accepts the assistance, the EAE D-SNP should assist the Member as needed, such as identifying and reaching out to a Medi-Cal fee-for-service point of contact, providing assistance in filing an appeal or grievance, helping to obtain documentation to support a request for Medi-Cal appeal or grievance, or completing paperwork that may be needed in filing an appeal or grievance.

EAE D-SNPs can refer to Appendix C for additional resources on Medi-Cal Dental appeals and grievances.

Medi-Cal Dental Benefits in D-SNP Member Materials

All D-SNPs must include information about Medi-Cal Dental benefits in any materials that provide Member information about D-SNP Supplemental Dental Benefits per the CY2024 SMAC. Requirements for integrated Member materials for EAE D-SNPs are outlined in the Integrated Materials D-SNP Policy Guide chapter and in CY2024 model templates. For all other Member materials, all D-SNPs that offer Supplemental Dental Benefits must include Medi-Cal Dental information in any materials that provide information on Supplemental Dental Benefits. This requirement is to increase transparency about the availability of Medicare and Medi-Cal dental benefits to ensure Members are informed of their benefits and how to access them.

DHCS recommends that all D-SNPs, at minimum, include contact information for the Medi-Cal Dental Provider Directory, such as the phone number to the Medi-Cal Dental Services Program customer service line (1-800-322-6384; TTY 1-800-735-2922) or a link to the online Medi-Cal Dental Provider Directory. DHCS also recommends that all D-SNPs include information on how Members can learn more about the Medi-Cal Dental program, such as the following:

> *For a full list of services covered by the Medi-Cal Dental Program, call 1-800-322-6384 (TTY 1-800-735-2922) or visit Smile, California. These resources can also help you locate a Medi-Cal dental provider and file a grievance or complaint.*

For EAE D-SNPs, information on Medi-Cal Dental Benefits has been included in several integrated Member materials (such as the Member Handbook). EAE D-SNPs must include Medi-Cal Dental information on all other Member-facing materials, such as webpages about Supplemental Dental Benefits on the D-SNP's website.

Non-EAE D-SNPs must include information about Medi-Cal Dental benefits in any Member materials that provide Member information about Supplemental Dental Benefits, including but not limited to the Evidence of Coverage (Member Handbook) and Member-facing webpages on the D-SNP's website. Non-EAE D-SNPs are encouraged to leverage the language from the EAE D-SNPs integrated Member materials, which is included below.

I. Dental Information Included in EAE D-SNP Integrated Member Handbook

Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; includes, but is not limited to, services such as:

- Initial examinations, X-rays, cleanings, and fluoride treatments
- Restorations and crowns
- Root canal therapy
- Partial and complete dentures, adjustments, repairs, and relines

CALL	TTY	WEBSITE
1-800-322-6384 *The call is free.* *Dental benefits are available through Medi-Cal Dental Fee-for-Service and Dental Managed Care (DMC) Programs. Medi-Cal Dental Fee-For-Service*	*1-800-735-2922* *This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.*	*http://www.dental.dhcs.ca.gov/*

CALL	TTY	WEBSITE
Program representatives are available to assist you from 8:00a.m. to 5:00 p.m., Monday through Friday		

In addition to the Medi-Cal Dental Fee-For-Service Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Sacramento and Los Angeles Counties. If you want more information about dental plans, or want to change dental plans, contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free.

II. Accessible Visuals for Members about Dental Benefits

In addition, DHCS recommends all D-SNPs leverage accessible visuals to help Members identify all dental benefits covered by the D-SNP's Supplemental Dental Benefits and Medi-Cal Dental Benefits. D-SNPs are encouraged to include these visuals in Member-facing materials, such as on the D-SNP's website. Two examples are included below:

[D-SNP Marketing Name] Dental Benefits	***Medi-Cal Dental Benefits (Dental Fee-for-Service or Dental Managed Care)***
Your [D-SNP Marketing Name] Dental Benefits include: » [List Supplemental Dental Benefits provided by the D-SNP]	*Your Medi-Cal Dental Benefits include:* » Dental exams (every 12 months) » Teeth cleaning (every 12 months) » Scaling and root planing » Fluoride varnish (every 12 months) » X-rays » Fillings » Crowns » Root canals » Partial and full dentures » Denture relines » Tooth removal » Emergency services

Type of Benefit	*Covered by [D-SNP Marketing Name]*	*Covered by Medi-Cal Dental*
Dental exams (every 12 months)		X
Teeth cleaning (every 12 months)		X
Scaling and root planing		X
Fluoride varnish (every 12 months)		X
X-rays		X
Fillings		X
Crowns		X
Root canals		X
Partial and full dentures		X
Denture relines		X
Tooth removal		X
Emergency services		X

Medi-Cal Dental Benefits in D-SNP Marketing Materials

All D-SNPs must include information about Medi-Cal Dental benefits in marketing materials. The specific language or information included about Medi-Cal Dental benefits is at the discretion of the D-SNP within the format of the models, as applicable, but D-SNPs must follow existing CMS requirements with respect to marketing and beneficiary communications outlined in 42 CFR Part 422 Subpart C and Subpart V and as described in the Medicare Communications and Marketing Guidelines (MCMG)[14].

DHCS recommends that all D-SNPs, at minimum, include contact information for the Medi-Cal Dental Provider Directory, such as the phone number to the Medi-Cal Dental

[14] See https://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/FinalPartCMarketingGuidelines

Services Program customer service line (1-800-322-6384; TTY 1-800-735-2922) or a link to the online Medi-Cal Dental Provider Directory in D-SNP marketing materials.

Additionally, DHCS recommends that D-SNPs leverage existing materials on Smile, California, to market Medi-Cal Dental benefits, such as the following callout box[15]:

> *As a Medi-Cal member, your benefits include dental coverage at little or no cost to you. Even if you have Medicare or Medicare Advantage, Medi-Cal can cover dental benefits not covered by Medicare. You are covered for these common services:*
>
> - Dental exams (every 12 months)
> - Teeth cleaning (every 12 months)
> - Scaling and root planing
> - Fluoride varnish (every 12 months)
> - X-rays
> - Fillings
> - Crowns
> - Root canals
> - Partial and full dentures
> - Denture relines
> - Tooth removal
> - Emergency services

[15] See the Medi-Cal Covers Dental Care for Seniors flyer

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, 2024. 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.
6) Quality of data received from D-SNPs in prior years.

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.

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. The table below outlines measures that D-SNPs will report summary level race and ethnicity data for select measures and all HEDIS measures.

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. AAP: HEDIS Adults' Access to Preventive/Ambulatory Health Services

Effectiveness of Care

II. CBP: HEDIS Controlling High Blood Pressure

III. GSD: HEDIS Glycemic Status Assessment for Patients With Diabetes (>9.0%) – Previously known as HBD-H9: HEDIS Poor HbA1c Control

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

Utilization and Risk Adjusted Utilization

V. PCR: HEDIS Plan All-Cause Readmissions

VI. ED BH: Emergency Department (ED) Behavioral Health Services Utilization

Care Coordination

VII. HRA1: Members with an Assessment Completed within 90 Days of Enrollment

VIII. HRA2: Members with an Annual Reassessment

IX. ICP1: Members With a Care Plan Completed Within 90 Days of Enrollment

X. ICP2: Members with a Current Care Plan (Created or Updated in the Last Year)

XI. GOC: Members with Documented Discussions of Care Goals

Organizational Structure and Staffing

XII. CCMR: Care Coordinator to Member Ratio

Medi-Cal Long-Term Services and Supports

XIII. CBAS: Community-Based Adult Services

XIV. IHSS: In-Home Supportive Services

XV. MSSP: Multipurpose Senior Services Program

XVI. LTC: Long-Term Care

Alzheimer's/Dementia Quality of Care

XVII. CHA: Cognitive Health Assessment

ECM-like Services

XVIII. ECM: ECM-like Services

Palliative Care

XIX. PAL: Palliative Care

Table: Summary of 2024 State-Specific D-SNP Reporting Requirements

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

Measure	Name	Reporting Frequency	Plan Types Required to Report	Race/Ethnicity Reporting
Access/Availability of Care				
I.	AAP: HEDIS Adults' Access to Preventive/ Ambulatory Health Services	Annually	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
Effectiveness of Care				
II.	CBP: HEDIS Controlling High Blood Pressure	Annually	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
III.	GSD: HEDIS Glycemic Status Assessment for Patients With Diabetes (>9.0%)	Annually	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
IV.	FUM: HEDIS Follow-Up After Emergency Department Visit for Mental Illness	Annually	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
Utilization and Risk Adjusted Utilization				
V.	PCR: HEDIS Plan All-Cause Readmissions	Annually	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
VI.	ED BH: Emergency Department (ED) Behavioral Health Services Utilization	Annually	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
Care Coordination				
VII.	HRA1: Members with an Assessment	Quarterly	All D-SNPs	Summary (according to

Measure	Name	Reporting Frequency	Plan Types Required to Report	Race/Ethnicity Reporting
	Completed within 90 Days of Enrollment			NCQA/HEDIS specifications)
VIII.	HRA2: Members with an Annual Reassessment	Annually	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
IX.	ICP1: Members With a Care Plan Completed Within 90 Days of Enrollment	Quarterly	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
X.	ICP2: Members with a Current Care Plan (Created or Updated in the Last Year)	Annually	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
XI.	GOC: Members with Documented Discussions of Care Goals	Annually	All D-SNPs	None
Organizational Structure and Staffing				
XII.	CCMR: Care Coordinator to Member Ratio	Annually	All D-SNPs	None
Medi-Cal Long-Term Services and Supports				
XIII.	CBAS: Community-Based Adult Services	Quarterly	EAE D-SNPs	Summary (according to NCQA/HEDIS specifications)
XIV.	IHSS: In-Home Supportive Services	Quarterly	EAE D-SNPs	Summary (according to NCQA/HEDIS specifications)

Measure	Name	Reporting Frequency	Plan Types Required to Report	Race/Ethnicity Reporting
XV.	MSSP: Multipurpose Senior Services Program	Quarterly	EAE D-SNPs	Summary (according to NCQA/HEDIS specifications)
XVI.	LTC: Long-Term Care	Quarterly	EAE D-SNPs	Summary (according to NCQA/HEDIS specifications)
Alzheimer's/Dementia Quality of Care				
XVII.	CHA: Cognitive Health Assessment	Annually	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
ECM-like Services				
XVIII.	ECM: ECM-like Services	Quarterly	All D-SNPs	Summary (according to NCQA/HEDIS specifications)
Palliative Care				
XIX.	PAL: Palliative Care	Quarterly	All D-SNPs	Summary (according to NCQA/HEDIS specifications)

Race/Ethnicity Stratification for Select Measures

DHCS is requiring D-SNPs to report race/ethnicity stratifications for all measures with the exception of CCMR and GOC. D-SNPs may use their data source of choice for reporting race/ethnicity and will be required to identify the source (i.e., D-SNPs may use Member race/ethnicity reported on Medi-Cal enrollment forms or another source). D-SNPs will submit summary data via the 2024 D-SNP Reporting Template stratified by the following race and ethnicity categories, aligning with NCQA standards:

(1) Race: For each Member included in the data element, report only one of the following nine categories for race

   a. White

b. Black or African American
c. American Indian and Alaska Native
d. Asian
e. Native Hawaiian and Other Pacific Islander
f. Some Other Race
g. Two or More Races
h. Asked but No Answer
i. Unknown

(2) Ethnicity: For each Member included in the data element, report only one of the following four categories for ethnicity

a. Hispanic/Latino
b. Not Hispanic/Latino
c. Asked but No Answer
d. Unknown

For HEDIS measures, D-SNPs should follow technical specifications provided by NCQA. DHCS will not be releasing a reporting template for HEDIS measures.

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.

Utilization, Care Coordination, and Organizational Structure and Staffing (VI, VII, VIII, IX, X, XI, 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.
- ICP2 (previously CA 1.5) was not required in 2023. However, the technical specifications for ICP2 has been updated as part of 2024 D-SNP Reporting Requirements.
- HRA1 and ICP1 must be reported on a quarterly basis to DHCS. Care plans and care plan completeness should be defined as written in Technical Specifications.
- HRA2, ICP2, CCMR, GOC, and ED BH must be reported on an annual basis to DHCS.

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

- 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.

Alzheimer's/Dementia Quality of Care Measure (XVII): 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.

New for CY 2024: ECM-like Services (XVIII)

- 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.
- All D-SNPs must report the ECM-like Services measure on a quarterly basis to DHCS.
- More information on D-SNPs providing ECM-like services is available in the Care Coordination chapter.

New for CY 2024: Palliative Care (XIX)

- 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.
- All D-SNPs must report the Palliative Care measure on a quarterly basis to DHCS.
- More information on palliative care requirements for D-SNPs is available in the Care Coordination chapter.

Additional details and reference materials for each measure are provided below. For race/ethnicity reporting requirements, please see table above.

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

- 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. CBP: HEDIS Controlling High Blood Pressure

- 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. GSD: HEDIS Glycemic Status Assessment for Patients with Diabetes – Glycemic Status >9.0%

- Additional information from NCQA: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/
- Previously known as HEDIS Poor HbA1c Control (HBD-H9).
- Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had glycemic status >9.0%.

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

- 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. PCR: HEDIS Plan All-Cause Readmissions

- 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. ED BH: Emergency Department (ED) Behavioral Health Services Utilization (formerly Core 9.1)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx
- Previously Core 9.1

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

VII. HRA1: Members with an Assessment Completed within 90 Days of Enrollment (formerly Core 2.1)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx
- Previously Core 2.1

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 2024: Members with an effective date in November and December 2023 should be included in quarter one 2024 data for HRA1, as they reached their 90th day of enrollment during quarter one 2024.

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. HRA2: Members with an Annual Reassessment (formerly Core 2.3)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx
- Previously Core 2.3

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. ICP1: Members with a Care Plan Completed Within 90 Days of Enrollment (formerly Core 3.2)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx
- Previously Core 3.2

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 2024: Members with an effective date in November and December 2023 should be included in quarter one 2024 data for ICP1, as they reached their 90th day of enrollment during quarter one 2024.
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. ICP2: Members with a Current Care Plan (Created or Updated within the Last Year) (formerly CA 1.5)

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

- Previously CA 1.5. Please note, this measure contains different specifications from the version of CA 1.5 that was sunsetted as part of 2023 D-SNP Reporting Requirements.

A. Total number of Members enrolled as of the last day of the current reporting period.
B. Total number of Members who had an ICP updated/completed during the previous reporting period.
C. Total number of Members with an ICP updated/completed during the current reporting period.
D. Total number of Members with a care plan updated/completed within 365 days of the most recent ICP updated/completed.
E. Total number of Members who did not have a care plan updated/completed during the previous reporting period.
F. Total number of Members with a care plan updated/completed during the current reporting period.

XI. GOC: Members with Documented Discussions of Care Goals (**formerly CA 1.6**)

- Additional information from DHCS: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx
- Previously CA 1.6

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. CCMR: Care Coordinator to Member Ratio (formerly Core 5.1)

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

» Previously Core 5.1

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. CBAS: Community-Based Adult Services

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 contract requirements, 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).

XIV. IHSS: In-Home Supportive Services

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 Members who received IHSS services for the reporting quarter.

XV. MSSP: Multipurpose Senior Services Program

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.

XVI. LTC: Long-Term Care

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).

XVII. CHA: 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.

XVIII. ECM: ECM-like Services

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

A. Total unique Members who received ECM-like services during the reporting period.

B. For each population of focus identified by the D-SNP in their Model of Care: Total Members identified as eligible for ECM-like services during the reporting period.

C. For each population of focus identified by the D-SNP in their Model of Care: Total Members who received ECM-like services during the reporting period.

D. For each population of focus identified by the D-SNP in their 2024 Model of Care: Total Members with initial outreach attempt during the reporting period.

E. For each population of focus identified by the D-SNP in their 2024 Model of Care: Number of Members with an in-person care management interaction.

XIX. PAL: Palliative Care

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

A. For each palliative care provider/provider organization that the plan is contracted with, report the 11-digit organization NPI. If the contracted provider is an individual provider, plans may report the provider's individual NPI.
B. Total number of unique Members newly enrolled in palliative care services within the reporting period for each provider/provider organization reported in element A.

D-SNP Reporting Requirements Clarifications

- 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. 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: California Specific Model of Care Matrix

2024 California-Specific Model of Care Matrix Document: Initial and Renewal Submission

Special Needs Plan (SNP) Contract Information

SNP Contact Information	Applicant's Information Field
Contract Name (as provided in HPMS)	*Enter Contract Name here*
Contract Number	*Enter Contract Number here (Also list other contracts where this MOC is applicable)*

Care Management Plan Outlining the Model of Care

In the following tables, list the page number and section of the corresponding description in your Care Management Plan for each Model of Care (MOC) element. Once you have completed this document, upload it into HPMS along with your MOC.

DHCS Instructions: California-specific elements are in red font. D-SNPs that are required by CMS to submit a new Model of Care or re-submit a Model of Care for CY 2024, including those with a new D-SNP only H contract for CY 2024, must reflect these state requirements and populate and submit the California Specific Model of Care Matrix Document to DHCS email box DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager, by February 15, 2023. D-SNPs should submit both the MOC and state-specific matrix to DHCS. DHCS recommends that D-SNPs submit the same MOC to both CMS and DHCS. D-SNPs are not required to submit the state-specific matrix to CMS.

For all D-SNPs in CY 2024, these requirements should be incorporated into Models of Care and implemented, regardless of prior Model of Care approval. D-SNPs that are not required by CMS to submit a Model of Care for CY 2024 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, and submit that off-cycle Model of Care update to DHCS email box DHCS_DSNP@dhcs.ca.gov, with cc to DHCS contract manager, by March 31, 2023. DHCS recommends that plans submitting off-cycle submission to DHCS also submit to CMS during NCQA off-cycle submission window. DHCS recommends that D-SNPs submit the same MOC to both CMS and DHCS. D-SNPs are not required to submit the state-specific matrix to CMS.

DHCS may provide feedback on MOC submissions, and DHCS requests any needed updated MOCs be provided to DHCS within 30 days of DHCS feedback to the plans.

For reference, the NCQA submission information for D-SNPs is available at this link: https://snpmoc.ncqa.org/resources-for-snps.

1. Description of the SNP Population

The identification and comprehensive description of the SNP-specific population is an integral component of the MOC because all of the other elements depend on the firm foundation of a comprehensive population description. The organization must provide information about its local target population in the service areas covered under the contract. Information about national population statistics is insufficient. The organization must provide an overview that fully addresses the full continuum of care of current and potential SNP enrollees, including end-of-life needs and considerations, if relevant to the target population served by the SNP.

Model of Care Element	Corresponding Page #/Section in Care Management Plan
Element A: Description of the Overall SNP Population The description of the SNP population must include, but not be limited to, the following: » Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP enrollees. » Detailed profile of the medical, social, cognitive, and environmental aspects, the living conditions, and the co-morbidities associated with the SNP population in the plan's geographic service area. » Identification and description of the health conditions impacting SNP enrollees, including specific information about other characteristics that affect health, such as population demographics (e.g., average age, gender, ethnicity) and potential health disparities associated with specific groups (e.g., language barriers, deficits in	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other). » Definition of unique characteristics for the SNP population served: o C-SNP: What are the unique chronic care needs for C-SNP enrollees? Include limitations and barriers that pose potential challenges for these C-SNP enrollees. o D-SNP: What are the unique health needs for D-SNP enrollees? Include limitations and barriers that pose potential challenges for these D-SNP enrollees. o I-SNP: What are the unique health needs for I- SNP enrollees? Include limitations and barriers that pose potential challenges for these I-SNP enrollees as well as information about the facilities and/or home and community-based services settings in which your enrollees reside.	
Element B: Sub-Population: Most Vulnerable Enrollees As a SNP, you must include a complete description of the specially-tailored services for enrollees considered especially vulnerable using specific terms and details (e.g., enrollees with multiple hospital admissions within three months, "medication spending above $4,000"). The description must differentiate between the general SNP population and that of the most vulnerable enrollees, as well as detail additional benefits above and beyond those available to general SNP enrollees. For this sub-population, D-SNPs in California must include, in addition to any other sub-populations determined by the D-SNP: 1) four or more populations of focus from the Medi-Cal Enhanced Care Management program; 2) enrollees with serious illness eligible for community-based palliative care referral using the Medi-Cal	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
palliative care general and disease-specific eligibility criteria, or an alternate set of criteria for palliative care referral that is no more restrictive than the Medi-Cal palliative care eligibility criteria; and 3) enrollees with positive screening result for cognitive impairment, diagnosis of Alzheimer's disease and related dementias, or documented dementia care needs. Other information specific to the description of the most vulnerable enrollees must include, but not be limited to, the following: » Description of the internal health plan procedures for identifying the most vulnerable enrollees within the SNP. Also include description of D-SNP palliative care referral eligibility criteria if it differs from the Medi-Cal palliative care eligibility criteria. » Description of the relationship between the demographic characteristics of the most vulnerable enrollees and their unique clinical requirements. Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, and other factor(s) affect the health outcomes of the most vulnerable enrollees. » Identification and description of the established partnerships with community organizations that assist in identifying resources for the most vulnerable enrollees, including the process that is used to support continuity of community partnerships and facilitate access to community services by the most vulnerable enrollees and/or their caregiver(s).	

2. Care Coordination

Care coordination helps ensure that SNP enrollees' healthcare needs, preferences for health services, and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP's provider network as well as the care coordination roles and responsibilities overseen by the enrollees' caregiver(s). The following MOC sub-elements are essential components to consider in the development of a comprehensive care coordination program; no sub-element must be interpreted as being of greater importance than any other. All five sub-elements below, taken together, must comprehensively address the SNP's care coordination activities.

Model of Care Element	Corresponding Page #/Section in Care Management Plan
Element A: SNP Staff Structure » Fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of SNP enrollees. This includes, but is not limited to, identification and detailed explanation of: o Employed and/or contracted staff who perform administrative functions, such as: enrollment and eligibility verification, claims verification and processing, etc. o Employed and/or contracted staff who perform clinical functions, such as: direct enrollee care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, etc. o Employed and/or contracted staff who perform administrative and clinical oversight functions, such as: license and competency verification, data analyses to ensure appropriate and timely healthcare services, utilization review, ensuring that providers use	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
appropriate clinical practice guidelines and integrate care transitions protocols. » Provide a copy of the SNP's organizational chart that shows how staff responsibilities identified in the MOC are coordinated with job titles. If applicable, include a description of any instances when a change to staff title/position or level of accountability was required to accommodate operational changes in the SNP. » Identify the SNP contingency plan(s) used to ensure ongoing continuity of critical staff functions. » Describe how the SNP conducts initial and annual MOC training for its employed and contracted staff, which may include, but not be limited to, printed instructional materials, face-to-face training, web-based instruction, and audio/video-conferencing. » Describe how the SNP documents and maintains training records as evidence to ensure MOC training provided to its employed and contracted staff was completed. For example, documentation may include, but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, and electronic training records. » Explain any challenges associated with the completion of MOC training for SNP employed and contracted staff, and describe what specific actions the SNP will take when the required MOC training has not been completed or has been found to be deficient in some way. » Describe how D-SNP care coordinators/managers participating in the Interdisciplinary Care Team (ICT) are trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal long-term services and supports programs, including home- and	

Model of Care Element	Corresponding Page #/Section in Care Management Plan
community-based services and long-term institutional care in California. » Describe training program for D-SNP dementia care specialists for Interdisciplinary Care Team (ICT).	
Element B: Health Risk Assessment Tool (HRAT) The quality and content of the HRAT should identify the medical, functional, cognitive, psychosocial, and mental health needs of each SNP enrollee. The content of, and methods used to conduct the HRAT have a direct effect on the development of the Individualized Care Plan (ICP) and ongoing coordination of Interdisciplinary Care Team (ICT) activities; therefore, it is imperative that the MOC include the following: o A clear and detailed description of the policies and procedures for completing the HRAT, including: o Description of how the HRAT is used to develop and update, in a timely manner, the ICP (MOC Element 2D) for each enrollee, and how the HRAT information is disseminated to and used by the ICT (MOC Element 2E). o Detailed explanation for how the initial HRAT and annual reassessment are conducted for each enrollee. o Description of how the SNP ensures that the results from the initial HRAT and the annual reassessment HRAT conducted for each individual are addressed in the ICP. o Detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the results of the HRAT, including the mechanisms to ensure communication of that information to the ICT, provider network, enrollees and/or their caregiver(s), as well as other SNP	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
personnel that may be involved with overseeing the SNP enrollee's ICP. If stratified results are used, include a detailed description of how the SNP uses the stratified results to improve the care coordination process. o Description of how the HRAT is used to detect potential cognitive impairment. o Description of how the HRAT identifies the following elements: ▪ Medi-Cal services the member currently accesses. ▪ Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in the California 2024 D-SNP Policy Guide, or similar questions. If a plan intends to use a variation of the LTSS questions provided, the questions must be reviewed and approved by DHCS. Plans may incorporate the questions into their HRAT in any order. ▪ Populations that may need additional screening or services, including California specific sub-populations identified Element 1B. ▪ Non-EAE D-SNPs: Description of how D-SNP will coordinate with unaligned Medi-Cal Managed Care Plans (MCPs) for enrollee care, including sharing copies of their mutual enrollee's completed HRAT.	

Model of Care Element	Corresponding Page #/Section in Care Management Plan
Element C: Face-to-Face Encounter Regulations at 42 CFR §422.101(f)(1)(iv) require that all SNPs must provide, on at least an annual basis, beginning within the first 12 months of enrollment, as feasible and with the individual's consent, for face-to-face encounters for the delivery of health care or care management or care coordination services and be between each enrollee and a member of the enrollee's ICT or the plan's case management and coordination staff, or contracted plan healthcare providers. A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter. California requires D-SNPs to provide the equivalent of Medi-Cal Enhanced Care Management (ECM) primarily through in-person contact. The face-to-face encounter is part of the overall care management strategy, and as a result, the MOC must include the following: » A clear and detailed description of the policies, procedures, purpose, and intended outcomes of the face-to-face encounter. » A description of who will conduct the face-to-face encounter, employed and/or contracted staff. » A description of the types of clinical functions, assessments, and/or services that may be provided during the face-to-face encounter. » A description of how health concerns and/or active or potential health issues will be addressed during the face-to-face encounter. » A description of how the SNP will conduct care coordination activities through appropriate follow-up, referrals, and scheduling as necessary. » A description of how the D-SNP will engage primarily through in-person contact with enrollees who qualify for	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
Medi-Cal ECM as specified in sub-populations identified in Element 1B. » A description of alternate methods (including telehealth) when in-person communication is unavailable or does not meet the needs of the enrollee, to provide culturally appropriate and accessible communication in accordance with enrollee choice.	
Element D: Individualized Care Plan (ICP) » The ICP components must include, but are not limited to: enrollee self- management goals and objectives; the enrollee's personal healthcare preferences; description of services specifically tailored to the enrollee's needs; roles of the enrollees' caregiver(s); and identification of goals met or not met. » When the enrollee's goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions. » Explain the process and which SNP personnel are responsible for the development of the ICP, how the enrollee and/or his/her caregiver(s) or representative(s) are involved in its development, and how often the ICP is reviewed and modified as the enrollee's healthcare needs change. If a stratification model is used for determining SNP enrollees' healthcare needs, then each SNP must provide a detailed explanation of how the stratification results are incorporated into each enrollee's ICP. » Describe how the ICP is documented and updated, including updates based on more recent HRAT information and where the documentation is	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
maintained to ensure accessibility to the ICT, provider network, enrollee, and/or caregiver(s). » Explain how updates and/or modifications to the ICP are communicated to the enrollee and/or their caregiver(s), the ICT, applicable network providers, other SNP personnel, and other stakeholders as necessary. » Describe how the ICP will be developed and updated by, and/or shared with the enrollee's palliative care team, as appropriate. » Describe how the ICP identifies any Medi-Cal carved-out services the member needs and how the D-SNP will facilitate coordination and access and document referrals, 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 Medi-Cal Community Supports providers o LTSS programs, including In Home Supportive Services, Community-Based Adult Services (CBAS), Multipurpose Senior Services Programs, and Regional Center services o Transportation to access Medicare and Medi-Cal services o Medi-Cal dental services » Non-EAE D-SNPs: How plans will coordinate with unaligned MCPs for enrollee care, including sharing copies of their mutual enrollee's completed ICPs.	

Model of Care Element	Corresponding Page #/Section in Care Management Plan
Element E: Interdisciplinary Care Team (ICT) » In the management of care, the SNP must use an ICT that includes a team of providers with demonstrated expertise and training, and, as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the targeted population of the SNP. For enrollees with serious illness participating in a palliative care program, the D-SNP must use a palliative care ICT. » Provide a detailed and comprehensive description of the composition of the ICT; include how the SNP determines ICT membership and a description of the roles and responsibilities of each member. Specify how the expertise, training, and capabilities of the ICT members align with the identified clinical and social needs of the SNP enrollees, and how the ICT members contribute to improving the health status of SNP enrollees. If a stratification model is used for determining SNP enrollees' health care needs, then each SNP must provide a detailed explanation of how the stratification results are used to determine the composition of the ICT. » Explain how the SNP facilitates the participation of enrollees and their caregivers as members of the ICT. » Describe how the enrollee's HRAT (MOC Element 2B) and ICP (MOC Element 2D) are used to determine the composition of the ICT, including those cases where additional team members are needed to meet the unique needs of the individual enrollee, including those California-specific sub-populations identified in element 1B.	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
» Explain how the ICT uses healthcare outcomes to evaluate established processes to manage changes and/or adjustments to the enrollee's healthcare needs on a continuous basis. » Identify and explain the use of clinical managers, case managers, or others who play critical roles in ensuring an effective interdisciplinary care process is being conducted. » Provide a clear and comprehensive description of the SNP's communication plan that ensures exchanges of enrollee information is occurring regularly within the ICT, including but not limited to the following: o Clear evidence of an established communication plan that is overseen by SNP personnel who are knowledgeable and connected to multiple facets of the SNP MOC. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, enrollees, caregiver(s), community organizations, and other stakeholders. o The types of evidence used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other. o How communication is conducted with enrollees who have hearing impairments, language barriers, and/or cognitive deficiencies. » Describe how the ICT will include the member's caregiver and a trained dementia care specialist, if the member has documented dementia care needs. » Describe the approach to train dementia care specialists in: understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver	

Model of Care Element	Corresponding Page #/Section in Care Management Plan
stress and its management; and, community resources for enrollees and caregivers.	
Element F: Care Transition Protocols » Explain how care transition protocols are used to maintain continuity of care for SNP enrollees. Provide details and specify the process and rationale for connecting the enrollee to the appropriate provider(s). » Describe which personnel (e.g., case manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MOC Element 2A. » Explain how the SNP ensures elements of the enrollee's ICP are transferred between healthcare settings when the enrollee experiences an applicable transition in care. This must include the steps that need to take place before, during, and after a transition in care has occurred. » Describe in detail the process for ensuring the SNP enrollee and/or caregiver(s) have access to and can adequately utilize the enrollees' personal health information to facilitate communication between the SNP enrollee and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network. » Describe how the enrollee and/or caregiver(s) will be educated about indicators that his/her condition has improved or worsened and how they will demonstrate their understanding of those indicators and appropriate self-management activities.	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
» Describe how the enrollee and/or caregiver(s) are informed about who their point of contact is throughout the transition process. » Describe transition protocols for beneficiaries as they move from different settings of care including community, institutional and hospital settings. The description should include care coordinator roles and responsibilities and protocols for assessments and provision of Medi-Cal home and community-based services, as well as coordination with Medi-Cal plans for non-EAE D-SNPs. The description should also include how the California State Medicaid Agency Contract and Policy Guide requirements for information sharing are incorporated into Care Transition Protocols.	
Element G: Medi-Cal Enhanced Care Management (ECM) Indicate where within the D-SNP model of care ECM-like services (those aligned with the seven ECM core services as outlined in the ECM Policy Guide) are reflected: 1) Outreach and Engagement 2) Comprehensive Assessment and Care Management Plan 3) Enhanced Coordination of Care 4) Health Promotion 5) Comprehensive Transitional Care 6) Member and Family Supports; and 7) Coordination of and Referral to Community and Social Support Services	

3. SNP Provider Network

The SNP Provider Network is a network of healthcare providers who are contracted to provide health care services to SNP enrollees. The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized healthcare needs of the target population as identified in MOC Element 1, and provide oversight information for all of its network types. Each SNP is responsible for ensuring their MOC identifies, fully describes, and implements the following sub-elements for its SNP Provider Network.

Model of Care Element	Corresponding Page #/Section in Care Management Plan
Element A: Specialized Expertise » Provide a complete and detailed description of the specialized expertise available to SNP enrollees in the SNP provider network that corresponds to the SNP population identified in MOC Element 1, including community-based palliative care providers. » The description must include evidence that the SNP provides each enrollee with an ICT that includes providers with demonstrated experience and training in the applicable specialty or area of expertise, or, as applicable, training in a defined role appropriate to their licensure in treating individuals that are similar to the target population. » Explain how the SNP oversees its provider network facilities and ensures its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP enrollees. Specialized expertise may include, but is not limited to: internal medicine physicians, endocrinologists, cardiologists, oncologists, mental health specialists, other. » Describe how providers collaborate with the ICT (MOC Element 2E) and the enrollee, contribute to the ICP	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
(MOC Element 2D), and ensure the delivery of necessary specialized services. For example, describe: how providers communicate SNP enrollees' care needs to the ICT and other stakeholders; how specialized services are delivered to the SNP enrollee in a timely and effective way; how reports regarding services rendered are shared with the ICT; and how relevant information is incorporated into the ICP.	
Element B: Use of Clinical Practice Guidelines & Care Transition Protocols » Explain the processes for ensuring that network providers utilize appropriate clinical practice guidelines and nationally-recognized protocols. This may include, but is not limited to: use of electronic databases, web technology, and manual medical record review to ensure appropriate documentation. » Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP enrollees. Provide details regarding how these decisions are made, incorporated into the ICP (MOC Element 2D), communicated with the ICT (MOC Element 2E), and acted upon. » Explain how SNP providers ensure care transition protocols are being used to maintain continuity of care for the SNP enrollee as outlined in MOC Element 2F.	*Enter corresponding page number and section here*
Element C: MOC Training for the Provider Network » Explain in detail how the SNP conducts initial and annual MOC training for network providers and out-of-network	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
providers seen by enrollees on a routine basis. This could include but is not limited to: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP's website. Include training on initial screening and comprehensive assessment for dementia. » Describe how the SNP documents and maintains training records as evidence of MOC training for their network providers. Documentation may include but is not limited to: copies of dated attendee lists, results of MOC competency testing, web- based attendance confirmation, electronic training records, and physician attestation of MOC training. » Explain any challenges associated with the completion of MOC training for network providers and describe what specific actions the SNP will take when the required MOC training has not been completed or is found to be deficient in some way.	

4. MOC Quality Measurement & Performance Improvement

The goals of performance improvement and quality measurement are to improve the SNP's ability to deliver healthcare services and benefits to its SNP enrollees in a high-quality manner. Achievement of those goals may result from increased organizational effectiveness and efficiency by incorporating quality measurement and performance improvement concepts used to drive organizational change. The leadership, managers, and governing body of a SNP must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes must be modified based on performance results.

Model of Care Element	Corresponding Page #/Section in Care Management Plan
Element A: MOC Quality Performance Improvement Plan » Explain in detail the quality performance improvement plan and how it ensures that appropriate services are being delivered to SNP enrollees. The quality performance improvement plan must be designed to detect whether the overall MOC structure effectively accommodates enrollees' unique healthcare needs. The description must include, but is not limited to, the following: o The complete process, by which the SNP continuously collects, analyzes, evaluates, and reports on quality performance based on the MOC by using specified data sources, performance, and outcome measures. The MOC must also describe the frequency of these activities. o Details regarding how the SNP leadership, management groups, and other SNP personnel and stakeholders are involved with the internal quality performance process. o Details regarding how the SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MOC Element 4B). o Process the SNP uses or intends to use to determine if goals/outcomes are met. There must be specific benchmarks and timeframes, and the SNP must specify the re-measurement plan for goals not achieved.	*Enter corresponding page number and section here*
Element B: Measurable Goals & Health Outcomes for the MOC » Identify and clearly define the SNP's measurable goals and health outcomes; describe how identified	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
measurable goals and health outcomes are communicated throughout the SNP; and evaluate whether goals were fulfilled from the previous MOC. Responses must include, but not be limited to, the following: ○ Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MOC Element 1. ○ Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT. ○ Enhancing care transitions across all healthcare settings and providers for SNP enrollees. ○ Ensuring appropriate utilization of services for preventive health and chronic conditions. » Identify the specific enrollee health outcomes measures that will be used to measure overall SNP population health outcomes, including the specific data source(s) that will be used. » Describe in detail how the SNP establishes methods to assess and track the MOC's impact on the SNP enrollees' health outcomes. » Describe in detail the processes and procedures the SNP will use to determine if the health outcomes goals are met or not met. » Provide relevant information pertaining to the MOC's goals as well as appropriate data pertaining to the fulfillment the previous MOC's goals. » For SNPs submitting an initial MOC, provide relevant information pertaining to the MOC's goals for review and approval.	

Model of Care Element	Corresponding Page #/Section in Care Management Plan
» If the MOC did not fulfill the previous MOC's goals, indicate in the MOC submission how the SNP will achieve or revise the goals for the next MOC.	
Element C: Measuring Patient Experience of Care (SNP Enrollee Satisfaction) » Describe the specific SNP survey(s) used and the rationale for selection of that particular tool(s) to measure SNP enrollee satisfaction. » Explain how the results of SNP enrollee satisfaction surveys are integrated into the overall MOC performance improvement plan, including specific steps to be taken by the SNP to address issues identified in response to survey results.	*Enter corresponding page number and section here*
Element D: Ongoing Performance Improvement Evaluation of the MOC » Explain in detail how the SNP will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC, including how quality will be continuously assessed and evaluated. » Describe the SNP's ability to improve, on a timely basis, mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation process. » Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.	*Enter corresponding page number and section here*
Element E: Dissemination of SNP Quality Performance related to the MOC » Explain in detail how the SNP communicates its quality improvement performance results and other pertinent	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
information on a routine basis to its multiple stakeholders, which may include but not be limited to: SNP leadership, SNP management groups, SNP boards of directors, SNP personnel and staff, SNP provider networks, SNP enrollees and caregivers, the general public, and regulatory agencies. » This description must include, but is not limited to, the scheduled frequency of communications and the methods for ad-hoc communication with the various stakeholders, such as: a webpage for announcements, printed newsletters, bulletins, and other announcement mechanisms. » Identify the individual(s) responsible for communicating performance updates in a timely manner as described in MOC Element 2A.	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 1296 (CMS-10565). The current expiration date is ***TBD***. The time required to complete this information collection is estimated to average 3-6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Appendix C: Dental Benefits Fact Sheet

Dental Benefits for Patients Dually Eligible for Medicare and Medi-Cal Information for Dental Providers

Dental Benefits in Medicare and Medi-Cal

Medicare and Medi-Cal provide different dental coverage. This document has information for providers administering dental services to dual eligible patients (individuals who have Medicare and Medi-Cal), to clarify the differences between Medicare and Medi-Cal dental benefits, and how the benefits can be coordinated.

Medicare Dental Benefits

Medicare, the primary payer for dual eligible patients, does not cover most dental care. Medicare may pay for some dental services that are closely related to other covered medical services. Medicare will also pay for certain dental services provided in a hospital setting.

Some Medicare Advantage plans offer Supplemental Dental Benefits. These are extra benefits beyond what Original (Fee-for-Service) Medicare covers. Supplemental Dental Benefits vary by plan and providers should refer to the patient's Medicare Advantage plan for an approved list of covered dental services. In order for a dual eligible patient to have their plan's Supplemental Dental Benefits covered, they must use an in-network provider.

Medi-Cal Dental Benefits

Medi-Cal covers a variety of dental benefits, administered by Medi-Cal dental providers. Medi-Cal will pay up to $1,800 a year for covered dental services. However, there is no limit for covered, medically necessary dental services. If any of these benefits are also covered by other insurers, they must be billed before Medi-Cal.

Medi-Cal dental benefits include but are not limited to:

- Diagnostic and preventive dental hygiene, including examinations (every 12 months), x-rays, teeth cleanings (every 12 months), and fluoride varnish (every 12 months)
- Fillings
- Root canal treatments
- Scaling and root planing
- Crowns

- Emergency services for pain control
- Tooth extractions
- Periodontal maintenance
- Complete and partial dentures, including denture relines

Dual eligible patients can access these services through a Medi-Cal dental provider. Most Medi-Cal patients receive dental services through Medi-Cal Dental Fee-For-Service; however, Medi-Cal Dental Managed Care is available in Los Angeles and Sacramento counties. Additional information can be found on the DHCS Medi-Cal Dental website.

Dental Coverage and Billing Requirements for Dual Eligible Patients

A dual eligible patient may receive dental benefits through both their Medicare Advantage plan and Medi-Cal. In some cases, a patient will access these services first through a Medicare Advantage dental provider, then through a Medi-Cal dental provider. Depending on the procedure, in-network dental providers can bill Medicare, including the Medicare Advantage plan, and/or Medi-Cal for covered dental benefits.

Medicare Billing Procedures

Original Medicare will pay for certain dental services, as outlined in the following Centers for Medicare & Medicaid Services (CMS) Article: Billing and Coding: Dental Services (A56663). You may also refer to the Medi-Cal Dental Provider Handbook, specifically the Medicare/Medi-Cal Crossover Claims portion of Section 2 and the Prepaid Health Plan (PHP)/Health Maintenance Organization (HMO) portion of Section 4. A provider must be enrolled with the Medicare program to receive reimbursement from Medicare. To bill Medicare for a patient with Original Medicare, contact the Medicare Administrative Contractor (Noridian).

Medicare Advantage plans that offer supplemental dental benefits will pay for certain additional dental services. Dental providers should refer to the plan's provider manual for more information about billing the plan for dental services.

Crossover Billing Procedures

Dental Services Covered by Original Medicare or Medicare Advantage

For dental services covered by Original Medicare or the Medicare Advantage plan, the services must be billed to Original Medicare or the Medicare Advantage plan first. In some instances, Medi-Cal may pay for a portion of Medicare dental benefits. This is known as a "crossover claim." For these dental services, it is the dental provider's responsibility to ensure that they have billed Original Medicare or the Medicare

Advantage plan before seeking reimbursement from Medi-Cal. Dental providers will then submit a claim to Medi-Cal with official documentation showing any action taken by Original Medicare or the Medicare Advantage plan (e.g., proof of payment, denial by Medicare, or patient's ineligibility). Note, to receive reimbursement from Medi-Cal, the provider must also be an enrolled Medi-Cal dental provider.

Medi-Cal Dental is always the payer of last resort. Medi-Cal will pay the dental provider any amount owed under state Medi-Cal law. If the amount Medi-Cal pays for the service is greater than what Medicare pays, Medi-Cal will pay the Medi-Cal dental enrolled provider the difference. Medi-Cal Dental will make a payment only if the payment made by the primary carrier and the patient's cost sharing is less than the maximum Medi-Cal allowance. Medi-Cal Dental will then pay up to the allowed amount.

Dental Services Not Covered by Original Medicare or Medicare Advantage

For Medi-Cal covered dental services not covered by Original Medicare or the Medicare Advantage plan, dental providers can bill Medi-Cal directly.

Balance Billing Prohibition

Providers cannot bill dual eligible patients for Medicare cost-sharing, such as co-pays, co-insurance, or deductibles for any covered services. This is known as balance billing, or "improper billing," and is illegal under both federal and state law[16]. For more information, visit the DHCS Balance Billing website.

Medi-Cal Billing Procedures

For dental services not covered by Original Medicare or the Medicare Advantage plan, but covered by Medi-Cal, Medi-Cal can only reimburse dental services provided by Medi-Cal enrolled providers. Dental providers are required to follow all standards and guidelines set forth in the Medi-Cal Manual of Criteria (MOC) and Medi-Cal Dental Schedule of Maximum Allowances (SMA) included in Medi-Cal Dental Provider Handbook. For example, many preventative dental services do not require submission of a prior authorization request. Services that require prior authorizations are listed in the Prior Authorization portion of Section 2 in the Medi-Cal Dental Provider Handbook.

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[16] Additional information is available at California Welfare and Institutions Code Section 14019.4 and Section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997.

Providers must review their proposed treatment plan against the MOC and SMA to determine if a treatment is a Medi-Cal covered service.

For patients enrolled in Medi-Cal Dental Managed Care plans, please contact the Medi-Cal Dental Managed Care plan for billing information for patients enrolled in those plans.

How to Enroll as a Medi-Cal Dental Provider

To enroll as a Fee-For-Service Medi-Cal dental provider, please visit the Provider Application and Validation for Enrollment (PAVE) Provider Portal. The PAVE portal is a web-based application that allows dental providers to submit enrollment applications and required documentation electronically. Please visit the Medi-Cal Dental Provider Outreach website for more information or contact the Provider Enrollment Division (PED) by using the Inquiry Form under "Provider Resources" on the website, calling the PED Message Center at (916) 323-1945, or emailing PAVE@dhcs.ca.gov for assistance with enrollment.

If interested in becoming a Dental Managed Care (DMC) provider, dental providers may contact the DMC plans as follows:

- Health Net Medi-Cal Dental Plan Provider Line: (888) 273-2713
- Access Dental Plan Provider Line: 800-640-4466 or ProviderRelations@premierlife.com
- Liberty Dental Plan Provider Line: (888) 700-0643 or the Liberty Dental Plan California Dentist and RDHAP enrollment website.

Appeals and Grievances

Medicare

Medicare dental providers can refer to the Medicare Learning Network Booklet on Medicare Parts A and B Appeals Process to submit an appeal if their patient has Original Medicare. If the patient is in a Medicare Advantage plan, the dental provider can submit an appeal to the plan on their patient's behalf. Additional information on how to submit an appeal can be found in the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Medicare dental providers are also encouraged to share resources from the Claims and Appeals webpage on Medicare.gov with their patients.

Medi-Cal

Medi-Cal Dental providers can submit appeals if Medi-Cal Dental denies or modifies a claim payment or authorization. There are three separate, specific procedures for asking Medi-Cal Dental to reevaluate or appeal the denial. More information about these procedures can be found in the Provider Appeals Process portion of Section 2 of the Medi-Cal Dental Provider Handbook.

Medi-Cal Dental providers are also encouraged to share resources with their patients, such as:

- The Medi-Cal Dental Complaint Process outlined in the Member Handbook; and
- A patient's Hearing Rights and how to request a State Hearing

Medi-Medi Plans and Dental Care Coordination

Medicare Medi-Cal Plans (Medi-Medi Plans) are a type of Medicare Advantage plan in California that are only available to patients dually eligible for both Medicare and Medi-Cal. Medi-Medi Plans provide Medicare Part A, B, and D services, specialized care coordination, and wrap-around Medi-Cal services. Medi-Medi Plan patients have their Medi-Cal and Medicare benefits and care coordinated by one organization. In 2024, Medi-Medi Plans will be available in the following counties: Fresno, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Clara, and Tulare. For additional information about Medi-Medi Plans view the DHCS Medi-Medi Plan website.

Medi-Medi Plan patients can receive the full range of dental benefits covered by Medicare, Medi-Cal, and any supplemental benefits offered by their Medi-Medi Plan. Medi-Medi Plans have additional requirements to coordinate the services covered by both Medicare and Medicaid. Dental providers should evaluate these patients for services provided under both Medicare and Medi-Cal.

Additionally, Medi-Medi Plans are required to develop individualized care plans for their patients. These plans are encouraged to identify a patient's dental needs in their individualized care plan and include dental providers in the patient's interdisciplinary care team.

Summary of the differences between Dental Services covered by Medicare and Medi-Cal for dual eligible patients.

Original (Fee-For-Service) Medicare	Medicare Advantage (Including Medi-Medi Plans)	Medi-Cal (Dental Fee-For Service and Dental Managed Care)
Examples of covered services include: » Some dental services covered in a hospital setting » Dental treatment that is necessary for the treatment of other disease. For example, treatment of a tooth infection preceding a medical procedure, such as an organ transplant	Examples of covered services include: » All dental benefits covered in Original Medicare » Supplemental dental benefits may vary, refer to plan's provider manual for list of covered services	Examples of covered services include: » Diagnostic and preventive dental hygiene, including examinations, x-rays, teeth cleanings, and fluoride varnish » Fillings » Root canal treatments » Scaling and root planing » Crowns » Emergency services for pain control » Tooth extractions » Periodontal maintenance » Complete and partial dentures, including denture relines
Billing procedures: » Must be a Medicare enrolled dental provider » Contact the Medicare Administrative Contractor (Noridian) for Medicare-covered services	Billing procedures: » Provider must be in the Medicare plan network. » Refer to the plan's provider manual for information about billing the plan for dental services	Billing procedures: » Must be a Medi-Cal enrolled dental provider » Refer to the Medi-Cal Dental Provider Handbook » FFS providers can contact the Telephone Service Center at 1-800-423-0507 or visit the Medi-Cal Dental website

Original (Fee-For-Service) Medicare	Medicare Advantage (Including Medi-Medi Plans)	Medi-Cal (Dental Fee-For Service and Dental Managed Care)
		at http://www.dental.dhcs.ca.gov/ for billing information. » DMC providers can contact the Medi-Cal Dental Managed Care plan for billing information for patients enrolled in those plans.

Appendix D: 2024 Enhanced Care Management Continuity of Care Policy and Operational Guidance for Dual Eligible Beneficiaries in D-SNPs

This document includes a table of scenarios for the CY2024 Enhanced Care Management (ECM) Continuity of Care (CoC) policy for Dual Eligible Members with an active authorization to receive ECM from their Medi-Cal Managed Care Plan (MCP) on or prior to 12/31/2023 and who are currently enrolled in or have elected to be in an Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plan (D-SNP) or a non-EAE D-SNP as of 1/1/2024. Note that the policies outlined below are applicable **only** to Members with an active authorization to receive ECM through the Medi-Cal MCP on or prior to 12/31/2023. For members in Fee-For-Service (FFS) Medicare or other Medicare Advantage (MA) plans (i.e., not D-SNPs), ECM will continue to be provided by the Medi-Cal MCP.

CY 2024 ECM CoC Policy for Dual Eligible Members in EAE and Non-EAE D-SNPs with an Active Authorization to Receive ECM from the Medi-Cal MCP

Members receiving ECM from their Medi-Cal MCP on or prior to 12/31/2023 who will be enrolled in a non-EAE D-SNP (as of 1/1/2024) and their Medi-Cal MCP enrollment does not change

1.A	Description
Scenario	Members who have an active authorization to receive Medi-Cal ECM on or prior to 12/31/2023, who were enrolled in a non-EAE D-SNP in 2023, **and who will stay with the same non-EAE D-SNP in 2024.**
Policy Guidance	ECM will continue to be provided by the Medi-Cal MCP for up to 12 months or until Member meets criteria for discontinuing ECM.
CoC Length of Time	Up to 12 months, or until Member meets circumstances for discontinuing ECM.
Operational Guidance	» **For Non-EAE D-SNP:** No action needed. MCP will outreach to the non-EAE D-SNP to confirm that ECM will continue to be provided to the Member through the MCP to ensure the non-EAE D-SNP does not duplicate services. » **For MCP:** Plans must use the 834 file to identify which non-EAE D-SNP the Member who will receive CoC is enrolled in. The non-EAE D-SNP H-Contract and PBP numbers for individual members are listed on the 834 file. Please refer to the CMS Landscape file for the name of the D-SNP plan. MCPs must use the D-SNP MCP Coordination Contact List[17]on the DHCS Teams Channel to identify contact information for the non-EAE D-SNPs. It is the responsibility of the MCP to coordinate with the non-EAE D-SNP to ensure the member is not provided with duplicate services.

[17] Additional information on the D-SNP MCP Coordination Contact List is available in the 2024 CalAIM D-SNP Policy Guide Care Coordination chapter.

1.B	Description
Scenario	Members who have an active authorization to receive Medi-Cal ECM on or prior to 12/31/2023, who were enrolled in Medicare FFS, a MA plan, or a non-EAE D-SNP in 2023, and **who choose to switch to a different non-EAE D-SNP in 2024 and their MCP does not change.**
Policy Guidance	ECM will continue to be provided by the Medi-Cal MCP for up to 12 months or until Member meets criteria for discontinuing ECM.
CoC Length of Time	Up to 12 months, or until Member meets circumstances for discontinuing ECM.
Operational Guidance	» **For Non-EAE D-SNP:** No action needed. MCP will outreach to the non-EAE D-SNP to confirm that ECM will continue to be provided to the Member through the MCP to ensure the non-EAE D-SNP does not duplicate services. » **For MCP:** Plans must use the 834 file to identify which non-EAE D-SNP a Member who will receive CoC is enrolled in. The non-EAE D-SNP H-Contract and PBP numbers for individual members are listed on the 834 file. Please refer to the CMS Landscape file for the name of the D-SNP plan. MCPs must use the D-SNP MCP Coordination Contact List on the DHCS Teams Channel to identify contact information for the non-EAE D-SNPs. It is the responsibility of the MCP to coordinate with the non-EAE D-SNP to ensure the member is not provided with duplicate services.

Members receiving ECM from their Medi-Cal MCP on or prior to 12/31/2023 who will newly enroll into an EAE D-SNP (as of 1/1/2024) and their Medi-Cal MCP does not change

1.C	Description
Scenario	Members who have an active authorization to receive Medi-Cal ECM on or prior to 12/31/2023, who were enrolled in[18] Medicare FFS, a MA plan, or a non-EAE D-SNP, and who choose to **switch to an EAE D-SNP in 2024 and their MCP does not change**. This may include members in Medi-Medi Plan expansion counties, where non-EAE D-SNPs are becoming EAE D-SNPs in 2024[19].
Policy Guidance	Beginning on 1/1/2024, for new EAE D-SNP Members (enrolled in the EAE D-SNP as of 1/1/2024) already receiving Medi-Cal ECM from their MCP, EAE D-SNPs shall provide ongoing continuity of care with the existing ECM providers, when possible, until the Member graduates from ECM.
CoC Length of Time	Until the Member graduates from ECM.
Operational Guidance	» **For EAE D-SNP:** EAE D-SNP must provide ECM-like care management to the Member based on requirements outlined in the CalAIM D-SNP Policy Guide Care Coordination chapter and state-specific Model of Care (MOC) matrix. EAE D-SNPs shall provide ongoing continuity of care with the existing ECM providers, when possible, until the Member graduates from ECM. » **For MCP:** No action needed.

[18] This also applies to Members who age into Medicare prior to 1/1/2024 and choose to enroll in an EAE D-SNP beginning in 2024.
[19] In 2024, EAE D-SNPs (Medi-Medi Plans) expanded to five additional counties: Fresno, Kings, Madera, Sacramento, and Tulare.

Members receiving ECM from their Medi-Cal MCP on or prior to 12/31/2023 who will newly enroll into an EAE or Non-EAE D-SNP (as of 1/1/2024) and their Medi-Cal MCP changes due to the Medi-Cal Matching Plan Policy[20]

1.D	Description
Scenario	Members who have an active authorization to receive Medi-Cal ECM on or prior to 12/31/2023, who were enrolled in[21] Medicare FFS, a MA plan, or a non-EAE D-SNP in 2023 and **who choose to switch to a non-EAE D-SNP and their MCP changes due to the Medi-Cal Matching Plan Policy.**
Policy Guidance	Beginning on 1/1/2024, for new non-EAE D-SNP Members (enrolled in the non-EAE D-SNP as of 1/1/2024) already receiving Medi-Cal ECM from their MCP, non-EAE D-SNPs shall provide ongoing continuity of care with the existing ECM providers, when possible, until the Member graduates from ECM. The non-EAE D-SNP is responsible for ECM-like care management because the member was disenrolled from their initial MCP, thus ending the MCP ECM relationship.
CoC Length of Time	Until the Member graduates from ECM.
Operational Guidance	» **For Non-EAE D-SNP:** Non-EAE D-SNP must provide ECM-like care management to the Member based on requirements outlined in the CalAIM D-SNP Policy Guide Care Coordination chapter and state-specific Model of Care (MOC) matrix. Non-EAE D-SNPs shall provide ongoing continuity of care with the existing ECM providers, when possible, until the Member graduates from ECM. » **For MCP:** No action needed.

[20] Medi-Cal Matching Plan Policy: If a Member joins a Medicare Advantage plan and there is a Medi-Cal plan that matches with that plan, the Member must choose that Medi-Cal plan. This policy does not change or affect a Member's choice of a Medicare plan. The matching policy applies to the following counties in 2024: Alameda, Contra Costa, Fresno, Kern, Kings, Madera, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Stanislaus, and Tulare.

[21] This also applies to Members who age into Medicare prior to 1/1/2024 and choose to enroll in a non-EAE D-SNP as of 1/1/2024.

1.E	Description
Scenario	Members who have an active authorization to receive Medi-Cal ECM on or prior to 12/31/2023, who were enrolled in[22] Medicare FFS, a MA plan, or a non-EAE D-SNP in 2023 and **who choose to switch to an EAE D-SNP in 2024 and their MCP changes due to the Medi-Cal Matching Plan Policy.** This may include members in Medi-Medi Plan expansion counties, where non-EAE D-SNPs are becoming EAE D-SNPs in 2024.
Policy Guidance	Beginning on 1/1/2024, for new EAE D-SNP Members (enrolled in the EAE D-SNP as of 1/1/2024) already receiving Medi-Cal ECM from their MCP, EAE D-SNPs shall provide ongoing continuity of care with the existing ECM providers, when possible, until the Member graduates from ECM. The EAE D-SNP is responsible for ECM-like care management because the member was disenrolled from their initial MCP, thus ending the MCP ECM relationship.
CoC Length of Time	Until the Member graduates from ECM.
Operational Guidance	» **For EAE D-SNP:** EAE D-SNP must provide ECM-like care management to the Member based on requirements outlined in the CalAIM D-SNP Policy Guide Care Coordination chapter and state-specific Model of Care (MOC) matrix. EAE D-SNPs shall provide ongoing continuity of care with the existing ECM providers, when possible, until the Member graduates from ECM. » **For MCP:** No action needed.

[22] This also applies to Members who age into Medicare prior to 1/1/2024 and choose to enroll in an EAE D-SNP beginning in 2024.

Members receiving ECM from their Medi-Cal MCP on or prior to 12/31/2023 who will be enrolled in a non-EAE D-SNP (as of 1/1/2024) and their Medi-Cal MCP changes due to the Medi-Cal MCP Transition[23]

1.F	Description
Scenario	Members who have an active authorization to receive Medi-Cal ECM on or prior to 12/31/2023, who were enrolled in a non-EAE D-SNP in 2023 and will remain in that non-EAE D-SNP in 2024, **and whose MCP will change due to the 2024 MCP Transition.**
Policy Guidance	ECM will continue to be provided by the receiving Medi-Cal MCP and will be subject to preexisting CoC requirements as established in the MCP Transition Policy Guide.
CoC Length of Time	Please see preexisting requirements in MCP Transition Policy Guide.
Operational Guidance	» **For Non-EAE D-SNP:** No action needed. MCP will outreach to the non-EAE D-SNP to confirm that ECM will continue to be provided to the Member through the MCP to ensure the non-EAE D-SNP does not duplicate services. » **For Receiving MCP:** Plans must use the guidance on CoC requirements in the MCP Transition Policy Guide. For coordination and communication with the non-EAE D-SNPs, plans must use the 834 file to identify which non-EAE D-SNP the Member who will receive CoC is enrolled in. The non-EAE D-SNP H-Contract and PBP numbers for individual members are listed on the 834 file. Please refer to the CMS Landscape file for the name of the D-SNP plan. MCPs must use the *D-SNP MCP Coordination Contact List* on the DHCS Teams Channel to identify contact information for the non-EAE D-SNPs. It is the responsibility of the receiving MCP to coordinate with the non-EAE D-SNP to ensure the member is not provided with duplicate services.

[23] MCP Transition: Beginning in 2024, Medi-Cal MCPs will be subject to new requirements to rigorously advance health equity, quality, access, accountability, and transparency to improve the Medi-Cal health care delivery system. As part of this transformation, some Medi-Cal MCPs are changing on January 1, 2024, as a result of four changes in how DHCS contracts with Medi-Cal MCPs. Additional information is available on the DHCS website.