CALAIM DUAL ELIGIBLE SPECIAL NEEDS PLANS POLICY GUIDE

Contract Year 2025

June 2024

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, and as of January 1, 2024, twelve counties will offer EAE D-SNPs: Fresno, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Clara, and Tulare. 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 Medi-Medi Plans (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) 2025, by providing additional details to supplement the 2025 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 2025. Updates will be published as guidance is added.

SUMMARY OF UPDATES AND KEY CHANGES

Date	Chapter/Section	Update/Change
6/26/24	II. Integrated Materials and Marketing for EAE D-SNPs	» Updates to template language and requirements
5/31/24	II. Integrated Materials and Marketing for EAE D-SNPs	» Initial Release
12/20/23	I. Care Coordination	» Initial Release
12/20/23	VI. Appendix A	» Initial Release
12/20/23	VI. Appendix B	» 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) 2025.

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) Chapter 5, and Chapter 16(b) of the Medicare Managed Care Manual. These state requirements are part of the DHCS SMAC requirements for CY 2025.

Per NCQA guidance, there are no significant changes to D-SNP Model of Care (MOC) policy for CY 2025. D-SNPs with MOCs expiring on December 31, 2024, must simultaneously submit their state-specific review matrix and MOC to DHCS via email by February 14, 2024. D-SNPs must follow CMS/NCQA guidance for submitting their MOC and CMS matrix via HPMS. Additional details are included in submission instructions at the end of this chapter. D-SNPs must assure that the Health Risk Assessments (HRA) conform to the DHCS revised caregiver provisions for 2025 (see HRA subsection for additional guidance) and should submit the HRA to DHCS as noted in the submission instructions at the end of this chapter. All D-SNPs must implement DHCS-specific MOC requirements in CY 2025. DHCS will provide feedback on state-specific elements of the MOC submissions, and DHCS will request any needed updates to the state-specific elements of the MOCs within 14 days of DHCS initial 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. 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).

Caregiver Services

In alignment with the CY 2024 Physician Fee Schedule (Final Rule), DHCS defines a Caregiver as "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation" and "a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition." All D-SNPs must include a question in the Member's HRA to identify any engaged Caregiver and submit the HRA tool to DHCS, per submission instructions at the end of this chapter. 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. Caregivers should be actively engaged in the Member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT). 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 inviting the MCP to participate 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. D-SNPs must provide sufficient care management to Members to ensure that Members who would otherwise qualify for Medi-Cal ECM are not adversely impacted by receiving care management exclusively through their D-SNP. Additional guidance on ECM continuity of care will be forthcoming.

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.[1] 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 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.

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

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;[2] 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

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

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.[3]

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.[4]

D-SNPs must have a process to identify Members who are eligible for palliative care, including a provider referral process.[5] 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

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

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

[5] 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.

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
- 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.

Care Coordination Deliverables: DHCS Submission Instructions

D-SNPs with MOC expiration date on December 31, 2024 (On-cycle MOC submission)

- **Care Coordination Deliverable for DHCS:** CY2025 Model of Care and CY2025 CA-Specific Matrix
- **Deadline to Submit to DHCS:** February 14, 2024
- **DHCS Submission Instructions:** Send to DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager

D-SNPs with MOC expiration date after December 31, 2024

- Not required to submit MOC or CA-Specific Matrix to DHCS

All D-SNPs

- **Care Coordination Deliverable for DHCS:** CY2025 D-SNP Health Risk Assessment
- **Deadline to Submit to DHCS:** February 14, 2024
- **DHCS Submission Instructions:** Send to DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager

II. INTEGRATED MATERIALS AND MARKETING 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. As EAE D-SNPs are Applicable Integrated Plans (as defined in 42 CFR § 422.561), they provide Members with a single set of materials that meets the Member materials requirements under both Medicare and Medi-Cal. In California's EAE D-SNP SMAC, DHCS requires that several materials (listed below) are integrated to help Members easily understand all of their benefits. Please note, EAE D-SNPs must suppress some Medi-Cal Member materials (such as Medi-Cal welcome packets) for these Members since the integrated materials take the place of Medi-Cal only materials and Medicare-only materials.

Note, the requirements outlined in this chapter also apply to SCAN's Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). SCAN must edit the CY2025 model templates to reflect specific Medi-Cal benefits that are carved-in to the SCAN Medi-Cal Managed Care contract such as Personal Care Services, Dental, and Behavioral Health.

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)[6]. These requirements are also included in California's SMAC for EAE D-SNPs in 2025.

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)

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

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 and other duplicative Medi-Cal materials as they would be confusing and unnecessary for Members in the EAE D-SNP.
- Member Handbook:
    - The Notice of Availability language incorporates the Medi-Cal DHCS tagline in Chapter 1 of the Member Handbook.
    - 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.
- Single Member ID Card
    - Plans may choose to include the Primary Care Provider Group/Name and Phone Number on the Member ID card; or
    - Plans may choose to include the Federally Qualified Health Center (FQHC) Name and Phone Number on the Member ID card in place of the Primary Care Provider Group/Name and Phone Number.
    - Note: Including the Primary Care Provider Group/Name or FQHC Name on the Member ID card is optional for plans.
- 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 guidance (the DHCS threshold and concentration standard languages), as specified in APL 21-004 or subsequent iterations, to Contractors on specific translation requirements for their Service Areas.

Alternate Formats

EAE D-SNPs[7] must provide materials[8] and Individualized Care Plans (ICPs) to Members on a standing basis in alternate formats and in any non-English language[9], 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

[7] Pursuant to 42 CFR §§ 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 CFR § 422.101(f)(1)(ii) for special needs plan enrollees.
[8] Required materials are described under 42 CFR § 422.2267(e).
[9] Any non-English language as identified in 42 CFR §§ 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.

point. The process[10] 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 22-026 or subsequent iterations. Contractor must operate the API in the manner specified in 45 CFR § 170.215 and include information per 42 CFR § 438.242(b)(5) and (6).

Review and Submission Process

The Centers for Medicare & Medicaid Services (CMS) will release the required integrated Member material models to all EAE D-SNPs through the Health Plan Management System (HPMS) in Q2, annually. In addition to the integrated Member material models, 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 models, EAE D-SNPs are required to submit their completed integrated Member material models 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 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. The redlined copies should be what plans have updated based on the current year's models (i.e., not comparing CY2024 to CY2025 materials). Plans should direct questions relating to DMHC materials approval to the assigned licensing reviewer. Of the integrated Member materials, the Formulary and Provider and Pharmacy Directory should be sent to DHCS only for review and approval. DMHC does not review these materials. Note: The processes may change for CY2026 integrated Member materials.

[10] 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)

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 15, 2024	August 14, 2024	September 30, 2024
Member Handbook	July 26, 2024	August 26, 2024	October 15, 2024
Summary of Benefits	July 15, 2024	August 14, 2024	October 15, 2024
Member ID Card	July 15, 2024	August 14, 2024	Provided to new enrollees within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.
Formulary	August 1, 2024	August 30, 2024	October 15, 2024
Provider and Pharmacy Directory	August 1, 2024	August 30, 2024	October 15, 2024

**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 Medicare Communications and Marketing Guidelines.[11]

For EAE D-SNPs that desire to conduct marketing with current members who are only in their Medi-Cal MCP offered by the parent organization, please see 42 CFR § 422.2264(b). Note, EAE D-SNPs are required by CMS and DHCS to submit all marketing materials in HPMS; however, in this scenario, DHCS does not need to review these Medicare marketing materials.

Notice of Availability

Per 42 CFR §§ 422.2267(e)(31) and 423.2267(e)(33), for CY2025, DHCS is requiring EAE D-SNPs to provide a Notice of Availability of language assistance services and auxiliary aids and services that, at a minimum, states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The EAE D-SNP must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in California and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.

To satisfy both Medicare and Medi-Cal requirements, EAE D-SNPs must use the template language below, which aligns with language used in Medi-Cal Managed Care Plan member materials. Note that this guidance replaces the requirement to use the CMS Multilanguage Insert (MLI) language and DHCS tagline language in EAE D-SNPs Member Handbook and applicable integrated materials for CY2025.

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

Notice of Availability Template Language

[Please list each language in 18pt font]

[English tagline] ATTENTION: If you need help in your language, call [1-xxx-xxxx] (TTY: [1-xxx-xxxx] or 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call [1-xxx-xxxx] (TTY: [1-xxx-xxxx] or 711). These services are free.

[Arabic tagline]

[Armenian tagline]

[Chinese tagline]

[Punjabi tagline]

[Hindi tagline]

[Hmong tagline]

[Japanese tagline]

[Korean tagline]

[Laotian tagline]

[Mien Tagline]

[Mon-Khmer, Cambodian tagline]

[Persian (Farsi) tagline]

[Russian tagline]

[Spanish tagline]

[Tagalog tagline]

[Thai tagline]

[Ukrainian tagline]

[Vietnamese tagline]

Medi-Medi Plan Member Handbook Template Text

In addition to the Notice of Availability text listed above, Medi-Medi Plans should also include the following text in the Medi-Medi Plan Member Handbook. DHCS recommends including this template text at the beginning of the Medi-Medi Plan Member Handbook (i.e., where it is included in the Medi-Cal Member Handbook template). This text must be provided in the language of the Handbook and in alignment with the requirements in the Medi-Cal Managed Care contract (Exhibit A, Attachment III, Subsection 5.1.3.I. Member Handbook). This text does not need to be translated into multiple languages. For example, if a Member's preferred language is Spanish, the text below would appear only in Spanish in the Spanish-language version of the Medi-Medi Plan Member Handbook.

Other languages [This paragraph should be in 18pt font]

You can get this Member Handbook and other plan materials in other languages at no cost to you. [Medi-Medi Plan marketing name] provides written translations from qualified translators. Call [Medi-Medi Plan's single member services telephone number] (TTY [member services TTY number] or 711). The call is free. [Medi-Medi Plan should edit "member services" as appropriate to match the name the Medi-Medi Plan uses. Medi-Medi Plan may also add contact information and information on member resources such as a member portal.] Refer to your Member Handbook to learn more about health care language assistance services such as interpreter and translation services.

Other formats [This paragraph should be in 18pt font]

You can get this information in other formats such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call [Medi-Medi Plan's single member services telephone number] (TTY

[member services TTY number] or 711). The call is free.

Interpreter services [This paragraph should be in 18pt font]

[Medi-Medi Plan marketing name] provides oral interpretation services, including sign language, from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters unless it is an emergency. Interpreter, linguistic, and cultural services are available for free. Help is available 24 hours a day, 7 days a week. For help in your language, or to get this Member Handbook in a different language, call [Medi-Medi Plan single member services or interpreter services telephone number] (TTY [interpreter services TTY number] or 711). The call is free.

III. 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. The content in this section mirrors the CY 2024 requirements.

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

[2025 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 and bracketed. D-SNPs with MOCs expiring on December 31, 2024 must simultaneously submit their state-specific review matrix and MOC to DHCS via email by February 14, 2024. DHCS will provide feedback on the state-specific elements of the MOC submissions, and DHCS will request any needed updates to the state-specific elements of the MOCs within 14 days of DHCS initial feedback to the plans.]

Deliverable for DHCS	Deadline to Submit to DHCS	DHCS Submission Instructions
D-SNPs with MOC expiration date on December 31, 2024 (On-cycle MOC submission)		
CY2025 Model of Care and CY 2025 CA-Specific Matrix	February 14, 2024	Send to DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager
D-SNPs with MOC expiration date after December 31, 2024		
Not required to submit MOC or CA-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 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 health	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
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	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
community-based palliative care referral using the Medi-Cal 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: » Employed and/or contracted staff who perform administrative functions, such as: enrollment and eligibility verification, claims verification and processing, etc. » 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. » 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 appropriate clinical practice guidelines and integrate care transitions protocols.	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
» 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	

Model of Care Element	Corresponding Page #/Section in Care Management Plan
supports programs, including home- and 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: » 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,	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
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 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 2025 D-SNP Policy Guide, or similar questions. 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. ▪ A question to identify any engaged Caregiver. ▪ 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.	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
» [A description of how the D-SNP will engage primarily through in-person contact with enrollees who qualify for 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. o 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.	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
» Describe how the ICP is documented and updated, including updates based on more recent HRAT information and where the documentation is 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	

Model of Care Element	Corresponding Page #/Section in Care Management Plan
○ 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.]	
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 [and supports active engagement in both ICP and ICT processes.] ○ 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	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
additional team members are needed to meet the unique needs of the individual enrollee, [including those California-specific sub-populations identified in element 1B.] o 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.	

Model of Care Element	Corresponding Page #/Section in Care Management Plan
» [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 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	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
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. » 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	

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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	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
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 (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	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
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.	
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 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.	*Enter corresponding page number and section here*

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	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
the overall performance improvement plan (MOC Element 4B). ○ 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.	
Element B: Measurable Goals & Health Outcomes for the MOC » Identify and clearly define the SNP's measurable goals and health outcomes; describe how identified 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.	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
» 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. » 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	*Enter corresponding page number and section here*

Model of Care Element	Corresponding Page #/Section in Care Management Plan
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.	
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 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.	*Enter corresponding page number and section here*

PRA Disclosure Statement

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