State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

CalAIM Dual Eligible Special Needs Plans Policy Guide

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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 developed two SMAC templates for 2023: the first for EAE-SNPs and the second for non-EAE D-SNPs. DHCS maintains the authority to contract or not to contract with D-SNPs.

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

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

Summary of Updates and Key Changes

Date	Chapter/Section	Update/Change	Notes
6/30/22	Care Coordination	• Specified language regarding training content for dementia care specialists	
6/30/22	Appendix A	• Revised formatting of LTSS questions for HRA	
6/9/22	Care Coordination	• Updated language regarding training content for dementia care specialists • Added language regarding ECM benefit for Duals	
6/9/22	Continuity of Care	• Initial Release	
12/30/21	Care Coordination	• Initial Release	

I. Care Coordination Requirements

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

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

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

Risk Stratification

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

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

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

Health Risk Assessment (HRA)

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

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

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

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

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

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

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

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

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

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

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

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

Care Transitions

D-SNPs must identify individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules. Health plan social services staff serving as liaisons for the LTSS provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. D-SNPs must identify these individuals and their contact information in materials for providers and beneficiaries.

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

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

Some EAE D-SNP members needing care management services through EAE D-SNPs may also meet the criteria for ECM populations of focus. However, there is significant overlap across the D-SNP model of care and ECM requirements, which could result in duplication and confusion for members and care teams if a member receives care management from both programs. Since member care management, as well as coordination across Medicare and Medi-Cal benefits, is a primary function of D-SNPs, DHCS intends for EAE D-SNPs to provide sufficient care management to members so that those members that would otherwise qualify for Medi-Cal ECM are not adversely impacted by receiving care management exclusively through their D-SNP. For 2023, DHCS guidance for EAE D-SNPs is to provide integrated care management across Medicare and Medi-Cal benefits with the intent that beneficiaries will receive any ECM-like services they may need through the D-SNP. For members already receiving Medi-Cal ECM from their MCP, D-SNPs shall provide ongoing continuity of care with existing ECM providers when possible, until the member graduates from ECM.

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

II. Information Sharing Policy (coming in 2022)

III. Network Guidance for EAE D-SNPs (coming in 2022)

IV. Network Guidance for non-EAE D-SNPs (coming in 2022)

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

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

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

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

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

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

Continuity of Care for Medicare Primary and Specialty Providers

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

- A member has an existing relationship with a primary or specialty care provider. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or a specialty care provider at least once during the 12 months prior to the date of their initial enrollment in the D-SNP for a non-emergency visit;
- The provider is willing to accept, at a minimum, payment from the D-SNP based on the current Medicare fee schedule, as applicable; and
- The provider does not have any documented quality of care concerns that would cause the D-SNP to exclude the provider from its network.

If the member leaves the D-SNP and later rejoins the D-SNP, then the D-SNP must offer the member a 12-month continuity of care period based on the date of re-enrollment, regardless of whether the member received continuity of care in the past. If a member

changes D-SNPs, the continuity of care period may start over one time. If the member changes D-SNPs a second time (or more), the continuity of care period does not start over, meaning the D-SNP is not required to offer the member a new 12-month period.

Requirements Regarding Primary Care Providers and Delegated Entities

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

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

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

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

Procedures for Requesting Continuity of Care

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

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

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

provider prior to the member's enrollment into the D-SNP. D-SNPs must approve any retroactive requests that:

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

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

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

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

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

Request Completion Timeline

Each continuity of care request must be completed within:

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

A continuity of care request is considered completed when:

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

Requirements after the Request Process is Completed

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

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

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

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

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

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

D-SNP Extended Continuity of Care Option

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

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

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

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

Member and Provider Outreach and Education

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

VI. Quality and Reporting Requirements for EAE D-SNPs (coming in 2022)

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: 2023 CalAIM EAE D-SNP Components Template

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

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

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

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

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

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

Health Risk Assessment (HRA) To the extent possible, while still meeting both Medicare and Medi-Cal requirements, the D-SNP should work with the aligned Medi-Cal managed care plan to create efficiencies in their respective HRA tools and processes to minimize the burden on members. Plans must make best efforts to create a single, unified HRA to meet the requirements for both the D-SNP and Medi-Cal managed care plans. Plans have flexibility in the design of their HRA tools as long the content specified below is included. Plans should rely on Medicare timeframes for the completion of initial and annual HRAs. To the extent that Medi-Cal and Medicare guidance for HRAs conflict, plans should follow Medicare guidance. D-SNPs must ensure their HRA identifies the following elements: 1. Medi-Cal services the member currently accesses. 2. Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in Appendix A or similar questions. If a plan intends to use a variation on the LTSS questions provided, the question must be reviewed and approved by DHCS. Plans may incorporate the questions into their HRA in any order. 3. Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease. If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the D-SNPs assessment process. HRAs must directly inform the development of member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.	
Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs) Both the ICP and ICT meeting should include, to the extent possible, services and providers from the Medi-Cal managed care and carved-out delivery systems, as appropriate for the member and consistent with their preferences. Plans must encourage participation of both members and primary care providers in development of the ICP and ICT activities. The ICP should be person-centered and informed by the member's HRA and past utilization of both Medicare and Medi-	

Cal services. One ICP should be used to meet both Medicare and Medi-Cal ICP requirements. To the extent that Medi-Cal and Medicare guidance for ICPs conflict, plans should follow Medicare guidance. The ICP must identify any carved-out services the member needs and how the D-SNP will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to: o Community Based Organizations such as those serving members with disabilities (e.g. independent living centers) and those serving members with dementia (e.g. Alzheimer's organizations) o County mental health and substance use disorder services o Housing and homelessness providers o Enhanced Care Management (ECM) and Community Supports (formerly ILOS) providers in the aligned MCP network o 1915(c) waiver programs, including MSSP o LTSS programs, including IHSS and Community-Based Adult Services (CBAS) o Medi-Cal transportation to access Medicare and Medi-Cal services D-SNP care coordinators/managers participating in the ICT must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS programs, including home- and community-based services and long-term institutional care. The ICT should include providers of any Medi-Cal services the member is receiving, including LTSS and Community Supports. Irrespective of having a formal Alzheimer's or dementia diagnosis, if the member has documented dementia care needs, including but not limited to: wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, and/or inability to manage ADLs/IADLS, the ICT must include the member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the member's preferences. Dementia care specialists must be trained in: understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees	

and caregivers. These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.	
Care Transitions D-SNPs must identify individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules. Health plan social services staff serving as liaisons for the LTSS provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. D-SNPs must identify these individuals and their contact information in materials for providers and beneficiaries.	