# CALAIM DUAL ELIGIBLE SPECIAL NEEDS PLAN POLICY GUIDE – CONTRACT YEAR 2026

**December 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. Note, most of the requirements in this Policy Guide will also apply to SCAN's Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP).

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, 2025, 12 counties: 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 (MCP). 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) 2026, by providing additional details to supplement the CY 2026 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 2026. Updates will be published as guidance is added.

# I. CARE COORDINATION REQUIREMENTS

The purpose of this chapter is to provide state-specific care coordination requirements to health plans operating EAE and non-EAE D-SNPs[1] in California in contract year (CY) 2026.

The state requirements described in this section are in addition to all existing Medicare D-SNP Model of Care (MOC) 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 State Medicaid Agency Contract (SMAC) requirements for CY 2026.

Every D-SNP must have a National Committee for Quality Assurance (NCQA) approved MOC. The MOC provides the basic framework under which the D-SNP will meet the needs of each of its Members. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each Member are identified by the D-SNP and addressed through the plan's care management practices. Details on MOC submission instructions are included at the end of this chapter, and the CY 2026 CA-Specific MOC Matrix is in Appendix A.

DHCS requires EAE D-SNPs to be directly responsible for care coordination and related member functions, unless the D-SNP has advance approval from DHCS. Having a standalone entity provide care coordination, separate from other key plan functions for D-SNP members, is not aligned with an integrated plan approach for dual members.

This chapter contains the following sections:

- D-SNP Populations
- California Integrated Care Management (CICM)
    - Introduction
    - Description of CICM Populations
    - Contracting with Community-Based Organizations for CICM Populations
    - Continuity of Care for Members Transitioning from Medi-Cal ECM to D-SNP CICM
    - In-Person Engagement for CICM Populations
    - Additional Requirements for CICM Populations

[1] Note, requirements in this chapter also apply to SCAN's Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP).

## D-SNP Populations

This chapter includes California-specific requirements for certain populations as specified in the California Integrated Care Management section. Please note, these state-specific requirements are in addition to federal requirements that apply to all populations served by D-SNPs. Per federal requirements, D-SNPs identify vulnerable populations[2] for care management interventions, such as disease-based groups. These plan-identified D-SNP populations are not subject to California Integrated Care Management requirements.

[2] Note, these requirements should be included in the D-SNP MOC section 1, Element B.

# California Integrated Care Management (CICM)

## Introduction

**California Integrated Care Management (CICM)** refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to Members. CICM layers state-specific requirements on top of federal D-SNP requirements. CY 2026 CICM requirements replace the CY 2024 and CY 2025 "ECM-like care management" requirements for D-SNPs.

DHCS acknowledges there is significant overlap across the D-SNP MOC and Medi-Cal Enhanced Care Management (ECM) requirements, which could result in duplication and confusion for Members and care teams if a Member receives care management from both programs. To avoid confusion and align with federal care management policy for D-SNPs, DHCS policy for CY 2026 continues to be that D-SNPs (rather than Medi-Cal MCPs) are responsible for care management for Members that may qualify for ECM. Dual eligible Members who are in Original Medicare or Medicare Advantage plans (not D-SNPs) receive ECM through their Medi-Cal MCP if they meet eligibility requirements. 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.

CICM policy applies to Members who may be eligible to receive ECM from their MCP. CICM requirements also address an additional vulnerable population: Members with Documented Dementia Needs.

## Description of CICM Populations

DHCS requires all D-SNPs provide CICM to the populations listed below. The CICM populations, along with each population's criteria as outlined in Appendix B, must be listed in the D-SNP MOC, and D-SNPs must use these criteria to determine Member eligibility. These populations reflect Medi-Cal ECM with the addition of Members with Documented Dementia Needs. D-SNPs must include all of the following CICM populations as vulnerable Members in their MOCs (Section 1, Element B):

- Adults Experiencing Homelessness
- Adults At Risk for Avoidable Hospital or Emergency Department Utilization
- Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Adults Transitioning from Incarceration

- Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization
- Adult Nursing Facility Residents Transitioning to the Community
- Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities as defined by California public health data on maternal morbidity and mortality (Birth Equity)
- Adults with Documented Dementia Needs

## Contracting with Community-Based Organizations for CICM Populations

D-SNPs must describe in the MOC, specifically how plan-led care management effectively identifies these unique and vulnerable populations, leverages in-person engagement with these Members, and effectively partners with relevant community-based organizations (CBOs) including community-based providers.

DHCS recommends that D-SNPs contract with CBOs that serve CICM populations, as described above, to augment D-SNP plan-based care management. A list of suggested CICM community-based provider types is included in Appendix C. EAE D-SNPs are also encouraged to leverage the CBO contracts the plan has within their Medi-Cal line of business.

In situations where a CBO providing CICM assigns a care manager to a Member, the D-SNP care manager must directly communicate with the CBO care manager to ensure the Member receives coordinated care.

## Continuity of Care for Members Transitioning from Medi-Cal ECM to D-SNP CICM

For Members who join a D-SNP on or after 1/1/26 and are already receiving Medi-Cal ECM from their MCP, D-SNPs shall provide ongoing continuity of care with existing Medi-Cal ECM providers, when possible, for up to 12 months. A D-SNP may offer a longer continuity of care period, but it is not required.

## In-Person Engagement for CICM Populations

For CICM populations, Member interactions are encouraged to be provided primarily either in-person or through a visual, real-time, interactive telehealth encounter. 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.

## Additional Requirements for Specific CICM Populations

Certain CICM populations require consideration regarding how to provide care management for these Members. The requirements for these select CICM populations supersede those listed above.

### Adults Experiencing Homelessness

For Members experiencing homelessness, CICM must be provided in-person.

### Adults with Documented Dementia Needs

D-SNPs must have trained dementia care specialists on Interdisciplinary Care Teams (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 Individualized Care Plan (ICP) to the extent possible and as consistent with the Member's preference.

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.

## Risk Stratification (For All D-SNP Members)

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, if available; and
- Any data and risk stratification available through the DHCS Population Health Management Platform (when it becomes available).

## Health Risk Assessment (For All D-SNP Members)

To the extent possible, while still meeting both Medicare and Medi-Cal requirements, the D-SNP should identify efficiencies in their respective Health Risk Assessment (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.

All 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 D 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 state-specific vulnerable populations (see CICM section) such as those with 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). The sub-regulatory guidance is located in Section 90 of Chapter 16(b) of the Medicare Managed Care Manual.

### 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 only D-SNPs that did not submit the HRA tool to DHCS for CY 2025 must do so for CY 2026, 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 ICP and ICT. HRAs must directly inform the development of Member's ICP and ICT, per federal requirements.

## Face-to-Face Encounters (For All D-SNP Members)

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. Per state-specific requirements, 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 and Interdisciplinary Care Teams (For All D-SNP Members)

Both the Individualized Care Plan (ICP) and Interdisciplinary Care Team (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 Members, primary care providers, and specialists 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.

### Individualized Care Plans

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.

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 warm transfers, 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

### Interdisciplinary Care Teams

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, Community Supports, and any carved-out services, as needed and consistent with the Member's preferences. This may also include any representatives from CBOs involved with the Member that a D-SNP may have contracted with to serve its CICM populations.

### Requirements for Non-EAE D-SNPs for ICPs and ICTs

In addition to the requirements above, non-EAE D-SNPs must adhere to the following guidance regarding ICPs and ICTs. Non-EAE D-SNPs should coordinate with unaligned MCPs including Medi-Cal providers for Member care, including sharing copies of their mutual Member's completed ICP and inviting the Medi-Cal providers 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 (per the definition of a D-SNP at 42 CFR 422.2). 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 (see additional information at the end of this chapter). MCP and care coordinator contact information must be included in the D-SNP care plan.

## Care Transitions (For All D-SNP Members)

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.

Non-EAE D-SNPs must have care transition protocols that include coordination with Medi-Cal plans. D-SNPs must have care transition protocols that reflect the SMAC requirements for Information Sharing.

# 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.[3] D-SNPs must either adopt the DHCS minimum eligibility criteria for palliative care, or they may submit broader eligibility criteria to DHCS for approval.

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

## 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.

### 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,[4] 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)

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

a. The Member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
b. The Member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
    a. The Member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    b. The Member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver Disease: Must meet (a) and (b) combined or (c) alone
    a. The Member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    b. The Member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    c. The Member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.[5]

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.[6]

D-SNPs must have a process to identify Members who are eligible for palliative care, including a provider referral process.[7] 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.

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

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

[7] 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.

## 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:

1. 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.
2. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
    a. Treatment plans, including palliative care and curative care
    b. Pain and medicine side effects
    c. Emotional and social challenges
    d. Spiritual concerns
    e. Patient goals
    f. Advance directives, including POLST forms
    g. Legally-recognized decision maker
3. 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.
4. 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.

5. 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.
6. 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.
7. 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.

# Operationalizing this Guidance

## 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 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)).

## MOC Submission Instructions

### D-SNPs with MOC expiration date on December 31, 2025 (On-cycle MOC submission)

- **Care Coordination Deliverable for DHCS:** CY 2026 Model of Care and CY 2026 CA-Specific Matrix
- **Deadline to Submit to DHCS:** February 12, 2025
- **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, 2025 (Off-cycle MOC submission)

- **Care Coordination Deliverable for DHCS:** CY 2026 Model of Care and CY 2026 CA-Specific Matrix
- **Deadline to Submit to DHCS:** February 12, 2025
- **DHCS Submission Instructions:** Send to DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager

## Care Coordination Deliverables: DHCS Submission Instructions

### D-SNPs who did not submit HRA for CY 2025

- **Care Coordination Deliverable for DHCS:** CY 2026 D-SNP Health Risk Assessment
- **Deadline to Submit to DHCS:** February 12, 2025
- **DHCS Submission Instructions:** Send to DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager

# APPENDIX A: CALIFORNIA SPECIFIC MODEL OF CARE MATRIX

## [2026 California-Specific] Model of Care Matrix Document: Initial and Renewal Submission

### Special Needs Plan (SNP) Contract Information

| SNP Contract 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.

**State Submission Requirements**

D-SNPs with MOCs expiring on December 31, 2025 (on-cycle MOC submission), must submit their state-specific matrix and MOC to DHCS via email by February 12, 2025. D-SNPs with MOC expiration date after December 31, 2025 (off-cycle MOC submission), must submit a revised version of their state-specific matrix and MOC based on the CY 2026 Care Coordination requirements to DHCS via email by February 12, 2025. The state-specific matrix should only be submitted to DHCS. DHCS will provide feedback on the state-specific elements of the MOC submissions, and will request any needed updates to the state-specific elements of the MOCs within 14 days of DHCS initial feedback to the plans. DHCS recommends that D-SNPs submit the same MOC to both CMS and DHCS.

**Federal Submission Requirements**

D-SNPs with MOCs expiring on December 31, 2025 (on-cycle MOC submission), must follow CMS instructions to submit the MOC via HPMS with the CMS-released matrix. D-SNPs with MOC expiration date after December 31, 2025 (off-cycle MOC submission), must ensure they meet CMS requirements at 42 CFR § 422.101(f)(3)(iv) for revisions to

the MOC. Per 42 CFR § 422.101(f)(3)(iv)(G), the timeframe for submitting off-cycle MOCs to CMS is between June 1st and November 30th of each calendar year, and D-SNPs are encouraged to submit off-cycle MOCs to CMS as early as possible within this timeframe. D-SNPs must submit to CMS the MOC matrix released by CMS in the Medicare Advantage (Part C) application, not the state-specific matrix. For reference, the NCQA MOC review criteria for D-SNPs is available on the NCQA webpage.]

| Deliverable for DHCS | Deadline to Submit to DHCS | DHCS Submission Instructions |
|---|---|---|
| **D-SNPs with MOC expiration date on December 31, 2025 (On-cycle MOC submission)** | | |
| CY 2026 Model of Care and CY 2026 CA-Specific Matrix | February 12, 2025 | Send to DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager |
| **D-SNPs with MOC expiration date after December 31, 2025 (Off-cycle MOC submission)** | | |
| CY 2026 Model of Care and CY 2026 CA-Specific Matrix | February 12, 2025 | Send to DHCS_DSNP@dhcs.ca.gov with cc to DHCS contract manager |

## 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 Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| **Element A: Description of the Overall SNP Population**<br><br>The description of the SNP population must include, but not be limited to, the following: | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| » Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP beneficiaries.<br>» A detailed profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with the SNP population in the plan's geographic service area.<br>» Identification and description of the health conditions impacting SNP beneficiaries, 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 such as: language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other).<br>» Definition of unique characteristics for the SNP population served:<br>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<br>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.<br>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 enrollees reside. | |
| **Element B: Sub-Population: Most Vulnerable Beneficiaries** | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| 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. [D-SNPs in California must include, in addition to any other sub-populations determined by the D-SNP: 1) all California Integrated Care Management (CICM) populations, as outlined in the CY 2026 Care Coordination chapter and Appendix A of the CY 2026 D-SNP Policy Guide; and 2) Members with serious illness eligible for 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.] Other information specific to the description of the most vulnerable enrollees must include, but not be limited to, the following:<br>» Description of the internal health plan procedures for identifying the most vulnerable enrollees within the SNP. [In addition to describing the plan procedures for identifying the most vulnerable Members, as determined by the D-SNP, D-SNPs must also:<br>o Include CICM populations criteria, as included in Appendix A of the CY 2026 D-SNP Policy Guide, and describe how plan-led care management effectively identifies the CICM populations.<br>o Include a description of D-SNP palliative care referral eligibility criteria if it differs from the Medi-Cal palliative care eligibility criteria.]<br>» Description of the relationship between the demographic characteristics of the most vulnerable enrollees and their | |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| 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.<br>» 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 beneficiaries and/or their caregiver(s).<br>o [State whether the D-SNP has contracted with community-based organizations to provide community-based care management to CICM populations, and, if so, identify and describe the community-based organizations the plan has contracted with.<br>o Describe how the plan effectively partners with community-based organizations, including community-based providers, to serve CICM populations.] | |

## 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 Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| **Element A: SNP Staff Structure**<br><br>» Fully define the SNP staff roles and responsibilities across all health plan functions that directly or indirectly affect the care coordination of beneficiaries enrolled in the SNP. This includes, but is not limited to, identification and detailed explanation of:<br>o Specific employed and/or contracted staff responsible for performing administrative functions, such as: enrollment and eligibility verification, claims verification and processing, other.<br>o Employed and/or contracted staff that perform clinical functions, such as: direct beneficiary care and education on self-management techniques, care coordination, pharmacy consultation, behavioral health counseling, other.<br>o Employed and/or contracted staff that performs 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.<br>» Provide a copy of the SNP's organizational chart that shows how staff responsibilities identified in the MODEL OF CARE 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.<br>» Identify the SNP contingency plan(s) used to ensure ongoing continuity of critical staff functions. | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| » Describe how the SNP conducts initial and annual MODEL OF CARE 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.<br>» Describe how the SNP documents and maintains training records as evidence to ensure MODEL OF CARE 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 MODEL OF CARE competency testing, web- based attendance confirmation, and electronic training records.<br>Explain any challenges associated with the completion of MODEL OF CARE training for SNP employed and contracted staff and describe what specific actions the SNP will take when the required MODEL OF CARE training has not been completed or has been found to be deficient in some way.<br>» [Describe how D-SNP care managers participating in the Interdisciplinary Care Team (ICT) are trained by the plan to identify and understand the full spectrum of Medicare and Medi-Cal long-term services and supports programs, including home- and community-based services and long-term institutional care in California.<br>» Describe training program for D-SNP dementia care specialists for Interdisciplinary Care Team (ICT).] | |
| **Element B: Health Risk Assessment Tool (HRAT)**<br><br>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 activities; therefore, it is imperative that the MODEL OF CARE | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| include the following:<br>» A clear and detailed description of the policies and procedures for completing the HRAT including:<br>o Description of how the HRAT is used to develop and update, in a timely manner, the Individualized Care Plan (MODEL OF CARE Element 2D) for each enrollee and how the HRAT information is disseminated to and used by the Interdisciplinary Care Team (MODEL OF CARE Element 2E).<br>o Detailed explanation for how the initial HRAT and annual reassessment are conducted for each enrollee.<br>o Description of how the SNP ensures that he results from the initial HRAT and the annual reassessment HRAT conducted for each individual are addressed in the ICP.<br>o Detailed plan and rationale for reviewing, analyzing, and stratifying (if applicable) the results of the HRAT, including the mechanisms to ensure communication of that information to the Interdisciplinary Care Team, provider network, enrollees and/or their caregiver(s), as well as other SNP personnel that may be involved with overseeing the SNP beneficiary's plan of care. If stratified results are used, include a detailed description of how the SNP uses the stratified results to improve the care coordination process.<br>» [Description of how the HRAT is used to detect potential cognitive impairment.<br>» Description of how the HRAT identifies the following elements: | |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| ○ Medi-Cal services the member currently accesses.<br>○ Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided in Appendix D of the CY 2026 D-SNP Policy Guide, or similar questions. Plans may incorporate the questions into their HRAT in any order.<br>○ Populations that may need additional screening or services, including California specific sub-populations identified in Element 1B.<br>○ A question to identify any engaged Caregiver.<br>» Non-EAE D-SNPs: Description of how D-SNP will coordinate with unaligned Medi-Cal Managed Care Plans (MCPs) for member care, including sharing copies of their mutual member's completed HRAT.] | |
| **Element C: Face-to-Face Encounter**<br><br>» 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. The face-to-face encounter is part of the overall care management strategy, and as a result, the MOC must include the following: | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| ○ A clear and detailed description of the policies, procedures, purpose, and intended outcomes of the face-to-face encounter.<br>○ A description of who will conduct the face-to-face encounter, employed and/or contracted staff.<br>○ A description of the types of clinical functions, assessments, and/or services that may be provided during the face-to-face encounter.<br>○ A description of how health concerns and/or active or potential health issues will be addressed during the face-to- face encounter.<br>» A description of how the SNP will conduct care coordination activities through appropriate follow-up, referrals, and scheduling as necessary.<br>» [A description of how the D-SNP may engage CICM populations through in-person contact. This description must also include how the D-SNP will provide in-person care management to the Adults Experiencing Homelessness CICM population, as required in the CY 2026 Care Coordination chapter.<br>» A description of 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.] | |
| **Element D: Individualized Care Plan (ICP)**<br><br>» The ICP components must include, but are not limited to: enrollee self-management goals and objectives; the beneficiary's personal healthcare preferences; description of services specifically tailored to the beneficiary's needs; roles of the beneficiaries' caregiver(s); and identification of goals met or not met. | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
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| ○ When the enrollees goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions.<br>» 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) is involved in its development and how often the ICP is reviewed and modified as the enrollees healthcare needs change. 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 incorporated into each enrollees ICP.<br>○ [Explain how the D-SNP facilitates the participation of Members and their caregivers as members of the ICP and supports active engagement in the ICP development process.]<br>» Describe how the ICP is documented and updated as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, enrollee and/or caregiver(s).<br>» 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.<br>» [Describe how the ICP will be developed and updated by, and/or shared with the Member's palliative care team, as appropriate.<br>» Describe how the ICP identifies any Medi-Cal carved-out services the Member needs and how the D-SNP will facilitate access and document referrals, including but not limited to warm transfers, referrals, and connections to:<br>○ Community Based Organizations such as those serving Members with disabilities (e.g. | |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
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| independent living centers) and those serving Members with dementia (e.g. Alzheimer's organizations)<br>○ County mental health and substance use disorder services<br>○ Housing and homelessness providers<br>○ Medi-Cal Community Supports providers<br>○ LTSS programs, including In Home Supportive Services, Community-Based Adult Services (CBAS), Multipurpose Senior Services Programs, and Regional Center services<br>○ Transportation to access Medicare and Medi-Cal services<br>○ Medi-Cal dental services<br>» Non-EAE D-SNPs: Describe how D-SNP will coordinate with unaligned Medi-Cal MCPs for member care, including sharing copies of their mutual member's completed ICPs.] | |
| **Element E: Interdisciplinary Care Team (ICT)**<br><br>» In the management of care, the SNP must use an ICT that 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 Members with serious illness participating in a palliative care program, the D-SNP must use a palliative care ICT, as described in the CY 2026 Care Coordination chapter.]<br>» 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 and capabilities of the ICT members align with the | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
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| 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 beneficiaries' 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.<br>○ Explain how the SNP facilitates the participation of enrollees and their caregivers as members of the ICT [and supports active engagement in the ICT process.<br>○ Explain how the ICT will include the Member's caregiver and a trained dementia care specialist, if the Member meets the criteria for the Adults with Documented Dementia Needs CICM population.<br>○ If the D-SNP has elected to contract with community-based organizations to serve its CICM populations, explain if and how the D-SNP facilitates the participation of these community-based organizations in a Member's ICT.]<br>○ Describe how the enrollees HRAT (MODEL OF CARE Element 2B) and ICP (MODEL OF CARE Element 2D) are used to determine the composition of the ICT; including those cases where additional team members are needed to meet the unique needs of the individual enrollee [including those California-specific sub-populations identified in Element 1B.]<br>○ Explain how the ICT uses healthcare outcomes to evaluate established processes to manage changes and/or adjustments to the enrollees health care needs on a continuous basis. | |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
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| » 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.<br>» 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 not be limited to, the following:<br>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 MODEL OF CARE. Explain how the SNP maintains effective and ongoing communication between SNP personnel, the ICT, beneficiaries, caregiver(s), community organizations and other stakeholders.<br>o The types of evidence used to verify that communications have taken place, e.g., written ICT meeting minutes, documentation in the ICP, other.<br>o How communication is conducted with beneficiaries who have hearing impairments, language barriers and/or cognitive deficiencies.<br>» [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 Members and caregivers.] | |
| **Element F: Care Transition Protocols**<br>» Explain how care transitions protocols are used to maintain continuity of care for SNP enrollees. Provide details and | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
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| specify the process and rationale for connecting the enrollee to the appropriate provider(s).<br>» 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 MODEL OF CARE Element 2A.<br>» Explain how the SNP ensures elements of the enrollees 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.<br>» Describe, in detail, the process for ensuring the SNP enrollee and/or caregiver(s) have access to and can adequately utilize the enrollees personal health information to facilitate communication between the SNP enrollee and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network.<br>» 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.<br>» Describe how the enrollee and/or caregiver(s) are informed about who their point of contact is throughout the transition process.<br>» [Describe transition protocols for Members 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 | |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
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| description should also include how the California State Medicaid Agency Contract requirements for information sharing are incorporated into Care Transition Protocols.] | |

## 3. SNP Provider Network

The SNP Provider Network is a network of healthcare providers who are contracted to provide health care services to SNP beneficiaries. The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized health care 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 MODEL OF CARE identifies, fully describes, and implements the following for its SNP Provider Network:

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
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| **Element A: Specialized Expertise**<br><br>» 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 MODEL OF CARE Element 1. [Include community-based palliative care providers and community-based organizations, including community-based providers, the D-SNP may have contracted with to provide community-based care management to CICM populations.]<br><br>» 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 are of expertise, or, as applicable, training in a defined role appropriate to their licensure in treating individuals that are similar to the target population. | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| » 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, endocrinologists, cardiologists, oncologists, mental health specialists, other.<br>» Describe how providers collaborate with the ICT (MODEL OF CARE Element 2D) and the beneficiary, contribute to the ICP (MODEL OF CARE Element 2C) 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 beneficiary in a timely and effective way; and 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 Transitions Protocols**<br>» 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.<br>» Define any challenges encountered with overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP enrollees. Provide details regarding how these decisions are made, incorporated into the ICP (MODEL OF CARE Element 2D), communicated with the ICT (MODEL OF CARE Element 2E) and acted upon. | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
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| » Explain how SNP providers ensure care transitions protocols are being used to maintain continuity of care for the SNP beneficiary as outlined in MODEL OF CARE Element 2F. | |
| **Element C: MODEL OF CARE Training for the Provider**<br><br>Network Regulations at 42 CFR§422.101(f)(2)(ii) require that SNPs conduct MODEL OF CARE training for their network of providers.<br><br>» Explain, in detail, how the SNP conducts initial and annual MODEL OF CARE training for network providers and out-of-network providers seen by enrollees on a routine basis. This could include, but not be limited to: printed instructional materials, face- to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP plans' website. [Include training on initial screening and comprehensive assessment for dementia.]<br>» Describe how the SNP documents and maintains training records as evidence of MODEL OF CARE training for their network providers. Documentation may include, but is not limited to: copies of dated attendee lists, results of MODEL OF CARE competency testing, web-based attendance confirmation, electronic training records, and physician attestation of MODEL OF CARE training.<br><br>Explain any challenges associated with the completion of MODEL OF CARE training for network providers and describe what specific actions the SNP Plan will take when the required MODEL OF CARE training has not been completed or is found to be deficient in some way. | *Enter corresponding page number and section here* |

## 4. MODEL OF CARE 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 organization 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 Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| **Element A: MODEL OF CARE Quality Performance Improvement Plan**<br><br>» 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 MODEL OF CARE structure effectively accommodates enrollees' unique healthcare needs. The description must include, but is not limited to, the following:<br>o The complete process, by which the SNP continuously collects, analyzes, evaluates and reports on quality performance based on the MODEL OF CARE by using specified data sources, performance and outcome measures. The MODEL OF CARE must also describe the frequency of these activities.<br>o Details regarding how the SNP leadership, management groups and other SNP personnel and stakeholders are involved with the internal quality performance process. | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
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| ○ Details regarding how the SNP- specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan (MODEL OF CARE Element 4B).<br><br>Process it uses or intends to use to determine if goals/outcomes are met, there must be specific benchmarks and timeframes, and must specify the re-measurement plan for goals not achieved | |
| **Element B: Measurable Goals & Health Outcomes for the MODEL OF CARE**<br><br>» Identify and clearly define the SNP's measurable goals and health outcomes and describe how identified measurable goals and health outcomes are communicated throughout the SNP organization. Responses must include but not be limited to, the following:<br>○ Specific goals for improving access and affordability of the healthcare needs outlined for the SNP population described in MODEL OF CARE Element 1.<br>○ Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT.<br>○ Enhancing care transitions across all healthcare settings and providers for SNP enrollees.<br>○ Ensuring appropriate utilization of services for preventive health and chronic conditions.<br>» Identify the specific enrollees 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 Elements | Corresponding Page #/ Section in Care Management Plan |
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| » Describe, in detail, how the SNP establishes methods to assess and track the MODEL OF CARE's impact on the SNP enrollees' health outcomes.<br>» Describe, in detail, the processes and procedures the SNP will use to determine if the health outcomes goals are met or not met.<br>» Provide relevant information pertaining to the MOC' goals as well a appropriate data pertaining to the fulfillment the previous MOC's goals.<br>» For SNP's submitting an initial MOC, provide relevant information pertaining to the MOC's goals for review and approval.<br>» If the MOC did not fulfill the previous MOC' 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 Member Satisfaction)**<br>» Describe the specific SNP survey(s) used and the rationale for selection of that particular tool(s) to measure SNP enrollee satisfaction.<br>» Explain how the results of SNP member satisfaction surveys are integrated into the overall MODEL OF CARE 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 MODEL OF CARE**<br>» Explain, in detail, how the SNP will use the results of the quality performance indicators and measures to support ongoing improvement of the MODEL OF CARE, including how quality will be continuously assessed and evaluated. | *Enter corresponding page number and section here* |

| Model of Care Elements | Corresponding Page #/ Section in Care Management Plan |
|---|---|
| » Describe the SNP's ability to improve, on a timely basis, mechanisms for interpreting and responding to lessons learned through the MODEL OF CARE performance evaluation process.<br>» Describe how the performance improvement evaluation of the MODEL OF CARE will be documented and shared with key stakeholders. | |
| **Element E: Dissemination of SNP Quality Performance related to the MODEL OF CARE**<br>» Explain, in detail, how the SNP communicates its quality improvement performance results and other pertinent information to its multiple stakeholders, which may include, but not be limited to: SNP leadership, SNP management groups, SNP boards of directors, SNP personnel & staff, SNP provider networks, SNP enrollees and caregivers, the general public, and regulatory agencies on a routine basis.<br>» 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.<br>» Identify the individual(s) responsible for communicating performance updates in a timely manner as described in MODEL OF CARE Element 2A. | *Enter corresponding page number and section here* |

# APPENDIX B: CRITERIA FOR CICM POPULATIONS

## Adults Experiencing Homelessness

Adults who:

1. Are experiencing homelessness, defined as meeting one or more of the following conditions:
    a. Lacking a fixed, regular, and adequate nighttime residence;
    b. Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
    c. Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);
    d. Exiting an institution into homelessness (regardless of length of stay in the institution);
    e. Will imminently lose housing in next 30 days;
    f. Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence;

AND

1. Have at least one complex physical, behavioral, or developmental need, with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

## Adults At Risk for Avoidable Hospital or ED Utilization

Adults who meet one or more of the following conditions:

1. Five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved adherence;
2. Three or more unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

## Adults with Serious Mental Health and/or SUD Needs

Adults who:

1. Meet the eligibility criteria for participation in or obtaining services through:
    a. SMHS delivered by Mental Health Plans (MHPs);
    b. The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program;

AND

2. Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure (four or more) of ACEs based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms;

AND

3. Meet one or more of the following criteria:
    a. Are at high risk for institutionalization, overdose, and/or suicide;
    b. Use crisis services, EDs, urgent care, or inpatient stays as the primary source of care;
    c. Experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months;
    d. Are pregnant or postpartum (12 months from delivery).

## Adults Transitioning from Incarceration

Adults who:

1. Are transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) OR transitioned from correctional facility within the past 12 months;

AND

2. Have at least one of the following conditions:
    a. Mental illness;
    b. SUD;
    c. Chronic Condition/Significant Non-Chronic Clinical Condition;
    d. Intellectual or Developmental Disability (I/DD);
    e. Traumatic Brain Injury (TBI);
    f. HIV/AIDS;
    g. Pregnant or Postpartum.

## Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization

Adults who:

1. Are living in the community who meet the SNF Level of Care (LOC) criteria, OR who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;

AND

2. Are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring);

AND

3. Are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

## Adult Nursing Facility Residents Transitioning to the Community

Adult nursing facility residents who:

1. Are interested in moving out of the institution; AND
2. Are likely candidates to do so successfully; AND
3. Are able to reside continuously in the community.

## Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities

Adults who:

1. Are pregnant OR are postpartum (through 12 months period);

AND

2. Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

## Adults with Documented Dementia Needs

Adults who:

1. Have a formal Alzheimer's or dementia diagnosis

OR

1. Have documented dementia care needs, including but not limited to:
    a. Wandering;
    b. Home safety concerns;
    c. Poor self-care;
    d. Behavioral issues;
    e. Issues with medication adherence;
    f. Poor compliance with management of co-existing conditions; AND/OR
    g. Inability to manage ADLs/IADLS

# APPENDIX C: SUGGESTED CICM COMMUNITY-BASED PROVIDER TYPES

Note, these are suggested provider types that a D-SNP could contract with for CICM populations.

- Street Medicine providers
- Homeless Navigation Centers
- Transitional Housing for Homeless Youth
- County Departments of Behavioral Health
- Community-Based Behavioral Health and Medication-Assisted Treatment (MAT) providers who also provide SMHS and/or DMC/DMC-ODS services
- CBAS Centers
- Area Agencies on Aging
- Home Health Agencies
- Centers for Independent Living
- Alzheimer's organizations
- Memory Care, Assisted Living, and Independent Living Organizations
- California Community Transitions Lead Organizations
- Affordable Housing Communities

Note: For the Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities CICM population, the following are types of providers that would only apply for Members eligible for this CICM population:

- OB/GYN Practices
- Midwifery Practices
- Entities that deliver the following services: Black Infant Health (BIH) Program, Perinatal Equity Initiative (PEI), Indian Health Program, American Indian Maternal Support Services (AIMSS)

# APPENDIX D: LTSS QUESTIONS FOR INCLUSION IN ALL D-SNP HRAS

The questions are organized in the following two tiers and all 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 Factors

**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