CalAIM
Dual Eligible Special Needs Plans
2023 Reporting Requirements Technical Specifications

November 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Introduction

The following document contains technical specifications for the 2023 Reporting Requirements and Quality Measures for Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs, also called Medicare Medi-Cal Plans), as well as non-EAE D-SNPs. Additional information from DHCS is available here: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx.

Contents are used from existing materials, including the:

- CY 2022 Core Reporting Requirements (as of 11/01/2021)
- CY 2022 California-Specific Reporting Requirements (as of 02/28/2022)
- American Academy of Neurology Mild Cognitive Impairment Quality Measurement Set (as of 03/25/2019)

Please note, additional information is included in the 2023 D-SNP Policy Guide, as well as the D-SNP Reporting Requirements and Reporting Templates. The D-SNP Reporting Requirements chapter in the 2023 D-SNP Policy Guide includes information on the Healthcare Effectiveness Data and Information Set (HEDIS) for both EAE and non-EAE D-SNPs and Long-Term Services and Supports (LTSS) reporting requirements for EAE D-SNPs.

Summary of Updates and Key Changes

Date	Chapter/Section	Update/Change	Notes
11/17/2023	• Care Coordination • FAQs	• Added clarifications on Core 2.1 and Core 3.2 • Revised CA 1.5 as no longer required for 2023 • Revised FAQs on Care Coordination measures	
6/29/2023	• Utilization • FAQs	• Added Core 9.1 for EAE and non-EAE D-SNPs • Added FAQs on Core 2.1 and 3.2	

Definitions

All definitions for terms defined in this section and throughout this Technical Specifications document apply whenever the term is used, unless otherwise noted.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: January 1 to March 31, April 1 to June 30, July 1 to September 30, and October 1 to December 31.

Calendar Year: All annual measures are reported on a calendar year basis. For example, Calendar Year (CY) 2023 represents January 1, 2023 through December 31, 2023.

In-Home Supportive Services (IHSS): Pursuant to Article 7 of the California Welfare and Institutions Code (WIC) (commencing with Section 12300) of Chapter 3, and WIC Sections 14132.95, 14132.952, and 14132.956, IHSS is a California program that provides in-home care for people who cannot safely remain in their own homes without assistance. To qualify for IHSS, an Enrollee must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program. IHSS includes the Community First Choice Option (CFCO), Personal Care Services Program (PCSP), and IHSS-Plus Option (IPO).

Individualized Care Plan (ICP or Care Plan): The plan of care developed by an Enrollee and/or an Enrollee's Interdisciplinary Care Team or health plan.

Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following:

1. IHSS (carved out of Medi-Cal managed care);

2. Community-Based Adult Services (CBAS);
3. Multipurpose Senior Services Program (MSSP) services (carved out of Medi-Cal managed care); and
4. Skilled nursing facility (SNF) services and subacute care services.

Multipurpose Senior Services Program (MSSP): The MSSP waiver provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. The MSSP waiver allows the individuals to remain safely in their homes.

Primary Care Provider (PCP): A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

Assessment

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

Reporting Frequency	Reporting Level	Reporting Periods	Due Date	Plan Types Required to Report
Quarterly	PBP	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period	EAE and non-EAE D-SNPs

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period. Members who were cross-walked from a CMC plan to a D-SNP within the Medicare Advantage	Field type: Numeric

Element Letter	Element Name	Definition	Allowable Values
		Organization (MAO) must not be included in Core 2.1. Only members with a CMC effective date in November and December 2022 who were cross-walked to a D-SNP within the MAO should be included in quarter one 2023 data, as they reached their 90th day of enrollment during quarter one 2023.	
B.	Total number of members who were documented as unwilling to participate in the assessment within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A. Unwillingness to participate must be clearly documented.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members the D-SNP was unable to reach, following three documented outreach attempts, to participate in the assessment within 90 days of enrollment.	Of the total reported in A, the number of members the D-SNP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Three outreach attempts must be clearly documented.
D.	Total number of members with an assessment completed within 90 days of enrollment.	Of the total reported in A, the number of members with an assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Completed assessments must be clearly documented.

Note: Please see email from CMS titled "HRA requirements for CA MMPs transitioning to D-SNPs for CY 2023." Per CMS, "D-SNPs will not be required to conduct a new initial health risk assessment after the beneficiary is moved from the MMP as long as it is not more than 365 days old. Instead, D-SNPs should use the date of the last MMP health risk assessment in determining the due date for the next annual reassessment after members transition to the D-SNP."

B. Quality Assurance (QA) Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- DHCS will perform an outlier analysis as needed.
- As data are received from D-SNPs over time, DHCS may apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.

- D-SNPs should validate that the sum of data elements B, C, and D is less than or equal to data element A.
- D-SNPs should validate that members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
- D-SNPs should validate that members included in data element A were enrolled as of the last day of the reporting period.
- D-SNPs should validate that members included in data element B were included in data element A.
- D-SNPs should validate that members included in data element C were included in data element A.
- D-SNPs should validate that members included in data element D were included in data element A.
- D-SNPs should validate that members reported in data element B were not reported in data elements C or D.
- D-SNPs should validate that members reported in data element C were not reported in data elements B or D.
- D-SNPs should validate that members reported in data element D were not reported in data elements B or C.
- D-SNPs should validate that members reported in data element B were clearly documented as unwilling to participate in the assessment within 90 days of enrollment.
- D-SNPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.
- D-SNPs should validate that members reported in data element D had a completed assessment clearly documented within 90 days of enrollment.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored. DHCS will evaluate the percentage of members who:

- Were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
    - Percentage = (B / A) * 100
- The D-SNP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
    - Percentage = (C / A) * 100
- Had an assessment completed within 90 days of enrollment.
    - Percentage = (D / A) * 100
- Were willing to participate and who could be reached who had an assessment completed within 90 days of enrollment.
    - Percentage = (D / (A – B – C)) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- D-SNPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the D-SNP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the D-SNP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member's effective enrollment date.
    - When reporting quarterly results for reporting periods, D-SNPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in reporting for the third quarter as long as they were still enrolled on the last

day of the reporting period).

Data Element B

- For data element B, D-SNPs should report the number of members who were documented as unwilling to participate in the assessment if a member (or the member's authorized representative):
  - Affirmatively declines to participate in the assessment, affirmatively declines care management activities overall, or refuses any contact with the D-SNP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the D-SNP.
  - Expresses willingness to complete the assessment but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 days). Discussions with the member must be documented by the D-SNP.
  - Schedules an appointment to complete the assessment but cancels or is a no-show and then is subsequently non-responsive to additional outreach attempts by the D-SNP. All attempts to contact the member must be documented by the D-SNP.
  - Initially agrees to complete the assessment, but then declines to answer a sufficient number of questions in the assessment, as determined by the D- SNP. The declination must be documented by the D-SNP.
- If a member was not reached after three outreach attempts, but then subsequently is reached and refuses the assessment within 90 days of enrollment, the member should be classified in data element B.

Data Element C

- For data element C, D-SNPs should report the number of members the D- SNP was unable to reach after three documented attempts to contact the member. D-SNPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email). If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.
- There may be instances when the D-SNP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the D-SNP's outreach efforts. So long as the D-SNP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

Data Element D

- The assessment for this measure should be the health risk assessment as included in the 2023 CalAIM D-SNP Policy Guide.
- If a member's assessment is in progress, but is not completed within 90 days of enrollment, then the assessment should not be considered completed, and therefore, the member should not be counted in data element D.
- If a member initially refused the assessment or could not be reached after three outreach attempts, but then subsequently completes the assessment within 90 days of enrollment, the member should be classified in data element D.

General Guidance

- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).
- D-SNPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to Core Measure 2.3.
- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within the required timeframe. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, D-SNPs should not include such members in the counts for data elements B or C.

F. Data Submission – D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

Core 2.3 Members with an annual reassessment.

Reporting Frequency	Reporting Level	Reporting Period	Due Date	Plan Types Required to Report
Annually	PBP	Calendar Year	By the end of the second month following the last day of the reporting period	EAE and non-EAE D-SNPs

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled as of the last day of the current reporting period.	Total number of members enrolled as of the last day of the current reporting period.	Field Type: Numeric
B.	Total number of members who had an assessment completed during the previous reporting period.	Of the total reported in A, the number of members who had an assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members with a reassessment completed during the current reporting period.	Of the total reported in B, the number of members who had a reassessment completed during the current reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of members with a reassessment completed within 365 days of the most recent assessment completed.	Of the total reported in C, the number of members with a reassessment completed during the current reporting period that occurred within 365 days of the most recent assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of C.
E.	Total number of members who did not have an assessment completed during the previous reporting period.	Of the total reported in A, the number of members enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of members with an assessment completed during the current reporting period.	Of the total reported in E, the number of members who had an assessment completed during the current reporting period.	Field Type: Numeric Note: Is a subset of E.

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- DHCS may perform an outlier analysis.
- As data are received from D-SNPs over time, DHCS may apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.

- D-SNPs should validate that data elements B and E are less than or equal to data element A.
- D-SNPs should validate that data element C is less than or equal to data element B.
- D-SNPs should validate that data element D is less than or equal to data element C.
- D-SNPs should validate that data element F is less than or equal to data element E.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored. DHCS will evaluate the percentage of members who:

- Had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period.
  - Percentage = (C / B) * 100
- Had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period that was within 365 days of the most recent assessment completed during the previous reporting period.

  - Percentage = (D / B) * 100
- Were enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period but had an assessment completed during the current reporting period.
  - Percentage = (F / E) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- D-SNPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the D-SNP.

Data Element B

- For reporting data element B, include all members who were enrolled as of the last day of the current reporting period who received an assessment (initial or reassessment) during the previous reporting period.

Data Element C

- For reporting data element C, include all members reported in data element B who had a reassessment completed at any time during the current reporting period.

Data Element D

- For reporting data element D, include all members reported in data element C who had a reassessment completed during the current reporting period that was completed within 365 days of the date of the member's most recent assessment (initial or reassessment) completed during the previous reporting period.
  - For example, if a member was assessed twice during CY 2022 (previous reporting period), first on May 15, 2022 and again on October 15, 2022, count 365 days continuously from October 15, 2022 to determine if a reassessment occurred within 365 days.
  - In this example, if the member completes a reassessment on September 15, 2023, they would be included in data element D for CY 2023 reporting. Conversely, if the member's reassessment was not completed until November 15, 2023, they would not be included in

data element D for CY 2023 reporting. In either case, the member would be captured in data element C.

- For members who disenroll and reenroll in the D-SNP, D-SNPs should count 365 days continuously from the member's most recent assessment date within the previous reporting period, even if that assessment was conducted during the member's prior enrollment period.

Data Element E

- For reporting data element E, include all members who were enrolled as of the last day of the current reporting period, who were enrolled for at least 90 continuous days during the previous reporting period who did not receive an assessment (initial or reassessment) during the previous reporting period.
    - For members who disenroll and reenroll in the D-SNP, D-SNPs should include members who had any continuous enrollment of 90 days or more in the previous year, even if that enrollment preceded a break in coverage by the D-SNP.
    - 90 days of enrollment will be equivalent to three full calendar months.

Data Element F

- For reporting data element F, include all members reported in data element E who had an assessment completed at any time during the current reporting period.

General Guidance

- The assessment for this measure should be the health risk assessment as applicable per the 2023 CalAIM D-SNP Policy Guide.
- For reporting all data elements, D-SNPs should report unduplicated counts of members meeting the criteria for each data element. Members with more than one assessment or reassessment completed during a reporting period should be reported only once in the relevant data elements.
- In certain circumstances, a member with a break in coverage who reenrolls in the D-SNP and has an assessment completed upon reenrollment during the current reporting period may be reported under both Core Measure 2.1 and Core Measure 2.3.
    - For example, consider a member that was previously assessed on June 15, 2022, subsequently disenrolled on October 1, 2022, reenrolled on January 1, 2023, assessed again on February 15, 2023, and remained enrolled as of December 31, 2023. The member would be counted in Quarter 1 2023 reporting for Core Measure 2.1 (data elements A and D) and in CY 2023 reporting for Core Measure 2.3 (data elements A, B, C,

and D).

- The term "current reporting period" in data elements A, C, D, and F refers to the current calendar year. The term "previous reporting period" in data elements B, D, and E refers to the prior calendar year.
- This measure is reported starting with the D-SNP's second year of operation (i.e., Calendar Year 2). All D-SNPs that have operated for at least two years must report the measure. CMC plans that transitioned to D-SNPs would be considered to have operated for at least two years.

F. Data Submission – D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

Care Coordination

Core 3.2 Members with a care plan completed within 90 days of enrollment.

Reporting Frequency	Reporting Level	Reporting Periods	Due Date	Plan Types Required to Report
Quarterly	PBP	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period	EAE and non-EAE D-SNPs

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period. Members who were cross-walked from a CMC plan to a D-SNP within the MAO must	Field type: Numeric

Element Letter	Element Name	Definition	Allowable Values
		not be included in Core 3.2. Only members with a CMC effective date in November and December 2022 who were cross-walked to a D-SNP within the MAO should be included in quarter one 2023 data, as they reached their 90th day of enrollment during quarter one 2023.	
B.	Total number of members who were documented as unwilling to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A. Unwillingness to participate must be clearly documented.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members the D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members the D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Three outreach attempts must be clearly documented.
D.	Total number of members with a care plan completed within 90 days of enrollment.	Of the total reported in A, the number of members with a care plan completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Completed care plans must be clearly documented.

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- DHCS will perform an outlier analysis as needed.
- As data are received from D-SNPs over time, DHCS may apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.

- D-SNPs should validate that the sum of data elements B, C, and D is less than or equal to data element A.
- D-SNPs should validate that members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
- D-SNPs should validate that members included in data element A were enrolled as of the last day of the reporting period.
- D-SNPs should validate that members included in data element B were included in data element A.
- D-SNPs should validate that members included in data element C were included in data element A.
- D-SNPs should validate that members included in data element D were included in data element A.
- D-SNPs should validate that members reported in data element B were not reported in data elements C or D.
- D-SNPs should validate that members reported in data element C were not reported in data elements B or D.
- D-SNPs should validate that members reported in data element D were not reported in data elements B or C.
- D-SNPs should validate that members reported in data element B were clearly documented as unwilling to complete the care plan within 90 days of enrollment.
- D-SNPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.
- D-SNPs should validate that members reported in data element D had a completed care plan clearly documented within 90 days of enrollment.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored. DHCS will evaluate the percentage of members who:

- Were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment.
    - Percentage = (B / A) * 100
- The D-SNP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment.

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

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- D-SNPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the D-SNP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the D-SNP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member's effective enrollment date.
  - When reporting quarterly results, D-SNPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in reporting for the third quarter as long as they were still enrolled on the last day of the reporting period).

Data Element B

- For data element B, D-SNPs should report the number of members who were documented as unwilling to complete a care plan if a member (or the member's authorized representative):
  - Affirmatively declines to complete the care plan, affirmatively declines care management activities overall, or refuses any contact with the D- SNP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the D-SNP.

  - Expresses willingness to complete the care plan but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the care plan within 90 days). Discussions with the member must be documented by the D-SNP.
  - Schedules an appointment to complete the care plan but cancels or is a no-show and then is subsequently non-responsive to additional outreach attempts by the D-SNP. All attempts to contact the member must be documented by the D-SNP.
  - Initially agrees to complete the care plan, but then declines to participate in the development of the care plan. The declination must be documented by the D-SNP.
- If a member could not be reached after three outreach attempts, but then subsequently is reached and refuses to complete a care plan within 90 days of enrollment, the member should be classified in data element B.

Data Element C

- For data element C, D-SNPs should report the number of members the D- SNP was unable to reach after three documented attempts to contact the member. The three documented outreach attempts to contact the member must be for the purpose of completing the care plan.
  - If a D-SNP was able to reach a member for the purpose of completing only an assessment, at least three new and distinct outreach attempts for the purpose of completing the care plan must be made and documented.
  - However, if a D-SNP was unable to reach a member for the purpose of completing both an assessment and a care plan, and has documented three unsuccessful outreach attempts, the D-SNP is not expected to make additional outreach attempts about the completion of a care plan. The D- SNP would report this member in data element C.
- D-SNPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email), as DHCS may validate this number. If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.
- There may be instances when the D-SNP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the D-SNP's outreach efforts. So long as the D-SNP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

Data Element D

- The care plan should meet state-specific criteria and include the appropriate domains as determined by the state in the 2023 CalAIM D-SNP Policy Guide.
- If a member's care plan is in progress, but is not completed within 90 days of enrollment, then the care plan should not be considered completed, and therefore, the member should not be counted in data element D.
- D-SNPs should only report completed care plans where the member or the member's authorized representative was involved in the development of the care plan.
- If a member initially refused to complete a care plan or could not be reached after three outreach attempts, but then subsequently completes a care plan within 90 days of enrollment, the member should be classified in data element D.

General Guidance

- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).
- D-SNPs should only report members with an initial care plan for this measure.
- There may be certain circumstances that make it impossible or inappropriate to complete a care plan within the required timeframe. For example, a member may be medically unable to participate and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a care plan. However, D-SNPs should not include such members in the counts for data elements B or C.

F. Data Submission – D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

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

Note: As of November 2023, D-SNPs are no longer required to report CA 1.5 for 2023. Technical specifications are provided below for reference only.

Reporting Frequency	Reporting Level	Reporting Periods	Due Date	Plan Types Required to Report
Quarter Note: As of November 2023, D-SNPs are no longer required to report CA 1.5 for 2023.	PBP	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period	EAE and non-EAE D-SNPs

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of high- risk members enrolled for 90 days or longer as of the end of the reporting period.	Total number of high-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.	Field Type: Numeric
B.	Total number of high-risk members who had an initial ICP completed.	Of the total reported in A, the number of high- risk members who had an initial ICP completed as of the end of the	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
		reporting period.	
C.	Total number of low-risk members enrolled for 90 days or longer as of the end of the reporting period.	Total number of low- risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.	Field Type: Numeric
D.	Total number of low-risk members who had an initial ICP completed.	Of the total reported in C, the number of low- risk members who had an initial ICP completed as of the end of the reporting period.	Field Type: Numeric Note: Is a subset of C.

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
   - DHCS will perform an outlier analysis.
   - As data are received from D-SNPs over time, DHCS will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.
   - D-SNPs should validate that data element B is less than or equal to data element A.
   - D-SNPs should validate that data element D is less than or equal to data element C.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored. DHCS will evaluate the percentage of:

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

Data Elements A and C

- D-SNPs should refer to the 2023 D-SNP Policy Guide for risk stratification requirements.
- D-SNPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the D-SNP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the D-SNP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment (or longer) with no gaps in enrollment.
- For the purposes of reporting data elements A and C, 90 days of enrollment will be equivalent to three full calendar months.

Data Elements B and D

- The completed initial ICPs reported in data elements B and D could have been completed at any point from the member's first day of enrollment through the end of the reporting period.
- D-SNPs should only report completed ICPs in data elements B and D when the member or the member's authorized representative was involved in the development of the ICP.

E. Data Submission – D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

CA 1.6 Members with documented discussions of care goals.

Reporting Frequency	Reporting Level	Reporting Period	Due Date	Plan Types Required to Report
Annually	PBP	Calendar Year	By the end of the second month following the last day of the reporting period	EAE and non-EAE D-SNPs

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an initial Individualized Care Plan (ICP) completed.	Total number of members with an initial ICP completed during the reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members with at least one documented discussion of care	Of the total reported in B, the number of members with at least one documented discussion of care goals	Field Type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
	goals in the initial ICP.	in the initial ICP.	
D.	Total number of existing ICPs revised.	Total number of existing ICPs revised during the reporting period.	Field Type: Numeric
E.	Total number of revised ICPs sampled that met inclusion criteria.	Of the total reported in D, the number of revised ICPs sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of revised ICPs with at least one documented discussion of new or existing care goals.	Of the total reported in E, the number of revised ICPs with at least one documented discussion of new or existing care goals.	Field Type: Numeric Note: Is a subset of E.

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.

- D-SNPs should validate that data element B is less than or equal to data element A.
- D-SNPs should validate that data element C is less than or equal to data element B.
- D-SNPs should validate that data element E is less than or equal to data element D.
- D-SNPs should validate that data element F is less than or equal to data element E.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored. DHCS will evaluate the percentage of:

- Members with an initial ICP completed during the reporting period who had evidence of

creation of at least one care goal documented in the initial ICP.

  - Percentage = (C / B) * 100

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

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- D-SNPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A should include all members with ICPs that were completed for the first time during the reporting period (i.e., the member did not previously have an ICP completed prior to the start of the reporting period). There can be no more than one initial ICP completed per member.
- Only ICPs that included participation from the member (or the member's authorized representative) in the completion of the ICP should be reported.

Data Elements B and E

- For reporting, the D-SNPs may elect to sample since this measure may require documentation review to identify data elements C and F.
- If a D-SNP does not elect to sample, data element B should be equal to data element A and data element E should be equal to data element D.
- For D-SNPs that elect to sample, the sample size should be 411, plus additional records should be oversampled to allow for substitution. Sampling should be systematic to ensure that all individuals eligible for a measure have an equal chance of inclusion. D-SNPs that elect to sample should complete the following steps:
  - **Step 1:** Determine the eligible population. Create a list of eligible members, including full name, date of birth, and event (if applicable).
  - **Step 2**: Determine the final sample size. The final sample size will be 411 unless the

eligible population is less than 411. If the eligible population is less than 411, follow Step 5 to determine the final sample size.

- **Step 3**: Determine the oversample which should include an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20 percent. If oversampling, round up to the next whole number when determining the oversample.
- **Step 4**: If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 6. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 5.
- **Step 5**: If the eligible population is less than or equal to the final sample size as determined in Step 2, the sample size can be reduced from 411 cases to a reduced final sample size by using the following formula:

$$Reduced\ Final\ Sample\ Size = \frac{Original\ Final\ Sample\ Size}{1 + \left(\frac{Original\ Final\ Sample\ Size}{Eligible\ Population}\right)}$$

  - Where the Original Final Sample Size is the number derived from Step 2, and the Eligible Population is the number derived from Step 1.
- **Step 6**: Sort the list of eligible members in alphabetical order by last name, first name, date of birth, and event (if applicable). Sort this list by last name from A to Z during even reporting periods and from Z to A in odd reporting periods (i.e., name will be sorted from A to Z in 2024 and from Z to A in 2023).
  - Note: Sort order applies to all components. For example, for reporting period 2024, the last name, first name, date of birth, and events will be ascending.
- **Step 7**: Calculate N, which will determine which member will start your sample. Round down to the nearest whole number.

$$N = \frac{Eligible\ Population}{Final\ Sample\ Size}$$

  - Where the Eligible Population is the number derived from Step 1. The Final Sample Size is either:
  - The number derived from Step 2, for instances in which the eligible population exceeds the final sample size as determined in Step 2. OR

        - The number derived in Step 5, for instances in which the eligible population was less than or equal to the number derived from Step 2.
    - **Step 8**: Randomly select starting point, K, by choosing a number between one and N using a table of random numbers or a computer-generated random number.
    - **Step 9**: Select every Kth record thereafter until the selection of the sample size is completed.

Data Element C

- The D-SNP should only count members in data element C when the discussion of care goals with the member (or the member's authorized representative) is clearly documented in the member's initial ICP.

Data Element D

- D-SNPs should include all ICPs for members who meet the criteria outlined in data element D, regardless of whether the members are disenrolled as of the end of the reporting period (i.e., include all ICPs regardless of whether the members are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element D should include all existing ICPs that were revised during the reporting period. D-SNPs should refer to the 2023 CalAIM D-SNP Policy Guide for specific requirements pertaining to updating the ICP.
- Only ICPs that included participation from the member (or the member's authorized representative) in the revision to the ICP should be reported.
- If a member's ICP is revised multiple times during the same reporting period, each revision should be reported in data element D.
    - For example, if a member's ICP is revised twice during the same reporting period, two ICPs should be counted in data element D.

Data Element F

- D-SNPs should only include ICPs in data element F when a new or previously documented care goal is discussed with the member (or the member's authorized representative) and is clearly documented in the member's revised ICP.
- If the initial ICP clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the ICP, then that ICP should not be reported in data element F.

General Guidance

- If a member has an initial ICP completed during the reporting period, and has their ICP revised during the same reporting period, then the member's initial ICP should be reported in data element A and the member's revised ICP should be reported in data element D.

F. Data Submission – D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

Organizational Structure and Staffing

Core 5.1 Care coordinator to member ratio.

Reporting Frequency	Reporting Level	Reporting Period	Due Date	Plan Types Required to Report
Annually	PBP	Calendar Year	By the end of the second month following the last day of the reporting period	EAE and non-EAE D-SNPs

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of full time equivalent (FTE) care coordinators working on the D- SNP.	Total number of FTE care coordinators working on the D-SNP as of the last day of the reporting period.	Field Type: Numeric
B.	Total number of FTE care coordinators assigned to care management and conducting assessments.	Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of FTE care coordinators that left the D-SNP.	Total number of FTE care coordinators that left the D-SNP during the reporting period.	Field type: Numeric

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- DHCS will perform an outlier analysis.
- As data are received from D-SNPs over time, DHCS will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.

- D-SNPs should validate that data element B is less than or equal to data element A.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored.

Note: This measure is not adjusted for case mix, and care coordination will vary for each D-SNP's care plan model structure. Therefore, this measure will be used solely to track care coordination investments and changes in each D-SNP's care coordinator to member ratio longitudinally.

DHCS will:

- Use enrollment data to evaluate the number of members per FTE care coordinator.
  - Rate = (Total Members Enrolled / A)
- Evaluate the percentage of FTE care coordinators who were assigned to care management and conducting assessments.
  - Percentage = (B / A) * 100
- Evaluate the percentage of FTE care coordinators that left the D-SNP during the reporting period.
  - Percentage = (C / (C + A)) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- D-SNPs should refer to their 2023 CalAIM D-SNP Policy Guide for the definition of care coordinator.
- FTE is defined as full time equivalent.

Data Element C

- Data element C includes care coordinators who are assigned to a different role within the D-SNP.

General Guidance

- To calculate the number of FTE care coordinators, add up all of the care coordinators' work hours during the reporting period and divide this value by the number of normal working hours for one full-time employee that occurred during the reporting period.
    - In instances where care coordinators support multiple lines of business, include only the time associated with the D-SNP.
- For all data elements, FTE reported values should be rounded to the nearest positive integer.
- All part-time and full-time care coordinators will be counted, regardless of whether they are subcontracted or employed directly by the D-SNP.

F. Data Submission – how D-SNPs will submit data collected to DHCS.

- D-SNPs will submit data collected for this measure through the DHCS D-SNP Reporting Requirements template.

CA 3.2 Care coordinator training for supporting self-direction

Reporting Frequency	Reporting Level	Reporting Period	Due Date	Plan Types Required to Report
Annually	PBP	Calendar Year	By the end of the second month following the last day of the reporting period	EAE and non-EAE D-SNPs

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of care coordinators who have been employed by the D-SNP for at least 30 days.	Total number of full-time and part-time care coordinators who have been employed by the D-SNP for at least 30 days at any point during the reporting period.	Field Type: Numeric
B.	Total number of care coordinators who have undergone training for supporting self-direction within the	Of the total reported in A, the number of care coordinators who have undergone training for supporting self-direction within the	Field Type: Numeric Note: Is a subset of A.

	reporting period.	reporting period.	

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.
   - DHCS will perform an outlier analysis.
   - As data are received from D-SNPs over time, DHCS will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.
   - D-SNPs should validate that data element B is less than or equal to data element A.

D. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored.
   - DHCS will evaluate the percentage of full-time and part-time care coordinators who have undergone training for supporting self-direction within the reporting period.
     - Percentage = (B / A) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

   <u>Data Element A</u>
   - If a care coordinator was not currently with the D-SNP at the end of the reporting period but was with the D-SNP for at least 30 days at any point during the reporting period, they should be included in this measure.

   <u>General Guidance</u>
   - D-SNPs should refer to the California 2023 CalAIM D-SNP Policy Guide for specific requirements pertaining to care coordinators and training for supporting self-direction.

F. Data Submission – D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

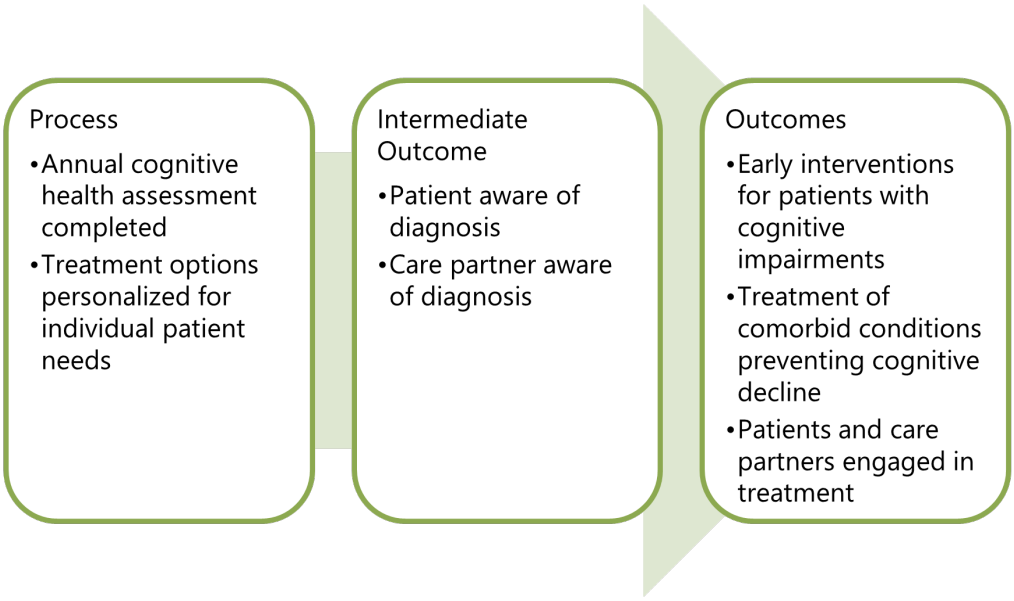
Mild Cognitive Impairment Measure Specifications

Annual Cognitive Health Assessment for Patients 65 years and older

Measure Title	Annual Cognitive Health Assessment for Patients 65 years and Older	
Description	Percentage of patients aged 65 and older who had cognition assessed.	
Measurement Period	Calendar Year (e.g., January 1, 2023 to December 31, 2023)	
Eligible Population	**Eligible Providers**	Medical Doctor (MD), Doctor of Osteopathy (DO), Neuropsychologist (PhD, PsyD), Psychologist (PhD, PsyD), Physician Assistant (PA), Advanced Practice Registered Nurse (APRN)
	Care Setting(s)	Outpatient Care
	Ages	Age 65 and older
	Event	Office visit
	Diagnosis	All patients
Denominator	Patients aged 65 and older	
Numerator	Patients who had cognition assessed* within the measurement period. Patients who had cognition assessed* at least once during the measurement period. *Cognition assessed is defined as use of one of the following validated objective tools (Users are encouraged to review possible copyright and use requirements prior to administration, as well as, ability to have the informant(s) potentially complete the validated tool. The tools are not necessarily equal and interchangeable. Clinician judgment is needed in selecting and interpreting the appropriate tool.): o Montreal Cognitive Assessment (MoCA)[1], o Mini-Mental State Examination (MMSE)[1-2], o Memory Impairment Screen (MIS)[1],	

	○ Saint Louis University Mental Status examination (SLUMS)[3], ○ Mini-Cog©[4], ○ Clinical Dementia Rating (CDR)[5], ○ Self-Administered Gerocognitive Examination (SAGE)[6], ○ Cognitive Health Assessment (CHA), or ○ Neuropsychological assessment results. ○ To perform well on this measure, the following key phrases are suggested for collection in a registry. These key phrases should be recorded within the measurement period: ○ "Order for referral for neuropsychological assessment", ○ "Neuropsychological results discussed/counseled/reviewed with patient", ○ "MoCA [OR SLUMS, MMSE, MIS, CDR, Mini-Cog, SAGE, CHA, or neuropsychological] results reviewed", OR ○ "MoCA [OR SLUMS, MMSE, MIS, CDR, SAGE, Mini-Cog] results" followed by numerical score ○ Presence of CPT code on encounter date or within the measurement period for neuropsychological testing would meet the measure: 96116, 96136, 96138, 96146
Required Exclusions	• Prior diagnosis of Mild Cognitive Impairment • Prior diagnosis of dementia
Allowable Exclusions	• Patient declines cognitive health assessment on date of encounter • On date of encounter, patient is not able to participate in a cognitive health assessment, including non-verbal patients, delirious, comatose, severely aphasic, severely developmentally delayed, severe visual or hearing impairment and for those patients, no knowledgeable informant available. • Patient previously had a cognitive assessment in the measurement period and prior results noted. • To perform well on this measure, we suggest using key phrases for collection in a registry. These key phrases should be recorded on the encounter date: ○ "Patient unable to communicate, no informant present" ○ "Patient unable to understand task" ○ "Patient declines cognitive assessment tool" ○ "Informant declines cognitive assessment"

	○ "Patient refuses cognitive assessment tool" ○ "Informant refuses cognitive assessment" ○ "Care partner [OR spouse, informant, caregiver] declines cognitive assessment" ○ "Patient screened and results noted." ○ "Patient previously assessed for cognitive impairment and results present."
Allowable Exclusion Inclusion Logic	Allowable exclusions can only help measure performance. If a patient has an allowable exclusion but is found to meet the numerator that patient is included in the count to meet the measure.
Exclusion Logic	Patients with prior diagnoses of MCI and dementia are excluded from the measure to prevent duplicative measurement in the calendar year. These patients are subject to other screening and assessment measures. (See Harmonization with Existing Measures below.) Patients or informants need to be able and willing to complete assessment for the assessment results to be valid. Additionally, patients previously assessed in the measurement period may be excluded if prior results are noted to reduce duplicative assessments.
Measure Scoring	Percentage
Interpretation of Score	Higher Score Indicates Better Quality
Measure Type	Process
Level of Measurement	Provider
Risk Adjustment	Not applicable for process measure.

For Process Measures Relationship to Desired Outcome	From American Academy of Neurology MCI Guideline: "Clinicians should assess for MCI with validated tools in appropriate scenarios (Level B). Clinicians should evaluate patients with MCI for modifiable risk factors, assess for functional impairment, and assess for and treat behavioral/neuropsychiatric symptoms (Level B)."[7] The Alzheimer's Association notes, "Informal observation alone by a physician is not sufficient (i.e., observation without a specific cognitive evaluation."[8] 

Opportunity to Improve Gap in Care	Opportunity exists to improve the recognition of MCI through routine screening of cognitive health in older adults who because of their age are at high risk [8,9]. The work group restricted the measure to patients over the age of 65, but encourages clinicians to screen all at-risk patients for MCI. The work group also notes an informant may help in identification of at-risk patients along with thorough cognitive assessment. Physicians fail to recognize about 50% of patients in their practice with significant cognitive deficits, missing an opportunity to offer appropriate evaluation and treatment [10]. Depending solely on a complaint is insufficient because patients may not recognize or report worsening memory problems to their physicians [11]. Although, there is conflicting evidence on the benefits of cognitive impairment screening for older adults, there is growing support for the assessment of patients over the age of 65 years old and the benefits of this screening[12-13].
Harmonization with Existing Measures	Although numerous cognitive screening measures exist for disease- specific conditions (such as multiple sclerosis, Parkinson's disease, dementia, and stroke), a cross-cutting measure is needed for all patients over the age of 65 years old for baseline assessment for MCI. Current measures focused on cognitive screening are listed below for clinician consideration when identifying the best measure to meet your population needs: • Percentage of actively enrolled home-based primary care and palliative care patients who received an assessment of their cognitive ability. • Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period. • Cognitive Assessment for patients with MS: https://www.aan.com/siteassets/home-page/policy-and-guidelines/quality/quality- measures/17mscognitive_impairement_pg.pdf • Cognitive impairment following a stroke: https://www.aan.com/siteassets/home-page/policy-and-guidelines/quality/quality- measures/17srcognitiveimpairement_pg.pdf • PD Cognitive Impairment or Dysfunction: https://www.aan.com/siteassets/home-page/policy-and-

	guidelines/quality/quality- measures/17pdcognitiveimpairement_pg.pdf
References	1. Tsoi KK, Chan JY, Hirai HW, et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Internal Medicine. 2015;175:1450-1458. 2. Creavin ST, Wisniewski S, Noel-Storr AH, et al. Mini-Mental State Examination (MMSE) for the detection of dementia in clinically unevaluated people aged 65 and over in community and primary care populations. Cochrane Database Syst Rev. 2016;(1):CD011145. 3. Feliciano L, Horning SM, Klebe KJ, et al. Utility of the SLUMS as a cognitive screening tool among a nonveteran sample of older adults. Am J Geriatr Psychiatry. 2013; 21(7):623-630. 4. Borson S, Scanlan JM, Chen P, Ganguli M. The Mini-Cog as a screen for dementia: validation in a population-based sample. Journal of the American Geriatrics Society. 2003;51(10):1451– 1454. 5. Morris JC. The Clinical Dementia Rating (CDR): current version and scoring rules. Neurology. 1993;43:2412–2414. 6. Scharre DW, Chang SI, Murden RA, et al. Self-administered Gerocognitive Examination (SAGE): a brief cognitive assessment instrument for mild cognitive impairment (MCI) and early dementia. Alzheimer Dis Assoc Disord. 2010; 24(1):64-71, 7. Petersen RC, Lopez O, Armstrong MJ, et al. Practice guideline update summary: Mild cognitive impairment. Neurology. 2018;90(3):126-135. 8. Cordell C, et al. Alzheimer's Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting. Alzheimer's & Dementia. 2013;9(2):141-150. 9. Hachinski V, Iadecola C, Petersen RC, et al. National Institute of Neurological Disorders and Stroke-Canadian Stroke Network vascular cognitive impairment harmonization standards. Stroke 2006;37:2220-2241. 10. Boustani M, Peterson B, Hanson L, et al. Screening for Dementia in Primary

	Care: A summary of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 2003: 138:927-937. 11. Vannini P, Hanseeuw B, Munro CE, et al. Anosognosia for memory deficits in mild cognitive impairment: Insight into the neuroal mechanism using functional and molecular imaging. Neuroimage Clin 2017; 15:408-414. 12. Tong T, Thokala P, McMillan B, et al. Cost effectiveness of using cognitive screening tests for detecting dementia and mild cognitive impairment in primary care. Int J Geriatr Psychiatry. 2017; 32:1392-1400. 13. U.S. Preventive Services Task Force. Final Recommendation Statement: Cognitive Impairment in Older Adults: Screening. December 2016. Available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cognitive-impairment-in-older-adults-screening Accessed on July 31, 2018.

Code System	Code	Code Description
		Age 65 and older
		AND
CPT	99201-99205	Office or Other Outpatient Visit – New Patient (E/M Codes)
CPT	99212-99215	Office or Other Outpatient Visit – Established Patient (E/M Codes)
CPT	99241-99245	Office or Other Outpatient Visit – New or Established Patient
CPT	99483	Cognitive Impairment and Care Plan Assessment
		AND
ICD-9		All
ICD-10		All

Utilization

Core 9.1 Emergency department (ED) behavioral health services utilization.

Reportin Frequency	Reportin Level	Reporting Period	Due Date	Plan Types Required to Report
Annually	PBP	Calendar Ye	By the end of the second month following the last day of the reporting period.	EAE and non-EAE D-SNPs

A. Data Element Definitions – details for each data element reported to DHCS, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of ED visits with a principal diagnosis related to behavioral health.	Total number of ED visits with a principal diagnosis related to behavioral health during the reporting period. Refer to D-SNP 2023 Core Values for Core Measure 9.1.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by DHCS to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- DHCS will perform an outlier analysis as needed.
- As data are received from D-SNPs over time, DHCS may apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each D-SNP prior to data submission.

- N/A.

CI. Analysis – how DHCS will evaluate reported data, as well as how other data sources may be monitored.

- DHCS will use enrollment data to evaluate the total number of ED visits with a principal diagnosis related to behavioral health per 10,000 member months during the reporting period.
  - Rate = (A / Total Member Months) * 10,000

CII. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- D-SNPs should include all ED visits with a principal diagnosis related to behavioral health for members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- D-SNPs should use the ED value set to identify ED visits. D-SNPs should use facility claims to identify ED visits.
- D-SNPs should use the Mental Health Diagnosis value set to identify a behavioral health diagnosis.
- If there are two different ED visits with the same date of service within the reporting period (and there are two separate, adjudicated claims), then both ED visits should be reported in data element A. Adjudicated claims refers to claims that are in final status, including paid claims and denied claims. Pending claims should not be included.
- D-SNPs should refer to 2023 D-SNP Core Values for Core Measure 9.1 for a list of diagnosis codes, linked on the DHCS Quality and Data Reporting webpage: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx

Data Element A Exclusion

- D-SNPs should exclude ED visits followed by admission to an acute or nonacute inpatient care setting (same or different facility as ED visit) on the date of the ED visit. To identify admissions to an acute or nonacute inpatient care setting:

  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
  - Identify the admission date for the stay
- An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay and should be excluded from data element A.

F. Data Submission – how D-SNPs will submit data collected to DHCS.

- D-SNPs will submit data collected for this measure to DHCS via the use of the D-SNP Reporting Template.

Frequently Asked Questions (FAQs)

Assessment

1. **How should plans fill out information for D-SNP measures that reference a prior year's reporting in 2023, e.g., Core 2.3 Members with an annual reassessment references, "Total number of members who had an assessment completed during the previous reporting period."**

   EAE D-SNPs that previously operated a CMC plan and are transitioning members into an EAE D-SNP should enter information for CMC members for previous years. If there is no data to report from a previous year because the plan did not operate a CMC plan or D-SNP in the previous year, leave the field blank and use the comments to explain that the plan did not report in previous years. Active members refers to those active on December 31st of the reporting year.

2. **For Core 2.1 Members with an assessment completed within 90 days of enrollment, how should plans account for a member transitioning from a CMC to MMP who had an HRA completed in 2022? For example, a CMC member had an HRA completed on 8/1/2022. Their effective date with the D-SNP is 1/1/2023. When is the plan expected to conduct outreach to complete the member's HRA?**

   Per CMS guidance:

   > Enrollees who were previously in a Medicare-Medicaid Plan and received an initial or annual HRA that were cross walked to a D-SNP within the MAO after the end of a Financial Alignment Demonstration will not need to participate in a second initial HRA.

   All annual reassessment HRAs are due to occur within 365 days of the last HRA. In the example above, this means that the plan would be expected to complete a new HRA for the member by 8/1/2023.

   In this example, the plan should not report this member in Element A. Instead, this member will be captured in the Core 2.3, members with an annual reassessment.

Care Coordination

1. **For Core Measure 3.2 Members with a care plan completed within 90 days of enrollment, should plans include CMC enrollees from November and December 2022 who have reached their 90th day of enrollment?**

   Plans should include CMC enrollees from November and December 2022 who have reached their 90th day of enrollment in Quarter 1 of 2023 in the Core 3.2 report submission. It is important to DHCS to ensure Members receive care plans within 90 days of enrolling into the plan, and this aligns with existing CMC reporting guidelines.

2. **For Core Measure 3.2 Members with a care plan completed within 90 days of enrollment, when are plans required to conduct ICPs for members transitioning from a CMC to an MMP?**

   D-SNPs are not required to conduct a new ICP after the beneficiary is moved from the MMP as long as the prior ICP is not more than 365 days old and there have not been significant changes in the individual's condition. Per CMS guidance:

   > D-SNPs can use the existing ICP that was conducted by the organization while the member was in the MMP. Please make sure that you update the ICP as appropriate based on any updates to the HRA while they are in the D-SNP, and follow all other regulatory requirements.

   Plans should use clinical judgement when deciding ICP discussion timing.

   For Core 3.2, members who were cross-walked from a CMC plan to a D-SNP within the MAO must not be included in Core 3.2.

   However, members with a CMC effective date in November and December 2022 who were cross-walked to a D-SNP within the MAO should be included in quarter one 2023 data, as they reached their 90th day of enrollment during quarter one 2023.

3. **How should plans do risk stratification for their members? Does Dual Plan Letter (DPL) guidance still apply? E.g., DPL 17-001 Health Risk Assessment and Risk Stratification Requirements for Cal Mediconnect (https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicy Letters/DPL2017/DPL17-001.pdf).**

   Guidance on risk stratification is included in the care coordination chapter of the D-SNP Policy Guide. Plans must adhere to relevant All Plan Letters, but DHCS will sunset Dual Plan Letters on

January 1, 2023.

Organizational Structure and Staffing

1. **Is Core 5.1, Care Coordinator to Member Ratio, reported on a quarterly or annual basis?**

   Core 5.1 is reported on an annual basis. The measure has been added to the Annual Reporting template.

Mild Cognitive Impairment Measure

1. **For the Mild Cognitive Impairment Annual Measure, can plans include assessments completed by health plan staff and assessments completed by a provider?**

   Yes, assessments may be completed by either health plan staff (including case managers) or providers.

2. **For the Mild Cognitive Impairment Annual Measure, does this include patients 65 and older as of December 31 of the reporting year?**

   Yes, per guidance in the American Academy of Neurology (AAN), the measure indicates patients 65 and older who had cognition assessed during the entire reporting period (January 1, 2023 through December 31, 2023). This means that if a person turns 65 during the reporting period, they should be included in the measure.

3. **For the Mild Cognitive Impairment measure, what tools can be used to assess patient cognition?**

   Per guidance in AAN, cognition assessed is defined as use of one of the following validated objective tools:

   - Montreal Cognitive Assessment (MoCA),
   - Mini-Mental State Examination (MMSE),
   - Memory Impairment Screen (MIS),
   - Saint Louis University Mental Status examination (SLUMS),
   - Mini-Cog©,
   - Clinical Dementia Rating (CDR),

- Self-Administered Gerocognitive Examination (SAGE),
- Cognitive Health Assessment (CHA), or
- Neuropsychological assessment results.

Note: Users are encouraged to review possible copyright and use requirements prior to administration, as well as, ability to have the informant(s) potentially complete the validated tool. The tools are not necessarily equal and interchangeable. Clinician judgment is needed in selecting and interpreting the appropriate tool.

4. **For the Mild Cognitive Impairment Annual Measure, does Column F refer to the total number of patients age 65 and older as of December 31 of each reporting year?**

   Per guidance in AAN, patients should be reported for the reporting period (January 1, 2023 through December 31, 2023). This means that if a person turns 65 during the reporting period, they should be included.

Other

1. **For the LTSS measures, should EAE D-SNPs report on both their Medi-Cal managed care plan values and their D-SNP values separately?**

   Yes, the D-SNP reporting template includes two rows for plans to report on their MCP and D-SNP LTSS measures separately. Plans should report the MCP values (excluding D-SNP membership) and their D-SNP values (excluding MCP values).

2. **What is the difference between the two IHSS measurements ("number of members referred to county for IHSS for the reporting period" and "number of member referrals received for IHSS for the reporting period").**

   "Number of members referred to county for IHSS for the reporting period" refers to any members that the plan refers to IHSS services directly. "Number of member referrals received for IHSS for the reporting period" refers to any member that the plan is aware of that is referred to IHSS (i.e., a referral source other than the plan).