**DRAFT Cal MediConnect Quarterly Plan Reporting Data Requirements**

The Department of Health Care Services (DHCS) plans to begin collecting data from plans on Community-based Adult Services (CBAS), In-home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Long-term Care Facility (LTC), and Care Plan Options (CPO) assessments, referrals, approvals, and denials. Specifically, DHCS will require the plans submit the following numbers to DHCS on a quarterly basis:

**CBAS**

* Members receiving CBAS on the first day of the reporting quarter
* Members receiving referrals for CBAS
* Members initially assessed for CBAS
* Members approved for CBAS following assessment
* Members reassessed for CBAS
* Members reapproved for CBAS
* Total members receiving CBAS in the quarter
* Members denied for CBAS because:
	+ CBAS not medically necessary
	+ Incomplete assessment
	+ Member refused service
	+ Member transitioned to other program or setting
	+ Other reason

**IHSS**

* ICTs with County social worker participation
* ICTS with prior plan trained County social worker participation
* Members referred to County IHSS
* Members referred to County for IHSS reassessment
* Hours changed as result of reassessment
	+ Hours increased
	+ Hours decreased
* Members currently receiving IHSS as of the last day of reporting quarter
* Total member referrals received from IHSS

**MSSP**

* Total ICTs with MSSP Care Manager Participation
* Members currently receiving MSSP as of the 1st day of the reporting quarter
* Member referrals made for MSSP

**LTC**

* Members currently residing in LTC facilities longer than 90 days as of the first day of the reporting quarter
* Member referrals made for LTC stays longer than 90 days
* Members initially assessed for LTC stays longer than 90 days
* Members initially approved for LTC stays longer than 90 days
* Members reassessed for LTC stays longer than 90 days
* Members reapproved for LTC stays longer than 90 days
* Total members receiving LTC stays longer than 90 days in quarter
* Members denied for LTC stays longer than 90 days because:
	+ LTC was not medically necessary
	+ Incomplete assessment
	+ Member refused service
	+ Member transitioned to other program or setting
	+ Other reason

**CPO**

* Members receiving CPO as of 1st day of quarterly reporting
* Member referrals made for CPO
* Members initially assessed for CPO
* Members initially approved for CPO
* Members reassessed or CPO
* Members reapproved for CPO
* Total members receiving CPO in quarter
* Members denied for CPO because:
	+ CPO not medically necessary
	+ Incomplete assessment
	+ Member refused service
	+ Member transitioned to other program or setting
	+ Other reason
* Types of CPO Authorized:
	+ Personal care (in addition to IHSS)
	+ Respite
	+ Care planning and management (Benefit similar to MSSP)
	+ Other