

DEPARTMENT OF HEALTH CARE SERVICES

CaAIM: Population Health Management (PHM) Policy Guide

Updated: January 2024

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I. Introduction

A. Purpose of the Population Health Management (PHM) Policy Guide

The California Advancing and Innovating Medi-Cal (CalAIM) PHM Policy Guide is one of three key California Department of Health Care Services (DHCS) guidance documents that set forth comprehensive requirements applicable for all Medi-Cal Managed Care health plans (MCPs) for the implementation of PHM, which began on January 1, 2023.

The other two guidance documents – [All Plan Letter \(APL\) 22-024 “Population Health Management Policy Guide”](#)¹ and the Amended 2023 MCP Contract provide baseline DHCS’ requirements for MCPs to implement the PHM Program. The PHM Policy Guide, APL 22-024, and Amended 2023 MCP Contract build upon the vision and foundational expectations outlined in the [Final PHM Strategy and Roadmap](#), which was released in July 2022.

The PHM Policy Guide outlines the expectations that DHCS has for how MCPs operate the PHM Program. Certain requirements will be phased in between January 1, 2023, and the effective date of the new MCP contract on January 1, 2024. The PHM Policy Guide will continue to evolve to clarify and provide details on the implementation of the PHM Program and will be regularly updated. Please refer to Section II-G for a detailed implementation timeline.

B. What Is the PHM Program?

The PHM Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. Specifically, the PHM Program intends to:

- Build trust with and meaningfully engage members;
- Gather, share, and assess timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes;
- Address upstream drivers of health through integration with public health and social services;
- Support all members in staying healthy;
- Provide care management services for members at higher risk of poor outcomes;
- Provide transitional care services (TCS) for members transferring from one setting or level of care to another;
- Reduce health disparities; and
- Identify and mitigates Social Drivers of Health (SDOH)

¹APL 22-024, which was published in November 2022, explains that the role of the PHM Policy Guide is to provide details of MCPs’ existing contractual requirements for the PHM Program.

The launch of the PHM Program is part of a broader arc of change to improve health outcomes that is further articulated in [DHCS' Comprehensive Quality Strategy \(CQS\)](#), which emphasizes the long-lasting impact of coupling quality and health equity efforts with prevention.²

Under the PHM Program, MCPs and their networks and partners will be responsive to individual member needs within the communities they serve while working within a common framework and set of expectations.

While the PHM Program is a statewide endeavor that interacts with other delivery systems and carved-out services and requires meaningful engagement and partnerships with members and other stakeholders, the requirements outlined in the PHM Policy Guide apply specifically to MCPs.

C. What Is the PHM Service?

Supporting the PHM roll out, DHCS will be launching a statewide PHM Service. The PHM Service will provide a wide-range of Medi-Cal stakeholders with data access and availability for Medi-Cal members' health history, needs, and risks, including historical administrative, medical, behavioral, dental, social service data, and other program information from current disparate sources. The PHM Service will utilize this data to support risk stratification, segmentation, and tiering; assessment and screening processes; potential medical, behavioral, and social supports; and analytics and reporting functions. The PHM Service will also improve data accuracy and improve DHCS' ability to understand population health trends and the efficacy of various PHM interventions and strengthen oversight.

Given the period between the launch of the PHM Program (January 2023) and the launch of the PHM Service, DHCS is clarifying expectations for PHM Program implementation within two distinct time periods: before and after the PHM Service is available. Prior to the launch of the PHM Service and prior to any requirements to use the PHM Service, DHCS will not require MCPs to develop new capabilities and infrastructure that would subsequently be replaced by the PHM Service. Additional guidance on how MCPs will be expected to use the PHM Service is forthcoming.

D. PHM Program Requirements

On January 1, 2023, all MCPs will be required to meet PHM standards and have either full National Committee for Quality Assurance³ (NCQA) Health Plan Accreditation or otherwise demonstrate to DHCS that they meet the PHM standards for NCQA Health

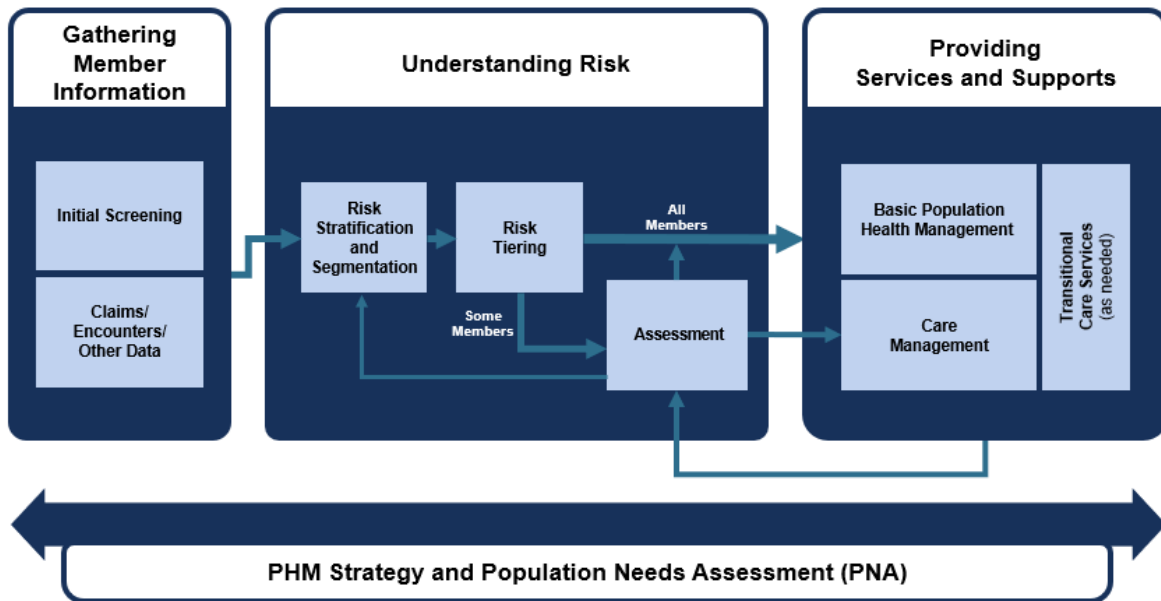
² The PHM Program is a part of CalAIM, which is a long-term commitment to transform and strengthen Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory:
<https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-Infographic.pdf>.

³ NCQA is a nonprofit organization committed to evaluating and publicly reporting on the quality of MCPs.

Plan Accreditation.⁴ By January 1, 2026, all MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation.

II. PHM Program

A. PHM Framework



DHCS uses the PHM Framework above consistently to promote common terminology and communication about PHM. MCPs are encouraged to use the PHM Framework within their organizations and are required to meet requirements in each of the four domains of this framework: PHM Strategy and Population Needs Assessment, Gathering Member Information, Understanding Risk, and Providing Services and Supports.

B. (Updated January 2024) Population Needs Assessment (PNA) and PHM Strategy

Note: This PHM Policy Guide has been updated, as of January 2024, to provide guidance on the modified PNA and PHM Strategy Deliverable for calendar years 2024-2027.

1) Overview

The PNA is the mechanism that MCPs use to identify the priority needs of their local communities and members and to identify health disparities. **Under the PHM Program, MCPs fulfill their PNA requirement by meaningfully participating in the**

⁴ PHM standards are one component of [NCQA Health Plan Accreditation](#), which also includes standards on Quality Management and Improvement, Network Management, Utilization Management, Credentialing and Recredentialing, Member' Rights and Responsibilities, Member Connections, and Medicaid Benefits and Services.

Community Health Assessments (CHAs)/and Community Health Improvement Plans (CHIPs) conducted by Local Health Jurisdictions (LHJs). DHCS' vision is for the PNA process to evolve to help either initiate or strengthen engagement among MCPs, LHJs and community stakeholders over time, fostering a deeper understanding of the health and social needs of members and the communities in which they live through cross-sector partnerships. This collaboration will ultimately enhance MCPs' ability to identify needs and strengths within members' communities so that MCPs and their community partners can reduce siloed approaches to population health management and more effectively improve the lives of members.

2) Relationship between PNA, PHM Strategy and the NCQA Requirements

As described earlier in this Policy Guide, all MCPs must meet NCQA Health Plan PHM requirements, effective January 1, 2023. By January 1, 2026, all MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation. Deliverables due to NCQA are separate from the deliverables that must be submitted to DHCS.

As part of Health Plan Accreditation, NCQA requires every plan nationally—not just MCPs, and not just those in California—to develop a “PHM Strategy” describing how it will meet the needs of its members over the continuum of care, with certain aspects being measured and updated annually. To inform its PHM Strategy for NCQA, each plan must annually complete an assessment of member needs and characteristics, including identification of subpopulations based on characteristics and needs. NCQA does not stipulate the specific types of data to be used to develop a population assessment, but encourages relying on integrated data from diverse sources, including information on SDOH. While NCQA emphasizes the importance of using the annual assessment to identify community resources and establishing linkages to those resources for plan members, its standards do not specify stakeholder types to be involved in the assessment itself. Although DHCS PNA requirements do not change NCQA requirements, DHCS seeks to reduce duplication and promote alignment with NCQA while ensuring that policy priorities specific to Medi-Cal PHM are addressed via the PHM Strategy Deliverable to DHCS.

3) Existing CHA/CHIP Requirements

CHAs and CHIPs are defined as follows:⁵

- A CHA, also known as a Community Health Needs Assessment (CHNA), is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community.
- A CHIP, also known as an Implementation Strategy, Implementation Plan, or Community Benefits Plan, is the output of the CHA. The CHIP is the action plan for how a community will use the data identified in the CHA to improve health outcomes.

⁵ See [PHAB Accreditation Standards \(Version 2022\)](#).

Since 2013, public health entities across the country (including state, local, territorial and Tribal public health entities) have been required to complete a CHA/CHIP when seeking to obtain and maintain voluntary Public Health Accreditation Board (PHAB) accreditation. PHAB accreditation requires that CHAs/CHIPs are completed at least every five years.⁶ Separately, non-profit hospitals develop CHAs to meet federal and state requirements to obtain and maintain their tax-exempt status.⁷ Some public health entities choose to complete a CHA/CHIP every three years to align with non-profit hospital community health needs assessments⁸ especially when there is geographic overlap between non-profit hospitals and public health entities.

PHAB provides broad guidance on how a CHA/CHIP should be conducted, allowing for significant variation by an entity. As such, an array of tools and processes may be used to conduct a CHA that complies with accreditation standards; the essential feature is that the assessment is developed through a participatory, collaborative process with various sectors of the community.

In California, historically, the California Department of Public Health (CDPH) has not had formal oversight over LHJs' CHAs/CHIPs but has provided technical assistance (TA) to LHJs regarding how to implement CHAs/CHIPs and has relied upon LHJs' CHAs/CHIPs to inform the State Health Assessment and Improvement Plan. With introduction of the [2022 Budget Act](#), all 61 LHJs⁹ must now submit a "Public Health Plan," (also known as a local Future of Public Health workplan) which should be informed by a CHA, CHIP, and/or Local Strategic Plan, by December 30, 2023, and by July 1 every three years thereafter.¹⁰ According to a recent DPH survey, nearly all LHJs expect to complete a CHA between 2023 and 2025, and a CHIP between 2023 and 2026.¹¹ There is currently variation among California LHJs regarding when they complete their CHAs and CHIPs, with some on three-year and others on five-year

⁶ Per CDPH's [memo](#) to LHJs, Moving to a three-year cycle, which all LHJs will be required to align with by forthcoming CDPH legislation, will continue to meet [PHAB Standards & Measures for Reaccreditation \(Version 2022\)](#).

⁷ [US Government. Patient Protection and Affordable Care Act, Pub L No. 111–148, § 9007 \(2010\)](#). See *also* Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3).

⁸ In California, examples of LHJ and nonprofit hospital collaboration include, but are not limited to, [San Francisco](#), [San Diego County](#), [Ventura County](#), [Mono County](#), [Pasadena City](#), [Santa Barbara County](#), and [Solano County](#).

⁹ For a list of local health service departments, see DPH's listing of [local health services/offices](#).

¹⁰ Per the [CA Budget Act of 2022, As a condition of funding, each local health jurisdiction shall, by December 30, 2023, and by July 1 every three years thereafter, be required to submit a public health plan to the department consistent with the requirements of subdivision \(c\). Each local public health plan shall be informed by the jurisdiction's most recent community health assessment, community health improvement plan, or strategic plan, and shall include proposed evaluation methods and metrics.](#)

¹¹ DPH survey of LHJs.

timelines. LHJs generally take 12 months to complete a CHA and at least six months to complete a CHIP.

Although California's LHJs use different data sources to inform their CHAs, they often emphasize wide community input and rely upon primary¹² and secondary¹³ data as well as quantitative and qualitative data on various topics (e.g., social and economic factors, health systems, public health and prevention, health disparities, health inequities, and/or community resources and assets). CHAs often leverage best practices to gather and analyze a broad sample of community input; and may involve multiple interviews, assessments, surveys, and listening tours.¹⁴ For example, the most recent San Diego CHA (2019–2021) includes data on educational attainment, unemployment rates, crime, air quality, distance to a public park, climate change, food insecurity, community engagement levels (i.e., volunteerism), and community resources, as well as statistics on COVID-19 and more traditional health measures on mortality, morbidity, life expectancy, chronic disease, infectious disease, sexually transmitted infections, behavioral health, and health disparities.¹⁵ The San Diego CHA examines this data through various lenses, including health equity, paying attention to SDOH, disparities, and the role of racism.¹⁶

Although CHA/CHIP governance structures vary across LHJs, they usually comprise a broad array of stakeholders from the community, including hospitals, local governmental agencies, academic institutions, foundations, health care provider organizations, social services organizations, and community-based organizations (CBOs).¹⁷ The CHA/CHIP

¹² Primary data means new data collected or directly observed from firsthand experience (e.g., interviews, surveys, focus groups, town halls). For more details, see [PHAB Accreditation Standards \(Version 2022\)](#).

¹³ Secondary data sources means data that has already been collected and published by another party (e.g., publicly reported state and national data sources). For more details, see [PHAB Accreditation Standards \(Version 2022\)](#).

¹⁴ See, for example, [2022 Santa Barbara County CHA](#) (which involved a county-wide survey and a listening tour); [Live Well San Diego Live Well CHA \(2019-2021\)](#) (which involved multiple community surveys, in-person community forums, a tele-town hall, and relied heavily upon the [MAPP framework](#), a community-driven planning process for improving community health that was developed by the National Association of County and City Health Officials (NACCHO) in collaboration with the Centers for Disease Control and Prevention (CDC)); and [2022 Pasadena County CHNA](#) (which involved key informant interviews and relied on the [American Hospital Association Community Health Improvement \(ACHI\) Assessment Toolkit](#), which supports collaboration among diverse partners working on CHAs/implementation plans). The [Public Health Advisory Board \(PHAB\)](#) lists both MAPP framework and the ACHI Community Health Assessment Toolkit as frameworks to support robust collaboration and community input.

¹⁵ [Live Well San Diego CHA \(2019-2021\)](#).

¹⁶ Ibid.

¹⁷ See, for example, the [2022 San Francisco CHNA](#), which was conducted as part of the San Francisco Health Improvement Partnership, a collaborative that includes academic institutions, hospitals, and CBOs.

may be governed by a steering or planning committee and supported by smaller work groups.¹⁸

Some recent examples of activities associated with CHAs/CHIPs in California LHJs are: Initiatives to address food insecurity (e.g., community garden projects,¹⁹ food delivery programs for seniors and persons experiencing homelessness,²⁰ and a storage and bulk-food processing hub for food recovery and redistribution²¹); community engagement activities and strategic partnerships to address trauma, treat addiction, and reduce violence^{22,23}; outreach activities to enroll community members in insurance²⁴; coalitions to support policy, systems and environmental changes to improve health;²⁵ and maternal and infant health campaigns.²⁶

4) MCPs' PNA Requirements

APL 23-021, effective January 1, 2023, established that:

- MCPs must meaningfully participate in the current or next available cycle of each LHJ's CHA/CHIP in the service areas where the MCP operates.
- MCPs must submit to DHCS a new annual "PHM Strategy" deliverable to update DHCS on the progress of this engagement and provide other updates on the PHM Program to inform DHCS' monitoring efforts.
- MCPs are no longer required to submit an annual PNA and PNA Action Plan under the requirements of APL 19-011, which is retired.
- MCPs remain accountable for meeting cultural, linguistic and health education needs of members, as defined in state and federal regulations.²⁷

APL 23-021 states that further operational details and updates will be found in this Policy Guide.

MCPs were required to use 2023 as an initial planning year. In the fall of 2023, all Prime MCPs were required to meet with the LHJs in their service areas to begin planning how they will meaningfully participate in the CHA/CHIP on the next cycle and develop an

¹⁸ See, for example, [2017-2021 Imperial County CHA & CHIP](#) (which was overseen by a steering committee that provided direction to a broader group of participating community partners and was also supported by workgroups focused on key health priority areas).

¹⁹ Pasadena [CHIP](#), San Diego [CHIP](#).

²⁰ San Francisco [CHIP](#)

²¹ Ventura County [CHIP](#)

²² Ventura County [CHIP](#)

²³ Mono County [CHIP](#)

²⁴ Pasadena [CHIP](#)

²⁵ Ventura County [CHIP](#)

²⁶ Ventura County [CHIP](#)

²⁷ MCPs' contractual requirements related to the PNA, the PHM Strategy, and other PHM deliverables remain consistent with Title 22 of the California Code of Regulations (CCR), Sections 53876, 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), Title 28 of the CCR, Section 1300.67.04, and Title 42 of the Code of Federal Regulations (CFR), sections 438.206(c)(2), 438.330(b)(4) and 438.242(b)(2).

associated “SMART” goal that is aligned with DHCS Bold goals. MCPs were required to submit the inaugural [DHCS PHM Strategy Deliverable](#) as an introductory step, showing that they had conducted this initial engagement. MCPs were also required to submit to DHCS the PHM Strategy they submitted to NCQA.

In 2024 and beyond, MCPs are required to continue to work with LHJs on CHAs/CHIPs, following the guidance on specific aspects of that joint work as set out below. Given that a core strength of LHJs’ CHAs/CHIPs is that they are driven by the unique needs of each community, the requirements outlined below provide overarching guidance but are not intended to be overly prescriptive. The intent is to continue to support these locally driven assessment processes, rather than to mandate a standardized process that all California communities must follow. Also, although the 2023 PHM Strategy SMART goals were to be aligned with DHCS’ Bold Goals, there is no requirement that LHJs’ CHAs/CHIPs must align with these Bold Goals. We imagine that many CHA/CHIPs, however, will address the Bold Goals’ broad focus areas of maternal and child health disparities, mental health, and substance use disorders. The explicit goal of this process is to incorporate and prioritize diverse community perspectives in health planning.

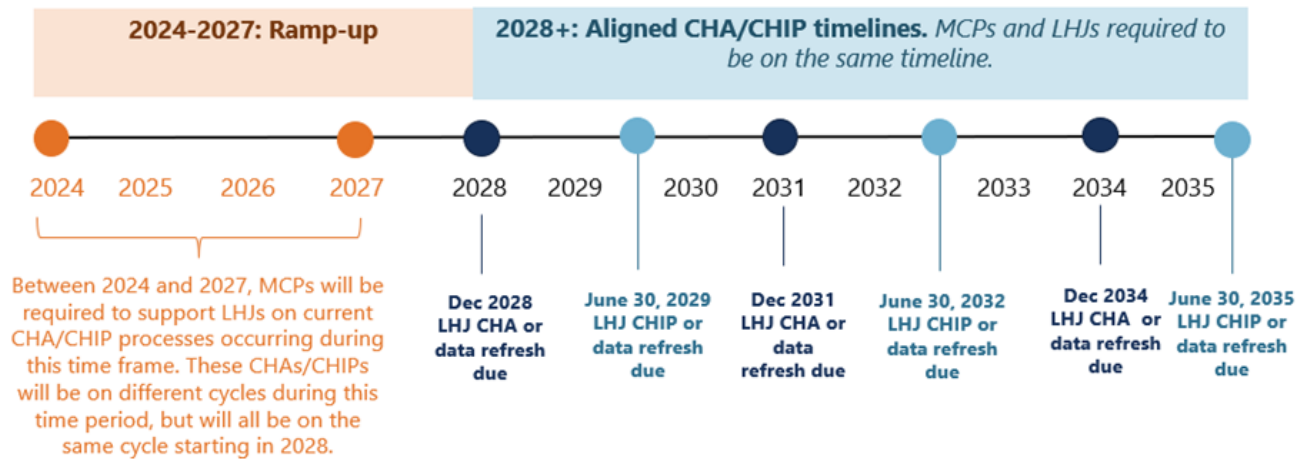
MCPs must also continue to follow all applicable NCQA requirements.

Timelines

DHCS and CDPH are collaborating to create a regulatory environment that supports effective and efficient joint work on CHAs/CHIPs between LHJs and MCPs. Thus, aligned with forthcoming [CDPH guidance](#), the cycles for LHJs’ CHA/CHIP development will become standardized across California starting in 2028.

- Between 2024 and 2027, LHJs’ CHAs/CHIPs will largely remain on different cycles. MCPs will be required to work with each LHJ on its CHA/CHIP according to the guidance below. Some LHJs will be expected to complete a CHA, others a CHIP, and others a full CHA/CHIP cycle within this three-year window.
- **Starting in 2028, all LHJs will be expected to be on the same three-year cycle with the LHJ CHA to be completed in December 2028 and the CHIP to be completed by June 30, 2029.**²⁸ Alignment of timelines across the state will help both LHJs and MCPs manage CHAs/CHIPs more effectively, including MCPs that operate in multiple counties, and will allow the state agencies to provide more effective TA. Given the significant investments in time and resources to CHA/CHIP development cycles and CHIP implementation, the LHJs would be permitted to consider the subsequent three-year cycle to be a “refresh” to quantitative data for both the CHA and CHIP in consultation with stakeholders. See below for a visual of the LHJ timeline outlining LHJ’s CHA/CHIP cycles.

²⁸ June 30, 2029 CHIP due date aligns with the new Public health plan due dates.



Collaboration Requirements in Jurisdictions with Differing MCP Contracting Arrangements

To initiate or advance meaningful collaboration between LHJs and MCPs at the local level, each Prime MCP must participate in the CHA/CHIP process led by each LHJ, including the three city LHJs, in their service area. Thus, a Prime MCP working in several LHJs must participate on multiple CHAs/CHIPs.

Prime MCPs²⁹ must ensure that any populations covered by a subcontracted MCP are included in their PNA process; that is, subcontracted MCPs³⁰ do not have to complete a separate PNA process but must be included in the process their Prime MCP has with the LHJ.

When multiple Prime MCPs operate in the same service area, MCPs must collaborate with each other as well as with the LHJ to foster a unified planning process. MCPs must coordinate on what types of staffing/funding are provided and what data is to be shared, as well as communications with the LHJs. For example, if an LHJ’s CHA/CHIP process identifies maternal health equity and disparities as a priority, the participating MCPs should collaborate to identify what resources are needed for 2024–2027; and together contribute their various relevant maternal health data sources and expertise by 2025.

Data Sharing Requirements

MCPs and LHJs both have data from which the other can benefit to improve population health, creating a more holistic picture of the multiple factors contributing to a community’s health than either can accomplish alone. While not all residents of communities are Medi-Cal members, the Medi-Cal population comprises over one-third

29 A Prime MCP is an MCP that directly contracts with DHCS to provide Medi-Cal services to members within the county or counties specified in their contract.

30 A Subcontracted MCP is an MCP that contracts with the Prime MCP to assume full or partial risk of a portion of the Prime MCP’s membership.

of California’s population and carries a disproportionate burden of social and medical complexity. Stakeholder responses to DHCS’ initial PNA Concept Paper in Spring 2023 included comments that:

- LHJs can benefit from data typically collected and used by MCPs (e.g., claims, utilization, encounter, quality, demographics and Healthcare Effectiveness Data and Information Set (HEDIS) data)
- MCPs can benefit from the following types of data typically collected through the CHA/CHIP process: demographics, SDOH (e.g., income, housing and homelessness, education and academic achievement, social environment and public safety, transportation, and physical environment), and data that might not be discernable through MCP claims data (e.g., exercise and nutrition)

Between 2024 and 2027, MCPs are expected to begin sharing data with LHJs in ways that support the CHA/CHIP process. This requirement applies regardless of the position of the LHJ in the CHA/CHIP cycle in calendar years 2024–2027.

DHCS will provide additional TA and clarifying guidance to support data-sharing among MCPs and LHJs.

2024 Requirements

In 2024, DHCS’ expectation is that MCP(s) and each LHJ in their service area must begin to identify priority areas in which the MCP will share data with the LHJ. Data to be shared may take the form of claims, encounters or other maintained health and social service information/data (e.g., quality, demographics, and HEDIS). If agreed upon by the LHJ, MCPs may also provide analytics support and share data through: reports, summary information, descriptive statistics, and projections to illuminate trends, disparities, or system utilization.

Each MCP and LHJ should select priority areas from the following that cut across LHJ priorities and CalAIM priorities for MCPs:

- | | |
|--|---|
| • Maternal health | • Housing insecurity/homelessness |
| • Child health | • Chronic disease prevention |
| • Health disparities/inequities | • Adult/childhood immunization |
| • Behavioral health/substance use disorder | • Other, agreed upon by the LHJ and MCP |
| • Justice involved/ reentry population | |

If multiple MCPs operate in an LHJ’s area, they must agree on the same priority areas. Decisions about data sharing priorities must be documented in the Collaboration Worksheet and 2024 PHM Strategy Deliverable, described below.

Please see the below text box for how the Data Exchange Framework (DxF) impacts these 2024 requirements.

2025 Requirements

Starting in Q2 of 2025 at the latest, MCPs must begin to share the data agreed upon in 2024 in accordance with all applicable laws and facilitated through data sharing agreements and a range of mechanisms and formats based on the level determined to be the best fit for LHJ capacity and priorities. Data must be shared in a timely manner when requested by the LHJ.

MCPs must share member-level data in accordance with all applicable law. Data sets must apply deidentification and suppression according to LHJ or MCP organizational guidelines for public use in collaborative analysis. Data should be disaggregated to the extent possible by REaL (race, ethnicity, and linguistic), SOGI (sexual orientation and gender identity), age and zip code.

Please see below text box for how the DxF impacts these 2025 requirements.

Box A: The Data-Exchange Framework (DxF). The DxF, which was established by the California Health and Human Service Agency on July 1, 2022, has implications for how MCPs share data with LHJs. The DxF includes a single Data Sharing Agreement and common set of Policies and Procedures (P&Ps) for governing the exchange of electronic health and social service information across the state. Although LHJs are not required to participate, some LHJs are becoming signatories.*

- **For LHJs that are DxF signatories:** As of January 31, 2024, MCPs must comply with the DxF provisions, P&Ps, and technical requirements as well as all applicable law when sharing data with DxF signatories. This applies as MCPs consider which data to share in 2024, and when they start to share data with LHJ signatories.
- **For LHJs that are not DxF signatories:** MCPs must comply with all applicable laws and are encouraged to follow DXF provisions, P&Ps, and technical requirements when deliberating which data to share and when they start to share data with LHJs that are not signatories.

* For an updated list of signatories to the DXF, please see this [link](#). As of publication, five county health departments were signatories; Alameda, Tuolumne, Ventura, Plumas, Tulare.

Requirements for MCPs to Contribute Resources to Support CHA/CHIP Processes

As part of meaningful participation in LHJs' CHAs/CHIPs, MCPs are required to contribute resources to support LHJs' CHAs/CHIPs in the service areas where they operate, in the form of funding and/or in-kind staffing, starting on January 1, 2025. MCPs are strongly encouraged to contribute these resources in a manner that is at least commensurate with the number of Medi-Cal members served by the MCP within a given LHJ jurisdiction.

Starting on January 1, 2024, MCPs are required to work with LHJs to determine what combination of funding and/or in-kind staffing the MCP will contribute to the LHJ CHA/CHIP process. See below for examples of types of funding and/or in-kind staffing that MCPs may contribute to LHJs' CHAs/CHIPs. Starting in 2024, MCPs are required to describe their resource contribution decisions in their MCP-LHJ Collaboration Worksheet and report to DHCS on their contribution decisions via their annual PHM Strategy Deliverable submission, as described in the sections below and in a form and manner to be specified by DHCS.

- **Funding:** MCP funding to LHJs for CHA/CHIP-related activities may be for purposes including but not limited to:
 - Administrative support
 - Project management
 - Consultants who specialize in providing support on CHAs/CHIPs (e.g., data collection and analysis, stakeholder outreach and meeting facilitation, subject matter experts on topics such as the MAPP process, report writing)
 - Governance (convening support, etc.)
 - Data infrastructure (e.g., web-based data-visualization tools, technology to support data sharing and analysis, and consultants/training to analyze data)
 - Community engagement (e.g., incentives/food for community participation, funds for childcare, and gas cards)
 - Communications (e.g., funding for media/messaging about CHA, sharing success stories, and consultants)
 - Contracts with CBOs
 - Implementation strategies (specific to CHIP)
 - TA sessions for LHJs/MCPs

- **In-Kind Staffing:** MCPs may contribute staffing or support for project management, data analysis, stakeholder engagement activities, or other administrative items. Staff or consultants contributing to these projects must have relevant public health background, and subject matter and technical expertise in the specific area where the LHJ seeks advice (e.g., if the LHJ would like expertise on understanding maternal health hospital utilization data, the MCP should provide a staff member with requisite expertise in maternal health and data analysis). MCP staff and/or consultants supporting these projects should ideally have experience in conducting health assessments.

Stakeholder Engagement

As noted above, LHJs' CHAs/CHIPs generally involve a wide array of stakeholders. MCPs working on LHJ CHAs/CHIPs will benefit over time from cultivating stronger relationships not only with the LHJs, but also with other participating community stakeholders, which represent different racial/ethnic groups, CBOs, and various

sectors—including: education, housing, and other health and social providers in the community.

Starting January 1, 2024, as part of meaningfully participating on the LHJ CHA/CHIP process, MCPs are expected to:

- Attend key CHA/CHIP meetings as requested by LHJs.
- Serve on the CHA/CHIP governance structure, including CHA/CHIP subcommittees, as requested by LHJs.

MCP staff serving as representatives at these meetings must have relevant public health background, relevant subject matter and technical expertise and appropriate decision-making authority at the MCP to be able to make decisions quickly or get the necessary approvals for actions to be taken quickly.

In addition, starting January 1, 2024, MCPs are required to engage their Community Advisory Committees (CACs) as part of their participation in the LHJs' CHA/CHIP process. Specifically:

- MCPs must regularly report on their involvement in and finding from LHJs' CHAs/CHIPs to their CACs.
- MCPs must obtain input/advice from their CACs on how to use findings from the CHAs/CHIPs to influence MCPs strategies and workstreams related to the Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.
- Over time, MCPs are encouraged to work with LHJs to rely on MCPs' CACs as a resource for stakeholder participation in LHJ CHAs/CHIPs (e.g., answer survey questions, and participate in focus groups, workgroups, and governance committees).

DHCS is still working with CDPH and other Tribal stakeholders regarding guidance and/or TA on Tribal engagement in the LHJ CHA/CHIP process.

Publishing Requirements

Starting on January 1, 2024, in services areas where a MCP operates, when an LHJ publishes its CHA/CHIP, the MCP must publish the CHA/CHIP on its website with a brief paragraph on how the MCP meaningfully participated (e.g., data, staffing, and funding) in the process.

MCP-LHJ Collaboration Worksheet

To support the MCPs and LHJ in each locality in beginning to work together, DHCS is publishing the "MCP-LHJ Collaboration Worksheet." The purpose of this Worksheet is to serve as a collaboration tool for MCPs to work and build relationships with LHJs and other MCPs in the same county, early in the CHA/CHIP process. While DHCS requires this Worksheet be completed by August 1, 2024, the Worksheet will not be submitted to DHCS.

DHCS is interested in supporting and understanding the progress of MCP-LHJ collaboration and will request to review the Worksheet of a few select MCPs. In

addition, MCPs will be asked to share some of their reflections, as recorded in this Worksheet, at a future TA session. MCPs will also be requested to share some of the findings reported in this Worksheet in their PHM Strategy Deliverable, which will be submitted to DHCS in October 2024.

PHM Strategy Deliverable

In October 2024, all Prime MCPs will be required to submit their annual PHM Strategy Deliverable using the DHCS template that will be available in Spring 2024. The template should be inclusive of any subcontracted populations (subcontractor entities do not have to fill out this template separately/independently of Prime MCPs).

MCPs will need to complete one PHM Strategy Deliverable per LHJ. As such, if an MCP operates in three different jurisdictions, it will need to submit three PHM Strategy Deliverables. For MCPs working with other MCPs in a county/city, MCPs will need to collaborate to submit a single shared PHM Strategy Deliverable.

For the 2024 PHM Strategy Deliverable, MCPs will need to report on:

- How are they meaningfully participating on LHJs' CHAs/CHIPs
- Bright spots
- Challenges
- How they are responding to community needs
- Updates to the SMART goals developed in 2023, as required by the 2023 PHM Strategy Deliverable that are to commence in 2024.
- In addition to the SMART goals, a description of how MCP involvement in LHJs' CHA/CHIP activities has impacted PHM Strategy
- Any other relevant PNA and PHM updates

MCPs will also need to provide updates to their NCQA PHM Strategy (inclusive of population assessment) since it was last submitted to DHCS in 2023.

In addition, in 2024, LHJs will be asked to respond to a survey to share their feedback on their experience collaborating with MCPs in this process. In combination with the data received from MCPs via their PHM Strategy submission, the LHJ survey data will provide comprehensive feedback to DHCS on how they may further support LHJ-MCP collaboration.

5) Additional Updates

By the end of 2024, DHCS will update this PHM Policy Guide with further operational details on the PNA and PHM Strategy Deliverables for 2025 and beyond.

C. (Updated January 2024) Gathering Member Information

An effective PHM approach begins with gathering accurate and robust information to understand each member's health and social needs, as well as their health goals and preferences, to ensure that they receive the right services at the right time and right place.

1) Leveraging Existing Health and Social Data

Building upon current requirements related to MCPs' use of various data sources for internal management and reporting purposes,³¹ MCPs will be required to leverage a broad set of data sources to support PHM Program information gathering, inform Risk Stratification and Segmentation (RSS), provide a broader understanding of the health needs and preferences of the member, and support more meaningful member engagement.

Data to be used as part of information gathering and to inform RSS include:

- Screenings and assessments;
- Managed care and fee-for-service (FFS) medical and dental claims and encounters;
- Social services reports (e.g., CalFresh; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); California Work Opportunity and Responsibility to Kids (CalWORKs); In-Home Services and Supports (IHSS));
- Electronic health records;
- Referrals and authorizations;
- MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment (MTOUD, also known as Medications for Opioid Use Disorder), and other substance use disorders (SUD), and other non-specialty mental health services information;³²
- County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) claims system;³³
- Pharmacy claims and encounters;

³¹ Under [current requirements](#) related to Management Information System (MIS) capabilities, MCPs must utilize various data elements both for internal management use and to meet the data quality and timeliness requirements of DHCS' Encounter Data submission.

³² In certain circumstances, the sharing of 42 C.F.R. Part 2 data may require a member's signed consent in accordance with state and federal law; please refer to the [2022 DHCS Data Sharing Authorization Guidance](#) for more information.

³³ In certain circumstances, the sharing of 42 C.F.R. Part 2 data may require a member's signed consent in accordance with state and federal law; please refer to the [2022 DHCS Data Sharing Authorization Guidance](#) for more information.

- Disengaged member reports (e.g., assigned members who have not utilized any services);
- Laboratory test results;
- Admissions, discharge, and transfer (ADT) data;
- Race, ethnicity, and language information;
- Sexual orientation and gender identity (SOGI) information;
- Disability status;
- Justice-involved data;
- Housing reports (e.g., through the [Homeless Data Integration System](#) (HDIS), Homelessness Management Information System (HMIS), and/or Z-code claims or encounter data); and
- For members under 21, information on developmental and adverse childhood experiences (ACEs) screenings.

DHCS understands that MCPs may have limited access to some of the required RSS data listed above and that some of these data may not be available until the PHM Service is fully operationalized. As such, during this period prior to Service launch, MCPs will be expected to make a good-faith effort to use and integrate the above data to the greatest extent possible from currently available data sources.

Once the PHM Service is available and supports access to and use of required data sources, MCPs will be required to use the PHM Service and the available data accessible through the Service – in accordance with federal and state privacy rules and regulations – to conduct RSS, screening and assessment, basic PHM, and member engagement and health education activities. DHCS anticipates only having historical data (e.g., through claims/encounters) at the time of PHM Service launch and expects MCPs to source more real-time data (e.g., ADT feeds) from local data sources even after the PHM Service is available.

Lastly, MCPs must expand their MIS capabilities to integrate these additional data sources in accordance with the MIS Capability section of the Amended 2023 MCP Contract and all NCQA Health Plan PHM standards. MCPs must adhere to data-sharing requirements as defined by the California Health & Human Services Agency [Data Exchange Framework](#).

2) Streamlining the Initial Screening Process

DHCS is issuing the guidance below to streamline several initial screening processes while ensuring compliance with federal and NCQA requirements. Change is needed with respect to screening and assessment as existing mechanisms do not always cultivate member trust and are often burdensome to members and other stakeholders.

Effective on January 1, 2023, DHCS is implementing the following changes to the Health Information Form (HIF)/Member Evaluation Tool (MET) and the Individual Health Education Behavior Assessment (IHEBA)/[Staying Healthy Assessment](#) (SHA).

[Modifications to the HIF/MET, Initial Health Appointment\(s\) and the IHEBA/SHA](#)

- The **HIF/MET** will still be required to be completed within 90 days of enrollment for new members. However, DHCS is clarifying that:

- MCPs may contract with providers for HIF/MET. If contracted, the provider is responsible for following up on positive screening results. If the HIF/MET is not contracted to be done by providers, the MCP must either directly follow up on positive screening results or contract with the provider to complete the follow-up (and share relevant information with the provider to do so).
- Initial Health Appointment(s)³⁴ results that are completed and shared back with the MCP within 90 days of enrollment would fulfill the HIF/MET requirement and, thus, the federal initial screening requirement.
- **The IHEBA/SHAs are eliminated.** However, DHCS is preserving the following requirements:
 - The **Initial Health Appointments(s)** must be completed within 120 days³⁵ of enrollment for new members and must continue to include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.³⁶

The Initial Health Appointment(s) requirement can be completed over the course of multiple visits. Telehealth visits can be used as an option for completing one or more components of the Initial Health Appointment(s) requirement, but not all of the requirement.

The Initial Health Appointment(s) is not required if the member's PCP determines that the member's medical record contains complete information that was updated within the previous 12 months. This information must be assessed by the PCP during the first 120 days of member enrollment. The conclusion of the PCP's assessment must be documented in the member's medical record. Other reasons a member may not complete the Initial Health Appointment(s) requirement are the following: Member disenrolled before 120 days; Member refuses Initial Health Appointment(s) completion; and reasonable attempts by the MCP or delegated provider to contact the member were unsuccessful. All Initial Health Appointment(s) requirement attempts should be documented in the member's medical record.

- For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be

³⁴ Starting in 2023, the Initial Health Assessment is known as the "Initial Health Appointment(s)." Current requirements for the Initial Health Assessment are contained in [APL 18-004](#), [APL 20-004](#) (rev.), [APL 22-017](#), and [APL 22-030](#).

³⁵ For members less than 18 months of age: within 120 calendar days of enrollment or within periodicity timelines established by the AAP Bright Futures for age 2 and younger, whichever is sooner. For adults aged 21 and over: within 120 days of enrollment. Specific time frames are included in the 2022 Medi-Cal Managed Care Contracts.

³⁶ These required Initial Health Appointment(s) elements are specified in 22 C.C.R. § 53851(b)(1).

covered over multiple appointments in accordance with the American Academy of Pediatrics (AAP) /Bright Futures periodicity schedule, as referenced in APL [23-005](#).³⁷

- MCPs should continue to hold network providers accountable for providing all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF). While MCPs may find it convenient for providers to complete the USPSTF required preventive screening during the first visit, DHCS no longer requires all of these elements to be completed during the first visit so long as members receive all required screenings in a timely manner consistent with USPSTF.
- DHCS will leverage existing Managed Care Accountability Sets (MCAS) measures focused on preventive services, such as Child and Adolescent Well-Care Visits and Adults' Access to Preventive/Ambulatory Health Services, as proxies for monitoring the Initial Health Appointment(s). A sample list of MCAS measures that will be used as a proxies is outlined below.

Sample MY 2023/RV 2024 MCAS Quality Measures As Proxies for the Initial Health Appointment(s)
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- | |
|--|
| <ul style="list-style-type: none">● Depression Screening and Follow-Up for Adolescents and Adults● Child and Adolescent Well – Care Visits● Childhood Immunization Status – Combination 10● Developmental Screening in the First Three Years of Life● Immunizations for Adolescents – Combination 2● Lead Screening in Children● Topical Fluoride for Children● Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits● Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits● Chlamydia Screening in Women● Breast Cancer Screening● Cervical Cancer Screening● Adults' Access to Preventive/Ambulatory Health Services |
|--|

[Corresponding APL Updates](#)

³⁷ For more information about the AAP/Bright Futures initiative and to view the most recent periodicity schedule and guidelines, go to <https://brightfutures.aap.org/Pages/default.aspx>. Additional information on the periodicity schedule is available at <https://www.aap.org/en-us/professional-resources/practicetransformation/managing-patients/Pages/Periodicity-Schedule.aspx>.

APLs	Upcoming Updates and Timing
APL 16-014 “Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries”	<ul style="list-style-type: none"> • This APL will be superseded to decouple requirements from outdated IHEBA/SHA requirements sometime in the future
APL 18-004 “Immunization Requirements”	<ul style="list-style-type: none"> • Supersedes APL 07-015 and PL 96-013.
APL 20-004 “Emergency Guidance for Medi-Cal Managed Care Plans in Response to COVID-19”	<ul style="list-style-type: none"> • Revised April 2023.
APL 22-030 “Initial Health Appointment”	<ul style="list-style-type: none"> • Supersedes APL 13-017 and PLs 13-001 and 08-003.

In addition to the above, DHCS is considering other ways to streamline the initial screening process by leveraging the PHM Service, when available, which will help reduce member screening fatigue as well as better connect members to services and supports and improve data sharing between plans and providers via California’s Data Exchange Framework. Through design work on the PHM Service, DHCS is exploring how the PHM Service can host screening and assessment functionalities that pre-populate relevant previously collected data to further mitigate duplication and burden on members.

3) Guidance for Screening and Assessments for Transitioning Members During the 2024 MCP Transition

Beginning in 2024, MCPs will be subject to new requirements to rigorously advance health equity, quality, access, accountability and transparency to improve the Medi-Cal health care delivery system. As part of this transformation, some MCPs are changing on January 1, 2024 as a result of how DHCS contracts with MCPs. Collectively, these changes comprise the January 1, 2024, MCP Transition.³⁸

This section explains requirements for three assessment and screening tools—the HIF/MET, Initial Health Appointment(s), and HRA-- in the context of the 2024 MCP Transition. This section refers to an MCP receiving new members from a previous MCP during the 2024 MCP Transition as a “receiving MCP” and those members who are in transition from one MCP to another as “transitioning members.”

³⁸ For more details, see the 2024 [Transition Policy Guide](#).

HIF/ MET

Receiving MCPs must complete the HIF/MET for transitioning members within 90 days of January 1, 2024 regardless of whether the previous MCP completed a HIF/MET for the member. MCPs may fulfill the HIF/MET requirement in ways consistent with this PHM Policy Guide.

Initial Health Appointment(s)

Receiving MCPs must ensure that a member has Initial Health Appointment(s) within 120 days of the member transitioning to the receiving MCP. The receiving MCP is not required to complete the Initial Health Appointment(s) requirement within 120 days if the member's primary care physician (PCP) determines that the member's medical record contains complete information, updated within the previous 12 months. Even if the member's PCP determines that the member's record contains complete information such that the Initial Health Appointment(s) requirement does not need to be conducted within 120 days, the receiving MCP still needs to complete a HIF/MET for members within 90 days of a member transitioning. All other Initial Health Appointment(s) requirements apply.

HRA

Receiving MCPs must adhere to the following for transitioning members identified as Seniors and Persons with Disabilities (SPD):

- **Transitioning members with no record of an HRA:** The receiving MCP must complete an HRA for transitioning members identified as SPD who do not have a record of an HRA and meet the definition of "high risk" per guidance outlined in the CalAIM: PHM Policy Guide and [APL 22-024](#).³⁹
- **Transitioning members who have an existing HRA:**
 - For transitioning members authorized to receive Long-Term Services and Supports (LTSS), the receiving MCP may rely upon an HRA conducted by the previous MCP on or after January 1, 2023. The receiving MCP must conduct an HRA if the previous MCP conducted the HRA before January 1, 2023, or if the transitioning member experienced a significant change in health status or level of care since the previous HRA, or upon receipt of new information that the receiving MCP determines as potentially changing a member's level of risk and need.
 - For all other transitioning members, the receiving MCP may rely upon an HRA conducted by the previous MCP before, on, or after January 1, 2023. The receiving MCP must conduct an HRA if the transitioning member experienced a significant change in health status or level of care since the

³⁹ CalAIM: PHM Policy Guide, Section D. Understanding Risk. Assessment and Reassessment to Understand Member Needs; [APL-22-024](#)

previous HRA, or upon receipt of new information that the receiving MCP determines as potentially changing a member's level of risk and need.

D. Understanding Risk

1) RSS and Risk Tiers

Risk Stratification and Segmentation (RSS) means the process of differentiating all members into separate risk groups and/or meaningful subsets. RSS results in the categorization of all members according to their care and risk needs at all levels and intensities.

Risk tiering means the assigning of members to risk tiers that are standardized at the State level (i.e., high, medium-rising, or low risk), with the goal of determining the appropriate level of care management or other specific services for members at each risk tier.

In accordance with the Population RSS and Risk Tiering section of the Amended 2023 MCP Contract, DHCS is setting expectations toward greater standardization with regard to how MCPs use RSS algorithms, employ risk tiers, and connect members to services.

The PHM Service will include a single, statewide, open-source RSS methodology with standardized risk tier criteria that will place all Medi-Cal members into high-, medium-rising-, and low-risk tiers. Therefore, DHCS requirements for RSS and risk tiering across all populations are set for two distinct time periods: prior to and after the RSS and risk tiering functionalities become available.

[For the Period Prior to Availability of the PHM Service RSS and Risk Tiering Functionalities](#)

a. RSS:

MCPs must meet the following requirements prior to the PHM Service's RSS functionalities becoming available:

- Utilize an RSS approach that:
 - Complies with NCQA Health Plan PHM standards, including using utilization data integrated with other data sources such as findings from the PNA, clinical and behavioral data, or population and social needs data;
 - Incorporates a minimum list of data sources listed in the "Information Gathering" section to the greatest extent possible;
 - Avoids and reduces biases to prevent exacerbation of health disparities;
 - Many current RSS methodologies rely on utilization or cost data only, which may result in racial, condition, or age bias. Many RSS methodologies look only at past costs or utilization, which tends to result in prioritizing white patients over Black patients because white patients have higher medical expenses. Similarly, conditions that generate greater health care expenditures, such as those requiring dialysis, are prioritized over those that generate fewer expenditures.

Lastly, older individuals with more chronic, complex conditions tend to be prioritized over younger individuals.⁴⁰

- To address these biases and improve outcomes for all of MCPs' members, MCPs are encouraged to use all relevant data, keep the information updated (e.g., through care managers), continuously evaluate key performance indicators and RSS outputs, use appropriate metrics to measure the accuracy and effectiveness of RSS model prediction of people who do or do not need help, and monitor whether RSS improves care for all populations.^{41,42}
- Stratifies members at least annually and during each of the following time frames:
 - Upon each member's enrollment.
 - Annually after each member's enrollment.
 - Upon a significant change in the health status or level of care of the member (e.g., inpatient medical admission or emergency room visit, pregnancy, or diagnosis of depression).
 - Upon the receipt of new information that the MCP determines as potentially changing a member's level of risk and need, including but not limited to information contained in assessments or referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), TCS, and Community Supports.
- Continuously reassess the effectiveness of the RSS methodologies and tools.

b. Risk Tiering:

Prior to the PHM Service's RSS and risk tiering capabilities becoming available, MCPs are **not** required to use standardized risk tiers (i.e., high, medium-risk, or low) across their members but must use their RSS approach to identify members who should be connected to available interventions and services, including care management, and ensure all members are connected to appropriate Basic Population Health Management (BPHM).

After the PHM Service RSS and Risk Tiering Functionalities Are Available

a. RSS and Risk Tiers

DHCS recognizes that some plans have developed and significantly invested in their own RSS approaches. Once the PHM Service's RSS functionality is available and vetted, DHCS will require MCP plans to use the PHM Service RSS outputs and tiers to support statewide standardization and comparisons; MCPs may supplement these outputs with local data sources and methodologies.

⁴⁰ "Beyond Racial Bias: Rethinking Risk Stratification In Health Care," Health Affairs Blog, January 15, 2020. DOI: 10.1377/hblog20200109.382726.

⁴¹ "Beyond Racial Bias: Rethinking Risk Stratification In Health Care," Health Affairs Blog, January 15, 2020. DOI: 10.1377/hblog20200109.382726.

⁴² "Topic-Specific Implementation Guides." Comprehensive Primary Care. The Center for Medicare & Medicaid Innovation. June 2014.

<https://downloads.cms.gov/files/cmimi/cpci-combined-implementationguide.pdf>.

Once the PHM Service RSS and risk tiering functionalities become available, the PHM Service will use the standardized criteria for all individuals served by Medi-Cal, taking information from all delivery systems into account. The PHM Service will place each individual into a risk tier (i.e., high, medium-rising, or low). MCPs will be required to use the PHM Service risk tiers to identify and assess member-level risks and needs and, as needed, connect members to services.

The risk tiers identified through the PHM Service will set a standard to identify members who require further assessment and connection to appropriate services. DHCS acknowledges that since the PHM Service will be using historical data, MCPs may have local data sources or real-time data that could supplement these outputs and may be used for the purpose of identifying additional members for further assessments and services. For example, while an MCP must assess the needs of any member who is identified as high-risk through the PHM Service, MCPs may use additional data sources to identify other members who require an assessment that the PHM Service may not have identified.

MCPs will not be able to manually “override” a risk tier given by the PHM Service on a member, as these risk tiers will be used to ensure equity and accountability across the state; however, MCPs will be expected to work with network providers to exercise judgment and shared decision-making with the member about the services a member needs, including through use of real-time information that may be available and through the assessment/reassessment process described below. The PHM Service risk tiers are designed to be a starting point for assessment but not a requirement for or barrier to services.

DHCS will issue additional guidance on MCPs’ use of risk tiers and required reporting prior to the statewide launch of the PHM Service.

2) Assessment and Reassessment to Understand Member Needs

After the RSS and risk tiering processes identify members that may need available interventions and services, additional efforts are required to better understand the members’ needs and preferences and meaningfully engage them in the most appropriate services and supports. In the context of the PHM Framework, the term “assessment” describes this process, and it involves requesting information from members about their health and individual needs. Generally, MCPs are expected to contract with providers to conduct assessment and integrate it with care and care management processes to the greatest extent possible, rather than siloed at the plan level. Either an MCP or a contracted provider, such as a Primary Care Provider (PCP), will conduct an additional assessment of members by asking them questions in a culturally and linguistically appropriate manner that builds trust with the member and seeks to define the nature of the risk factor(s) and/or problem(s) a member is experiencing; determine a member’s overall needs and preferences, health goals, and priorities; and aid in the development of specific treatment recommendations to meet the member’s needs and preferences.

Importantly, this assessment process is separate and distinct from “screening” in that it is more comprehensive, and because it occurs after members have been identified by the RSS and risk tiering processes (which is informed by screening data).

Populations Required to Receive an Assessment and Re-assessment

Assessments vary in length and scope, and some are mandated by federal and/or state law, by NCQA, or by DHCS’ new PHM requirements. Populations required to receive an assessment include:

- Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver).⁴³
- Those entering CCM (per NCQA).
- Those entering ECM.
- Children with Special Health Care Needs (CSHCN).⁴⁴
- Pregnant individuals.⁴⁵
- Seniors and persons with disabilities who meet the definition of “high risk” as established in existing APL requirements,⁴⁶ namely:
 - Members who have been authorized to receive:
 - IHSS greater than, or equal to, 195 hours per month;
 - Community-Based Adult Services (CBAS), and/or
 - Multipurpose Senior Services Program (MSSP) Services.
 - Members who:
 - Have been on oxygen within the past 90 days;
 - Are residing in an acute hospital setting;
 - Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
 - Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);

⁴³ 42 C.F.R. § 438.208; CA W.I.C. § 14182(c)(12). A Standard Terms and Conditions of Federal 1115 Demonstration Waiver titled “A Bridge to Reform.”

⁴⁴ Aligned with [federal regulations](#), DHCS CQS states, “Each MCP is required to implement and maintain a program for [CSHCN], who are defined by the state as having, or being at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond that generally required by children. Each MCP’s CSHCN program is required to include standardized procedures for identifying CSHCN at enrollment and on a periodic basis after enrollment. Members identified as CSHCN must receive comprehensive assessment of health and related needs. The MCP must implement methods for monitoring and improving the quality and appropriateness of care for CSHCN.”

⁴⁵ Medi-Cal Managed Care Boilerplate Contract, Exhibit A, Attachment 10, Scope of Services, 7. Pregnant Women.

⁴⁶ [APL 22-024](#).

- Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
 - Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
 - Have cancer and are currently being treated;
 - Are pregnant;
 - Have been prescribed antipsychotic medication within the past 90 days;
 - Have been prescribed 15 or more prescriptions in the past 90 days;
 - Have a self-report of a deteriorating condition; and
 - Have other conditions as determined by the MCP, based on local resources.
- Prior to the statewide RSS and risk tiers becoming available through the PHM Service, MCPs will be required to assess members who are identified at high risk through their own RSS approaches (e.g., upon enrollment, annually after enrollment, based on significant change in health status or level of care, or upon receipt of new information that the MCP determines as potentially changing a member's level of risk and need).
 - Once the statewide RSS and risk tiers are available through the PHM Service, MCPs will be required at a minimum to assess members who are identified as high-risk through the PHM Service.

An annual re-assessment is required for CSHCN⁴⁷ and those with LTSS needs⁴⁸. Prenatal, postpartum and trimester reassessments that are comparable to the [American College of Obstetricians and Gynecologists \(ACOG\)](#) and [Comprehensive Perinatal Services Program \(CPSP\)](#) standards per Title 22 C.C.R are required for pregnant individuals. There is no annual re-assessment requirement for those enrolled in ECM or CCM, and Seniors and Persons with Disabilities. However, most MCPs complete an annual re-assessment for members enrolled in ECM or CCM.

Changes to Assessment Requirements

To reduce current duplicative and burdensome processes, MCPs are encouraged to contract with providers to conduct assessment and integrate it with care and care management to the greatest extent possible. Whether the assessment is performed in person, telephonically, or by telehealth, it should be conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

Assessment results are also expected to be shared between MCPs and providers responsible for following up with the member, similar to the expectation to be put in

⁴⁷ Centers for Medicare and Medicaid Services: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability [Final Rule](#)

⁴⁸ 42 CFR § 438.208 - Coordination and continuity of care.

place for HIF/MET screening (above). MCPs must also follow up on any positive assessment result or contract with the PCP to complete the follow-up.

Box B: Changes to Seniors and Persons with Disabilities Health Risk Assessment (HRA) Requirements

Effective January 1, 2023, assessment requirements for Seniors and Persons with Disabilities (which are called HRA requirements) are simplified, while specific member protections are kept in place. DHCS has consistently heard feedback that the existing HRA requirements often contribute to duplicative or otherwise burdensome processes for members, whereby the same information is taken in via one or more screening tools and by the HRA, as well as through the usual course of care at the provider level. Therefore:

Starting in 2023, MCPs are not required to retain the use of their existing HRA tools that were previously approved by DHCS under the APLs 17-012 and 17-013, although they may choose to do so, and instead must follow stipulations put forth in APL 22-024. Furthermore, MCPs, or contract entities, must continue to assess members who may need LTSS, using the existing standardized LTSS referral questions (see Appendix 3) according to federal and state law. MCPs must also comply with federal regulations that stipulate specific care plan requirements for members with LTSS needs.

Additionally, for 2023, DHCS retains the requirement that MCPs assess Seniors and Persons with Disabilities who meet the definition of “high risk” for Seniors and Persons with Disabilities as outlined above, even if they do not have LTSS needs. MCPs may alternatively leverage their ECM and/or CCM assessment tools, or components of those tools, for Seniors and Persons with Disabilities considered at “high risk.” If MCPs decide to retain existing HRA tools, they are encouraged to adapt them to allow delegation to providers.

DHCS also simplified the expected timeline for assessment of those with LTSS needs to align with NCQA’s requirements for care management assessments, which include beginning to assess within 30 days of identifying the member through RSS, referral, or other means, and completing assessment within 60 days of that identification.

[Corresponding APL Updates](#)

E. Providing PHM Program Services and Supports

1) Basic Population Health Management (BPHM)

BPHM is an approach to care that ensures needed programs and services are made available to each member, regardless of the member’s risk tier, at the right time and in the right setting. In contrast to care management, which is focused on populations with significant or emerging needs, all MCP members receive BPHM, regardless of their level of need. BPHM replaces DHCS’ previous “Basic Case Management” requirements.

BPHM includes access to primary care, care coordination,⁴⁹ navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the new CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children under EPSDT.

Although the key components of BPHM are not new, DHCS has not previously articulated them as a comprehensive package of services and supports that all MCP members can expect.

BPHM is ultimately the responsibility of the MCP. Some functions of BPHM will need to be retained by the MCP, such as authorizing specialty services in a timely manner and providing a full suite of wellness and prevention and chronic disease management programs. However, MCPs are encouraged to contract with providers to provide certain components of BPHM, as described below, while ensuring appropriate oversight in meeting required responsibilities and functions. For example:

- For members who are successfully engaged in primary care, for example, MCPs should contract with PCPs (including Federally Qualified Health Centers (FQHCs), counties, or other primary care) to be responsible for select care coordination and health education functions, whenever feasible.
- For members who have been assigned a PCP but have not yet engaged with the PCP (e.g., assigned but not seen or lost to follow-up), MCPs may contract with the PCP to provide outreach. If the PCP makes contact with and engages the

APLs	Upcoming Updates and Timing
APL 22-024 “Population Health Management Policy Guide”	<ul style="list-style-type: none">• Supersedes APL 17-013 and APL 17-012.

member, the MCP may also contract with the PCP for BPHM care coordination and health education functions whenever feasible. If a member does not engage with a PCP, MCPs are fully responsible for the provision of BPHM.

- For members enrolled in ECM, and since ECM, by design, happens in the

⁴⁹ 42 CFR § 438.208

community by an ECM provider, the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of their care management.

Required BPHM Elements and Processes:

In accordance with the Basic Population Health Management section of the Amended 2023 MCP Contract, MCPs must comply with the following requirements:

a. Access, Utilization, and Engagement with Primary Care

To ensure all members have access to and are utilizing primary care, MCPs must:

- Ensure members have an ongoing source of primary care;
- Ensure members are engaged with their assigned PCPs (such as helping to make appointments, arranging transportation, and providing health education on the importance of primary care);
- Identify members who are not using primary care via utilization reports and enrollment data, which are stratified by race and ethnicity;
- Develop strategies to address different utilization patterns; and
- Ensure non-duplication of services.

All BPHM services should promote health equity and align with [National Standards for Culturally and Linguistically Appropriate Services](#) (CLAS), which is a U.S. Department of Health and Human Services (HHS)-developed framework of 15 standards focused on the delivery of services in a culturally and linguistically appropriate manner that is responsive to patient needs, beliefs, and preferences.

Starting in 2024, DHCS will expand reporting requirements to include reporting on primary care spending as a percentage of total spending stratified by age ranges and race/ethnicity.

b. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports

Even though some Medi-Cal services are typically carved-out of the MCP benefit package, MCPs must ensure that members have access to needed services that address all their health and health-related needs, including developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs.

MCPs are required to partner with primary care and other delivery systems to guarantee that members' needs are addressed. This includes ensuring that each member's assigned PCP plays a key role in coordination of care, ensuring each member has sufficient care coordination and continuity of care with out-of-network providers, and communicating with all relevant parties on the care coordination provided. MCPs must also assist members in navigation, provider referrals, and coordination of health and services across MCPs, settings, and delivery systems.

MCPs should begin to establish relationships and processes to meet Closed Loop Referral requirements by January 2025. Closed Loop Referrals are defined in the 2024 Re-Procurement as coordinating and referring the member to available community

resources and following up to ensure services were rendered. MCPs must ensure Closed Loop Referrals, in compliance with all federal and state laws, to:

- ECM;
- Community Supports;
- Services provided by CHWs, peer counselors, and local community organizations;
- Dental providers;
- California Children’s Services (CCS);
- Developmental Services (DD);
- CalFresh;
- WIC providers;
- County social service agencies and waiver agencies for IHSS and other home- and community-based services (HCBS); and
- The appropriate delivery system for specialty mental health services to ensure members receive timely mental health services (in the MCP provider network, county Mental Health Plan (MHP) network, or Medi-Cal FFS delivery system) without delay regardless of where they initially seek care, in accordance with DHCS’ “No Wrong Door” policy;⁵⁰ and
- The appropriate delivery system for SUD services (in DMC or DMC-ODS).⁵¹

Beginning in January 2025, MCPs are also required to coordinate warm handoffs with local health departments and other public benefits programs including, but not limited to, CalWORKs, Early Start, and Supplemental Security Income (SSI).

Starting in January 2024, MCPs are required to enter into Memorandums of Understanding (MOUs) with various programs and services, including county MHPs to facilitate care coordination and information exchange.^{52,53}

c. Information Sharing and Referral Support Infrastructure

To support effective BPHM, MCPs are required to implement information-sharing processes and referral support infrastructure. MCPs must ensure appropriate sharing and exchange of member information and medical records by providers and MCPs in accordance with professional standards and state and federal privacy laws and regulations.

d. (Updated August 2023) Integration of Community Health Workers (CHWs) in PHM

MCPs will be required to describe how they will integrate CHWs in their PHM Strategy

⁵⁰ [APL 22-005](#)

⁵¹ 2024 Re-Procurement, Exhibit A, Attachment III, 5.5. This requirement will take effect in 2024.

⁵² Amended 2023 MCP Contract.

⁵³ DHCS has launched the CalAIM Behavioral Health Quality Improvement Program (BH QIP). BHQIP has three domains, one of which focuses on data-sharing agreements among MCPs, county MHPs, and DMC-ODS plans. More information is available at <https://www.dhcs.ca.gov/bhqip>.

and had to attest this integration as part of their PHM Readiness Deliverable. As trusted members of the community, CHWs may be able to address a variety of health and health-related issues, including, but not limited to: supporting members' engagement with their PCP, identifying and connecting members to services that address SDOH needs, promoting wellness and prevention, helping members manage their chronic disease, and supporting efforts to improve maternal and child health. CHWs may include individuals known by a variety of job titles, including promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below

DHCS launched a new CHW benefit on July 1, 2022, which is a pathway for reimbursement for a specific set of CHW services. These reimbursable CHW services are defined by State Plan Amendment 22-0001 and Title 42 Code of Federal Regulations (C.F.R.) Section 440.130(c).^{54,55} Even prior to the launch of this new benefit, MCPs may have already employed CHWs to implement a wide array of activities, including BPHM-related interventions, such as wellness and prevention. The new CHW benefit provides a new mechanism for providing and reimbursing for BPHM services provided by CHWs.

e. (Updated August 2023) Wellness and Prevention Programs

MCPs are required to provide comprehensive wellness and prevention programs that, at minimum, meet NCQA requirements, including offering evidence-based self-management tools that provide information on at least the following areas:

- Healthy weight (BMI) maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying depressive symptoms

Through their required annual PHM Strategy, MCPs will report how they are using community-specific information, gained in the more collaborative PNA efforts starting in 2024, to design and implement evidence-based wellness and prevention strategies to meet the unique needs of their populations that are inclusive of addressing one or more of the Bold Goals Initiatives described in DHCS' **CQS**. Starting in 2024, MCPs will be required to report annually, through their PHM Strategy, on how they are using community-specific information, gained in the more collaborative PNA efforts to design and implement evidence-based wellness and prevention strategies to meet the unique needs of their populations, as well as to drive toward the Bold Goals Initiative in DHCS' **CQS**. The expectation is that over time, these wellness programs result in improved outcomes, such as decreasing population prevalence of specific chronic diseases, rates

⁵⁴ See 42 C.F.R. 440.130(c). The C.F.R. is searchable, available at: <https://www.ecfr.gov/>.

⁵⁵ CHW SPA information is available at <https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx>.

of strokes and heart attacks, food access insecurity, and other conditions amenable to upstream risk factor modification.

f. Programs Addressing Chronic Disease

MCPs are required to offer evidence-based disease management programs in line with NCQA requirements at a minimum. These programs must incorporate health education interventions, identify members for engagement, and seek to close care gaps for the cohorts of members participating in the interventions with a focus on improving equity and reducing health disparities. DHCS requires that these programs address the following conditions at a minimum:

- Diabetes
- Cardiovascular disease
- Asthma
- Depression

While all MCPs must offer programs that target the above conditions, MCPs' chronic disease programs should additionally be tailored to the specific needs of each plan's Medi-Cal populations and connected with the PNA and PHM Strategy, along with other community programs (e.g., local health jurisdiction chronic disease initiatives, focus areas for plan community reinvestment programs, data collection efforts by local public health and community organizations).

g. Programs to Address Maternal Health Outcomes

Improving maternal health is one of the DHCS [CQS](#)' Bold Goals, which specifically seeks to improve maternity outcomes and birth equity, including access to prenatal and postpartum care. DHCS also introduced the doula benefit on January 1, 2023, to improve culturally competent birth care. PHM programs offered by MCPs have a key role to play in improving outcomes in this area by supporting quality improvement and health disparity reduction efforts with their network providers and addressing systemic discrimination in maternity care, particularly [for Black, Native American, and Pacific Islander birthing persons](#).

MCPs must continue to meet all requirements for pregnant individuals, including covering the provision of all medically necessary services for pregnant women, implementing and administering a comprehensive risk assessment tool that is comparable to the American College of Obstetricians and Gynecologists ([ACOG](#)) and standards per Title 22 C.C.R. Section 51348 developing individualized care plans to include obstetrical, nutrition, psychosocial, and health education interventions, and providing appropriate follow-ups.^{56,57,58} Future guidance will be issued for MCPs regarding best practices to address maternal health outcomes. [Comprehensive Perinatal Service Program \(CPSP\) standards](#) per Title 22 C.C.R. Section 51348

developing individualized care plans to include obstetrical, nutrition, psychosocial, and health education interventions, and providing appropriate follow-ups.^{59,60,61} Future guidance will be issued for MCPs regarding best practices to address maternal health outcomes.

h. PHM for Children

All children under the age of 21 enrolled in Medicaid are entitled under [federal](#) and [state](#) law to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which requires that children enrolled in Medi-Cal receive all screening, preventive, and medically necessary diagnostic and treatment services, regardless of whether the service is included in the Medicaid State Plan or available to adults.

MCPs must meet requirements outlined in the Other Population Health Requirements for Children and the Services for Members under 21 sections of the Amended 2023 MCP Contract:

- Ensure all members under 21 receive Initial Health Appointment(s) within 120 calendar days of enrollment or within the schedule for children age 18 months and younger, whichever is sooner.
- Provide preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the [Advisory Committee on Immunization Practices \(ACIP\) childhood immunization schedule](#).
- Ensure that all medically necessary services, including those that are not covered for adults, are provided as long as they could be Medicaid-covered services.
- Coordinate health and social services for children between settings of care and across other MCPs and delivery systems. Specifically, MCPs must support children and their families in accessing medically necessary physical, behavioral, and dental health services, as well as social and educational services.
- Actively and systematically promote EPSDT screenings and preventive services to children and families.

MCPs must ensure EPSDT is provided to all children and youth as part of their PHM Program, including BPHM, CCM, and ECM. Starting in 2024, as part of MCPs' annual PHM Strategy submission, MCPs are required to review the utilization of children's preventive health visits and developmental screenings and outline their strategies for

⁵⁹ [2022 Medi-Cal Managed Care Contract and PL 12-003](#).

⁶⁰ Section 1902(e)(5) of the Social Security Act 6; 42 C.F.R. § 435.170. The Centers for Medicaid and CHIP Services, [SHO #21-007](#).

⁶¹ Effective April 1, 2022, DHCS extended the postpartum care coverage period for currently eligible and newly eligible pregnant individuals. The American Rescue Plan Act (ARPA) Postpartum Care Expansion (PCE) extends the coverage period from 60 days to 365 days (one year) for individuals eligible for pregnancy and postpartum care services in Medi-Cal and the Medi-Cal Access Program (MCAP). ARPA PCE coverage includes the full breadth of medically necessary services during pregnancy and the extended postpartum period.

improving access to those services, as well as articulate and track how BPHM may be deployed to ensure any follow-up and care coordination needs identified from screenings are delivered. For example, BPHM should ensure that all children with abnormal vision screenings receive glasses or that all children with an abnormal developmental screen receive additional required testing. As part of BPHM, MCPs continue to be required to meet all EPSDT requirements related to timely access to services.

In addition, to support children enrolled in Medi-Cal in accessing and receiving wellness and prevention programs, starting in 2024, MCPs will also be required to enter into MOUs with WIC providers. Then starting in 2025, MCPs will be required to enter into MOUs with First 5 programs and providers and every Local Education Agency (LEA) in each county within their service area for school-based services to strengthen provision of EPSDT within schools.

2) Care Management Programs

a. Complex Care Management (CCM)

CCM equates to “Complex Case Management,” as defined by NCQA. MCPs are already required to provide CCM. MCPs will continue to be required to provide CCM in 2023, in line with the requirement that all MCPs must meet NCQA PHM standards on January 1, 2023.

CCM is a service for MCP members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner.

Following NCQA’s requirements, MCPs must consider CCM to be an opt-out program – (i.e., members may choose not to participate in CCM if it is offered to them), and MCPs may delegate CCM to providers and other entities who are themselves NCQA-certified.

Required CCM Elements and Processes:

In accordance with the Care Management Programs section of the Amended 2023 MCP Contract and in line with NCQA CCM requirements, MCPs must comply with the following CCM requirements:

i. Eligibility

CCM is a service intended for higher- and medium-risk members and is deliberately more flexible than ECM. MCPs are allowed to determine their own eligibility criteria (within NCQA guardrails⁶²) based on the risk stratification process outlined above and local needs identified in the PNA.

ii. Core Service Components:

CCM must include:

⁶² NCQA 2021 Health Plan Accreditation PHM Standards. PHM 5: Complex Case Management.

1) Comprehensive Assessment and Care Plan

As in ECM, CCM must include a comprehensive assessment of each member's condition, available benefits, and resources (including Community Supports), as well as development and implementation of a Care Management Plan (CMP) with goals, monitoring, and follow-up.

2) Services and Interventions

CCM must include a variety of interventions for members who meet the differing needs of high and medium-/rising-risk populations, including:

- Care coordination focused on longer-term chronic conditions
- Interventions for episodic, temporary member needs
- Disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education
- Community Supports, if available and medically appropriate, and cost-effective

CCM must also include BPHM as part of the care management provided to members. For children and youth under age 21, CCM must include EPSDT; all medically necessary services, including those that are not necessarily covered for adults, must be provided as long as they could be Medicaid-covered services.

iii. Care Manager Role

1) Assignment of a CCM Care Manager

MCPs must assign a care manager for every member receiving CCM. Following NCQA's requirements, MCPs may delegate CCM to providers and other entities who are themselves NCQA-certified. PCPs may be assigned as care managers when they are able to fulfill all CCM requirements.

If multiple providers perform separate aspects of care coordination for a member, the MCP must:

- Identify a care manager
- Communicate the identity of the care manager to all treating providers and the member
- Maintain policies and procedures to:
 - Ensure compliance and non-duplication of medically necessary services.
 - Ensure delegation of responsibilities between the MCP and the member's providers meets all care management requirements.

MCPs must provide the member's PCP with the identity of a member's assigned care manager (if the PCP is not assigned to this role) and a copy of the member's CMP.

2) Care Manager Responsibilities

CCM care managers are required to ensure all BPHM requirements and NCQA CCM standards are met. This includes conducting assessments of member needs to identify and close any gaps in care and completing a CMP for all members receiving

CCM. CCM care managers must also ensure communication and information sharing on a continuous basis and facilitate access to needed services for members, including Community Supports, and across physical and behavioral health delivery systems. MCPs should provide assistance with navigation and referrals, such as to CHWs or community-based social services.

b. Enhanced Care Management (ECM)

ECM, which went live in January 2022, is a new statewide managed care benefit that addresses the clinical and nonclinical needs of Medi-Cal's highest-need members through intensive coordination of health and health-related services.⁶³ For detailed requirements and implementation timeline for ECM, please refer to the [Finalized ECM and Community Supports MCP Contract Template](#) and [ECM Policy Guide](#).

ECM is community-based, interdisciplinary, high touch, person-centered, and provided primarily through in-person interactions. MCPs are required to contract with "ECM Providers," existing community providers such as FQHCs, Counties, County behavioral health providers, Local Health Jurisdictions, CBOs, and others, who will assign a Lead Care Manager to each member. The Lead Care Manager meets members wherever they are – on the street, in a shelter, in their doctor's office, or at home. ECM eligibility is based on members meeting specific "Populations of Focus" criteria. These Populations of Focus are going live in phases throughout 2022 and 2023.

For children and youth under age 21, CCM must include EPSDT; all medically necessary services, including those that are not necessarily covered for adults, must be provided as long as they could be Medicaid-covered services.

Starting in Q2 2022 and extending for at least three years, DHCS instituted MCP [quarterly reporting requirements](#) to monitor the implementation of ECM. DHCS monitors outcomes for the group served by ECM and evaluates whether and how the existing Populations of Focus definitions and policies may be improved over time to ensure that the ECM benefit continues to serve those with the highest needs.

ECM and CCM Overlap Policy and Delegation

An individual cannot be enrolled in ECM and CCM at the same time; rather, CCM is on a care management continuum with ECM. CCM can be used to support members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all members in CCM previously received ECM, and not all members who step down from ECM require CCM. DHCS encourages MCPs to work with providers to contract for a care management continuum of ECM and CCM programs, wherever possible, including as a way to maximize opportunities for members to step down from ECM to CCM or BPHM under the care of a single provider.

⁶³ ECM requirements are contained in the [ECM Policy Guide](#) and [website](#). This document does not alter or add to ECM program design or requirements.

3) (Updated October 2023) Transitional Care Services (TCS)

Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

Under PHM and in line with CalAIM, MCPs are accountable for providing strengthened TCS beginning on January 1, 2023 and fully implemented for all members by January 1, 2024 across all settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports. This includes critical TCS tasks, such as ensuring that medication reconciliation is completed upon discharge by the discharging facility, and that every member has follow-up care by a provider, including another medication reconciliation completed post-discharge to reduce medication discrepancies, errors, and adverse drug events that are common and can lead to poor outcomes in transitions.⁶⁴

For some of the TCS requirements in this Policy Guide and in the MCP Contract, another entity, such as the care manager or the discharging facility, may be responsible for completing a task. However, the MCPs are ultimately accountable for ensuring all TCS are provided to all transitioning members.⁶⁵

The transitional care policies are consistent with the [CQS](#) and are being measured through quality reporting and Key Performance Indicators (KPIs). Moving forward, as future policy guidance is developed to ensure member-centered care during this critical time, additional quality and process measures and reporting will be added to be synergistic with these TCS policies.

Although it is not a required component of TCS at this time, MCPs are strongly encouraged to provide Emergency Department (ED) follow up as part of TCS, especially for the highest risk members, noting that current MCAS quality reporting includes ensuring timely follow-up for members with ED visits for mental health or SUD reasons. In addition, MCPs are strongly encouraged to provide ED follow up as part of TCS for pregnant and postpartum individuals (through 12 months postpartum), given the association of ED visits and maternal morbidity and mortality.

⁶⁴ Poor, or lack of medication reconciliation [presents a significant risk](#) for adverse drug events, especially for the highest risk populations. Accurate and timely medication conciliation is a critical element of TCS for ensuring patient safety during transitions of care.

⁶⁵ The accountable entity is always the MCP. Responsible entity is the entity who must complete the task or service. For example, MCPs are both the accountable and responsible entity for knowing when their members are admitted, discharged, or transferred. Separately, while MCPs are accountable for ensuring discharging facilities complete their discharge planning process per TCS requirements, the discharge facility is the responsible entity who must perform discharge planning activities.

a. Phased TCS Implementation Timeline

For the PHM Program launch on January 1, 2023 and extended implementation by January 1, 2024, each MCP must have an implementation plan to meet the following timeline.⁶⁶

i. By January 1, 2023

- MCPs must know when members are admitted, discharged or transferred for **all members**;
- MCPs must implement timely prior authorizations for **all members**;
- MCPs must assign a care manager/single point of contact who will complete all required TCS responsibilities for **all high-risk transitioning members**.⁶⁷

ii. By January 1, 2024

- In addition to the requirements applying from January 2023, MCPs must add support for TCS for **lower-risk transitioning members**.

The following three sections provide details of each required component: those required for all members in transition; those required for high-risk members in transition; and those required for lower risk members in transition starting in 2024.

b. Required TCS Elements and Processes for All MCP Members (Effective 1/1/23)

i. Admission, Discharge, and Transfer (ADT)

In accordance to Interoperability and Patient Access Final Rule set forth at CMS-9115-F, and the CalHHS Data Exchange Framework (DxF), general acute care hospitals and emergency departments, as defined by HSC §1250, (together “Participating Facilities”), must send admission, discharge, or transfer (ADT) notifications by January 31, 2024 to other organizations that have signed the DxF Data Sharing Agreement if requested in advance of the ADT Event.^{68,69} The DxF also encourages but does not require skilled nursing facilities, as defined by HSC §1250 to send admission, discharge, or transfer (ADT) notifications by January 31, 2024. Participating facilities are required to send notification of ADT Events unless prohibited by Applicable Law; they must also accept notification of ADT Events from any other Participant and send notification of ADT Events as requested using a secure method compliant with the Privacy Standards and Security Safeguards Policy and Procedure and in a format acceptable and supported by

⁶⁶ The MCP is not required to submit the plan for DHCS review, but must provide it to DHCS upon request.

⁶⁷ For members enrolled in multiple payors, the phased transitional care implementation policy remains the same as outlined in the “Required TCS Elements and Processes, ix. Guidance for Members Enrolled with Multiple Payors” section.

⁶⁸ HSC § 130290; [CalHHS DxF Technical Requirements for Exchange Policy and Procedure](#)

⁶⁹ An ADT Event is defined as an admission, discharge, or transfer.

the requesting Participant.⁷⁰ These DxF requirements will support MCPs capabilities to receive ADT notifications from a variety of Participating Facilities.

Under TCS, MCPs are responsible for knowing, in a timely manner, when all of their members have planned admissions, and when they are admitted, discharged, or transferred, and therefore experiencing a transition, through the following mechanisms:

- MCPs are expected to enter agreements with all contracted general acute care hospitals and emergency departments, as defined by HSC §1250 to receive ADT notifications from them whenever their members are admitted, discharged or transferred, and request such notification in advance of the ADT Event, when possible. The 2024 Medi-Cal MCP contract also requires skilled nursing facilities, as defined by HSC §1250 that currently maintain electronic records to send them ADT notifications whenever their members are admitted, discharged or transferred, and request such notification in advance of the ADT Event, when possible. MCPs are responsible for providing up to date Member rosters to their contracted general acute care hospitals, emergency departments, and skilled nursing facilities (together “Participating Facilities”) so that such facilities can send notifications to the MCPs whenever one of their members is admitted, discharged or transferred to or from their facility. To meet this expectation, MCPs may receive these ADT notifications from “intermediaries”, defined as a health information exchange network, health information organization, or technology vendor that assists a “Participating Facility” in the Exchange of Health and Social Services Information. Example intermediaries might include nationwide networks or frameworks, vendors that provide applicable services, health information organizations including Qualified HIOs, or community information exchanges.
- MCPs are responsible for receiving and using ADT notifications from all contracted “Participating Facilities”.
- For all other “Participating Facilities” that the MCPs members are admitted, discharged or transferred from or to, MCPs are expected to identify mechanisms to ensure they are notified by the facility in a timely manner whenever one of their members is admitted, discharged, or transferred. These can include but are not limited to requirements for notification by admitting facilities and institutions directly or leveraging existing prior authorization requests.

⁷⁰ The Data Exchange Framework requirements do not apply to rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with fewer than 100 acute care beds, state-run acute psychiatric hospitals, and any nonprofit clinic with fewer than 10 health care providers until January 31, 2026.

ii. Prior Authorizations and Timely Discharges

As referenced in the TCS section of the MCP Contract, MCPs must ensure timely prior authorizations (when possible, prior to discharge) and discharges for all members, which includes, but is not limited to, ensuring that prior authorizations required for a member's discharge are processed in a timely manner, consistent with the policies and timelines outlined in regulations and in [APL 21-011](#), and assisting with placement at facilities within MCPs' provider networks, if necessary. DHCS encourages MCPs to monitor the efficacy of these processes by tracking administrative days, avoidable days, and prior authorization turnaround times at the facility level.

iii. Identification of High- vs. Lower-risk Transitioning Members

Effective January 1, 2024, different minimum TCS requirements apply for high-risk and lower-risk transitioning members as set out below.

“High-risk” transitioning members means **all** members listed under Section D: Understanding Risk, 2) Assessment and Reassessment to Understand Member Needs in this Policy Guide,⁷¹ i.e.:

- Those with LTSS needs;
- Those in or entering CCM or ECM;
- Children with special health care needs (CSHCN);
- Pregnant individuals: for the purposes of TCS, “pregnant individuals” includes individuals hospitalized during pregnancy, admitted during the 12-month period postpartum, and discharges related to the delivery;⁷²
- Seniors and persons with disabilities who meet the definitions of “high-risk” established in existing APL requirements;⁷³
- Other members assessed as high-risk by RSST.⁷⁴

In addition to these groups, and in recognition of high risk of poor outcomes in transition for MCP members enrolled in multiple payors, those transitioning from SNFs, and those at high risk who are potentially not captured by the above categories, MCPs must **also** consider the following members “high-risk” for the purposes of TCS:

- Any member who has been served by county SMHS and/or DMC or DMC-ODS (if known) within the last 12 months, or any member who has been identified as

⁷¹ Refer Section D 2) for full definitions and more information.

⁷² Additional detailed guidance will be forthcoming on TCS requirements for pregnant and postpartum individuals experiencing a care transition.

⁷³ APLs [17-012](#) and [17-013](#)

⁷⁴ MCPs should use their own RSST algorithms prior to the PHM Service RSS and risk tiering functionalities become available. However, once the PHM Service RSS and risk tiering functionalities are available, MCPs must use the PHM Service's risk tiers. In addition, MCPs must stratify members at least annually or upon a significant change in the health status or level of the member. For more details, please refer to Section II. PHM Program, D. Understanding Risk 1) RSS and Risk Tiers.

having a specialty mental health need or substance use disorder by the MCP or discharging facility;^{75,76}

- Any member transitioning to or from a SNF;
- Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS.

iv. MCP Oversight of Facility Discharge Planning Process

TCS requirements build on, rather than supplant, existing requirements on facilities. Hospitals must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements; and certain similar requirements apply to SNFs.⁷⁷

Under TCS, MCPs are accountable for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by federal and state requirements. MCPs must ensure discharging facilities complete a discharge planning process that:

- Engages members, and/or members' parents, legal guardians, or Authorized Representative, as appropriate, when being discharged from a hospital, institution or facility.⁷⁸

⁷⁵ The transitions that qualify include any discharges from any acute care facility, including hospitals, SNFs and inpatient psychiatric facilities. For more information about TCS requirements for the members admitted to inpatient psychiatric facilities when the MCP is not the primary payer, please refer to Section e. Guidance for Members Enrolled with Multiple Payors.

⁷⁶ MCPs must utilize SMHS data from DHCS to identify members receiving or eligible for services from a county MHP. For members receiving or eligible for services from a DMC/DMC-ODC, MCPs must make best efforts to identify them through data sharing processes established under the required MOU with DMC-ODS entities (starting in 2024), review of ICD-10 code data, and data from Medi-Cal Rx, in addition to having the discharging facility refer eligible individuals.

⁷⁷ The following discharge and transition planning requirements apply to various types of facilities. This list is not exhaustive; it is the responsibility of the discharging facility to ensure they are compliant with all applicable requirements.

- Centers for Medicare and Medicaid (CMS) CoPs requirements set forth in federal regulations include but are not limited to: [42 CFR § 482.43](#); [42 CFR § 482.24](#). CMS requirements for LTC facilities include but are not limited to: [42 CFR § 483.21](#)
- State Requirements include, but are not limited to: [HSC § 1262.5](#); [Knox-Keene Act KKA CCR Title 28 § 1300.67 \(b\)](#); [HSC § 1373.96](#); [WIC § 14186.3\(c\)\(4\)](#);
- [Joint Commission Requirements](#) include but are not limited to: PC.04.01.01; PC.04.01.03; PC.04.02.01; PC.02.02.01; RC.02.04.01.

⁷⁸ [42 CFR § 482.43](#); [HSC § 1262.5](#)

- Focuses on the member’s goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
- Uses a consistent assessment process and/or assessment tools to identify members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals’ current processes. Hospitals are currently already required to identify these members and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.⁷⁹
 - For high-risk members, MCPs must ensure the discharging facility shares this information with the MCPs’ assigned care manager and that the discharging facilities have processes in place to refer to members to ECM or Community Supports, as needed.
 - For members not already classified as high-risk by the MCP per above definitions under Section iii. Identification of High- vs. Lower-Risk Transitioning Members, the discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to the MCP for:
 - Any member who has a specialty mental health need or substance use disorder.
 - Any member who is eligible for an ECM Population of Focus
 - Any member whom the clinical team feels is high risk and may benefit from more intensive transitional care support upon discharge.
- Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities’ current requirements.⁸⁰
- Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.⁸¹
 - This must include a medication reconciliation upon discharge that includes education and counseling about the member’s medications⁸².
- Coordinates care with:

⁷⁹ [42 CFR § 482.43](#); [42 CFR § 482.24](#); Joint Commission Requirements: RC.02.04.01

⁸⁰ [42 CFR § 482.43](#); [42 CFR § 482.24](#)

⁸¹ [HSC § 1262.5](#)

⁸² This refers to the pre-discharge medication reconciliation. Medication reconciliation should be completed upon discharge by the discharging facility (pre-discharge) and a second reconciliation must be complete after discharge once the member is in their new setting (post-discharge).

- **The member’s designated family caregiver(s).** The MCP should ensure they are notified of the member’s discharge or transfer to another facility.⁸³
- **Post-discharge providers.** The MCP should ensure they are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient’s condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.⁸⁴

c. Minimum TCS Elements and Processes for High-Risk Members (Effective 1/1/23)

As noted in the TCS section of the MCP Contract, TCS for High-Risk Members is accomplished by ensuring that a single point of contact, herein referred to as a care manager⁸⁵, who must assist high-risk members throughout their transition and ensure all required care coordination and follow-up services are complete as described under care manager responsibilities below.

i. Identify the Care Manager Responsible for TCS

Once a member has been identified as being admitted and as being high-risk, the MCP must identify a care manager, who is the single point of contact responsible for providing longitudinal support and ensuring completion of all TCS across all settings and delivery systems, and that members are supported in a culturally and linguistically appropriate manner from discharge planning until they have been successfully connected to all needed services and supports.

For members already enrolled in CCM or ECM at the time of the transition, the MCP must ensure that the member’s assigned ECM Lead Care Manager or CCM care manager is that identified care manager and provides all TCS.

“Longitudinal support” means that a single relationship must span the whole transition. For members who do not already have a care manager through ECM or CCM, the MCP may choose either to use its own staff to accomplish this, or to contract with the hospital, the PCP or another appropriate delegate such as an accountable care organization (ACO).⁸⁶ DHCS encourages plans to work with their networks to create models of care that do not duplicate work, including the engagement of discharging facilities to take on the full scope of longitudinal TCS.

⁸³ [HSC § 1262.5](#)

⁸⁴ [42 CFR § 482.43](#); [42 CFR § 482.24](#); Joint Commission Requirements: RC.02.04.01

⁸⁵ A care manager can have a variety of experiences or credentials to support transitional care activities and does not need to be a licensed provider. However, care manager assignment should consider the level of need for each member.

⁸⁶ This arrangement for MCP contracted entities to provide TCS is not considered formal delegation and therefore, MCPs would not be subject to requirements outlined in [APL 17-004](#).

Many high-risk members in transition will meet criteria for ECM or CCM for the first time on account of the event or condition that necessitated the facility stay. At any time in the TCS process, the discharging facility, or the TCS care manager should screen and refer a member for longer term care management programs (ECM or CCM) and/or Community Supports.

Working with a care manager is optional for members. MCPs must ensure that the member is offered the direct assistance of the care manager, but members may choose to have limited or no contact with the care manager. In these cases, at a minimum, the MCP must ensure that discharging facilities comply with federal and state discharge planning requirements listed above and that the care manager assists in all care coordination among the discharging facility, the PCP, or any other identified follow-up providers, and the follow-up is complete.

ii. Communication of Assignment to the Care Manager

MCPs are required to communicate both with the responsible care manager (or contracted care manager) and with the discharging facility in a timely manner so that the care manager can coordinate with the discharge facility on discharge planning and support access to available services.⁸⁷

For high-risk members in transition, their assigned care managers (including ECM and CCM) must be notified within 24 hours of admission, transfer or discharge when an ADT feed is available or within 24 hours of the MCP being aware of any planned admissions, or of any admissions, discharges or transfers for instances where no ADT feed exists (such as for SNF admissions). However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

MCPs must notify the identified responsible care manager of the assignment and of the member's admission status, including the location of admission, and ensure that the discharging facility has the name and contact information, including phone number of the identified care manager. MCPs must also ensure the member has the care manager's contact information. A best practice is for the care manager to work with the discharging facility to incorporate the care manager name and contact number in the discharging facility's discharge document that the member receives.

iii. Care Manager Responsibilities

The care manager responsible for TCS is responsible for coordinating and verifying that high-risk members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. As set out above, the hospital/discharging facility's responsibility to perform discharge planning does not supplant the need for TCS, although the TCS responsibility may be fully contracted out to the hospital/facility to allow a single team to

⁸⁷ In the instance that the care manager is at the facility, the MCP's role is to communicate with the facility.

perform discharge and TCS. If MCPs contract with or delegate TCS to providers or facilities, MCPs must have a monitoring plan in place to ensure all required TCS are completed.

The care manager is responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the care manager does not need to perform all activities directly, they must coordinate and ensure completion of following critical TCS tasks:

- **Coordinating with Discharging Facility to ensure member engagement and comprehensive information sharing and coordination of care:** A core responsibility of the care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member and to ensure the member participates in the care plan and receives and understands information about their needed care. To do this, the care manager must complete the following:
 - Risk Assessment:
 - The care manager must assess member's risk for adverse outcomes to inform needed TCS. This must include, reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The care manager may supplement this risk assessment as needed through member engagement. During this process, the care manager must also identify members who may be newly eligible for ongoing care management (ECM/CCM), and/or Community Supports and make appropriate referrals.
 - Discharge Instructions:
 - Care Managers must receive and review a copy of the discharging facility's discharge instructions given to the member, including the medication reconciliation completed upon discharge by the discharging facility.
 - After discharge, upon member engagement, care manager must review the discharge instructions with the member and ensure that member can have any questions answered.
 - A best practice (not required) is for the care manager to work with the facility to ensure that the care manager's name and contact information are integrated into the discharge documents.
 - Discharge Summary and Clinical Information Sharing:
 - Care Managers must receive and review a copy of the discharging facility's discharge summary once it is complete.^{88,89}

⁸⁸ [42 CFR § 482.43](#); [42 CFR § 482.24](#); Joint Commission Requirements: RC.02.04.01

⁸⁹ If the discharge summary is not complete after 30 days, the care manager is not responsible for its receipt.

- Care Managers must ensure all follow-up providers have access to the needed clinical information from the discharging facility, including the discharge summary.
- **Necessary Post-Discharge Services and Follow-Ups:** Knowing that immediately post-discharge is an especially vulnerable time for high-risk members, support and follow-up post-discharge are critical aspects for the care manager responsible for TCS, including tasks in the MCP contract and as described below:
 - Member Outreach:
 - The identified care manager is responsible for contacting the member within 7 days of discharge (may be sooner) and supporting the member in all needed TCS care identified at discharge, as well as any new needs identified through engagement with the member or their care providers.
 - Ensuring needed post-discharge services are provided and follow-ups are completed, including (but not limited to) by assisting with making follow up provider appointments, to occur within 7 days post-discharge; connecting to the PCP (if different);⁹⁰ and arranging transportation.
 - SUD and mental health treatment initiation or continuation for those who have an identified SUD or Mental health condition.
 - Medication reconciliation, post discharge:⁹¹
 - Care manager must ensure this is complete after individual is discharged. This can be done by the follow-up provider, such as the PCP, or by the care manager if they hold an appropriate license, or by another team member on the care manager's team that has appropriate license, in a manner that is consistent with California's licensing and scope of practice requirements, as well as applicable federal and state regulations.
 - Completion of referrals to social service organizations, and referrals to necessary at-home services (DME, home health, etc.).
 - Connection to community supports as needed.
 - For members who are transferred to/from nursing facilities, ensure completion of care coordination tasks in the contract including:
 - Ensure outpatient appointments are scheduled prior to discharge;
 - Verify that Members arrive safely and have their medical needs met;
 - Follow-up with Members to ensure all TCS needs and requirements have been met.

⁹⁰ For members who have not had a visit with their PCP in the last 12 months, MCPs are responsible for providing health education and connection to the PCP (MCP Contract, Section 4.3.8 Basic Population Health Management, A. 8); for high-risk members in transition, the care manager should perform this function as part of TCS.

⁹¹ This refers to the post-discharge medication reconciliation. Medication reconciliation should be completed upon discharge by the discharging facility (pre-discharge) and a second reconciliation must be complete after discharge once the member is in their new setting (post-discharge).

iv. End of TCS for High-Risk Members

TCS for high-risk members extends until the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document. TCS for high-risk members should always extend at least 30 days post-discharge. If the MCP has delegated TCS, the MCP must ensure that the delegate follows and coordinates services for the member until all aforementioned activities are completed. For those who have ongoing unmet needs, eligibility for ECM or CCM and/or Community Supports should be reconsidered.

For members who may not respond to the MCP's outreach attempts or did not attend scheduled follow-up ambulatory visits, the MCP must make reasonable effort to ensure members are engaged and that the follow-up ambulatory visits are completed. For example, the care manager must ensure the members know that TCS support is available for at least 30 days or use CHWs to conduct outreach and attempt to engage the members in person.

For members with multiple care transitions within a 30-day period, the MCP must ensure the same care manager is assigned to support them through all these transitions. If the second transition is within 7 days of the first transition, then the care manager must ensure the follow up visit is completed within 7-days post discharge after the last transition. The care manager must also provide TCS support for at least 30 days after the last transition. These members should be considered for ECM/CCM and/or Community Supports eligibility.

d. Minimum TCS Elements and Processes for Lower-Risk Members (Effective 1/1/24)

Lower-risk members in transition are defined as those not included in the high-risk definition above. MCPs are required to meet contract requirements for lower-risk members as outlined in the TCS section of the MCP Contract with the specific operational requirements listed in this Policy Guide, starting on January 1, 2024.

For lower-risk members, a single care manager managing the entire transition is not required. Rather, the MCP is required to ensure that (1) the member has access to a specialized TCS team (at the MCP or a delegate)⁹² for a period of at least 30 days from the discharge; and (2) ambulatory follow-up occurs.

i. Dedicated Team/Phone Number for Member Contact and Support

The MCP must ensure that it has a dedicated team and phone number to support transitioning members telephonically when they request help. The required features of this dedicated support service are as follows:

- **Minimum Requirements for the Dedicated TCS Team:** The MCP's TCS team must meet the following requirements:

⁹² This arrangement for MCP contracted entities to provide TCS is not considered formal delegation and therefore, MCPs would not be subject to requirements outlined in [APL 23-006](#).

- First point of member contact may be a trained customer service representative or similar unlicensed team member. However, the team must consist of additional staff and support to provide an escalation pathway to allow the member to reach care management/clinical staff, who can address any of their issues that require licensed care providers. This may include nurse care managers or physicians.
- The team must be able to access discharge planning documents, if needed, to assist members with questions regarding care at the discharging facility, including medication changes.
- The team must be able to provide assistance for any TCS need, including (but not limited to) help with access to ambulatory care, appointment scheduling, referrals/handoffs to needed social services or community-based resources, including arranging NEMT.
- The team must be able to place and coordinate referrals to longer term care management programs (ECM/CCM) and/or Community Supports at any point during the transition.
- **Minimum Requirements for the Phone Line:**
 - MCPs must offer, at minimum, dedicated telephonic support services for members experiencing a transition of care. MCPs may leverage existing member support telephone services to meet this requirement. MCPs are encouraged to offer additional modalities beyond telephonic support services such as text-messaging or in-person CHW supports, as appropriate to members.
 - During business hours, plans must ensure that members are able to connect with a live team dedicated to TCS. If using an automated phone tree under “member services” or similar, transitioning members must not have to select more than one option before reaching this dedicated line.
 - Outside of business hours, the plan must ensure that:
 - Members are referred to emergency services if needed;
 - Members can leave a message;
 - Messages are shared with the dedicated TCS team. A TCS team staff must respond to members within 1 business day after the initial phone call.
- **Member Communication of TCS Support:**
 - MCPs must ensure lower risk members in transition receive direct communication about the dedicated TCS team and phone line and how to access it. MCPs must make best efforts to ensure members receive this information no later than 24 hours after plans are notified of the discharge.
 - Acceptable methods of notification include text messaging, automated phone calls, incorporating into discharge documents, and letters (either as supplemental to other efforts or if no other effort was effective). Electronic platform-based communication/bidirectional text messaging may also be used but must not take the place of the dedicated line. Plans may choose to use more than one method of notification.

ii. Necessary Post-Discharge Services and Follow-Ups for Lower-Risk Members

In addition to the dedicated call line, the MCP must ensure that each lower-risk member in transition completes a follow-up ambulatory visit with a physician or advanced practice provider (with prescribing authority) within 30 days of discharge for necessary post-discharge care and services, such as medication reconciliation post-discharge, which is a critical TCS requirement. In addition, for any members who have open preventive services care gaps or have not had a PCP visit within 12 months, MCPs must ensure that each lower-risk member has PCP follow up in addition to any other non-PCP ambulatory visits that may be needed. The MCP is strongly encouraged to support members' follow up visits with their PCPs/ambulatory providers within 14 days of discharge. If a PCP or ambulatory follow up visit has not been completed within 14 days, then MCPs are encouraged to use CHWs through the CHW benefit⁹³ or partner with the member's PCP to facilitate member outreach and engagement by the PCP to facilitate the completion of the PCPs/ambulatory visit within 30 days post-discharge.

iii. End of TCS for Lower-risk Members

MCPs must continue to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge. In addition to accepting referrals to longer term care management at any point during the transition, MCPs must use data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or Community Supports.

e. Guidance for Members Enrolled with Multiple Payors

Consistent with the policy that the MCP is responsible for coordinating whole-person care, even for services or benefits carved-out of Medi-Cal managed care, the MCP or its contracted care manager is responsible for ensuring transitional care coordination for its members as outlined above. This also applies in instances where the MCP is not the primary source of coverage for the triggering service (e.g., hospitalization for a Medicare FFS dual-eligible member, or an inpatient psychiatric admission covered by a County MHP). MCPs and county MHPs must share necessary data and information to coordinate care for TCS per MHP-MCP MOU requirements.⁹⁴

For all members enrolled with multiple payors undergoing any transition, MCPs must know when their members are admitted, discharged, or transferred; MCPs must notify existing Medi-Cal care managers (ECM or CCM) of admissions, discharges, and transfers; and MCPs must conduct prior authorizations and coordinate, in a timely manner, for any Medi-Cal covered benefits where Medi-Cal is the primary payor.⁹⁵

⁹³ [APL 22-016](#)

⁹⁴ MHP-MCP MOU Template, 11. Data Sharing and Confidentiality. a. Data Exchange; CalAIM Data Sharing Authorization Guidance VERSION 2.0 June 2023 available at: <https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf>.

⁹⁵ Examples of services where MCP is the primary payor for individuals dually eligible for Medicare and Medi-Cal include but are not limited to CBAS, LTC services, transportation to medical appointments, hearing aids and routine eye exams (when not covered by a Medicare Advantage (MA) plan), Community Supports, and ECM.

However, there are specific modifications to the assignment of a care manager and care manager responsibilities as follows:

Requirements for Members Dually Eligible for Medi-Cal and Medicare in Medicare Medi-Cal Plans or Dual-Eligible Special Needs Plans (D-SNPs):

For admissions, transfers and discharges involving dually eligible members enrolled in Medicare Medi-Cal Plans (MMPs), or members enrolled in any other D-SNP, the MMP/ D-SNP is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including services delivered via Medi-Cal Managed Care and Medi-Cal FFS. Thus, the Medi-Cal MCP is not responsible for assigning a transitional care manager/having dedicated TCS team/phone number or any transitional care responsibilities for dually eligible beneficiaries enrolled in MMPs or D-SNPs. However, if a member has an existing ECM or CCM care manager, the MCP is responsible for notifying that care manager of the admission, discharge or transfer.

For admissions, transfers and discharges involving MCP members dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA plans (except D-SNPs), MCPs remain responsible for ensuring all transitional care requirements are complete, including assigning or delegating a care manager or having a dedicated TCS team/phone number.

Requirements for When County MHPs or DMC-ODS Are the Primary Payors:

For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where the county MHP is the primary payor, and for members who are admitted for residential SUD treatment, including residential withdrawal management, where DMC-ODS is the primary payor, MHPs or DMC-ODS are primarily responsible for coordination of care with the member upon discharge. However, MHPs and DMC-ODS have limited access/ability to coordinate across the MCP or physical health care needs, therefore:

- Given these members are considered high-risk as defined in Section c. 3. iii. Identification of High- vs. Lower-risk Transitioning Members, in addition to the required TCS elements and processes for all MCP members outlined above (e.g., knowing when members are admitted, discharged, and transferred and processing prior authorizations in a timely manner), MCPs will also be required to assign or contract with a care manager to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services such as ECM, CCM, and/or Community Supports.
- As outlined in the BPHM section above, in 2024, MCPs are required to have MOUs with required entities, including County MHPs and DMC-ODS, to facilitate care coordination and ensure non-duplication of services. Under the MOUs, MCPs are required to develop a process with MHPs and DMC-ODS entities to coordinate transitional care services for members.

Additional Requirements for Inpatient Medical Admission with Transfer to Inpatient Psychiatry or Residential Rehab:

For members who are admitted initially for a medical admission and transferred or discharged to a behavioral health facility, including a SUD psychiatric or a residential rehab facility (including intra-hospital transfers to a psychiatric-distinct unit of a hospital):

- MCPs are responsible for all TCS during the transfer/discharge to the behavioral health facility.
- TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination. In these instances, this likely will be after the member arrives at the behavioral health facility, medication reconciliation has occurred, and all information sharing between institutions is complete.
- After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, MCPs must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

f. DHCS Monitoring of TCS

If the MCP contracts with or delegates to facilities or providers to provide full scope or specific components of TCS, the MCP must have robust monitoring and enforcement process in place to hold facilities or providers accountable for providing all required TCS outlined above.

DHCS will monitor MCPs' TCS implementation through specific PHM Monitoring KPIs, including "Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge" and "Percentage of acute hospital stay discharges which had follow- up ambulatory visit within 7 days post hospital discharge", as well as member outcomes through specific quality measures. More details on DHCS monitoring of TCS implementation will be forthcoming including how DHCS will monitor timely authorizations and discharges and 30-day post-discharge follow-up for lower-risk members, in addition to a greater focus on primary care engagement or use of services such as ECM, CCM, or Community Supports for those who have had a transition. For additional details and future guidance on DHCS monitoring of TCS, please see Section III Monitoring Approach for Implementation of the PHM Program.

III. Monitoring Approach for Implementation of the PHM Program

The purpose of DHCS' PHM Program monitoring approach is to assess the overall implementation, operations, and effectiveness of each MCP's PHM program and understand the impact on outcomes and health equity over time.

To monitor MCPs' PHM programs, DHCS will review the holistic performance of PHM Program implementation at each MCP through monitoring performance across multiple PHM categories. These categories are organized by the following monitoring domains: PHM program areas/themes, populations, and cross-cutting priorities. Core aspects of the PHM program areas include basic population health, RSST, CCM, ECM, and TCS. Specific populations for which DHCS will be monitoring the implementation of the PHM

Program in 2023 include Children and Youth, Birthing Populations, and Individuals with Behavioral Health Needs, which align with the clinical focus areas in DHCS’s [CQS](#). DHCS anticipates monitoring the implementation of the PHM Program for seniors and dual-eligible members as a population of focus in the future. In 2023, DHCS will also be monitoring equity across all monitoring domains and categories. The monitoring domains and detailed categories are found in Table 1.

Table 1. PHM Monitoring Domains and Categories

Monitoring Domains	Categories
PHM Program Areas/Themes	Basic Population Health Management (BPHM)
	<ul style="list-style-type: none"> • Prevention Services
	<ul style="list-style-type: none"> • Primary Care Engagement/ Appropriate Utilization
	<ul style="list-style-type: none"> • Chronic Disease Management
	<ul style="list-style-type: none"> • CHW Integration
	Risk Stratification Segmentation and Tiering (RSST)
	Complex Care Management (CCM)
	Enhanced Care Management (ECM)
	Transitional Care Services (TCS)
Populations	Children and Youth
	Birthing Populations
	Individuals with Behavioral Health Needs
Cross Cutting Priorities	Equity (include all stratified measures)

Within each category, DHCS will identify and review a set of quality measures, and where needed to supplement these quality measures, DHCS will also review key performance indicators (KPIs). Existing quality and performance improvement processes, such as the Medi-Cal Managed Care Accountability Set (MCAS) and the CalAIM Incentive Payment Program (IPP), assess each measure individually and, as applicable, applies rewards or penalties against individual measure performance within a specific time period. For PHM monitoring, DHCS will not be reviewing each measure individually, but will instead review the overall picture revealed by the performance across all the measures within a category to understand if core aspects of a MCP’s PHM program are working as intended. The intent is also to look over time — using early measure performance as a baseline and looking for improvements, as well as identifying outliers. By reviewing each monitoring category, DHCS will be able to spot

priority issue areas that require direct DHCS follow-up with MCPs and identify areas in the PHM Program requirements that need additional DHCS guidance or clarifications.

DHCS will conduct routine engagement with MCPs throughout each year on MCPs' PHM programs to ensure regular, bidirectional communication on implementation challenges and successes. DHCS will use these meetings to discuss PHM monitoring data, gather additional information about how the MCP is doing on PHM, and deliver key messaging around expectations for the PHM Program. In addition, DHCS expects that MCPs will use its own monitoring approaches to regularly assess its own PHM program.

The PHM monitoring approach will evolve over time and add KPIs and quality measures to monitoring categories. DHCS may also add additional populations or cross cutting priorities. Once the PHM Service is fully implemented, the monitoring strategy will change to leverage its reporting and analytics functionalities.

Monitoring Measures

To take a more holistic view across PHM while also minimizing reporting burden on MCPs, DHCS identified existing quality measures to monitor MCPs' PHM Programs' impact on outcomes and access to services. DHCS is leveraging existing data that DHCS already has from MCAS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality measures reported through the annual quality and performance improvement process as well as through its Core Set reporting processes.

Where quality measures by themselves were insufficient to fully monitor a category, DHCS identified a limited number of new high-priority KPIs. MCPs will be required to report these KPIs at the plan level on a quarterly basis.

PHM Program monitoring will begin in Q3 2023. MCPs will submit their first KPIs in August 2023 from Q1 and Q2 2023. While audited 2023 quality measure data will not be available until 2024, DHCS will begin looking at quality measures in 2023, using 2022 data.

A. Quality Measures

DHCS will review existing data from a subset of MCAS and CAHPS quality measures reported through the existing annual quality and performance improvement process to monitor MCPs' PHM Programs. See Table 2 below for a list of the quality measures DHCS will review for PHM monitoring; the table also indicates which quality measures will be used for the children and youth, birthing populations, and individuals with behavioral health needs population-level analyses. MCPs will not need to report any additional quality measure data at this time.

Under the existing quality process, MCPs must stratify certain quality measures per NCQA by race and ethnicity (as noted in Table 2 below); DHCS will review MCPs' stratified performance on these measures as part of its PHM monitoring approach.

MCPs currently submit quality measure data to DHCS at the reporting unit level⁹⁶ in January-May, and audited measure data are released to DHCS in July for internal validation. For PHM monitoring, DHCS will aggregate the existing data from the below quality measures to be able to review at the plan level. For more details about the quality measures, please see Appendix 5: List of Quality Measures and Descriptions for PHM Monitoring Approach. DHCS may review additional existing MCAS and CAHPS measures in the future.

Table 2. PHM Monitoring Quality Measures

Quality Measures to be Reviewed for PHM Monitoring Starting in August 2023	Stratified by race/ethnicity per NCQA categorizations	Reviewed for Children and Youth population analysis	Reviewed for Birthing population analysis	Reviewed for Individuals with Behavioral Health Needs population analysis
Depression Screening and Follow-Up for Adolescents and Adults	ü	ü		ü
Depression Remission or Response for Adolescents and Adults		ü		ü
Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits	ü	ü	ü	
Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits	ü	ü		

⁹⁶ DHCS defines a “reporting unit level” as a single county, a combined set of counties, or a region as determined and pre-approved by DHCS.

Quality Measures to be Reviewed for PHM Monitoring Starting in August 2023	Stratified by race/ethnicity per NCQA categorizations	Reviewed for Children and Youth population analysis	Reviewed for Birthing population analysis	Reviewed for Individuals with Behavioral Health Needs population analysis
Child and Adolescent Well-Care Visits	ü	ü		
Developmental Screening for the First Three Years of Life		ü		
Lead Screening for Children		ü		
Childhood Immunization Status: Combination 10	ü	ü		
Immunizations for Adolescents: Combination 2	ü	ü		
Topical Fluoride for Children		ü		
Prenatal Depression Screening and Follow Up			ü	ü
Postpartum Depression Screening and Follow Up			ü	ü
Colorectal Cancer Screening	ü			
Chlamydia Screening in Women				
Breast Cancer Screening	ü			
Cervical Cancer Screening				
Ambulatory Care: Emergency Department (ED) Visits		ü		
Adults' Access to Preventive/Ambulatory Health Services				
Asthma Medication Ratio	ü			
Controlling High Blood Pressure	ü			

Quality Measures to be Reviewed for PHM Monitoring Starting in August 2023	Stratified by race/ethnicity per NCQA categorizations	Reviewed for Children and Youth population analysis	Reviewed for Birthing population analysis	Reviewed for Individuals with Behavioral Health Needs population analysis
Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9%)	ü			
Antidepressant Medication Management: Acute Phase Treatment				ü
Antidepressant Medication Management: Continuation and Maintenance Phase				ü
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase		ü		ü
Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase		ü		ü
Pharmacotherapy for Opioid Use Disorder	ü			ü
Follow-Up After ED Visit for Mental Illness – 30 days	ü			ü
Follow-Up after ED Visits for Substance Use – 30 days	ü			ü
Plan All-Cause Readmissions	ü			
Potentially Preventable 30-day Post-Discharge Readmission	ü			
Prenatal and Postpartum Care: Postpartum Care	ü		ü	

Quality Measures to be Reviewed for PHM Monitoring Starting in August 2023	Stratified by race/ethnicity per NCQA categorizations	Reviewed for Children and Youth population analysis	Reviewed for Birthing population analysis	Reviewed for Individuals with Behavioral Health Needs population analysis
Prenatal and Postpartum Care: Timeliness of Prenatal Care	ü		ü	
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate			ü	
CAHPS: Getting Needed Care (Adult and Child)		ü		
CAHPS: Getting Care Quickly (Adult and Child)		ü		

B. KPIs

DHCS will also review a set of high-priority KPIs for more frequent, active, and real-time monitoring of program operations and effectiveness. KPIs are intended to be indicators that plans should already track internally to manage their own performance. MCPs must report KPIs at the plan level on a quarterly basis. DHCS may request more granular county or member-level data if any issues arise during the plan-level review. Additional KPIs may be added in the future once the PHM Service is implemented. Data that MCPs already report on for the ECM Quarterly Implementation Monitoring Reporting (QIMR) and the CalAIM Incentive Payment Program (IPP) will be leveraged for some KPIs to decrease MCP reporting burden. **Therefore, MCPs will only be required to report on five new KPIs specific to PHM monitoring.**

While MCPs are required to report the five new KPIs to DHCS at the plan level on a quarterly basis, DHCS expects that MCPs calculate all of the KPIs at the member-level on a monthly basis to monitor their own performance and have a real-time understanding of the operations and effectiveness of their PHM program.

DHCS will calculate the KPIs at a plan level using existing data from DHCS where possible and match against what MCPs submit on a quarterly basis. If there are inconsistencies, DHCS will probe further and request member-level data from MCPs if needed.

See Table 3 below for a list of the KPIs DHCS will review for PHM monitoring; the table also indicates which KPIs will be used for the children and youth, birthing populations, and individuals with behavioral health needs population-level analyses. KPIs for the

RSST PHM monitoring category will not be implemented until the PHM Service RSST functionalities are available. For more details about the KPIs, please see Appendix 4: List of KPIs and Technical Specifications for PHM Monitoring Approach.

Table 3. PHM Monitoring KPIs

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
BPHM – Primary Care Engagement /Appropriate Utilization	Percentage of members who had more ED visits than primary care visits within a 12-month period	ü			
	Percentage of members who had at least one primary care visit within a 12-month period	ü			
	Percentage of members with no ambulatory or preventive visit within a 12-month period	ü			
BPHM – CHW Integration	Percentage of members who received CHW benefit			ü	
Complex Care Management (CCM)	Percentage of members eligible for CCM who are successfully enrolled in the CCM program	ü			
Enhanced Care	Percentage of members enrolled in ECM				ü

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
Management (ECM)	Percentage of members enrolled in ECM "Individuals Experiencing Homelessness" Population of Focus (POF)				ü
	Percentage of members enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" POF				ü
	Percentage of members enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs" POF		ü		ü
	Percentage of members enrolled in ECM "Individuals Transitioning from Incarceration" POF				ü
	Percentage of members enrolled in ECM "Adults Living in the Community and At Risk for LTC				ü

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
	Institutionalization " POF				
	Percentage of members enrolled in ECM "Adult Nursing Facility Residents Transitioning to the Community" POF				ü
	Percentage of members enrolled in all ECM Children and Youth POFs	ü			ü
	Percentage of members enrolled in ECM "Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness" POF	ü			ü
	Percentage of members enrolled in ECM "Children and Youth At Risk for Avoidable Hospital or ED Utilization" POF	ü			ü
	Percentage of members enrolled in ECM "Children and Youth with Serious Mental	ü			ü

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
	Health and/or SUD Needs” POF				
	Percentage of members enrolled in ECM “Children and Youth Transitioning from Incarceration” POF	ü			ü
	Percentage of members enrolled in ECM “Children and Youth Enrolled in California Children’s Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition” POF	ü			ü
	Percentage of members enrolled in ECM “Children and Youth Involved in Child Welfare” POF	ü			ü
Transitional Care Services (TCS)	Percentage of contracted acute care facilities from which MCPs receive ADT notifications			ü	
	Percentage of contracted skilled nursing facilities			ü	

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
	from which MCPs receive ADT notifications				
	Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge				
	Percentage of acute hospital stay discharges which had follow-up ambulatory visit within 7 days post hospital discharge			ü	

MCPs will be required to stratify and report these five new KPIs by race, ethnicity, language, and age on a plan-level as specified in Appendix 5: PHM Monitoring KPI Technical Specifications:

- Percentage of members who had more ED visits than primary care visits within a 12-month period;
- Percentage of members who had a primary care visit within a 12-month period;
- Percentage of members with no ambulatory or preventive visit within a 12-month period;
- Percentage of members eligible for CCM who are successfully enrolled in the CCM program; and
- Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge.

While MCPs are required to report these stratified KPIs to DHCS at the plan level on a quarterly basis, DHCS expects that MCPs stratify the KPIs at the member-level on a monthly basis to monitor their own performance particularly with regard to health equity.

For the three KPIs that DHCS has internal data on (percentage of members who had more ED visits than primary care visits within a 12-month period; percentage of members who had a primary care visit within a 12-month period; and percentage of members with no ambulatory or preventive visit within a 12-month period), DHCS will calculate stratifications using the same technical specifications in Appendix 5: List of KPIs and Technical Specifications for PHM Monitoring Approach. Then DHCS will match these internal stratifications with what MCPs submit on a quarterly basis. If there are inconsistencies, DHCS will probe further and request member-level data from MCPs if needed.

MCPs will not be required to adjust stratification approaches for KPI data reported through IPP reporting or ECM QMIR.

Starting in 2024, DHCS will begin to measure referrals made by the members' assigned transitional care managers resulting in enrollment into CCM as well as the ECM "Adults Living in the Community and At Risk for LTC Institutionalization" POF, "Adult Nursing Facility Residents Transitioning to the Community" POF and "Individuals At Risk for Avoidable Hospital or ED Utilization" POF. MCPs should already be monitoring these KPIs internally given the 2023 contractual requirement for assigned transitional care managers to make appropriate referrals for high-risk members. Also starting in 2024, DHCS will measure vision screening and dental care/coordination for children. Once the PHM Service is live, DHCS will monitor the percentage of eligible members enrolled in WIC and CalFresh. DHCS envisions evolving and updating the KPIs as appropriate as new policy requirements go into effect, such as providing transitional care services for all populations in 2024 or completing closed-loop referrals in 2025.

C. How DHCS will Monitor MCPs' PHM Programs and Conduct Enforcement When Needed

As stated above, DHCS will review the overall picture revealed by both KPIs and quality measures in each PHM monitoring domain and category, including patterns, trends, and outliers, to gain a holistic perspective on PHM Program implementation and operations at each MCP.

DHCS will review quality measures and KPIs in each PHM domain and monitoring category by examining the following:

- How MCPs performed compared to each other, with special attention to which plans are outliers (both above and below average performance);
- Whether MCPs made year-to-year improvements or maintained their performance if they were already high performers; and
- For quality measures only, whether MCPs performed below benchmarks such as Minimum Performance Levels (to the extent benchmarks exist). DHCS is not instituting benchmarks for KPIs at this time.

If any concerns arise in any PHM monitoring category, DHCS will engage in the following activities to drive improvement in MCPs' PHM programs:

- Meeting with MCPs to learn more and ask questions about their PHM Program, such as:
 - How does your PHM program support this monitoring category? What specific program initiatives address improvements in the category?
 - What changes have you made to your PHM program in the last year?
 - What internal monitoring do you have in place to manage your PHM program performance?
 - What challenges does your MCP face in addressing member's health in this category?
 - How is your PHM program addressing equity within this category?
- Requesting additional policies and procedures, or more granular data, including member-level data, if appropriate
- Via the technical assistance mechanisms already provided to MCPs by the Quality and Health Equity Transformation team to improve program implementation, operations, effectiveness, or outcomes. The Quality and Health Equity Transformation Branch staff will provide guidance throughout the year.

Existing quality and performance improvement enforcement requirements associated with MCAS measure performance will not change; PHM monitoring will be distinct, and in alignment with, these current requirements, as described above.

DHCS will also meet with high-performing outliers to understand and share best practices among MCPs in various PHM domains to support scaling and spread of promising practices.

Over time, if MCPs do not meet the PHM program requirements and achieve successful PHM outcomes, DHCS may impose Corrective Action Plans (inclusive of Quality Improvement Assessment and Strategic Plan), sanctions, and/or liquidated damages, as set out in the MCP contract, for MCPs' failure to comply with the PHM program requirements, the MCP contract, and/or applicable state and federal laws.⁹⁷

For questions and additional information, please email PHMSection@dhcs.ca.gov.

D. Illustrative Example of DHCS Review of PHM Monitoring Category/Populations

Table 4 provides an example of which quality measures and KPIs DHCS will review to monitor how a MCP is performing on primary care engagement/appropriate utilization and how it is implementing its PHM program for children and youth.

Table 4. Illustrative Example of PHM Monitoring for BPHM – Primary Care Engagement/Appropriate Utilization and for Children and Youth

⁹⁷ Welfare and Institutions Code, § 14197.7

PHM Monitoring Category	KPIs	Quality Measures
BPHM: Primary Care Engagement/ Appropriate Utilization	<ul style="list-style-type: none"> • Percentage of members who had more ED visits than primary care visits within a 12-month period • Percentage of members who had at least one primary care visit within a 12-month period • Percentage of members with no ambulatory or preventive visit within a 12-month period 	<ul style="list-style-type: none"> • Ambulatory Care: ED Visits • Adults' Access to Preventive/Ambulatory Health Services • Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits • Well-Child Visits in the First 30 Months of Life - 15 to 30 Months – Two or More Well-Child Visits • Child and Adolescent Well-Care Visits • CAHPS: Getting Needed Care • CAHPS: Getting Care Quickly
Children and Youth Population⁹⁸	<ul style="list-style-type: none"> • Percentage of members under 21 eligible for CCM who are successfully enrolled in the CCM program • Percentage of members who had more ED visits than primary care visits in within a 12-month period • Percentage of members enrolled in all ECM Children and Youth POFs • Percentage of members enrolled in ECM “Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness” Children and Youth POFs • Percentage of members enrolled in ECM “Children and Youth At Risk for Avoidable Hospital or ED Utilization” POF 	<ul style="list-style-type: none"> • Depression Screening and Follow-Up for Adolescents • Depression Remission or Response for Adolescents • Well-Child Visits in the First 30 Months of Life-0 to 15 Months-Six or More Well-Child Visits • Well-Child Visits in the First 30 Months of Life-15 to 30 Months-Two or More Well-Child Visits • Child and Adolescent Well-Care Visits • Developmental Screening for the First Three Years of Life • Lead Screening for Children • Childhood Immunization Status: Combination 10 • Immunizations for Adolescents: Combination 2 • Topical Fluoride for Children • Ambulatory Care: Emergency Department (ED) Visits

⁹⁸ These KPIs and quality measures are not additional measures; they are categorized in “Table 2. PHM Monitoring Quality Measures” and “Table 3. PHM Monitoring KPIs” above but are included here for a population-level analysis.

PHM Monitoring Category	KPIs	Quality Measures
	<ul style="list-style-type: none"> Percentage of members enrolled in ECM “Children and Youth with Serious Mental Health and/or SUD Needs” POF Percentage of members enrolled in ECM “Children and Youth Transitioning from Incarceration” POF Percentage of members enrolled in ECM “Children and Youth Enrolled in California Children’s Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition” POF Percentage of members enrolled in ECM “Children and Youth Involved in Child Welfare” POF 	<ul style="list-style-type: none"> Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase CAHPS: Getting Needed Care (Child) CAHPS: Getting Care Quickly (Child)

IV: (Updated January 2024) Implementation Timeline

The most recent PHM Program implementation timeline is outlined below. It includes the timeline for anticipated DHCS policy/guidance, MCP deliverable due dates, and general PHM Program go-live dates. For more information about key milestones and go-live dates for all CalAIM initiatives, please refer to the DHCS [CalAIM Timelines webpage](#).

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
2023			
Q1	<ul style="list-style-type: none"> January 1: <ul style="list-style-type: none"> Elimination of IHEBA/SHA and Replacement of Initial Health Assessment 		<ul style="list-style-type: none"> January 1: PHM Program Goes Live statewide with the following requirements, to the extent not already met:

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
	<p>with Initial Health Appointment(s)</p> <ul style="list-style-type: none"> ▪ APLs 17-012 and 17-013 were superseded by APL 22-024. ▪ Q2: Publish DHCS Monitoring Approach for Implementation of the PHM Program 		<ul style="list-style-type: none"> ▪ NCQA Health Plan PHM standards or show equivalent ▪ Good-faith effort to use DHCS-listed data sources to perform RSS ▪ Wellness/prevention as required by NCQA ▪ Initiatives to improve pregnancy outcomes ▪ CCM as defined by NCQA ▪ TCS requirements <p>▪ January 1: ECM goes live in all counties for LTC Populations of Focus</p>
Q3		<ul style="list-style-type: none"> ▪ May: PHM Policies and Procedures due for new plans to align with requirements in APL 22-024⁹⁹ 	
Q3	<ul style="list-style-type: none"> ▪ August: APL 19-011 is superseded by APL 23-021 on new PNA/PHM Strategy deliverable requirements, 	<ul style="list-style-type: none"> ▪ August: MCPs to submit first set of data on KPIs for PHM monitoring 	<ul style="list-style-type: none"> ▪ July 1: ECM goes live in all counties for Children and Youth Populations of Focus

⁹⁹ To align with requirements in APL 22-024, PHM Policies and Procedures are required to cover NCQA Health Plan PHM standards or equivalent; readiness to use diverse data sources to guide RSS; approach to screening and assessment within revised 2023 requirements; approach to assessing for care management within revised 2023 requirements; and approach to BPHM, CCM, and TCS.

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
	<p>which is accompanied by updates to the PHM Policy Guide with near time guidance on the PNA and PHM Strategy deliverable.</p>		
Q4:	<ul style="list-style-type: none"> ▪ October: Updates to the Policy Guide with modified guidance on TCS policy and specific guidance on screening and assessments under the 2024 MCP Transition. ▪ December: Updates to the Policy Guide with more detailed guidance on the modified PNA. 	<ul style="list-style-type: none"> ▪ October: PHM Strategy Deliverable due for current plans under revised requirements. Annual submission thereafter. 	
2024			
Q1	<ul style="list-style-type: none"> ▪ January 1: New MCP Contract Goes Live 		<ul style="list-style-type: none"> ▪ January 1: ECM goes live in all counties for Birth Equity Population of Focus
Q2			

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
Q3		<ul style="list-style-type: none"> ▪ October: PHM Strategy Deliverable due for the first time for new plans and annually thereafter 	
2025			
Q1-Q4	<ul style="list-style-type: none"> ▪ CQS Bold Goals must be met 	<ul style="list-style-type: none"> ▪ The first modified PNA under the new approach per updated DHCS requirements and guideline 	
2026			
Q1-Q4		<ul style="list-style-type: none"> ▪ MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation 	

(Updated January 2024) Appendix 1: Key Terminology

1. **Admission, discharge, and transfer (ADT) feed** is a standardized, real-time data feed sourced from a health facility, such as a hospital, that includes members' demographic and healthcare encounter data at time of admission, discharge, and/or transfer from the facility.
2. **Assessment** is a process or set of questions for defining the nature of a risk factor or problem, determining the overall needs or health goals and priorities, and developing specific treatment recommendations for addressing the risk factor or problem. Health assessments can vary in length and scope.
3. **Basic Population Health Management (BPHM)** is an approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
4. **Care manager** is an individual identified as a single point of contact responsible for the provision of care management services for a member.
5. **Care Management Plan (CMP)** is a written plan that is developed with input from the member and/or their family member(s), guardian, authorized representative, caregiver, and/or other authorized support person(s), as appropriate, to assess strengths, risks, needs, goals, and preferences, and make recommendations for service needs.
6. **Complex Care Management (CCM)** is an approach to care management that meets differing needs of high-and rising-risk members, including both longer-term chronic care coordination and interventions for episodic, temporary needs. Medi-Cal Managed care plans (MCPs) must provide CCM in accordance with all NCQA CCM requirements.
7. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** is a federal entitlement that states are required to provide to all children under age 21 enrolled in Medicaid. This includes any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan.¹⁰⁰
8. **Enhanced Care Management (ECM)** is a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of high-cost and/or high-need members who meet ECM Populations of Focus eligibility criteria through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
9. **Health Information Form (HIF)/Member Evaluation Tool (MET)** is a screening tool that is required to be completed within 90 days of MCP enrollment for new members. It fulfills the federal initial screening requirement.¹⁰¹
10. **Health Risk Assessment (HRA)** is an assessment required for Seniors and Persons with Disabilities. Effective January 1, 2023, HRA assessment requirements

¹⁰⁰ EPSDT in Medicaid. Medicaid and CHIP Payment and Access Commission. <https://www.macpac.gov/subtopic/epsdt-in-medicaid/>. DHCS specific requirements on EPSDT is outlined in [APL 23-010](#).

¹⁰¹ 42 CFR 438.208(b)(3)-(4)

for Seniors and Persons with Disabilities are simplified, while specific member protections are kept in place.

11. **Initial Health Appointment(s)** previously called Initial Health Assessment, now refers to appointment(s) required to be completed within 120 days of MCP enrollment for new members and must include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.¹⁰²
12. **Long-Term Care (LTC)** includes specialized rehabilitative services and care provided in a Skilled Nursing Facility, subacute facility, pediatric subacute facility, or Intermediate Care Facilities (ICFs).¹⁰³
13. **Long-Term Services & Supports (LTSS)** includes services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS and includes carved-in and carved-out services.¹⁰⁴
14. **Risk stratification and segmentation (RSS)** is the process of separating member populations into different risk groups and/or meaningful subsets using information collected through population assessments and other data sources. RSS results in the categorization of members with care needs at all levels and intensities.
15. **Risk tiering** is the assigning of members to standard risk tiers (i.e., high, medium-rising, or low), with the goal of determining appropriate care management programs or specific services.
16. **Population Health Management (PHM)** is a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
17. **The Population Health Management (PHM) Service** collects and links Medi-Cal beneficiary information from disparate sources and performs risk stratification and segmentation (RSS) and tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multiparty data access and use in accordance with state and federal law and policy.
18. **Population Health Management Strategy (PHM Strategy)** is a comprehensive plan of action for addressing member needs across the continuum of care, based on Population Needs Assessment (PNA) results, data-driven risk stratification, predictive analysis, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions. Each MCP would be required to include, at a minimum, a description of how it will:

¹⁰² These required Initial Health Appointment(s) elements are specified in 22 C.C.R. § 53851(b)(1).

¹⁰³ 2024 Re-Procurement. Exhibit A, Attachment I, Definitions and Acronyms

¹⁰⁴ 2024 Re-Procurement. Exhibit A, Attachment I, Definitions and Acronyms

- Keep all members healthy by focusing on wellness and prevention services;
 - Identify and manage care and services for members with high and rising risk;
 - Ensure effective transition planning across delivery systems or settings, through care coordination and other means, to minimize patient risk and ensure appropriate clinical outcomes for the member; and
 - Identify and mitigate member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance health equity.
19. **Screening** is a brief process or questionnaire for examining the possible presence of a particular risk factor or problem to determine whether a more in-depth assessment is needed in a specific area of concern.
20. **Social drivers of health (SDOH)** are the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning and quality-of-life outcomes and risk factors.
21. **Transitional care services (TCS)** are services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).
22. **Wellness and prevention programs** are programs that aim to prevent disease, disability, and other conditions; prolong life; promote physical and mental health and efficiency; and improve overall quality of life and well-being.

Appendix 2: Upcoming Updates to All Plan Letters (APLs)

Topic Within PHM Framework	Existing APLs	Upcoming Updates and Timing
PNA and PHM Strategy	APL 23-021 “Population Needs Assessment and PHM Strategy”	<ul style="list-style-type: none"> Supersedes 19-011.
HRA/Risk Stratification/Care Management Plans	APL 22-024 “Population Health Management Policy Guide”	<ul style="list-style-type: none"> Supersedes APL 17-013 and APL 17-012.
Initial Health Appointment(s) and IHEBA/SHA	APL 22-030 “Initial Health Appointment”	<ul style="list-style-type: none"> Supersedes PL 08-003, 13-001, and APL 13-017
	APL 16-014 “Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries”	<ul style="list-style-type: none"> This APL will be superseded to decouple requirements from outdated IHEBA/SHA requirement sometime in the future.
	APL 18-004 “Immunization Requirements”	<ul style="list-style-type: none"> No changes.
	APL 20-004 “Emergency Guidance for Medi-Cal Managed Care Plans in Response to COVID-19”	<ul style="list-style-type: none"> No changes.

Appendix 3: Standardized Long-Term Services and Supports (LTSS) Referral Questions

These standardized LTSS referral questions from APL 17-013 will continue to be required for MCPs or their delegates to use to assess members who may need LTSS. The questions are organized in the following two tiers, and MCPs must take a holistic view of questions in both tiers and identify members in need of follow-up assessment:

- 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 italics are not part of the questions but provide the intent of the questions.

Tier 1 LTSS Questions:

Activities of Daily Living Functional Limitations/Instrumental Activities of Daily Living Limitations/Functional Supports (Functional Capacity Risk Factor)

Question 1: Do you need help with any of these actions? (Yes/No to each individual action)

- a) Taking a bath or shower
- b) Going up stairs
- c) Eating
- d) Getting dressed
- e) Brushing teeth, brushing hair, shaving
- f) Making meals or cooking
- g) Getting out of a bed or a chair
- h) Shopping and getting food
- i) Using the toilet
- j) Walking
- k) Washing dishes or clothes
- l) Writing checks or keeping track of money
- m) Getting a ride to the doctor or to see your friends
- n) Doing house- or yardwork
- 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 okay? (Yes/No)

Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)

Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No)

Tier 2 LTSS Questions:

Fall Risk (Functional Capacity Risk Factor)

Question 8a: Have you fallen in the last month? (Yes/No)

Question 8b: Are you afraid of falling? (Yes/No)

Financial Insecurity or Poverty (Social Determinants Risk Factor)

Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)

Isolation (Social Determinants Risk Factor)

Question 10: Over the past month (30 days), how many days have you felt lonely?
(Check one)

- None – I never feel lonely
- Less than five days
- More than half the days (more than 15)
- Most days – I always feel lonely

Appendix 4: List of Quality Measures and Descriptions for PHM Monitoring Approach

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
NA (DSF-E)	NCQA	Depression Screening and Follow-Up for Adolescents and Adults	<p>The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.</p> <ul style="list-style-type: none"> • Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument. • Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
1392 (W30-6+)	NCQA	Well-Child Visits in the First 30 Months of Life – Six or More Well-Child Visits	Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.
1392 (W30-2+)	NCQA	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months – Two or More Well-Child Visits	Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months.
1516 (WCV)	NCQA	Child and Adolescent Well-Care Visits	Assesses children 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.
1448 (DEV)	OHSU	Developmental Screening for the First Three Years of Life	For members 1-3 years of age, percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			tool in the 12 months preceding or on their first, second or third birthday.
NA (LSC)	NCQA	Lead Screening for Children	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
0038 (CIS-10)	NCQA	Childhood Immunization Status: Combination 10	The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.
1407 (IMA-2)	NCQA	Immunizations for Adolescents: Combination 2	Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.
2528 (TFL-CH)	DQA	Topical Fluoride for Children	Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year.
NA (PND-E)	NCQA	Prenatal Depression Screening and Follow Up	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			<p>follow-up care. Two rates are reported.</p> <ul style="list-style-type: none"> • Depression Screening: The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. • Follow-Up on Positive Screen: The percentage of deliveries in which members received follow-up care within 30 days of screening positive for depression.
NA (PDS-E)	NCQA	Postpartum Depression Screening and Follow Up	<p>The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported.</p> <ul style="list-style-type: none"> • Depression Screening: The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the prenatal period. • Follow-Up on Positive Screen: The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
0034 (COL-E)	NCQA	Colorectal Cancer Screening	<p>Assesses adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography</p>

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			colonography every 5 years, stool DNA test every 3 years.
0033 (CHL)	NCQA	Chlamydia Screening in Women	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
NA (BCS-E)	NCQA	Breast Cancer Screening	Assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.
0032 (CCS)	NCQA	Cervical Cancer Screening	Assesses women who were screened for cervical cancer using any of the following criteria: <ul style="list-style-type: none"> • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
NA (AMB-ED)	NCQA	Ambulatory Care: Emergency Department (ED) Visits	Assesses ED utilization, which tracks the number of ED visits. ED visits is defined as: each visit to an ED is counted once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: <ul style="list-style-type: none"> • An ED visit (ED Value Set).

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			<ul style="list-style-type: none"> • A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).
NA (AAP)	NCQA	Adults' Access to Preventive/Ambulatory Health Services	The percentage of members 20 years and older who had an ambulatory or preventive care visit.
NA (DRR)	NCQA	Depression Remission or Response for Adolescents and Adults	<p>The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.</p> <ul style="list-style-type: none"> • Follow-Up PHQ-9. The percentage of members who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score. • Depression Remission. The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score. • Depression Response. The percentage of members who showed response within 4–8 months after the initial elevated PHQ-9 score.
1800 (AMR)	NCQA	Asthma Medication Ratio	Assesses adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
0059 (HBD)	NCQA	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9%)	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: HbA1c poor control (>9.0%).
0018 (CBP)	NCQA	Controlling High Blood Pressure	Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).
0105 (AMM-Acute)	NCQA	Antidepressant Medication Management: Acute Phase Treatment	Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. <i>Effective Acute Phase Treatment:</i> Adults who remained on an antidepressant medication for at least 84 days (12 weeks).
0105 (AMM-Cont)	NCQA	Antidepressant Medication Management: Continuation Phase Treatment	Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. <i>Effective Continuation Phase Treatment:</i> Adults who remained on an antidepressant medication for at least 180 days (6 months).
0108 (ADD-Init)	NCQA	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	<i>Initiation Phase:</i> Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.
0108 (ADD-C&M)	NCQA	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	<i>Continuation and Maintenance Phase:</i> Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase.
NA (POD)	NCQA	Pharmacotherapy for Opioid Use Disorder	Assesses the percentage of opioid use disorder (OUD) pharmacotherapy treatment events among members age 16 and older that continue for at least 180 days (6 months).
3489 (FUM)	NCQA	Follow-Up after ED Visit for Mental Illness - 30 days	Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 30 days.
3488 (FUA)	NCQA	Follow-Up after ED Visit for Substance Use - 30 day	Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. <ul style="list-style-type: none"> ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
1768 (PCR)	NCQA	Plan All-Cause Readmissions	Assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge among commercial (18 to 64), Medicaid (18 to 64) and Medicare (18 and older) health plan members. As well as reporting observed rates, NCQA also specifies that plans report a predicted probability of readmission to account for the prior and current health of the member, among other factors. A separate readmission rate for hospital stays discharged to a

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			skilled nursing facility among members aged 65 and older is reported for Medicare plans. The observed rate and predicted probability is used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less readmissions than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the readmission rate across all health plans to produce a risk-standardized rate which allows for national comparison.
NA (PPR)	CMS	Potentially Preventable 30-day Post-Discharge Readmission	Assesses readmissions during a 30-day period after discharge from the post-acute care provider (LTC reporting only)
1517 (PPC-Pst)	NCQA	Prenatal and Postpartum Care: Postpartum Care	<i>Postpartum Care.</i> The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.
1517 (PPC-Pre)	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care	<i>Timeliness of Prenatal Care.</i> The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
NA (NTSV CB)	The Joint Commission (TJC)	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	Identifies the proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions), via cesarean birth
0006	Agency for Healthcare	CAHPS: Getting Needed Care (Adult and Child)	The survey asked enrollees how often it was easy for them to get appointments with specialists and

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
	Research and Quality		get the care, tests, or treatment they needed through their health plan.
0006	Agency for Healthcare Research and Quality	CAHPS: Getting Care Quickly (Adult and Child)	The survey asked enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed.

(Updated August 2023) Appendix 5: List of KPIs and Technical Specifications for PHM Monitoring Approach

KPIs to be reported starting in August 2023	PHM Program Area	Definitions
Percentage of members who had more ED visits than primary care visits within a 12-month period	BPHM - Primary Care Engagement/ Appropriate Utilization	<p>Numerator: The number of members who have more ED visits than primary care visits within a 12-month period.</p> <p>Denominator: The total number of enrolled members in the MCP.</p>
Percentage of members who had at least one primary care visit within a 12-month period	BPHM - Primary Care Engagement/ Appropriate Utilization	<p>Numerator: The number of members who had at least one PCP visit within a 12-month period.</p> <p>Denominator: The total number of enrolled members in the MCP.</p>
Percentage of members with no ambulatory or preventive visit within a 12-month period	BPHM - Primary Care Engagement/ Appropriate Utilization	<p>Numerator: The number of members who no ambulatory or preventive visit within a 12-month period.</p> <p>Denominator: The total number of enrolled members in the MCP.</p>
Percentage of members who received CHW benefit	BPHM - CHW Integration	<p>Numerator: The number of unique members who had at least one CHW benefit encounter during the reporting period.</p> <p>Denominator: The total number of enrolled members in the MCP during the reporting period.</p>
Percentage of members eligible for CCM who are successfully enrolled in the CCM program	CCM	<p>Rate A Numerator: The number of members who are enrolled in CCM for 1 or more days during the Measurement Period.</p> <p>Rate A Denominator: The number of members eligible for CCM for 1 or more days during the Measurement Period.</p> <p>Rate B Numerator: The number of members who are enrolled in CCM for 1 or more days during the Measurement Period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period.</p> <p>Rate B Denominator: The number of members eligible for CCM for 1 or more days during the Measurement Period, excluding</p>

KPIs to be reported starting in August 2023	PHM Program Area	Definitions
		those members who were enrolled in CCM for 1 or more days during the previous Measurement Period.
Percentage of members enrolled in ECM	ECM	Numerator: The number of members who are enrolled in ECM. Denominator: The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Individuals Experiencing Homelessness" Population of Focus (POF)	ECM	Numerator: The number of members who are enrolled in ECM "Individuals Experiencing Homelessness" POF. Denominator: The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" POF	ECM	Numerator: The number of members who are enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" POF. Denominator: The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs" POF	ECM	Numerator: The number of members who are enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use Disorder (SUD)" POF. Denominator: The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Individuals Transitioning from Incarceration" POF	ECM	Numerator: The number of members who are enrolled in ECM "Individuals Transitioning from Incarceration" POF. Denominator: The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization" POF	ECM	Numerator: The number of members who are enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization" POF. Denominator: The total number of enrolled members in the MCP.

KPIs to be reported starting in August 2023	PHM Program Area	Definitions
Percentage of members enrolled in ECM "Adult Nursing Facility Residents Transitioning to the Community" POF	ECM	<p>Numerator: The number of members who are enrolled in ECM "Adult Nursing Facility Residents Transitioning to the Community" POF.</p> <p>Denominator: The total number of enrolled members in the MCP.</p>
Percentage of members enrolled in all ECM Children and Youth POFs	ECM	<p>Numerator: The number of members who are enrolled in all ECM "Children and Youth" POFs.</p> <p>Denominator: The total number of members under 21 enrolled in the MCP.</p>
Percentage of members enrolled in all ECM "Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness" POF	ECM	<p>Numerator: The number of members who are enrolled in all ECM "Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness" Children and Youth POFs.</p> <p>Denominator: The total number of members under 21 enrolled in the MCP.</p>
Percentage of members enrolled in ECM "Children and Youth At Risk for Avoidable Hospital or ED Utilization" POF	ECM	<p>Numerator: The number of members who are enrolled in ECM "Children and Youth At Risk for Avoidable Hospital or ED Utilization" POF.</p> <p>Denominator: The total number of members under 21 enrolled in the MCP.</p>
Percentage of members enrolled in ECM "Children and Youth with Serious Mental Health and/or SUD Needs" POF	ECM	<p>Numerator: The number of members who are enrolled in ECM "Children and Youth with Serious Mental Health and/or SUD Needs" POF.</p> <p>Denominator: The total number of members under 21 enrolled in the MCP.</p>
Percentage of members enrolled in ECM "Children and Youth Transitioning from Incarceration" POF	ECM	<p>Numerator: The number of members who are enrolled in ECM "Children and Youth Transitioning from Incarceration" POF.</p> <p>Denominator: The total number of members under 21 enrolled in the MCP.</p>
Percentage of members enrolled in ECM "Children and Youth Enrolled in California Children's	ECM	<p>Numerator: The number of members who are enrolled in ECM "Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition" POF.</p>

KPIs to be reported starting in August 2023	PHM Program Area	Definitions
Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition” POF		Denominator: The total number of members under 21 enrolled in the MCP.
Percentage of members enrolled in ECM “Children and Youth Involved in Child Welfare” POF	ECM	Numerator: The number of members who are enrolled in ECM “Children and Youth Involved in Child Welfare” POF. Denominator: The total number of members under 21 enrolled in the MCP.
Percentage of contracted acute care facilities from which MCPs receive ADT notifications	Transitional Care Services	Numerator: The number of general contracted acute facilities from which MCPs receive ADT feeds. Denominator: The total number of contracted general acute facilities.
Percentage of contracted skilled nursing facilities from which MCPs receive ADT notifications	Transitional Care Services	Numerator: The number of contracted skilled nursing facilities from which MCPs receive ADT feeds. Denominator: The total number of contracted skilled nursing facilities. Skilled Nursing Facilities exclude intermediate care facilities/developmentally disabled (ICF/DD)
Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge	Transitional Care Services	Numerator: The number of transitions for high-risk members during the Intake Period followed by at least one interaction with their assigned care manager within 7 days of post discharge. Denominator: The number of transitions for high-risk members during the Intake Period.
Percentage of acute hospital stay discharges who had follow-up ambulatory visits within 7 days post hospital discharge	Transitional Care Services	Numerator: The number of acute care hospital live discharges among enrolled MCP members during the measurement period with an ambulatory visit within 7 days post hospital discharge. Denominator: The number of live discharges from acute care hospitals among enrolled MCP members during the measurement period.

DHCS will leverage data that MCPs already report on where possible for PHM monitoring. Below are the KPIs DHCS will leverage from IPP and [ECM QMIR](#):

IPP:

- Percentage of members who received CHW benefit
- Percentage of contracted acute care facilities from which MCPs receive ADT notifications
- Percentage of contracted skilled nursing facilities from which MCPs receive ADT notifications
- Percentage of acute hospital stay discharges which had follow-up ambulatory visits within 7 days post hospital discharge.

ECM:

- Percentage of members enrolled in ECM
- Percentage of members enrolled in ECM "Individuals Experiencing Homelessness" Population of Focus (POF)
- Percentage of members enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" POF
- Percentage of members enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs" POF
- Percentage of members enrolled in ECM "Individuals Transitioning from Incarceration" POF
- Percentage of members enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization" POF
- Percentage of members enrolled in ECM "Adult Nursing Facility Residents Transitioning to the Community" POF
- Percentage of members enrolled in ECM "Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness" POF
- Percentage of members enrolled in ECM "Children and Youth At Risk for Avoidable Hospital or ED Utilization" POF
- Percentage of members enrolled in ECM "Children and Youth with Serious Mental Health and/or SUD Needs" POF
- Percentage of members enrolled in ECM "Children and Youth Transitioning from Incarceration" POF
- Percentage of members enrolled in ECM "Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition" POF
- Percentage of members enrolled in ECM "Children and Youth Involved in Child Welfare" POF
- Percentage of members enrolled in all ECM Children and Youth POFs

MCPs are required to submit data for the five new KPIs following the technical specifications outlined below.

PHM KPI 1: Members Utilizing Emergency Department Care More than Primary Care

Description

The number and percentage of members who had more emergency department (ED) visits than primary care visits within a 12-month period.

Definitions

Measurement Period	The 12-month period beginning 15 months prior to the time of reporting. For instance, if submitting on August 15, 2023, the measurement period would start on May 15, 2022, and end on May 14, 2023.
ED Visit	An ED visit as defined by the NCQA ED Value Set .
Primary Care Provider	<p>Primary care is defined by DHCS as care usually rendered in ambulatory settings by Primary Care Providers (PCP) and emphasizes the Member's preventive health needs, general health needs, and chronic disease management.</p> <p>A PCP is a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN).</p>
Primary Care Visit	A primary care visit is defined as an ambulatory or preventive visit delivered by a Primary Care Provider, as identified in the methodology below. For the purposes of this KPI, a primary care visit does not have to be with a member's assigned PCP.

Eligible Population

Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Continuous Enrollment	There are no continuous enrollment criteria for this measure. The count of members for the measure should be a point-in-time count at the time of submission.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period.

Administrative Specification

Denominator	<p>The total cumulative and unduplicated number of enrolled members in the Managed Care Plan during the Measurement Period.</p> <p>To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets:</p> <ul style="list-style-type: none"> • Hospice Encounter Value Set
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	<ul style="list-style-type: none"> • <u>Hospice Intervention Value Set</u> 												
Numerator	<p>The number of enrolled members who have had more ED visits than Primary Care Visits within a 12-month period.</p> <p>For each member, determine:</p> <p><u>ED Visits:</u> Use the NCQA <u>ED Value Set</u> to calculate the number of ED visits in the Measurement Period for each member.</p> <p><u>Primary Care Visits</u> Use the following steps to calculate the number of <u>Primary Care Visits</u> in Measurement Period for each member.</p> <p><u>Step 1:</u> Use the following NCQA value sets to identify ambulatory or preventive care visits in the last 12 months for each member:</p> <ul style="list-style-type: none"> • <u>Ambulatory Visits Value Set.</u> • <u>Other Ambulatory Visits Value Set.</u> • <u>Telephone Visits Value Set.</u> • <u>Online Assessments Value Set.</u> • <u>Well-Care Value Set</u> <p><u>Step 2:</u> Of these visits, identify those visits conducted by primary care providers based on National Provider Identifier (NPI) information. Exclude all visits that do not meet either of these NPI attributions for primary care providers:</p> <ul style="list-style-type: none"> • The NPI of the rendering or billing provider of the visit is flagged as a primary care provider on at least one of the monthly <u>274 Provider Files</u> that the Managed Care Plan submits to DHCS during the Measurement Period. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • The NPI of the rendering or billing provider of the visit is represented in the <u>National Plan and Provider Enumeration System (NPPES)</u> as being a primary care provider, as defined by the following provider types by the first four digits of their taxonomy codes in the claim or encounter data for the visit: <table border="1" data-bbox="508 1625 1416 1892"> <thead> <tr> <th data-bbox="508 1625 1036 1703">Provider Type</th> <th data-bbox="1036 1625 1416 1703">First Digits of Taxonomy</th> </tr> </thead> <tbody> <tr> <td data-bbox="508 1703 1036 1738">General practitioner</td> <td data-bbox="1036 1703 1416 1738">207D</td> </tr> <tr> <td data-bbox="508 1738 1036 1774">Internist</td> <td data-bbox="1036 1738 1416 1774">207R</td> </tr> <tr> <td data-bbox="508 1774 1036 1810">Pediatrician</td> <td data-bbox="1036 1774 1416 1810">2080</td> </tr> <tr> <td data-bbox="508 1810 1036 1845">Family practitioner</td> <td data-bbox="1036 1810 1416 1845">207Q</td> </tr> <tr> <td data-bbox="508 1845 1036 1892">Non-physician medical practitioner</td> <td data-bbox="1036 1845 1416 1892">363L, 363A</td> </tr> </tbody> </table>	Provider Type	First Digits of Taxonomy	General practitioner	207D	Internist	207R	Pediatrician	2080	Family practitioner	207Q	Non-physician medical practitioner	363L, 363A
Provider Type	First Digits of Taxonomy												
General practitioner	207D												
Internist	207R												
Pediatrician	2080												
Family practitioner	207Q												
Non-physician medical practitioner	363L, 363A												

Obstetrician-gynecologist (OB-GYN)	207V																												
<p>Step 3: Of remaining visits, identify visits delivered in a primary care setting. is a site of usual delivery of primary care, as defined the taxonomy code for Service Setting within the visit. Include only visits that have the following Service Settings:</p>																													
<table border="1"> <thead> <tr> <th data-bbox="506 487 1036 564">Service Setting</th> <th data-bbox="1036 487 1414 564">First Digits of Taxonomy</th> </tr> </thead> <tbody> <tr> <td data-bbox="506 564 1036 600">Community Health</td> <td data-bbox="1036 564 1414 600">261QC1500</td> </tr> <tr> <td data-bbox="506 600 1036 636">Corporate Health</td> <td data-bbox="1036 600 1414 636">261QC1800</td> </tr> <tr> <td data-bbox="506 636 1036 672">Health Service</td> <td data-bbox="1036 636 1414 672">261QH0100</td> </tr> <tr> <td data-bbox="506 672 1036 707">Migrant Health</td> <td data-bbox="1036 672 1414 707">261QM1000</td> </tr> <tr> <td data-bbox="506 707 1036 743">Primary Care</td> <td data-bbox="1036 707 1414 743">261QP2300</td> </tr> <tr> <td data-bbox="506 743 1036 779">Public Health, State or Local</td> <td data-bbox="1036 743 1414 779">261QP0905</td> </tr> <tr> <td data-bbox="506 779 1036 814">Student Health</td> <td data-bbox="1036 779 1414 814">261QS1000</td> </tr> <tr> <td data-bbox="506 814 1036 850">Critical Access Hospital</td> <td data-bbox="1036 814 1414 850">261QC0050</td> </tr> <tr> <td data-bbox="506 850 1036 886">Medical Specialty</td> <td data-bbox="1036 850 1414 886">261QM2500</td> </tr> <tr> <td data-bbox="506 886 1036 921">Multi-Specialty</td> <td data-bbox="1036 886 1414 921">261Q1300X</td> </tr> <tr> <td data-bbox="506 921 1036 999">Clinic/Center Not Otherwise Specified</td> <td data-bbox="1036 921 1414 999">261Q00000</td> </tr> <tr> <td data-bbox="506 999 1036 1035">Federally Qualified Health Center</td> <td data-bbox="1036 999 1414 1035">261QF0400</td> </tr> <tr> <td data-bbox="506 1035 1036 1094">Rural Health</td> <td data-bbox="1036 1035 1414 1094">261QR1300</td> </tr> </tbody> </table>		Service Setting	First Digits of Taxonomy	Community Health	261QC1500	Corporate Health	261QC1800	Health Service	261QH0100	Migrant Health	261QM1000	Primary Care	261QP2300	Public Health, State or Local	261QP0905	Student Health	261QS1000	Critical Access Hospital	261QC0050	Medical Specialty	261QM2500	Multi-Specialty	261Q1300X	Clinic/Center Not Otherwise Specified	261Q00000	Federally Qualified Health Center	261QF0400	Rural Health	261QR1300
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Community Health	261QC1500																												
Corporate Health	261QC1800																												
Health Service	261QH0100																												
Migrant Health	261QM1000																												
Primary Care	261QP2300																												
Public Health, State or Local	261QP0905																												
Student Health	261QS1000																												
Critical Access Hospital	261QC0050																												
Medical Specialty	261QM2500																												
Multi-Specialty	261Q1300X																												
Clinic/Center Not Otherwise Specified	261Q00000																												
Federally Qualified Health Center	261QF0400																												
Rural Health	261QR1300																												
<p>Step 4: Sum the identified primary care visits, representing the total number of <u>Primary Care Visits</u> during the measurement period for each member.</p>																													
<p>Step 5: identify the number of members for whom the number of <u>ED Visits</u> is greater than the number of <u>Primary Care Visits</u> during the Measurement Period.</p>																													

Data Elements for Calculation and Reporting

Report at the plan-level both the count and percentage of total enrolled members, including by the required stratifications below, for whom the number of ED visits is greater than the number of Primary Care Visits within a 12-month period.

Stratify data by:

(1) Age:

- a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older

Note: For age-based stratification, use the member’s age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the “12-20 years” group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the “6-11 years” group.

- (2) Race: Report only one of the following 9 categories for race
 - a. White
 - b. Black or African American
 - c. American Indian and Alaska Native
 - d. Asian
 - e. Native Hawaiian and Other Pacific Islander
 - f. Some Other Race
 - g. Two or More Races
 - h. Asked but No Answer
 - i. Unknown
- (3) Ethnicity: Report only one of the following 4 categories for ethnicity per member
 - a. Hispanic/Latino
 - b. Not Hispanic/Latino
 - c. Asked but No Answer
 - d. Unknown
- (4) Language: Report on the member's primary spoken language (one language per member)
 - a. English
 - b. Spanish
 - c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
 - d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

This KPI aligns with value sets used in other measures required for reporting to DHCS as referenced above, especially the NCQA Value Sets:

- ED Value Set
- Ambulatory Visits Value Set
- Other Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Well-Care Value Set

DHCS will calculate this measure independently to compare with Managed Care Plan-reported rates. If there are discrepancies between Managed Care Plan-calculated and DHCS-calculated rates, DHCS will work with the MCP to obtain member-level data, meet with MCPs to learn more and ask questions about their PHM Program, or request to review additional policies and procedures.

PHM KPI 2: Members Engaged in Primary Care

Description

The number and percentage of members who had at least one primary care visit within a 12-month period.

Definitions

Measurement Period	The 12-month period beginning 15 months prior to the time of reporting. For instance, if submitting on August 15, 2023, the measurement period would start on May 15, 2022, and end on May 14, 2023.
Primary Care Visit	An ambulatory or preventive visit delivered by a general practitioner in a general care setting, as defined by health care service categorization codes and place of service codes.
Primary Care Provider	<p>Primary care is defined by DHCS as care usually rendered in ambulatory settings by Primary Care Providers (PCP), and mid-level practitioners, and emphasizes the Member's general health needs as opposed to Specialists focusing on specific needs.</p> <p>A PCP is a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN).</p>
Primary Care Visit	A primary care visit is defined as an ambulatory or preventive visit delivered by a Primary Care Provider, as identified in the methodology below. For the purposes of this KPI, a primary care visit does not have to be with a member's assigned PCP.

Eligible Population

Continuous Enrollment	There are no continuous enrollment criteria for this measure. The count of members for the measure should be a point-in-time count at the time of submission.
Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period.

Administrative Specification

Denominator	The total cumulative and unduplicated number of enrolled members in the Managed Care Plan during the Measurement Period.
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	<p>To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets:</p> <ul style="list-style-type: none"> • <u>Hospice Encounter Value Set</u> • <u>Hospice Intervention Value Set</u> 														
<p>Numerator</p>	<p>The number of members who had one or more Primary Care Visit(s) within a 12-month period.</p> <p>Use the following steps to calculate the number of <u>Primary Care Visits</u> in Measurement Period for each member.</p> <p><u>Step 1:</u> Use the following NCQA value sets to identify ambulatory or preventive care visits in the last 12 months for each member:</p> <ul style="list-style-type: none"> • <u>Ambulatory Visits Value Set.</u> • <u>Other Ambulatory Visits Value Set.</u> • <u>Telephone Visits Value Set.</u> • <u>Online Assessments Value Set.</u> • <u>Well-Care Value Set</u> <p><u>Step 2:</u> Of these visits, identify those visits conducted by primary care providers based on National Provider Identifier (NPI) information. Exclude all visits that do not meet either of these NPI attributions for primary care providers:</p> <ul style="list-style-type: none"> • The NPI of the rendering or billing provider of the visit is flagged as a primary care provider on at least one of the monthly <u>274 Provider Files</u> that the Managed Care Plan submits to DHCS during the Measurement Period. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • The NPI of the rendering or billing provider of the visit is represented in the <u>National Plan and Provider Enumeration System (NPPES)</u> as being a primary care provider, as defined by the following provider types by the first four digits of their taxonomy codes in the claim or encounter data for the visit: <table border="1" data-bbox="508 1482 1416 1820"> <thead> <tr> <th data-bbox="508 1482 1036 1556">Provider Type</th> <th data-bbox="1036 1482 1416 1556">First Digits of Taxonomy</th> </tr> </thead> <tbody> <tr> <td data-bbox="508 1556 1036 1598">General practitioner</td> <td data-bbox="1036 1556 1416 1598">207D</td> </tr> <tr> <td data-bbox="508 1598 1036 1640">Internist</td> <td data-bbox="1036 1598 1416 1640">207R</td> </tr> <tr> <td data-bbox="508 1640 1036 1682">Pediatrician</td> <td data-bbox="1036 1640 1416 1682">2080</td> </tr> <tr> <td data-bbox="508 1682 1036 1724">Family practitioner</td> <td data-bbox="1036 1682 1416 1724">207Q</td> </tr> <tr> <td data-bbox="508 1724 1036 1766">Non-physician medical practitioner</td> <td data-bbox="1036 1724 1416 1766">363L, 363A</td> </tr> <tr> <td data-bbox="508 1766 1036 1820">Obstetrician-gynecologist (OB-GYN)</td> <td data-bbox="1036 1766 1416 1820">207V</td> </tr> </tbody> </table>	Provider Type	First Digits of Taxonomy	General practitioner	207D	Internist	207R	Pediatrician	2080	Family practitioner	207Q	Non-physician medical practitioner	363L, 363A	Obstetrician-gynecologist (OB-GYN)	207V
Provider Type	First Digits of Taxonomy														
General practitioner	207D														
Internist	207R														
Pediatrician	2080														
Family practitioner	207Q														
Non-physician medical practitioner	363L, 363A														
Obstetrician-gynecologist (OB-GYN)	207V														

Step 3: Of remaining visits, identify visits delivered in a primary care setting. is a site of usual delivery of primary care, as defined the taxonomy code for Service Setting within the visit. Include only visits that have the following Service Settings:

Service Setting	First Digits of Taxonomy
Community Health	261QC1500
Corporate Health	261QC1800
Health Service	261QH0100
Migrant Health	261QM1000
Primary Care	261QP2300
Public Health, State or Local	261QP0905
Student Health	261QS1000
Critical Access Hospital	261QC0050
Medical Specialty	261QM2500
Multi-Specialty	261Q1300X
Clinic/Center Not Otherwise Specified	261Q00000
Federally Qualified Health Center	261QF0400
Rural Health	261QR1300

Data Elements for Reporting

Report at the plan-level both the count and percentage of total enrolled members, including by the required stratifications below, who had at least one visit with a primary care provider within a 12-month period.

Stratify data by:

(1) Age:

- a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older
Note: For age-based stratification, use the member’s age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the “12-20 years” group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the “6-11 years” group.

(2) Race: Report only one of the following 9 categories for race

- a. White
- b. Black or African American
- c. American Indian and Alaska Native
- d. Asian
- e. Native Hawaiian and Other Pacific Islander
- f. Some Other Race
- g. Two or More Races
- h. Asked but No Answer

- i. Unknown
- (3) Ethnicity: Report only one of the following 4 categories for ethnicity per member
 - a. Hispanic/Latino
 - b. Not Hispanic/Latino
 - c. Asked but No Answer
 - d. Unknown
- (4) Language: Report on the member's primary spoken language (one language per member)
 - a. English
 - b. Spanish
 - c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
 - d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

This KPI aligns with value sets used in other measures required for reporting to DHCS as referenced above, especially the NCQA Value Sets:

- ED Value Set
- Ambulatory Visits Value Set.
- Other Ambulatory Visits Value Set.
- Telephone Visits Value Set.
- Online Assessments Value Set.
- Well-Care Value Set

DHCS will calculate this measure independently to compare with Managed Care Plan-reported rates. If there are discrepancies between Managed Care Plan-calculated and DHCS-calculated rates, DHCS will work with the MCP to obtain member-level data, meet with MCPs to learn more and ask questions about their PHM Program, or request to review additional policies and procedures.

PHM KPI 3: Members Not Engaged in Ambulatory Care

Description

The percentage of members with no ambulatory or preventive visit within a 12-month period.

Definitions

Measurement Period	The 12-month period beginning 15 months prior to the time of reporting. For instance, if submitting on August 15, 2023, the measurement period would start on May 15, 2022, and end on May 14, 2023.
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Eligible Population

Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Continuous Enrollment	There are no continuous enrollment criteria for this measure. The count of members for the measure should be a point-in-time count at the time of submission.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period.

Administrative Specification

Denominator	<p>The total cumulative and unduplicated number of enrolled members in the Managed Care Plan during the measurement period.</p> <p>To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets:</p> <ul style="list-style-type: none"> • <u>Hospice Encounter Value Set</u> • <u>Hospice Intervention Value Set</u>
Numerator	<p>The number of members who had no (zero) ambulatory or preventive visits within a 12-month period.</p> <p>Use the following value sets to identify ambulatory or preventive care visits within a 12-month period for each member:</p> <ul style="list-style-type: none"> • <u>Ambulatory Visits Value Set.</u> • <u>Other Ambulatory Visits Value Set.</u> • <u>Telephone Visits Value Set.</u> • <u>Online Assessments Value Set.</u> • <u>Well-Care Value Set</u>

Data Elements for Reporting

Report at the plan-level both the count of and percentage of total enrolled members, including by the required stratifications below, who had no (zero) ambulatory or preventive visits within a 12-month period.

Stratify data by:

(1) Age:

- a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older
Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-20 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 9 categories for race

- a. White
- b. Black or African American
- c. American Indian and Alaska Native
- d. Asian
- e. Native Hawaiian and Other Pacific Islander
- f. Some Other Race
- g. Two or More Races
- h. Asked but No Answer
- i. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member

- a. Hispanic/Latino
- b. Not Hispanic/Latino
- c. Asked but No Answer
- d. Unknown

(4) Language: Report on the member's primary spoken language (one language per member)

- a. English
- b. Spanish
- c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
- d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

This KPI aligns with value sets used in other measures required for reporting to DHCS as referenced above, especially the NCQA Value Sets:

- Ambulatory Visits Value Set
- Other Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Well-Care Value Set

DHCS will calculate this measure independently to compare with Managed Care Plan-reported rates. If there are discrepancies between Managed Care Plan-calculated and DHCS-calculated rates, DHCS will work with the MCP to obtain member-level data, meet with MCPs to learn more and ask questions about their PHM Program, or request to review additional policies and procedures.

PHM KPI 4: Percentage of Eligible Members enrolled in Complex Care Management

Description

The number and percentage of members eligible for Complex Care Management (CCM) who are successfully enrolled in the CCM program.

This measure has two rates:

- **KPI 4 Rate A:** CCM enrollment among all eligible members
- **KPI 4 Rate B:** CCM enrollment among eligible members who were not already enrolled during the previous reporting period.
 - Note: MCPs are not required to report KPI 4 Rate B for the first submission on August 15, 2023.

Rate B looks at the subset of members that who were not enrolled in CCM in the last reporting period and identifies new enrollment into CCM.

Definitions

Measurement Period	The 90-day period starting 135 days prior to the submission date and ending 45 days preceding the submission date. For instance, if submitting on August 15, 2023, the measurement period would start on April 2, 2023, and end on June 30, 2023.
Complex Care Management Program	Complex Care Management in this measure equates to “Complex Case Management,” as defined by NCQA and described by Plans in their submissions to the Department of Health Care Services.
Eligible for Complex Care Management	Eligibility criteria for Complex Care Management varies by Managed Care Plan. Each Managed Care Plan should use its most current criteria when analyzing this measure.

Eligible Population

Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Continuous Enrollment	There are no continuous enrollment criteria for this measure. The count of members for the measure should be a point-in-time count at the time of submission.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period.

Administrative Specifications

Rate A Denominator	The total cumulative and unduplicated number of members eligible for CCM for 1 or more days during the Measurement Period.
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	To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets: <ul style="list-style-type: none"> • <u>Hospice Encounter Value Set</u> • <u>Hospice Intervention Value Set</u>
Rate A Numerator	The number of members who are enrolled in CCM for 1 or more days during the Measurement Period.

Rate B identifies enrollment in CCM among members who are eligible but were not already receiving CCM services during the previous reporting period. This rate assesses new uptake of CCM services.

Rate B Denominator	The total cumulative and unduplicated number of members eligible for CCM for 1 or more days during the Measurement Period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period. To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets: <ul style="list-style-type: none"> • <u>Hospice Encounter Value Set</u> • <u>Hospice Intervention Value Set</u>
Rate B Numerator	The number of members who are enrolled in CCM for 1 or more days during the Measurement Period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period.

Data Elements for Reporting

Report at the plan-level both the count and percentage of members eligible for CCM who are successfully enrolled in the CCM program.

Stratify data by:

- (1) Age:
 - a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older
Note: For age-based stratification, use the member’s age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the “12-20 years” group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the “6-11 years” group.
- (2) Race: Report only one of the following 9 categories for race
 - a. White
 - b. Black or African American
 - c. American Indian and Alaska Native
 - d. Asian
 - e. Native Hawaiian and Other Pacific Islander
 - f. Some Other Race
 - g. Two or More Races
 - h. Asked but No Answer

- i. Unknown
- (3) Ethnicity: Report only one of the following 4 categories for ethnicity per member
 - a. Hispanic/Latino
 - b. Not Hispanic/Latino
 - c. Asked but No Answer
 - d. Unknown
- (4) Language: Report on the member's primary spoken language (one language per member)
 - a. English
 - b. Spanish
 - c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
 - d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

DHCS requires current Managed Care Plans to submit Policies and Procedures on CCM Models of care to align with requirements in [APL 22-024](#). Because CCM eligibility criteria vary by Managed Care Plan, DHCS will compare submitted rates with each Managed Care Plan's eligibility criteria for context. Because CCM is not captured in claims and encounter data, DHCS reserves the right to ask Plans to submit member-level CCM enrollment in the future.

PHM KPI 5: Care Management for High-Risk Members after Discharge

Description

The number and percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge.

This measure's denominator includes events experienced by members who both:

- Are identified as being high-risk, as defined below
- Meet the definition for acute and non-acute care stays, as defined below

Definitions

Intake Period	The 12-month period starting 15 months and 7 days prior to the time of reporting. For instance, if submitting on August 15, 2023, the intake period would start on May 8, 2022, and end on May 7, 2023.
Measurement Period	The 12-month and 7-day period beginning 1 day after the beginning of the Intake Period and ending 7 days after the end of the Intake Period. For instance, if submitting on August 15, 2023, the measurement period would start on May 9, 2022, and end on May 14, 2023.
Transitions	Defined as the end of Inpatient and observation stays and Nonacute inpatient stays. <ul style="list-style-type: none"> • Inpatient and observation stay is defined by combining the NCQA <u>Inpatient Stay Value Set</u> and NCQA <u>Observation Stay Value Set</u> • Nonacute inpatient stay is defined by the NCQA <u>Nonacute Inpatient Stay Value Set</u>
Assigned care manager	Defined as “the single point of contact responsible for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.” MCPs can assign members to a care manager either by using its own staff or contracting with other contracted entities (e.g., hospitals, ACOs, PCPs, etc.).”
Day post discharge	Day is defined as calendar days, irrespective of whether the day falls on a weekend or holiday. A post-discharge occurs after the date of discharge. This definition excludes both interactions that occur while the member is still in an inpatient setting and interactions that occur on the same calendar day of discharge.
High-risk	Defined below as a subset of “Populations Required to Receive an Assessment and Re-assessment.” Members with these risk factors should receive transitional care services starting January 1, 2023. These high-risk groups include: <ul style="list-style-type: none"> • Members receiving long-term services and supports (LTSS)

	<ul style="list-style-type: none"> • Members eligible for Complex Care Management • Members eligible for Enhanced Care Management. This criterion includes all active populations of focus at the time of measurement. • Members enrolled in the California Children’s Services (CCS) program • Members who are pregnant • Members assessed to be high-risk by the Plan’s risk stratification and segmentation approaches prior to PHM Service RSST functionality is live.
Interaction	An interaction is a synchronous interaction involves the use of in-person, telephonic, or audio-visual communication in real time. This definition excludes asynchronous communication such as leaving voicemails or portal-based communications.
Long Term Supports and Services	Long Term Supports and Services (LTSS) are defined as services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member’s choice, which may include the member’s home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long Term Care (LTC) and Home and Community Based Services (HCBS) as well as carved-in and carved-out services. A subset of these services are operationalized for this measure.

Eligible Population

Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Continuous Enrollment	There are no continuous enrollment criteria for this measure.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period. Members enrolled in MMPs or any other D-SNPs.

Administrative Specification

Denominator	The number of transitions for high-risk members during the Intake Period To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets: <ul style="list-style-type: none"> • <u>Hospice Encounter Value Set</u> • <u>Hospice Intervention Value Set</u>
Numerator	The number of transitions for high-risk members during the Intake Period followed by at least one interaction with their assigned care manager within 7 days post discharge.

	If members have multiple transitions of care involving discharge from an acute care setting, count these episodes separately.
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To identify denominator-qualifying events, identify admissions in both acute inpatient and non-acute inpatient admissions during the Intake Period using the following NCQA Value Sets:

- Inpatient Stay Value Set
- Observation Stay Value Set
- Nonacute Inpatient Stay Value Set

These value sets include admissions in acute inpatient, skilled nursing, and residential treatment settings. Among these events, exclude any events not experienced by members who meet the following operationalized definition of “High Risk”:

High Risk Group	Data Source and Process
Eligible for Complex Care Management	Internal Managed Care Plan Data and Identification Process. For guidance on Aid-Code-based methods on identifying youth currently or formerly engaged with the foster care system, see the Enhanced Care Management Policy Guide , pg. 97.
Eligible for Enhanced Care Management	
Assessed to be high-risk by the Plan’s risk stratification and segmentation approaches	
Enrolled in the California Children’s Services (CCS) program	
Members who are pregnant	Use the <u>NCQA Pregnancy Value Set</u> to identify members who are pregnant during care episode of the discharge event or through any other care episode in the 30 days prior to the discharge event.
Receiving Long Term Supportive Services	Internal Managed Care Plan Data and Identification Processes. LTSS is defined above, and Plans should specifically include the following groups: <ul style="list-style-type: none"> • Those who received Home Health (HH) services in the 30 days prior to the admission date of the discharge event, as identified by Vendor Code (44) • Those who received In-Home Supportive Services (IHSS) in the 30 days prior to the admission date of the

	<p>discharge event (data as available to Plan)</p> <ul style="list-style-type: none"> • Those who had one or more long-term care (LTC) stay in the 30 days prior to the admission date of the discharge event
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For numerator compliance, evaluate each denominator-qualifying event using the following steps:

Step 1: Identify the date of discharge of the denominator-qualifying event experienced by a member in a high-risk group.

Step 2: Count all synchronous post-discharge interactions between an Assigned Care Manager and the member experiencing the denominator-qualifying event occurring during the period starting on the calendar day after discharge and ending seven calendar days after discharge.

For this measure, the calendar date of discharge can be considered Day 0. Numerator-compliant interactions should occur on Days 1 to 7 after the discharge event.

Step 3: Identify numerator compliance by excluding all denominator-qualifying events for which the number of contacts calculated in Step 2 is zero.

Treat each denominator-qualifying event separately, meaning that each individual member can have multiple transitions of care during the measurement period.

Data Elements for Reporting

Report at the plan-level both the count of and percentage of transitions experienced by high-risk members followed by an assigned care manager visit within 7 days after discharge.

Stratify data by:

(1) Age:

a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older

Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-20 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 9 categories for race

a. White

b. Black or African American

c. American Indian and Alaska Native

d. Asian

e. Native Hawaiian and Other Pacific Islander

- f. Some Other Race
 - g. Two or More Races
 - h. Asked but No Answer
 - i. Unknown
- (3) Ethnicity: Report only one of the following 4 categories for ethnicity per member
- a. Hispanic/Latino
 - b. Not Hispanic/Latino
 - c. Asked but No Answer
 - d. Unknown
- (4) Language: Report on the member's primary spoken language (one language per member)
- a. English
 - b. Spanish
 - c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
 - d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

This measure presumes utilization of ADT feeds or other methods to identify member discharges. Care manager contact information should be obtained from Plans' internal care management information systems.