CALAIM: POPULATION HEALTH MANAGEMENT (PHM) POLICY GUIDE

JANUARY 2026

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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 the PHM Program, 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 MCP Contract provide baseline DHCS' requirements for MCPs to implement the PHM Program. The PHM Policy Guide, APL 22-024, and 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. 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.

Please note: Formatting edits were made throughout this version of the PHM Policy Guide to ensure compliance with DHCS brand standards; these changes impacted the format for headers and bullets throughout the document.

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,

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[1] APL 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.

» 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 mitigate Social Drivers of Health (SDOH).

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 are 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 Medi-Cal Connect?

Supporting the PHM roll out, DHCS is launching a statewide PHM Service. The PHM Service, branded as Medi-Cal Connect, will provide a wide-range of Medi-Cal stakeholders with data access and availability for Medi-Cal members' health history,

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[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.

needs, and risks, including historical administrative, medical, behavioral, dental, social service data, and other program information from current, disparate sources. Medi-Cal Connect will use this data to support risk stratification, segmentation, and tiering; assessment and screening processes; potential medical, behavioral, and social supports; and analytics and reporting functions. Medi-Cal Connect will also improve data accuracy and improve DHCS' ability to understand population health trends and the efficacy of various PHM interventions and strengthen oversight. This innovative service will grow and mature over time, in partnership with our stakeholders. For further details on implementation, see section II.D. "Understanding Risk."

D. PHM Program Requirements

Since January 1, 2023, all MCPs are required to meet PHM standards and have either full National Committee for Quality Assurance[3] (NCQA) Health Plan Accreditation or otherwise demonstrate to DHCS that they meet the PHM standards for NCQA Health Plan Accreditation.[4] By January 1, 2026, all MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation.

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

[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.

II. PHM PROGRAM

A. PHM Framework

Figure 1. PHM Framework
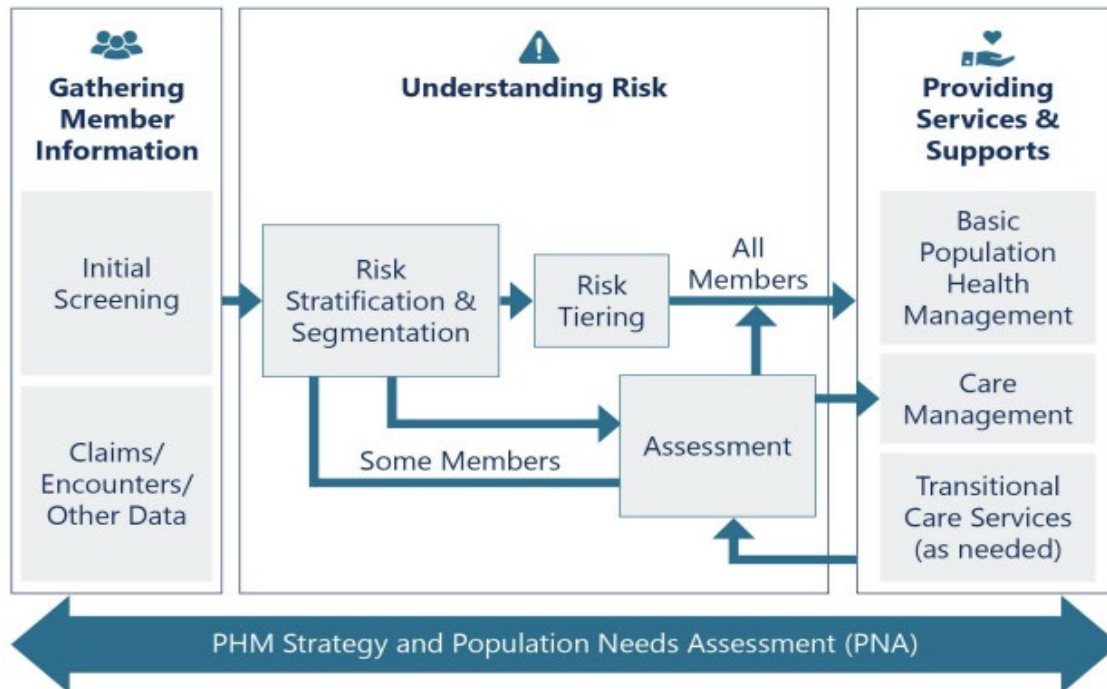
DHCS uses the PHM Framework above consistently to promote common terminology and communication about PHM. MCPs are encouraged to use the PHM Framework within their organizations and are required to meet requirements in each of the four domains of this framework: Local Planning and PHM Strategy, Gathering Member Information, Understanding Risk, and Providing Services and Supports.

B. Local Planning and PHM Strategy (Updated January 2026)

Note: This section has been updated to align with Behavioral Health Services Act reforms. Updates include renaming the "Population Needs Assessment" requirements to "Local Planning" requirements and clarifying intersections with community reinvestments. The updates also eliminate historical requirements and background that are no longer relevant for MCPs.

1. Overview

Under the PHM Program, MCPs must meaningfully participate in the

Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) conducted by Local Health Jurisdictions (LHJs). The term local planning is used to describe these requirements. This aligns with terminology used to describe similar county behavioral health department requirements to participate in the LHJ CHA/CHIP processes under the Behavioral Health Act (BHSA). Previous versions of this guide as well as APL 23-021, MCP contract language and other related statutes and guidance may still reference this requirement as the Population Needs Assessment (PNA), which is the deliverable that MCPs historically submitted to DHCS to identify priority needs of their local communities and members and health disparities. MCPs no longer submit a PNA deliverable to DHCS but do need to comply with all local planning requirements as outlined below.

DHCS' vision is for local planning requirements 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.

The MCP local planning policies detailed here are aligned with key statewide initiatives as described in Section II.B.4 of the PHM Policy Guide: These include:

» The recently enacted BHSA reforms, detailed in the BHSA County Policy Manual. These reforms seek to strengthen cross-sector partnerships, specifically among county behavioral health departments, LHJs, and MCPs, to help advance statewide population behavioral health goals.

» Community Reinvestment requirements, detailed in APL 25-004, which directs MCPs to invest in the communities they serve with a focus on aligning these investments with identified local health needs.

2. Existing CHA/CHIP Requirements for LHJs

CHAs and CHIPs are defined as follows:[5]

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

» 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.

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 assessments[8] 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 the introduction of the

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[6] Per CDPS'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 HIP, Ventura County CHA, Mono County CHA, and Santa Barbara County CHA.

2022 Budget Act, all 61 LHJs[9] have been required to submit a "Public Health Plan," (also known as a local Future of Public Health workplan) which is informed by a CHA, CHIP, and/or Local Strategic Plan, since December 30, 2023, and by July 1 every three years thereafter.[10] According to a 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 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 primary[12] and secondary[13] 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 2019-2021 San Diego CHA

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[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.
[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

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

Some 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 redistribution[21]); community engagement activities and strategic partnerships to address trauma, treat addiction, and reduce violence[22,23]; outreach activities to enroll community members in insurance[24]; coalitions

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collaboration among diverse partners working on CHAs/implementation plans). The 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.

[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.

to support policy, systems and environmental changes to improve health;[25] and maternal and infant health campaigns.[26]

3. MCPs' Local Planning Requirements (Updated January 2026)

[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 an annual "DHCS 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.

Since 2023, MCPs have been working with LHJs on CHAs/CHIPs, consistent with the requirements described in this Policy Guide, which have evolved over time, taking a phased approach to setting expectations for MCPs' meaningful participation in LHJ CHA/CHIPs in terms of **collaboration, data-sharing, resource contribution and stakeholder engagement.** These requirements outlined below provide overarching guidance but are not intended to be overly prescriptive, given that a core strength of LHJs' CHAs/CHIPs is that they are driven by the unique needs of each community. The intent here is to continue to support these locally driven assessment processes, rather than to mandate a standardized process that all California communities must follow. MCPs must also continue to follow all applicable NCQA requirements.

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[25] [Ventura County CHIP.](#)

[26] Ibid

[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).

a. 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 in multiple CHAs/CHIPs.

Prime MCPs must ensure that any populations covered by a subcontracted MCP are included in their local planning process; that is, subcontracted MCPs[28] do not have to complete a separate local planning 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.

b. Data Sharing Requirements

MCP meaningful participation on LHJ CHA/CHIP process also entail data sharing. 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 of California's population and carries a disproportionate burden of social and medical complexity. Stakeholders[29] have highlighted that:

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[28] 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.

[29] Stakeholders provided feedback on the value proposition of greater MCP and LHJ collaboration in response to DHCS 2023 PNA Concept Paper.

» 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 required to share data with LHJs in ways that support the CHA/CHIP process and are based on priority areas identified jointly by the MCP and LHJ. This requirement applies regardless of the position of the LHJ in the CHA/CHIP cycle in calendar years 2024–2027. If multiple MCPs operate in an LHJ's area, they must agree on the same priority areas.

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

Data 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.

In 2024, MCP(s) and each LHJ in their service area were required to select priority areas from the following that cut across LHJ priorities and CalAIM priorities for MCPs:

» Maternal health
» Child health
» Health disparities/inequities
» Behavioral health/substance use disorder
» Justice involved/ reentry population

» Housing insecurity/homelessness
» Chronic disease prevention
» Adult/childhood immunization
» Other, agreed upon by the LHJ and MCP

Since Q2 2025, MCPs must share data aligned with identified priority areas 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 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 requirements.

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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 the [DXF Signatory List](#). As of publication, five county health departments were signatories: Alameda, Tuolumne, Ventura, Plumas, Tulare.

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c. Resource Contribution Requirements

As part of meaningful participation in LHJs' CHAs/CHIPs, MCPs must contribute resources to support LHJs' CHAs/CHIPs in the service areas where they operate, in the form of funding and/or in-kind staffing, since 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.

MCPs are required to work with LHJs to determine the appropriate 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. MCPs are required to describe their resource contribution decisions and activities via their annual DHCS 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:

  - o Administrative support
  - o Project management
  - o 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)
  - o Governance (convening support, etc.)
  - o Data infrastructure (e.g., web-based data-visualization tools, technology to support data sharing and analysis, and consultants/training to analyze data)
  - o Community engagement (e.g., incentives/food for community participation, funds for childcare, and gas cards)
  - o Communications (e.g., funding for media/messaging about CHA, sharing success stories, and consultants)
  - o Contracts with CBOs
  - o Implementation strategies (specific to CHIP)
  - o 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 Requirements

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.

Since January 1, 2024, as part of meaningfully participating in the LHJ CHA/CHIP process, MCPs must:

» 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, since January 1, 2024, MCPs must 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.

d. Publishing Requirements

Since January 1, 2024, in services areas where an MCP operates, when an LHJ publishes its CHA/CHIP, the MCP must publish the CHA/CHIP on its public-facing websites (specifically public-facing member and provider websites) with a brief paragraph on how the MCP meaningfully participated (e.g., data, staffing, and funding) in the process.

e. 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.**[30] 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.
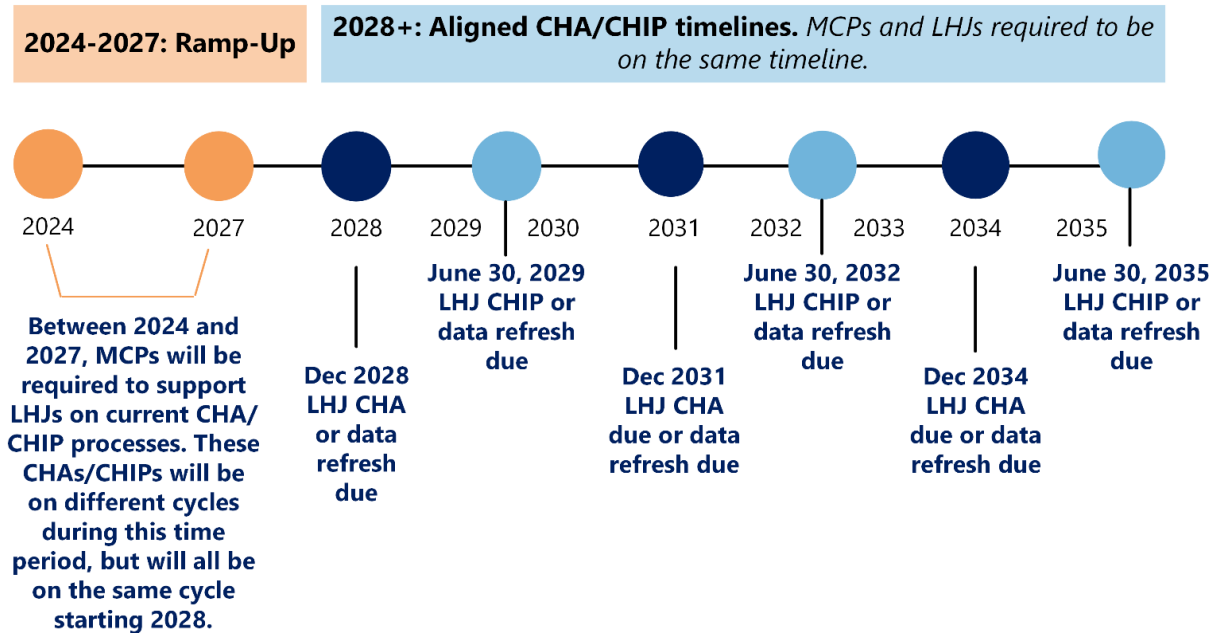
See below for a visual of the LHJ timeline outlining LHJ's CHA/CHIP cycles.[31]

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[30] The June 30, 2029 CHIP due date aligns with the new Public health plan due dates.
[31] The timeline above aligns with county behavioral health departments' BHSA requirements to engage in LHJ CHAs and CHIPs.

Figure 2. Local Planning Timeline

2024-2027: Ramp-Up	2028+: Aligned CHA/CHIP timelines. *MCPs and LHJs required to be on the same timeline.*

2024 — **2027**

2028 — **2029** — **2030** — **2031** — **2032** — **2033** — **2034** — **2035**

Between 2024 and 2027, MCPs will be required to support LHJs on current CHA/CHIP processes. These CHAs/CHIPs will be on different cycles during this time period, but will all be on the same cycle starting 2028.

Dec 2028 LHJ CHA or data refresh due

June 30, 2029 LHJ CHIP or data refresh due

Dec 2031 LHJ CHA due or data refresh due

June 30, 2032 LHJ CHIP or data refresh due

Dec 2034 LHJ CHA due or data refresh due

June 30, 2035 LHJ CHIP or data refresh due

4. DHCS PHM Strategy Deliverable

All Prime MCPs are required to submit their DHCS PHM Strategy Deliverable annually using the DHCS-issued template for the applicable reporting year. Beginning in 2026, the PHM Strategy Deliverable will be due the first business day of February, reporting on activities of the prior calendar year. The template should be inclusive of any subcontracted populations (subcontractor entities do not have to fill out this template separately/independently of Prime MCPs).

For the annual DHCS PHM Strategy Deliverable, MCPs will be required to report on the following:

- » Progress toward DHCS Bold Goals, statewide population behavioral health goals, and other DHCS quality measures,
- » How are they meaningfully participating in LHJs' CHAs/CHIPs,
- » Bright spots and challenges,
- » How are they responding to community needs,
- » How MCP involvement in LHJs' CHA/CHIP activities and BHSA County Behavioral Health Integrated Plan (see below) has impacted the DHCS PHM Strategy Deliverable, and

> » Any other relevant PHM updates.

MCPs also must provide an attestation confirming their annual NCQA PHM Strategy (inclusive of population assessment) submissions.

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

Please note in previous versions of the PHM Strategy, MCPs were required to provide updates on the shared goal(s) and "SMART" objective(s). No additional reporting on this topic will be required through the PHM Strategy Deliverable in 2026 and going forward; however, DHCS may follow up with MCPs individually as needed. [32]

5. Intersection with Other Policies

a. Community Reinvestment Policy

The Community Reinvestment Policy, as described in APL 25-004, outlines requirements for MCPs with positive net income to invest a minimum percentage of that net income in communities in which they operate. Investments must be directly informed by community needs identified in each LHJs' CHA/CHIP, and MCPs must engage

LHJs and County Behavioral Health Departments in the planning and decision-making processes when developing their Community Reinvestment Plans. As part of Community Reinvestment Plan submissions to DHCS, MCPs are required to submit attestations from Public Health Directors and Behavioral Health Directors of each LHJ in the MCPs' service areas indicating the proposed Community Reinvestment Plan is generally agreeable to the Public Health Director and Behavioral Health Director and aligns with community needs identified in the CHA/CHIP. In addition to engaging LHJs, MCPs must also engage

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[32] In 2023, all Prime MCPs were required to meet with the LHJs in their service areas to begin planning for participation in upcoming CHA/CHIP cycles and develop shared goal(s) and "SMART" objective(s) that are 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. These activities were intended as a foundational step to support early collaboration following the new local planning requirements. The 2024 and 2025 PHM Strategy deliverables asked questions related to progress on meeting these SMART objectives.

with the community through consultations with Community Advisory Committees (CACs) to solicit Community Reinvestment recommendations. The initial Community Reinvestment Plan for the first investment period is due to DHCS on September 1, 2026, and a subsequent Community Reinvestment Plan is due in September every year thereafter within the three-year investment period. A new Community Reinvestment planning and investment cycle begins every three years.

MCPs are prohibited from using Community Reinvestment funds on activities included in the MCP Contract or carved out of the MCP Contract but covered under Medi-Cal. Therefore, MCP contributions, whether through funding and/or in-kind staffing, to support LHJs' CHAs/CHIPs are a separate and distinct requirement from Community Reinvestment and these do not count toward the MCPs' Community Reinvestment obligation.

In the case of any conflict between this Policy Guide and the Community Reinvestment Policy, as described in APL 25-004, the terms of the APL shall prevail. [33]

b. BHSA Requirements

To further strengthen cross-sector partnerships, DHCS is aligning local planning policies outlined in this PHM Policy Guide with BHSA reforms passed in March 2024.

As detailed in separate guidance,[34] effective January 1, 2025, county behavioral health departments are required to consider the CHA/CHIP of each LHJ that covers residents of its county when developing its Integrated Plan (IP). The IP is a three-year prospective global spending plan that describes how the county behavioral health delivery system will utilize available behavioral health funding. Additionally, each county behavioral health department must also engage with MCPs and LHJs on CHAs/CHIPs. The requirements for county behavioral health departments' engagement mirror MCP requirements for meaningful participation in LHJs' CHAs and CHIPs, which requires collaboration, stakeholder engagement, and data sharing. Each county behavioral health IP must also be aligned with statewide population behavioral health goals and associated measures that focus on improving wellness (e.g., quality of life) and decreasing adverse outcomes (e.g., suicides). MCPs are also required to work towards the same statewide population behavioral health goals in collaboration with county

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[33] APL 25-004
[34] Please see the Behavioral Health Services Act County Policy Manual for additional information.

behavioral health departments and will report progress as part of the DHCS PHM Strategy Deliverable. In November 2025, DHCS released a [BHSA Local Planning Process Collaboration Toolkit](#) designed to support county behavioral health departments in meeting BHSA local planning requirements effective January 1, 2025. The toolkit provides optional resources, recommended strategies, and promising practices that counties may use to support collaboration with LHJs on CHA and CHIP activities. The toolkit may also serve as a reference for MCPs and LHJs seeking to better understand their roles and participation within the BHSA local planning framework.

c. NCQA Requirements

As described earlier in this Policy Guide, since January 1, 2023, all MCPs must meet NCQA Health Plan PHM requirements. Effective January 1, 2026, all MCPs must maintain 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 local planning 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 DHCS PHM Strategy Deliverable to DHCS.

C. Gathering Member Information (Updated January 2026)

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,[35] MCPs are 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 (MAT also known as Medications for Opioid Use Disorder), and other substance use disorders (SUD), and other non-specialty mental health services information,[36]

» County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS)

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[35] Under Medi-Cal Managed Care 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.
[36] 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.

information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) claims system,[37]

» Pharmacy claims and encounters,

» 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),

  » Information provided by county First 5s[38], 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 Medi-Cal Connect is fully operationalized. As such, during this period prior to Service launch, MCPs are 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 Medi-Cal Connect is available and supports access to and use of required data sources, MCPs maybe required to use Medi-Cal Connect and the available data accessible through the platform – in accordance with federal and state privacy rules and

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[37] 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.
[38] County First 5s are local, county-based entities in each of California's 58 counties to provide essential resources and services at the local level to support child development, care, and education of children up to age five.

regulations – to conduct RSS activities, with details defined in future policy updates. 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 (Updated January 2024)

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).

a. 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 fulfill the HIF/MET requirement in one of two ways:

o 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) 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.

» By contract year 2027, D-SNPs that are applicable integrated plans per the definition at 42 CFR 422.561, which include California's Exclusively Aligned Enrollment D-SNPs (Medi-Medi Plans) and Fully Integrated Dual Eligible Special

Needs Plan (FIDE-SNP), must conduct a comprehensive HRA that meets Medicare requirements at 42 CFR 422.101(f)(1)(i) through (iv) and Medicaid requirements at 42 CFR 438.208(b)(3), such that enrollees complete a single integrated assessment for Medicare and Medicaid. Thus, for dually eligible members enrolled in these plans, the HIF/MET is not required as of contract year 2027. However, the HIF/MET will be required for dually eligible members that are in Original Medicare or other Medicare Advantage plans (i.e., those that do not meet the definition of applicable integrated plans per 42 CFR 422.561).

» **The IHEBA/SHAs are eliminated.** However, DHCS is preserving the following requirements:

▪ The **Initial Health Appointment(s)** aim to provide both MCPs and providers with comprehensive and up-to-date member information upon a member enrolling in a new plan, so the plan and/or provider can help meet the member's needs. Initial Health Appointment(s) must be completed within 120 days[39] 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.[40] Initial Health Appointment(s) 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 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 Primary Care Provider (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

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[39] 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.

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

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 covered over multiple appointments in accordance with the American Academy of Pediatrics (AAP) /Bright Futures periodicity schedule, as referenced in APL 23-005.[41]

» For members who are dually eligible for Medi-Cal and Medicare and enrolled in a Dual Eligible Special Needs Plan (D-SNP) that is an applicable integrated plan as defined in 42 CFR 422.561, which includes California's Exclusively Aligned Enrollment D-SNPs (Medi-Medi Plans) and Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), the Medicare care coordination provisions and HRA requirements meet the MCP IHA requirements.

» Effective July 1, 2026, for dually eligible members enrolled in Original Medicare or a Medicare Advantage plan other than a Medi-Medi Plan or FIDE-SNP, MCPs must ensure members engage in primary care consistent with IHA requirements. This requirement may be met by inquiring about the member's primary care engagement through the HIF/MET and documenting that the member was seen by a primary care provider (PCP) within the past 12 months. If the member was not seen by a PCP within the past 12 months, the requirement may be met by assisting the member in identifying and connecting with a PCP who accepts the member's Medicare coverage (either Original Medicare or the member's Medicare Advantage plan, as applicable), or by conducting a warm handoff to a care

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[41] More information about the AAP/Bright Futures initiative and the most recent periodicity schedule and guidelines are available on the Bright Futures website. Additional information on the periodicity schedule is available on the AAP website.

coordination entity affiliated with the member's Medicare Advantage plan, if applicable.

» 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 guidelines.

» To ensure member needs are being met, DHCS is using existing Managed Care Accountability Sets (MCAS) measures focused on preventive services, such as Child and Adolescent Well-Care Visits and Breast and Cervical Cancer Screening, as proxies to measure plan compliance with the Initial Health Appointment(s). A sample list of MCAS measures that are used as proxies is outlined below. DHCS may change or augment this list of proxy measures in the future.

Sample MY 2025/RY 2026 MCAS Quality Measures as Proxies for the Initial Health Appointment(s)
» Childhood Immunization Status – Combination 10
» Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits
» Breast Cancer Screening
» Cervical Cancer Screening

b. Corresponding APL Updates

APLs	Updates and Timing
APL 16-014 "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries"	» This APL was superseded to decouple requirements from outdated IHEBA/SHA requirements sometime in the future

APLs	Updates and Timing
APL 18-004 "Immunization Requirements"	» Supersedes APL 07-015 and PL 96- 013.
APL 20-004 "Emergency Guidance for Medi-Cal Managed Care Plans in Response to COVID-19"	» Revised April 2023.
APL 22-030 "Initial Health Appointment"	» Supersedes APL 13-017 and PLs 13-001 and 08-003

In addition to the above, DHCS is exploring ways to streamline care coordination and support service delivery through the development of the Longitudinal Member Record (LMR) in Medi-Cal Connect. DHCS is releasing LMR access to MCPs initially and will then evaluate use of the LMR by community-based care managers in subsequent releases of Medi-Cal Connect. Plan-based care managers may find the LMR to be useful in its aggregation of data across systems and incorporation of risk tier into the member level view.

3. Guidance for Screening and Assessments for Transitioning Members During the 2024 MCP Transition (Updated January 2024)

Beginning in 2024, MCPs are 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 changed on January 1, 2024, as a result of how DHCS contracts with MCPs. Collectively, these changes comprise the January 1, 2024, MCP Transition.[42]

This section explains requirements for three assessment and screening tools—the HIF/MET, Initial Health Appointment(s), and Health Risk Assessment (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"

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[42] For more details, see the 2024 Transition Policy Guide.

and those members who are in transition from one MCP to another as "transitioning members."

a. HIF/ MET

The 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.

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.

b. 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 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.

c. 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.[43]

  » **Transitioning members who have an existing HRA:**

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

o   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.

o   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 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 Stratification and Segmentation (Updated January 2026)

1. Statewide Risk Tiers and RSST Overview

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

Risk tiering, as used in this Policy Guide, refers to assigning members to standardized State-defined tier levels (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 MCP Contract, DHCS is implementing a single, statewide, open-source RSS approach with standardized risk tiering criteria that will place all Medi-Cal members into high, medium-rising, and low-risk tiers. These tiers are intended to guide population health strategies while ensuring alignment with federal and state policies. The combined process of risk stratification, segmentation, and tiering within Medi-Cal Connect is referred to as DHCS's RSST approach.

The RSST approach includes distinct models tailored to specific populations: Adult, Pediatric, and Birthing Populations. MCPs will be expected to incorporate each model as it becomes available and develop processes to engage members during the RSST Initial Implementation Period. Each model is designed to reflect the unique risk factors and care needs of its respective population. MCPs should prepare to integrate these outputs into care management workflows as part of their overall RSST readiness.

At launch of Medi-Cal Connect for MCPs, the use of RSST risk tiers is strongly encouraged but not required. As such, DHCS defines two distinct time periods:

> » **Initial Implementation Period:** This period begins with the launch of the RSS and risk tiering functionalities to MCPs and will end no earlier than July 2026. MCPs will have access to but not be required to use DHCS's standardized RSST risk tiers during this time.

> » **Required Implementation Period:** This period begins no earlier than July 2026. MCPs will be required to use DHCS's standardized RSST tiering.

a. RSST Requirements During the Initial Implementation Period
Allowable RSS and RSST Approaches:

DHCS recognizes that MCPs may have developed and/or significantly invested in their own RSS approaches. During the Initial Implementation Period ending no earlier than July 2026, MCPs may continue using their own RSS models (internally developed or commercially available), the Medi-Cal Connect RSST approach, or a combination of both approaches. If using a combination of both approaches, MCPs may incorporate a portion of DHCS's RSST approach as a pilot.

Regardless of the RSS and/or RSST methodologies used by MCPs, **all** MCPs are required to continue using an RSST approach that meets all of the requirements below:

> » Complies with NCQA Health Plan PHM standards, including using utilization data integrated with other data sources such as the CHA/CHIP, 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 past utilization or cost data, which can unintentionally introduce racial, condition-based or age-related biases. For example, such models may prioritize high-cost conditions or individuals with

historically greater expenditures. Additionally, these methodologies may overlook the needs of specific subpopulations, especially those who historically use fewer services.[44]

- To address these biases and improve outcomes, MCPs are encouraged to use quality improvement strategies and ensure that risk stratification results are actively integrated into care management workflows to support timely, equitable member interventions. MCPs should also establish appropriate metrics to measure the accuracy and effectiveness of RSS model in predicting who does or does not need help, and monitor where RSS improves care for all populations..[45] [46]

» Stratifies members at least annually and during each of the following time frames:

- o Upon each member's enrollment.
- o Annually after each member's enrollment.
- o 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).
- o 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.

DHCS strongly encourages MCPs to use Medi-Cal Connect's RSST outputs during this ramp-up period, and MCPs may supplement these outputs with their own local data sources and methodologies. **Use of the RSS methodology and risk tiers from Medi-Cal Connect meets all the above requirements.**

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[44] "Beyond Racial Bias: Rethinking Risk Stratification In Health Care," Health Affairs Blog, January 15, 2020

[45] "Beyond Racial Bias: Rethinking Risk Stratification In Health Care," Health Affairs Blog, January 15, 2020.

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

Additional MCP Requirements:

> **» Assessment of Members Identified as High-risk**

Regardless of the specific RSS or RSST approach MCPs choose to adopt during the Initial Implementation Period, MCPs must continue to conduct needs assessments of all members identified to be high-risk, as outlined in Assessment and Re-Assessment section below.

> **» Readiness to Implement DHCS RSST Approach**

During the initial implementation period, MCPs are required to develop and implement internal processes and technical infrastructure to ingest and integrate DHCS' RSST risk tiers into their care management systems (e.g. building APIs to receive monthly risk tier data).

MCPs must update policies and procedures and ensure readiness for implementation of RSST risk tiers. These functions include how care managers receive, interpret, and act on RSST data, such as triggering specific interventions aligned with member needs. These approaches should include clear protocols for how risk tier data is shared with care teams, used to prioritize outreach, guide assessment frequency, and inform individualized care planning. At the end of the Initial Implementation period, MCPs will be required to ingest and implement Medi-Cal Connect risk tiers on a monthly basis.

Regardless of the specific RSS or RSST methodologies used, MCPs must continue to treat these processes as tools to guide, not restrict, access to services and benefits. For instance, MCPs should not limit access to behavioral health services to members identified as high-risk for poor behavioral health outcomes by RSS or RSST methodologies.

In addition, MCPs should collaborate with network providers to exercise clinical judgment and shared decision-making with members. This includes incorporating real-time information and findings from the assessment process to guide service decisions, regardless of whether a member is identified as being high-risk via RSS or RSST methodologies.

During the Initial Implementation period, DHCS will collaborate with MCPs to compare the RSST risk tiers with local methodologies and tools. This process aims to improve alignment, enhance predictive accuracy, and support continuous improvement of both State and plan-level approaches to identifying and addressing member risk. This

collaboration will inform refinements to future policy and promote shared learning across MCPs.

b. RSST Requirements After the Medi-Cal Connect RSST Initial Implementation Period

After the RSST Initial Implementation period and no earlier than July 2026, MCPs will be required to use the standardized RSST risk tiers from Medi-Cal Connect to identify member needs, guide assessments, and connect members to appropriate services. DHCS will issue further guidance prior to the requirement taking effect.

2. Assessment and Reassessment to Understand Member Needs

RSS and risk tiering processes described above are foundational requirements for identifying members who may need further assessment. Based on these processes, MCPs must assess members identified as potentially needing services to understand their needs and preferences and to engage them in appropriate care and supports. Under the PHM Framework, "assessment" refers to a more comprehensive process of gathering information from members about their health and individual needs. After the RSST Initial Implementation period and no earlier than July 2026, MCPs will be expected to ensure that all members flagged as high-risk through the Medi-Cal Connect RSST are assessed to determine their specific needs. Populations that will be required to receive assessments and re-assessments are included in **2.a** below. Assessment requirements will apply to members identified as high-risk by any of the RSST models, which include the Adult, Pediatric, and Birthing models. MCPs should ensure assessment protocols are responsive to the specific needs of each population. DHCS anticipates offering further guidance on required assessments in a future PHM Policy Guide update. MCPs are encouraged to contract with providers to conduct assessments and integrate findings into care and care management processes rather than keeping them siloed at the plan level. Assessments should be conducted by MCPs or contracted providers—such as care managers or care coordinators—using culturally and linguistically appropriate methods to build trust. This process is distinct from "screening" in that it is more comprehensive and occurs after a member has been identified by the RSS and risk tiering processes, which are informed by screening data. While screening identifies potential issues broadly, assessment aims to understand the member's full context, preferences and barriers to care.

a. 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. DHCS's requirements for Population Health Management are intended to complement—not replace—existing federal and/or state policy on required assessments. Populations currently required to receive an assessment independent of risk stratification, segmentation, and tiering processes include:

- » Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver).[47]
- » Those entering CCM (per NCQA).
- » Those entering ECM.
- » Children with Special Health Care Needs (CSHCN).[48]
- » Pregnant individuals.[49]
- » Seniors and persons with disabilities who meet the definition of "high-risk" as established in existing APL requirements,[50] namely:
  - o 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.
  - o Members who:
    - Have been on oxygen within the past 90 days,
    - Are residing in an acute hospital setting,

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[47] 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."

[48] 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."

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

[50] APL 22-024

- 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),
- 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.

In addition to the above list, any member identified as high-risk through the MCP's RSS or RSST process must receive an assessment. Allowable RSS and RSST methodologies and requirements for these processes are detailed above.

The assessment requirement is waived for dually eligible members who are enrolled in a Dual Eligible Special Needs Plan (D-SNP) that is an applicable integrated plan as defined in 42 CFR 422.561, which includes California's Exclusively Aligned Enrollment D-SNPs (Medi-Medi Plans) and Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), since the Medicare and DHCS HRA requirements fulfill these requirements.

An annual re-assessment is required for CSHCN[51] and those with LTSS needs[52]. However, the annual reassessment requirement is waived for dually eligible members with LTSS needs who are enrolled in a D-SNP that is an applicable integrated plan (see above), since the Medicare and DHCS comprehensive annual HRA requirements fulfill these requirements. Prenatal, postpartum and trimester reassessments that are comparable to the [American College](#) [of Obstetricians and Gynecologists (ACOG)](#) and

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[51] 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. [CMS Final Rule](#).
[52] 42 CFR § 438.208 - Coordination and continuity of care.

[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.

> **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.

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

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.

The HRA requirement is waived for dually eligible members who are enrolled in a Dual Eligible Special Needs Plan (D-SNP) that is an applicable integrated plan as defined in 42 CFR 422.561, which includes California's

b. Corresponding APL Updates

APLs	Upcoming Updates and Timing
» **[APL 17-013](#) "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities**" » **[APL 17-012](#) "Care Coordination Requirements for Managed Long-term Services and Supports"**	» APL 17-013 and APL 17-012 were superseded by [APL 22-024](#). Specific requirements from these APLs that still apply to MCPs are outlined within this PHM Policy Guide.

E. Providing PHM Program Services and Supports: BPHM and Care Management Programs

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,[53] 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 member, the MCP may also contract with the PCP for BPHM care coordination and health

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[53] 42 CFR § 438.208

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 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.

a. 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:

i. 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.

ii. 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.

Effective January 2025, MCPs were 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).

Effective January 2024, MCPs were required to enter into Memorandums of Understanding (MOUs) with county First 5s and other entities to facilitate care coordination and information exchange.[54],[55] See the DHCS MOU webpage for a complete list of all entities where the MCP is required to enter into a MOU, as well as additional information on MOUs.

iii. Closed-Loop Referrals (*Added July 2025*)

MCPs are required to implement Closed-Loop Referral requirements beginning in July 2025. The goal of Closed-Loop Referrals (CLRs) is to increase the share of Medi-Cal Members successfully connected to the services they need by identifying and closing gaps in referral practices and service availability. DHCS defines a CLR as a referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a known closure. CLR requirements and applicable services are further defined in the CLR Implementation Guidance, an addendum to the PHM Policy Guide.

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[54] Amended 2023 MCP Contract.
[55] 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 the DHCS web page on CalAIM Behavioral Health Quality Improvement Program.

iv. 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.

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

MCPs may be required to describe how they integrate CHWs in their DHCS PHM Strategy Deliverable 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 promotors, 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).[56,57] 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.

vi. Wellness and Prevention Programs (Updated August 2023)

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:

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[56] *See* 42 C.F.R. 440.130(c). The C.F.R. is searchable, available at: https://www.ecfr.gov/.
[57] CHW SPA information is available at the DHCS webpage on California's Medicaid State Plan (Title XIX).

- » Healthy weight (BMI) maintenance

- » Smoking and tobacco use cessation

- » Encouraging physical activity

- » Healthy eating

- » Managing stress

- » Avoiding at-risk drinking

- » Identifying depressive symptoms

Starting in 2024, MCPs may be required to report annually, through their DHCS PHM Strategy Deliverable, on how they are using community-specific information, gained through LHJ-led CHA/CHIP activities which fulfill the local planning requirements, 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 Comprehensive Quality Strategy](). The expectation is that over time, these wellness programs result in improved outcomes, such as decreasing population prevalence of specific chronic diseases, rates of strokes and heart attacks, food access insecurity, and other conditions amenable to upstream risk factor modification. such as decreasing population prevalence of specific chronic diseases, rates of strokes and heart attacks, food access insecurity, and other conditions amenable to upstream risk factor modification.

vii. 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 findings derived through LHJ-led CHA/CHIP activities 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).

viii.   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 Website)]() and 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. Future guidance will be issued for MCPs regarding best practices to address maternal health outcomes.[58, 59, 60]

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[58] [2022 Medi-Cal Managed Care Contract]() and [PL 12-003.]()

[59] 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]().

[60] 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.

ix. 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[61][62].

MCPs must meet requirements outlined in the Other Population Health Requirements for Children and the Services for Members under section 4.3.9 of the 2025 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, developmental, 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, MCPs are required to review the utilization of children's preventive health visits and developmental screenings and outline their strategies for 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

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[61] Early and Periodic Screening, Diagnostic and Treatment Federal Requirements
[62] Provider Information Medi-Cal for Kids & Teens

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. MCPs may be required to report on those findings in the annual DHCS PHM Strategy Deliverable submission.

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 county First 5 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.

i. 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:

» **Eligibility**

- CCM is a service intended for higher- and medium-/rising-risk members and is deliberately more flexible than ECM. MCPs are allowed to determine their own eligibility criteria (within NCQA guardrails[63]) based on the risk stratification process outlined above and local needs identified in the CHA/CHIP.

ii. Core Service Components:

CCM must include:

» **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.

» **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

» **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.

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[63] NCQA 2021 Health Plan Accreditation PHM Standards. PHM 5: Complex Case Management.

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:

o Identify a care manager

o Communicate the identity of the care manager to all treating providers and the member

o 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.

iv. 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, county First 5s, and/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.[64] For detailed requirements and implementation timeline for ECM, please refer to the Finalized ECM and Community Supports MCP Contract Template and ECM Policy Guide.

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

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.

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.

i. 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.

F. Providing PHM Services & Supports: Transitional Care Services (TCS) (Updated January 2026)

1. TCS Overview

a. TCS Definition

Care transitions are defined as a member transferring from one setting or level of care to another (hereafter, "transitioning members"), 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 TCS for all members across all settings and delivery systems, ensuring members are supported from discharge planning until successful connection to all needed services and supports. This includes critical TCS tasks, such as ensuring the following: medication reconciliation is completed upon discharge by the discharging facility, 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.[65]

Effective July 1, 2026, in addition to existing high-risk and lower-risk TCS categories, MCPs are accountable for providing two revised TCS categories for pregnant and postpartum members[66] ("pregnancy and postpartum TCS"), which largely integrate existing PHM and CPSP requirements, as well as nationally-recognized clinical guidelines and recommendations. For both categories, MCPs and their contracted entities must complete the TCS Birthing Supports Checklist, designed to ensure that members are connected to a minimum standard of appropriate medical, behavioral health, and whole-person services and supports (see section F.5.c. "TCS Birthing Supports Checklist"), also in alignment with existing requirements. Under pregnancy and postpartum TCS, in addition to the definition of transition above, any end of pregnancy event will be considered a transition regardless of hospital stays. Pregnancy and postpartum TCS should be provided regardless of setting and including, but not limited to, any discharging location where the member gave birth (e.g., hospital, freestanding birthing centers (FBCs), or home births).

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[65] 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. Transitions of Care: Managing Medications.

[66] Pregnant and postpartum members are defined as any member who is pregnant or within 12 months postpartum, starting from the last day of pregnancy, regardless of whether the pregnancy ended in live or stillbirth, or spontaneous or therapeutic abortion. The pregnancy and postpartum TCS categories apply to events occurring during pregnancy and through 12 months postpartum. However, delivery-related pregnancy and postpartum TCS supports are limited to 60 days following delivery and do not extend for the full postpartum period. Delivery is one type of qualifying event within the pregnancy/postpartum timeframe; other qualifying events (e.g., post-pregnancy non-delivery discharges) may also occur. If a member experiences any qualifying events during pregnancy or the 12-month postpartum period, including delivery and non-delivery events, the member should receive pregnancy and postpartum TCS (high- or moderate-intensity).

Pregnancy and postpartum TCS categories are a part of the broader [Birthing Care Pathway](#) efforts, which aim to reduce maternal morbidity and mortality. The expectations associated with these categories are consistent with existing MCP requirements to ensure access to CPSP-like services and to support members in connecting with appropriate services and supports, such as those aligned with ACOG and AAP Bright Futures Guidelines. [67]

For some of the TCS requirements in this Policy Guide and in the MCP Contract, another entity, such as the care manager, ECM Lead Care Manager, perinatal provider, 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.[68]

The TCS policies are consistent with the [DHCS 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.[69]

b. Overview of TCS Categories

MCPs are required to offer TCS for all members experiencing a care transition. Since

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[67] Medi-Cal Managed Care Boilerplate Contract, Exhibit A, Attachment III, Subsections 5.3.4 (Services for Members Less Than 21 Years of Age) & 5.3.6 (Pregnant and Postpartum Members).
[68] 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.
[69] Declercq ER, Liu C, Cabral HJ, Amutah-Onukagha N, Diop H, Mehta PK. [Emergency Care Use During Pregnancy and Severe Maternal Morbidity](#). *JAMA Netw Open* (2024).

January 1, 2023, DHCS had categorized all pregnant and postpartum Medi-Cal managed care members as high-risk. Starting February 2026, MCPs may begin early (optional) implementation of pregnancy and postpartum TCS categories and are no longer required to consider all pregnant and postpartum members to be high-risk. Full implementation of the pregnancy and postpartum TCS categories – high-intensity and moderate-intensity – is required by July 1, 2026.[70] Until an MCP has fully implemented the pregnancy and postpartum TCS categories, it must continue to provide high-risk TCS for any pregnant or postpartum member who is transitioning.

DHCS has established a set of TCS requirements that MCPs must provide for all members undergoing a care transition, as well as additional, specific requirements for members in four different categories:

1. High-Risk (Not Pregnant or postpartum)

2. Lower-Risk (Not Pregnant or Postpartum)

3. High-Intensity Pregnancy and Postpartum, and

4. Moderate-Intensity Pregnancy and Postpartum.

The following section (F.2.) introduces the foundational TCS requirements that apply to all transitioning members. Sections F.3. through F.5. build on this by outlining requirements by category. Guidance for members enrolled with multiple payers is described in section F.6.; oversight and monitoring across all TCS categories are addressed in section F.7.

Table 1: Overview of TCS Categories provides a high-level overview of the four TCS categories and the Medi-Cal members served.

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[70] Due to elevated vulnerability, all pregnant and postpartum members will receive moderate or high-intensity TCS; a lower-risk TCS category will not apply to this population.

Table 1. Overview of TCS Categories

High-Risk TCS (Not Pregnant or Postpartum)	Lower-Risk TCS (Not Pregnant or Postpartum)	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
Any member that is not pregnant or postpartum and who meets high-risk criteria outlined in section F.2.c."Identification of TCS Category for Transitioning Members".	Any member that is not pregnant, postpartum, or identified as high-risk per the criteria outlined in section F.2.c. "Identification of TCS Category for Transitioning Members".	Any pregnant or postpartum member who meets any one of the criteria for high-intensity TCS outlined in section F.5.a. "Identification of Members for High- vs. Moderate Intensity Pregnancy and Postpartum TCS".	Any pregnant or postpartum member who does not meet the criteria for the high-intensity TCS outlined in section F.5.a. "Identification of Members for High- vs. Moderate Intensity Pregnancy and Postpartum TCS".

2. TCS Requirements for All MCP Members in Every TCS Category

a. Identifying a Transitional Event: Admission, Discharge, and Transfer (ADT), Pregnancy Identification

MCPs must identify all members eligible for TCS in a timely manner. For members who are admitted to a facility, identification should occur at the time of admission. For pregnant and postpartum members, MCPs must identify a member's pregnancy as early in pregnancy as possible, such as through timely receipt of a claim from the first prenatal visit or communication from a provider.

In accordance with the Interoperability and Patient Access Final Rule set forth at CMS-9115- F, and the CalHHS Data Exchange Framework (DxF), effective January 31, 2024, general acute care hospitals and emergency departments, as defined by HSC §1250, (together "Participating Facilities"), must send admission, discharge, or transfer (ADT) notifications to other organizations that have signed the DxF Data Sharing Agreement if requested in advance of the ADT Event. [71,72] The DxF also encourages but does not

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[71] HSC § 130290; CalHHS DxF Technical Requirements for Exchange Policy and Procedure
[72] An ADT Event is defined as an admission, discharge, or transfer.

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 the requesting Participant.[73] These DxF requirements will support MCPs capabilities to receive ADT notifications from a variety of Participating Facilities.

DHCS does not provide real-time data on members' admission, discharges, or transfers. Under TCS, MCPs are responsible for knowing, in a timely manner, when all of their members are pregnant, 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 (HIE) 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,

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[73] 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.

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 facilities that the MCPs members are admitted, discharged or transferred from or to where ADT feeds may not exist (e.g., FBCs), 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.

» MCPs are responsible for identifying members who are pregnant as early in pregnancy as possible through claims or direct notification from providers or members.

b. MCP Contractually Required Services, Including Prior Authorizations with Timely Discharges and All MCP-Covered Benefits and Services

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.

MCPs are also responsible for providing any MCP-specific service for which a member is eligible, including ECM, Community Supports, and transportation services, as described in the MCP Contract.

c. Identification of TCS Category for Transitioning Members

MCPs must identify the appropriate category of TCS for every transitioning member based on the criteria outlined below.

» **High-Risk (Not Pregnant or Postpartum) Category:** Members who must receive "high-risk" TCS include **all** members listed under Section D.2. "Understanding Risk, 2) Assessment and Reassessment to Understand Member Needs" in this Policy Guide,[74] excluding pregnant or postpartum members. Pregnant or postpartum members must instead receive high- or moderate-intensity pregnancy and postpartum TCS, as appropriate (see section F.5. for additional details). As further described in section D.2., members who must receive high-risk TCS include:

o Those with LTSS needs;

o Those in or entering ECM or CCM;

o Children with special health care needs (CSHCN);

o Seniors and persons with disabilities who meet the definitions of "high-risk" established in existing APL requirements;[75]

o Other members assessed as high-risk by RSST.[76]

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:

o 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

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[74] Refer Section D.2) for full definitions and more information.

[75] APL 17-012 and APL 17-013.

[76] 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 required, 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) Statewide Risk Tiers and RSST Overview.

having a specialty mental health need or substance use disorder by the MCP or discharging facility; [77,78]

- o Any member transitioning to or from a SNF;

- o 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.

» **Lower-Risk (Not Pregnant or Postpartum) Category:** Any member that is not pregnant, postpartum, or identified as high-risk per the above criteria may receive lower-risk TCS.

» **High-Intensity Pregnancy and Postpartum Category:** Any pregnant or postpartum member who meets any one of the criteria outlined in section F.5. in this Policy Guide.

» **Moderate-Intensity Pregnancy and Postpartum Category:** Any pregnant or postpartum member who does not meet the high-intensity criteria outlined in section F.5. in this Policy Guide.

d. 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.[79]

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[77] 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 F.6. "Guidance for Members Enrolled with Multiple Payors".
[78] 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.
[79] 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: (1) Centers for Medicare and Medicaid (CMS) CoPs requirements set forth in federal regulations include but are not limited to: 42 CFR §

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.[80]

» 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.[81]

o For high-risk members, MCPs must ensure the discharging facility shares this discharge plan with the MCPs' assigned care manager and that the discharging facilities have processes in place to refer to members to ECM and/or Community Supports, as needed.

» For members not already classified as high-risk by the MCP per above definitions under section F.2.c. "Identification of TCS Category for 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:

482.43; 42 CFR § 482.24. CMS requirements for LTC facilities include but are not limited to: 42 CFR § 483.21; (2) 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.
[80] 42 CFR § 482.43; HSC § 1262.5
[81] 42 CFR § 482.43; 42 CFR § 482.24; Joint Commission Requirements: RC.02.04.01.

- o Any member who has a specialty mental health need or substance use disorder.

- o Any member who is eligible for an ECM Population of Focus

- o 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.[82]

» 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.[83]

» This must include a medication reconciliation upon discharge that includes education and counseling about the member's medications.[84]

» Coordinates care with:

- o **The member's designated family caregiver(s).** The MCP should ensure they are notified of the member's discharge or transfer to another facility.[85]

- o **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.[86]

3. TCS Requirements for High-Risk Members (Not Pregnant or Postpartum)

As noted in the TCS section of the MCP Contract, TCS for High-Risk Members is

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[82] 42 CFR § 482.43; 42 CFR § 482.24.
[83] HSC § 1262.5.
[84] 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).
[85] HSC § 1262.5
[86] 42 CFR § 482.43; 42 CFR § 482.24; Joint Commission Requirements: RC.02.04.01

accomplished by ensuring that a single point of contact, herein referred to as a care manager[87], 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. This section outlines requirements for all high-risk members.

a. Identify the Care Manager Responsible for TCS

Once a member has been identified as being admitted and 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 ECM or CCM at the time of the transition, the MCP must ensure that the member's assigned ECM Lead Care Manager or CCM care manager is the 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).[88] 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.

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

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[87] 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.
[88] 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.

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. Care managers must be able to review discharge instructions and answer member questions as needed.

b. 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.[89]

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.

c. 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

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

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 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 or advanced practice providers (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 the 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 follow-up plan for the member and to ensure the member participates in the development of the care plan and receives and understands information about their needed care. To do this, the care manager must complete the following:

o 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.

o 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.

o 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.[90],[91]

- 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:

o Member Outreach:

- The identified care manager is responsible for successfully connecting with[92] 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.

o Ensuring needed post-discharge services are provided and follow-ups are completed, including (but not limited to) by assisting with making follow-up

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[90] [42 CFR § 482.43; 42 CFR § 482.24;](#) Joint Commission Requirements: RC.02.04.01
[91] If the discharge summary is not complete after 30 days, the care manager is not responsible for its receipt.
[92] Successful connection requires synchronous communication with the member.

provider appointments, to occur within 7 days post-discharge; connecting to the PCP (if different);[93] and arranging transportation.

o SUD and mental health treatment initiation or continuation for those who have an identified SUD or mental health condition.

o Medication reconciliation, post discharge:[94]

  ▪ 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.

o Completion of referrals to social service organizations (CalFresh, etc.), and referrals to necessary at-home services (DME, home health, etc.).

o Connection to community supports as needed.

o 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.

d. 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

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[93] 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.

[94] 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).

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.

4. TCS Requirements for Lower-Risk Members (Not Pregnant or Postpartum)

Lower-risk members in transition are defined as not pregnant or postpartum and 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, effective 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)[95] for a period of at least 30 days from the discharge; and (2) ambulatory follow-up occurs.

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[95] 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.

a. Dedicated Team/Phone Number ("TCS Call Line") 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:

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

  o 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.

  o 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.

  o 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.

  o 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.

» **Requirements for the Phone Line:**

  o MCPs must offer, at minimum, dedicated telephonic support services ("TCS Call Line") for members experiencing a transition of care. MCPs may leverage existing member support telephone services to meet this requirement. DHCS encourages MCPs to be innovative in meeting member's needs and fulfilling TCS requirements. MCPs can contract with hospitals, ACOs, PCPs or other entities to ensure the completion of TCS and minimize the number of calls while still meeting member's needs. 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.

- DHCS does not have a specific expectation for the volume of calls MCPs are required to conduct to engage members for TCS support and will be monitoring the efficacy of TCS, instead of number of attempted member outreach.

» **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.

b. 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 benefit[96] 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.

c. 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 or discharge, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or Community Supports.

d. Summary of Key TCS Requirements for High-Risk and Lower-Risk Members

Table 2 highlights several, though not all, key TCS requirements for members who meet high-risk and lower-risk criteria.

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[96] APL 22-016

Table 2: High- and Lower-Risk TCS: Key Requirements

Activity	High-Risk TCS (Not Pregnant or Postpartum)	Lower-Risk TCS (Not Pregnant or Postpartum)
MCP: Assignment for Care Coordination	▪ MCP to assign and notify the Single Point of Contact/Care Manager responsible for all TCS care management responsibilities ▪ MCP to provide additional support as needed through TCS Call Line	▪ MCPs to directly notify members about the dedicated TCS team/phone line and how to access it ▪ MCP to support members as needed through the TCS Call Line
Discharge Facility Coordination	▪ TCS care manager to coordinate with the discharge facility	▪ MCP to provide support to the discharge facility as needed through the TCS Call Line
Follow-Up Care Coordination	▪ TCS care manager to ensure all needs are met, including those listed on the discharge summary and/or instructions and medication reconciliation	▪ MCP to support as needed through the TCS Call Line
Post-Discharge Outreach	▪ TCS care manager to perform outreach with successful connection to member within 7 calendar days post-discharge	▪ MCP to support as needed through the TCS Call Line
Follow-Up Visit	▪ TCS care manager to ensure follow-up visit with medical provider occurs within 7 days post-discharge	▪ MCP must ensure follow-up visit with medical provider occurs within 30 days post-discharge
TCS Support Begins	▪ TCS support begins on admission	▪ TCS support begins on admission
TCS Support Ends	▪ TCS support ends when all needs are met, and a minimum of 30 days post discharge	▪ TCS support ends at a minimum of 30 days post discharge

5. Pregnancy and Postpartum TCS, Including Other Required Care Coordination Requirements for Transitioning Members

California has the largest proportion and highest number of births in the United States, representing about one out of every eight births in the nation.[97] While California's pregnancy-related mortality ratio—pregnancy-related deaths per 100,000 births—is one of the lowest in the nation, around 70 pregnant and birthing people die each year from pregnancy or childbirth complications.[98] Many more individuals experience serious complications during pregnancy and childbirth. Severe Maternal Morbidity (SMM) rates in California have risen in recent years and are higher among pregnant individuals enrolled in Medi-Cal compared to other types of insurance.[99]

Pregnant and postpartum Medi-Cal members often experience unmet health-related social needs and report limited understanding of the Medi-Cal benefits and other public or social service supports available to them during pregnancy and the postpartum period.[100] Research suggests that compared to those with commercial insurance, Medicaid-insured postpartum individuals were less likely to have a usual source of care and used fewer primary, specialty, and dental services, and had higher rates of depression, food insecurity, intimate partner violence (IPV), and financial strain.[101]

For these reasons and more, pregnant and postpartum Medi-Cal members may require additional Medi-Cal-covered services as well as other public and social supports to promote successful care transitions and positive health outcomes during and after pregnancy.

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[97] California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, California Births Dashboard, Last Modified June 2025.
[98] California Department of Public Health, Center for Maternal Child, and Adolescent Health Division, California Pregnancy-Associated Mortality Review (CA-PAMR), Last Modified December 2025.
[99] California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, Severe Maternal Morbidity Dashboard , Last Modified November 2025.
[100] California Department of Health Care Services, Birthing Care Pathway Report, Last Modified February 2025.
[101] Daw, J. R., Underhill, K., Liu, C., & Allen, H. L. (2023). *The health and social needs of Medicaid beneficiaries in the postpartum year: Evidence from a multistate survey*. Health Affairs Vol. 42, No. 11.

MCPs are contractually required to provide care consistent with nationally recognized clinical guidelines, as well as Medi-Cal care coordination requirements specific to pregnancy and postpartum. Pregnancy and postpartum TCS builds on this foundation by defining two categories and a TCS Birthing Supports Checklist (see section F.5.c. "TCS Birthing Supports Checklist") that integrates existing requirements designed to meet the unique needs of pregnant and postpartum members. Pregnancy and postpartum TCS consolidates care coordination elements from existing policies into a single, comprehensive approach to care management and coordination during pregnancy and the postpartum period. It is intended to improve outcomes for pregnant and postpartum members and streamline MCP implementation. Key policy and programs requirements integrated into this approach includes:

> **MCP Contract Provisions:** Pursuant to the MCP Contract, MCPs must submit policies and procedures for the provision of each of the following services and to address how each requirement will be met : 1) prenatal and postpartum care comparable to CPSP standards[102,103]; 2) use of ACOG standards and guidelines[102]; 3) comprehensive risk assessment tool for all pregnant Members; and 4) referral to Specialists (*Exhibit A, Attachment III – 5.3 Scope of Services Operational Readiness Requirement*). MCPs must ensure that Network Providers deliver all Grade A and Grade B preventive screenings for adults and children as recommended by the USPSTF, as well as those outlined in the AAP Bright Futures Periodicity Schedule

> **PHM Strategy**: This section integrates existing care management and care coordination requirements from other parts of this PHM Policy Guide

MCPs will be required to provide moderate- and high-intensity pregnancy and postpartum TCS effective July 1, 2026. No pregnant or postpartum members may receive "lower-risk TCS".[104] As stated in section F.1.a. "TCS Definition" above, MCPs are

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[102] Per the MCP Contract, "contractor must utilize the most current standards or guidelines of ACOG and CPSP to ensure Members receive quality perinatal and postpartum services".

[103] Pregnancy and postpartum TCS requirements do not modify or replace CPSP or CPSP-like services requirements. As outlined in DHCS' Birthing Care Pathway report, the Department is exploring opportunities to strengthen the delivery of comprehensive perinatal services across both the FFS delivery system and Medi-Cal MCPs.

[104] All pregnant individuals on Medi-Cal have one or multiple physical or social risks and would benefit from coordination and connection to services for the period of pregnancy and immediately postpartum. According to the California Department of Public Health's Dashboard

encouraged to implement the moderate- and high-intensity TCS categories earlier, starting February 2026. MCPs that do not elect early implementation must continue to provide high-risk TCS support for any pregnant or postpartum member who is transitioning until the required implementation date of July 1, 2026.

a. Identification of Members for High- vs. Moderate-Intensity Pregnancy and Postpartum TCS

Pregnant and postpartum members are defined as any member who is pregnant or within 12 months postpartum, starting from the last day of pregnancy, regardless of whether the pregnancy ended in a live or stillbirth, or spontaneous or therapeutic abortion[105]. MCPs must be able to identify members who meet this definition and determine the appropriate TCS category – high- or moderate-intensity – based on established criteria outlined below. Once identified, pregnant and postpartum members must receive pregnancy and postpartum TCS for any transitional event occurring during this period, including both non-delivery and delivery-related admissions.[106]

> » **Timeline for Assessing High-Intensity TCS.** MCPs must assess members for high-intensity criteria at the following points[107]:
>
>   o As soon as pregnancy is known.

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on SMM, in 2022 California's overall rate of SMM was 101.9 per 10,000 deliveries and SMM for Medi-Cal members was even higher at 114.1 per 10,000 deliveries.

[105] The pregnancy and postpartum TCS categories apply to events occurring during pregnancy and through 12 months postpartum. However, delivery-related pregnancy and postpartum TCS supports are limited to 60 days following delivery and do not extend for the full postpartum period. Delivery is one type of qualifying event within the pregnancy/postpartum timeframe; other qualifying events (e.g., post-pregnancy non-delivery admissions/discharges) may also occur. If a member experiences any qualifying events during pregnancy or the 12-month postpartum period, inclusive of delivery and non-delivery events, the member should receive pregnancy and postpartum TCS (high- or moderate-intensity).

[106] Pregnancy and postpartum TCS includes limited support related to the infant(s) – as applicable for pregnancies resulting in live births in which the member maintains custody of the infant(s) – with the intent of assisting the pregnant or postpartum member in ensuring their infant attends well-child visits and is enrolled in health insurance. If additional TCS is needed for the infant, under high-risk or lower-risk criteria, it would be provided directly to the infant as a member, if enrolled or deemed eligible in the MCP.

[107] DHCS expects MCPs to use their own data in a timely manner, as DHCS experiences additional data lags when receiving and processing data from MCPs.

o Upon any changes in setting or status (including all admissions related or unrelated to delivery, referral from provider, or a new diagnosis).

o Upon delivery.

o Upon any update in the member's RSST risk tier.

» **High-Intensity TCS Category**[108] includes all of the following members:

o Members that have an admission to a hospital that is unrelated to their delivery at any point during pregnancy or within 12 months after the end of their pregnancy.

o Are assessed as high-risk by RSST[109]

o Having any one of DHCS-specified list of medical, behavioral health, or social risk criteria, including:[110]

▪ Medical Risk

• Any member who has an [Obstetric Comorbidity Index](#) (OCI)[111] Score of >6 *(MCPs must use existing claims data to calculate an OCI*

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[108] Once a member is identified as eligible for high-intensity pregnancy and postpartum TCS through any qualifying event/criteria listed in this section, they remain in the high-intensity category until all required TCS are completed.

[109] MCPs may use their own risk stratification or the PHM Service RSST prior to its use being required. However, once the PHM Service RSST use is required, MCPs must use the PHM Service's risk tiers. Note that prior to PHM Service RSST, MCPs must stratify members at least annually or upon a significant change in the health status or level of the member. Details on the use and frequency of updates for PHM Service RSST tier use will be updated in future policy.

[110] Criteria were selected to allow MCPs to use existing claims data and information that plans already have to support implementation.

[111] Easter, Sarah Rae et al. [Prospective clinical validation of the obstetric comorbidity index for maternal risk assessment](#). *American Journal of Obstetrics & Gynecology*, Volume 220, Issue 1, S198 - S199 (2019).

> *score for all pregnant and postpartum members, with a score >6 indicating high-risk for SMM)* [112, 113]

- Behavioral Health Risk

  - Any member determined eligible for or received services by county SMHS and/or DMC/DMC-ODS services in the last 24 months (to be distinguished from 12 months as outlined in section F.2.c. "Identification of TCS Category for Transitioning Members" for high-risk (not pregnant or postpartum members))

  - Any member who has known/suspected significant mental health or substance use disorder conditions based on claims in the past year (including diagnoses on medical claims or Medi-Cal Rx pharmacy claims for medications used for mental health or SUD needs) [114]

- Social Risk

  - Any member with a Medi-Cal Connect flag indicating potential qualification for ECM or Community Supports [114]

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[112] The OCI is a maternal risk-assessment tool that converts comorbidities into a single score (0–45), with higher scores indicating greater risk for SMM. Conditions in the OCI are mapped to claims data, and MCPs should use existing data to calculate scores. Each condition contributes a weighted value; the total score is the sum of these values. For guidance on claims-based use, MCPs should see [Validation of an obstetric comorbidity index in an external population](#) (Metcalfe et al., BJOG, Vol. 122, Issue 13). OCI may also used at the point of care. If a network hospital or other provider is using OCI, MCPs should establish data exchange with the entity to receive real-time OCI scores. If this is not feasible, MCPs must educate providers and ensure network referrals for high-intensity pregnancy and postpartum TCS services for members who meet criteria.

[113] Members already identified as meeting criteria for high-intensity TCS should continue receiving high-intensity TCS without the MCP needing to recalculate OCI. For all other members who do not meet criteria for high-intensity TCS (i.e., those receiving moderate-intensity TCS), OCI should be recalculated upon identification of a new diagnosis that is included in the OCI.

[114] Any member with known or suspected significant mental health or substance use disorder, or ECM and/or Community Supports needs, will be flagged in Medi-Cal Connect. Until the flag becomes available, MCPs may rely on their own data and discretion to determine how to implement this requirement. Once the flag is available, MCPs must use the Medi-Cal Connect flag.

- Any member currently authorized for Community Supports (e.g., housing-related supports, medically tailored meals, respite services, personal care/homemaker service)[112]

o Any member that meets high-risk criteria in another TCS risk category (e.g., LTSS or ECM) as outlined in section F.2.c. above

o Any member that is referred by a provider, care team, or discharging facility as high-risk in medical, behavioral health, or social risk based on their clinical judgment

» **Moderate-Intensity TCS Category** includes all of the following members:

o Pregnant and postpartum members who do not meet the criteria for high-intensity TCS must receive moderate-intensity TCS[115]

b. Overview of Pregnancy and Postpartum TCS Requirements

TCS must be provided during transitional events throughout pregnancy and the postpartum period (defined as the 12 months following the end of pregnancy). Eligible transitional events include any hospital or SNF discharge, as well as end of pregnancy.[116] Services should begin no later than the beginning of the 3rd trimester and prior to a transitional event to ensure a successful transition. This includes proactive engagement and timely connection of members to necessary services and supports as outlined in the TCS Birthing Supports Checklist.

c. TCS Birthing Supports Checklist

MCPs and their contracted entities must ensure completion of the TCS Birthing Supports Checklist for all pregnant and postpartum members, regardless of whether they meet criteria for high- or moderate- intensity categories.[117] MCPs are responsible for ensuring

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[115] Even if an MCP's RSST algorithm classifies a pregnant or postpartum member as lower-risk, all pregnant and postpartum members must receive at least moderate-intensity pregnancy and postpartum TCS.

[116] "End of pregnancy" is defined as the last day of the pregnancy (irrespective of whether the pregnancy ends in a live or stillbirth, or spontaneous or therapeutic abortion (SAB/TAB), regardless of where the end of pregnancy takes place.

[117] For members who experience an end of pregnancy event not resulting in a live birth (i.e., stillbirths, SABs, TABs), it is important the MCP and/or the contracted care coordination entity use emotionally and culturally sensitive communication when engaging the member and consider the supports that are most appropriate/responsive to their needs.

their contracted or assigned providers complete this checklist.[118] The purpose of this checklist is to ensure all members who are pregnant or postpartum and their infants are connected to a minimum standard of appropriate medical, behavioral health, and whole person services and supports. MCPs are already responsible for informing, referring, and connecting members to many of these services through existing MCP contract, CPSP and PHM requirements, as well as national guidelines from ACOG, USPSTF, and [AAP Bright Futures](#).

Care coordination requirements differ between the two TCS categories but both categories include referral and/or warm handoff to all services and supports on the TCS Birthing Supports Checklist for which a member has needs, meets eligibility, and aligns with their preferences. This includes access to culturally and linguistically aligned services and supports, consistent with Medi-Cal policy.

The TCS Birthing Supports Checklist is designed to be used by the primary body responsible for care coordination – either the TCS care manager or the care coordination entity. The TCS Birthing Supports Checklist can be used by both licensed (e.g., registered nurse (RN), certified nurse midwife (CNM), licensed midwife (LM), licensed clinical social worker (LCSW)) or unlicensed (e.g., CHWs, doulas, case managers) individuals on the care team. If a TCS care manager/care coordination entity is not within their scope or able to perform a specific activity/referral, they must ensure a warm handoff (to the extent possible) to a qualified care team member who is able to deliver the services (e.g., refer the member to a qualified care team member for postpartum depression screening and ensure timely follow-up based on results of the screening).

» **Timeline for completing the checklist**: Coordinating care for items on this checklist should occur throughout the pregnancy and postpartum periods. Coordination for services such as lactation, food, or transportation supports should start as early in the pregnancy as possible, when the need is identified, and prior to the end of pregnancy.

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[118] Recognizing that Birthing Supports Checklist items are coordinated/completed throughout the pregnancy and postpartum periods, DHCS encourages MCPs and contracted entities to integrate and adapt the checklist into existing workflows and EHRs. This checklist outlines required elements but is not meant to be a required form.

» **MCP Coordination:** Entities that are assigned or contracted by the MCP to complete TCS care coordination activities for their members may always contact the MCP for assistance in completing any of the below activities through the TCS Call Line, as the MCP is responsible for ensuring their contracted or assigned providers complete this Checklist. If the entity does not have or know the TCS Call Line information, they may connect through the plan's member service department.

Box C: TCS Birthing Supports Coordination Checklist (Pregnant – Postpartum Period)

The care manager or care coordination entity must ensure referral and/or warm hand off of the following services if the member has needs, meets eligibility for referral, and aligns with their preferences*:

<u>Medical Supports:</u>

» Postpartum visit according to ACOG/USPSTF Guidelines
  - o Validated Behavioral Health Screenings
  - o <u>IPV Screening</u> Using Evidence-Based Tool
  - o Reproductive Life Planning
» Pediatric visits according to AAP Bright Futures schedule through 2-month well-child visit
» Any other follow-up visits recommended by a provider (e.g., specialty provider) or included in the discharge summary and/or instructions
» Primary Care Provider visit scheduled (if no visit scheduled within the past 1 year)

<u>Whole Person Needs:</u>

Food, Nutrition Education, and Breastfeeding Supports
» WIC
» CalFresh
» Lactation Services

MCP Benefits
» Transportation Services
» Doula Services
» Appointment Assistance
» Breast Pumps
» ECM[***]
» Community Supports[***]
» CHW Services

Family Support Services
» Paid Family Leave
» Home Visiting[^]
» Parenting Resources[§]

> **Box C: TCS Birthing Supports Coordination Checklist Cont. (Pregnant – Postpartum Period)**
>
> <u>**Whole Person Needs Cont.:**</u>
>
> *Infant Support*
> - » Health Insurance for Infants
> - » WIC (including infant formula)
>
> <u>**Behavioral Health Needs**</u>
> - » Behavioral Health Supports (e.g., Non-Specialty Mental Health Services (NSMHS), Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS), Drug Medi-Cal (DMC))
> - » Dyadic Services
>
> **This includes access to culturally and linguistically aligned services and supports, consistent with Medi-Cal policy.*
> *^Home Visiting services include (but are not limited to) CDPH California Home Visiting Program (CHVP), CDSS CalWORKs Home Visiting, American Indian Maternal Support Services (AIMSS), and county First 5s, as applicable*
> ****DHCS' Closed Loop Referral (CLR) policy requires MCPs to close the loop for ECM and Community Supports services.*
> *§Parenting resources include (but are not limited to) Home Visiting services, MCP educational information, First 5, and Black Infant Health.*

d. Requirements for High-Intensity Pregnancy or Postpartum TCS (Effective July 1, 2026)

MCPs must follow all requirements outlined in section F.3. "TCS Requirements for High-Risk Members (Not Pregnant or Postpartum)" of this PHM Policy Guide when providing high-intensity TCS, with additional requirements for high-intensity Pregnancy and Postpartum TCS, as outlined below.

As noted in the TCS section of the MCP Contract and section F.3. "TCS Requirements for High-Risk Members (Not Pregnant or Postpartum)", MCPs must ensure that a single

point of contact (TCS care manager)[119] is assigned to each pregnant or postpartum member who meets criteria for high-intensity TCS and that the care manager is notified of their assignment and of the member's status. MCPs may choose either to use its own staff to accomplish this, or to contract with the hospital, a care manager embedded with the primary perinatal care team, or another appropriate delegate, such as an ACO. For members already enrolled in ECM or CCM at the time of the transition, the MCP must ensure that the member's assigned ECM Lead Care Manager (which may not be MCP staff) or CCM care manager is the identified TCS care manager and provides all high-intensity TCS. DHCS encourages plans to work with their perinatal provider networks to create models of care that do not duplicate work, particularly for perinatal providers with strong expertise and experience providing care management to pregnant and postpartum members. The TCS care manager is responsible for all TCS care management responsibilities and must assist the pregnant or postpartum member throughout their transition (see section F.3. for detailed requirements). Members re-engaged in high-intensity TCS due to an admission following the end of their pregnancy must be assigned to the same TCS care manager they were previously assigned to (consistent with section F.3.c. for all high-risk members). In these circumstances, the TCS care manager is responsible for delivering the full scope of high-intensity TCS, including revisiting/ensuring completion of the TCS Birthing Supports Checklist and fulfilling all additional requirements outlined in the section below.

i. **Beginning and End of High-Intensity Pregnancy and Postpartum TCS**

    » **Beginning of High-Intensity Pregnancy and Postpartum TCS:** TCS begins as soon as it is determined that the member meets criteria for high-intensity TCS, and no later than the beginning of the 3rd trimester, whichever is sooner (if the pregnancy status is not known until later, TCS must be engaged as soon as pregnancy is known). For pregnant and postpartum members identified as meeting criteria for high-intensity TCS due to an admission for reasons other than for delivery (and not already engaged in high-intensity TCS), high-intensity TCS begins at the time of admission.

    » **End of High-Intensity Pregnancy and Postpartum TCS:** When all of the member's needs are met and no sooner than 60 days following the end of

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[119]Consistent with general TCS policy, 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.

pregnancy or 30 days post discharge if the member is admitted for reasons other than delivery (whichever is later).[120] In addition to the minimum time of support, the following three requirements must be met:

- o Completion of the postpartum visit with a medical provider;[121]

- o Completion of the two-month well-child visit[122,123]

- o Completion of all recommended follow-up listed in the discharge summary and/or instructions.[124]

If a member has an admission more than 60 days after the end of pregnancy, TCS must continue for a minimum of 30 days after the day of discharge.

ii. Communication of Assignment to Care Manager in High-Intensity Pregnancy and Postpartum TCS

MCPs must follow all requirements outlined in section F.3. in this Policy Guide, ensuring that the responsible TCS care manager and discharging facility are informed of the assignment in a timely manner so that the TCS manager can begin coordinating with the discharge facility on discharge planning and support access to available services, including those listed on the TCS Birthing Supports Checklist (see section F.5.c. "TCS Birthing Supports Checklist").

Effective July 1, 2026, in addition to notifying the discharging facility, MCPs must also notify the perinatal provider of the TCS care manager assignment. As noted above, whenever possible, DHCS encourages MCPs to delegate the TCS care manager role (which must be a single point of contact) to a contracted perinatal provider with strong

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[120] Members who meet criteria for high-intensity TCS early in pregnancy must receive high-intensity services from the moment they are identified through at least 60 days following the end of pregnancy, potentially receiving these services for months.

[121] A postpartum visit aligns with ACOG guidelines and is therefore also required of MCPs under the MCP contract and CPSP.

[122] As applicable for pregnancies resulting in live births in which the member maintains custody of the infant.

[123] A two-month well-child visit aligns with AAP Bright Futures Periodicity Schedule and is therefore also required of MCPs under the MCP contract and PHM policy.

[124] Completion of all recommended follow-up outlined in the discharge instructions or discharge summary is required for all high-risk members, including those who are not pregnant or postpartum, since the inception of TCS in 2024.

care management experience. However, MCP staff may fulfill these high-intensity TCS requirements if an appropriate contracted perinatal provider cannot serve in this role.

iii. Care Manager Responsibilities in High-Intensity Pregnancy and Postpartum TCS

The TCS care manager responsible for providing TCS must coordinate and verify that members who meet the high-intensity criteria receive TCS as described in section F.3. This includes the following key activities:

» **Discharge Facility Coordination:** Coordination with the discharging facility and sharing of the discharge summary with providers.

» **Post-Discharge or Post-Pregnancy Outreach with Successful Connection:** Completion of post-discharge or post-pregnancy outreach to the member within 7 calendar days of discharge or if the end of pregnancy event does not include an admission, following the end of pregnancy, though it may be sooner.[125]

» **Follow-Up Care Coordination:** Ensuring that all of the member's needs are met, including those listed on the discharge summary and/or instructions, as well as any new needs identified through engagement with the member, their care providers, or by completing the TCS Birthing Supports Checklist (see Box C above).

If a postpartum member is re-engaged in high-intensity TCS due to an admission, their TCS care manager must revisit/ensure completion of relevant items in the TCS Birthing Supports Checklist.

e. Requirements for Moderate-Intensity Pregnancy and Postpartum TCS (Effective July 1, 2026)

Pregnant and postpartum members who do not meet the criteria for high-intensity pregnancy and postpartum TCS (see section F.5.a.) qualify for the moderate-intensity category.

Moderate-intensity TCS is designed to allow members to receive TCS through their routine perinatal providers – implemented as part of normal perinatal care practices – with additional support as needed from MCPs through the TCS Call Line. Moderate-intensity TCS includes requirements for care coordination by a contracted entity able to

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[125] Successful connection requires synchronous communication with the member.

provide care coordination, which could be a perinatal provider clinic or other perinatal care team (e.g., doula).[126] Specifics for moderate-intensity TCS are outlined below.

i. **Beginning and End of Moderate-Intensity Pregnancy and Postpartum TCS**

» **Beginning of Moderate-Intensity Pregnancy and Postpartum TCS:** TCS begins no later than the beginning of the 3rd trimester. If the MCP becomes aware of the pregnancy later than the beginning of the 3rd trimester (e.g., at delivery or at 34 weeks gestation), and the member is determined to require moderate-intensity TCS (e.g., the member does not meet criteria for high-intensity TCS), the MCP must ensure that a care coordination entity begins providing TCS support for the member as early as possible (as soon as they identify the pregnancy or delivery).

» **End of Moderate-Intensity Pregnancy and Postpartum TCS:** Moderate-intensity TCS ends when all of the member's needs are met, and at least through 60 days following the end of pregnancy. In addition to the minimum time of support, the following three requirements must be met:

o Completion of the postpartum visit with a medical provider[127];

o Completion of the two-month well-child visit[128]

o Completion of all recommended follow-up listed in the discharge summary and/or instructions.

ii. **Identify the Care Coordination Entity Responsible for Moderate-Intensity Pregnancy and Postpartum TCS**

Beginning February 2026, MCPs may elect to fulfill TCS requirements by assigning a single care coordination entity for members who meet criteria for moderate-intensity TCS. DHCS encourages MCPs to assign a contracted entity to serve in this role and integrate TCS responsibilities. However, MCP staff may fulfill these moderate-intensity TCS requirements if an appropriate contracted entity cannot serve in this role.

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[126] Care coordination entities – including doulas – may serve in this role so long as their contracts with MCPs support it. See section F.5.e.vi. "Additional MCP Contracting Requirements for Moderate-Intensity Pregnancy and Postpartum TCS" for additional details.
[127] A postpartum visit aligns with ACOG guidelines and is therefore also required of MCPs under the MCP contract and CPSP.
[128] A two-month well-child visit aligns with AAP Bright Futures Periodicity Schedule and is therefore also required of MCPs under the MCP contract and PHM policy.

The care coordination entity does not need to be a single identified individual. Rather, TCS care coordination can be shared across multiple staff within the entity (e.g., a clinician, nurse, CHW, or scheduling staff), as part of the normal delivery of perinatal care.

The care coordination entity is responsible for delivering care coordination activities for the member under moderate-intensity TCS.

iii. Communication of Assignment to Care Coordination Entity in Moderate-Intensity Pregnancy and Postpartum TCS

MCPs must ensure that the responsible care coordination entity is informed of their TCS responsibilities in a timely manner to begin coordinating support and services, including those listed on the TCS Birthing Supports Checklist (see section F.5.c. "TCS Birthing Supports Checklist").

MCPs must also ensure that the care coordination entity receives support from the MCP as needed, including access to the TCS Call Line.

iv. Care Coordination Entity Responsibilities for Moderate-Intensity Pregnant and Postpartum Members

With MCP oversight (see section F.7.a. "DHCS Oversight of MCPs' TCS"), the assigned care coordination entity is responsible for completing the following care coordination tasks:

» **Discharge Documentation Review:** Includes obtaining and reviewing the discharge summary and/or instructions from the delivery to review with the member and to ensure any recommended follow-up is provided to the Member, in addition to the remainder of the TCS Birthing Supports Checklist. The care coordination entity should work with the discharging facility, provider, or MCP (through the TCS Call Line) to obtain a copy of the discharge instructions/summary if they do not receive a copy of the discharge summary and /or instructions directly.

» **Post Pregnancy Outreach with Successful Connection:** The TCS care coordination entity must connect with the member within at least 21 calendar days following the end of pregnancy (or sooner based on member needs)[129]

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[129] Successful connection requires synchronous communication with the member.

» **Birthing Supports Checklist & Follow-Up Care Coordination:** The TCS care coordination entity is responsible for ensuring the completion of all needed referrals/follow-ups and ensuring all of the member's needs are met, including those listed on the discharge summary and/or instructions, as well as any new needs identified through engagement with the member, their care providers, or by completing the TCS Birthing Supports Checklist (see Box C above).

v. Additional MCP Requirements in Moderate-Intensity Pregnancy and Postpartum TCS

In addition to the requirements listed in section F.4. above for all members, MCPs are also responsible for the following specific requirements for moderate-intensity TCS:

» **Dedicated Team/Phone Number for Member Contact and Support**

o 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 outlined in section F.4.

o MCPs must remain available to supplement the care coordination entities' efforts through the dedicated TCS Call Line. MCPs must also ensure that the TCS Call Line is available to care coordination entities who require access to the discharge summary and/or instructions and/or require support in understanding or applying the TCS Birthing Supports Checklist.

vi. Additional MCP Contracting Requirements for Moderate-Intensity Pregnancy and Postpartum TCS

To ensure effective implementation of TCS for members receiving moderate-intensity pregnancy and postpartum TCS, MCPs must establish processes that guarantee the capability, quality, and accountability of contracted care coordination entities. The following expectations outline recommended MCP action related to entity capability, tracking, and training:

» **Ensuring Care Coordination Entity Capability and Infrastructure**

o MCPs must ensure that all contracted entities responsible for providing moderate-intensity TCS have the capability and infrastructure to meet minimum TCS responsibilities outlined above.

o MCPs must only contract with entities that have qualified staff with experience and training in care coordination for pregnant and postpartum individuals.

Contracted entities should also possess the knowledge and experience required to refer and/or ensure warm handoffs for all services and supports listed on the TCS Birthing Supports Checklist.

» **Tracking of Approved Care Coordination Entities**

o It is best practice for MCPs to implement robust internal procedures to select, vet, and contract with entities who have care coordination functions and can meet minimum TCS requirements.

o MCPs are encouraged to maintain a list of contracted entities who routinely successfully provide moderate-intensity care coordination services for TCS.

» **Care Coordination Entity Training and TA**

o MCPs are encouraged to provide comprehensive training and ongoing technical support to contracted entities on the appropriate use and application of the TCS Birthing Supports Checklist to ensure streamlined application.

vii. Summary of Key High- and Moderate-Intensity Pregnancy and Postpartum TCS Requirements

Table 3: High- and Moderate-Intensity Pregnancy and Postpartum TCS, Including Other Required Care Coordination Requirements: Key Requirements

Activity	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
MCP: Assignment for Care Coordination	▪ MCP to assign and notify the Single Point of Contact/Care Manager responsible for all TCS care management responsibilities ▪ Members re-engaged in high-intensity TCS due to a post-pregnancy admission must be assigned the same care manager ▪ MCP to provide additional support as needed through the TCS Call Line	▪ MCP to contract with a care coordination entity (e.g., doula group, perinatal provider's office) to complete TCS care coordination responsibilities as part of normal care ▪ MCP to provide additional support as needed through the TCS Call Line

Activity	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
Discharge Facility Coordination	TCS care manager to coordinate with the discharge facility	- MCP to provide support to the discharge facility as needed through the TCS Call Line - MCP to support care coordination entity in obtaining discharge summary and/or discharge instructions as needed - MCP to provide support as needed through the TCS Call Line
Follow-Up Care Coordination	- TCS care manager to review discharge summary and/or instructions from discharge facility with member - TCS care manager to ensure all needs are met, including those listed on the discharge summary and/or instructions and the TCS Birthing Supports Checklist	- TCS care coordination entity to review discharge summary and/or instructions from discharge facility with member - TCS care coordination entity to ensure all needs are met, including those listed on the discharge summary and/or instructions and the TCS Birthing Supports Checklist - MCP to provide support as needed through the TCS Call Line
Post-Discharge or Post-Pregnancy Outreach with Successful Connection to Member	TCS care manager to perform member outreach with successful connection within 7 calendar days of discharge or following the end of pregnancy	TCS care coordination entity performs member outreach with successful connection within 21 calendar days following the end of pregnancy (or sooner based on member needs)

Activity	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
Follow-Up Visit	▪ Provider visits per ACOG guidelines and discharge instructions	▪ Provider visits per ACOG guidelines and discharge instructions
TCS Support Begins	▪ As soon as it is determined that the member meets high-intensity criteria, and no later than the beginning of the 3rd trimester[130]	▪ No later than the beginning of the 3rd trimester
TCS Support Ends	▪ No sooner than 60 days following end of pregnancy or 30 days post discharge (if the member is admitted for reasons other than delivery) (whichever is later) and must include the completion of the following three milestones: ○ Postpartum visit ○ Two-month well child visit ○ Completion of specific recommended follow-up visits identified in the discharge summary and/or instructions	▪ No sooner than 60 days following end of pregnancy and must include the completion of the following three milestones: ○ Postpartum visit ○ Two-month well child visit ○ Completion of specific recommended follow-up visits identified in the discharge summary and/or instructions

6. 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

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[130] If the pregnancy status not known until later, then the MCP must engage as soon as pregnancy is known), or at the time of non-delivery admission (pre- or post-delivery)

care for TCS per MHP-MCP MOU requirements.[131]

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.[132]

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

a. 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.

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

For members who are admitted for an acute psychiatric hospital, psychiatric health

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[131] MHP-MCP MOU Template, 11. Data Sharing and Confidentiality. a. Data Exchange; CalAIM Data Sharing Authorization Guidance VERSION 2.0 June 2023
[132] 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.

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 F.2.c. "Identification of TCS Category for 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.

c. 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.

7. DHCS Oversight and Monitoring of MCPs' 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.

a. DHCS Oversight of MCPs' TCS

To ensure effective implementation of MCPs' TCS across populations and risk tiers, DHCS will conduct oversight of MCPs and their contracted entities. DHCS' oversight over MCPs will differ based on TCS category as outlined below.

i. DHCS Oversight of MCPs High-Risk TCS (Not-Pregnant or Postpartum) and High-Intensity Pregnancy and Postpartum TCS

MCPs are accountable for providing TCS in the high-risk and high-intensity categories. DHCS will conduct targeted, member-level oversight to ensure that MCPs and their contracted entities are meeting TCS requirements for members receiving high-risk and high-intensity TCS. Monitoring activities will apply to both the high-risk and the high-intensity TCS categories and include:

> » Individual-level monitoring and case reviews
>
> » Site visits to MCPs
>
> » Audits of TCS delivery
>
> » Review of TCS-related KPIs, including quarterly reporting, once available

ii. DHCS Oversight of MCPs Moderate-Intensity Pregnancy and Postpartum TCS

DHCS will monitor MCPs' oversight of contracted entities that are responsible for delivering TCS to pregnant and postpartum members that have been determined to meet the definition for moderate-intensity TCS. DHCS will not complete targeted, member-level monitoring. Instead, oversight will focus on whether MCPs have the following quality assurance mechanisms in place:

> » Random spot checks and chart reviews

- » Member interviews or surveys

- » Monitoring of data on completed services

- » Corrective action processes (e.g., via additional training, increased monitoring, direct TCS provision by MCP staff, or termination of the contracted entity if they are unable to provide minimum TCS requirements)

- » Review of TCS-related KPIs, including quarterly reporting, once available

iii. DHCS Oversight of MCPs Lower-Risk TCS

DHCS will monitor MCPs' processes and procedures to ensure the appropriate delivery of lower-risk TCS. Oversight may include:

- » Monitoring of MCPs' processes and procedures for the fulfillment of lower-risk TCS to Medi-Cal Members

- » Random spot checks or record review for call line operation, availability of the call line for member communication, and member support

- » Review of TCS related KPIs, including quarterly reporting, once available

b. DHCS Monitoring of MCPs' 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 Care Management for High-Risk Members after Discharge (CMHRD) and Follow-Up Ambulatory Visit After Hospital Discharge (FUAH)", as well as member outcomes through specific quality measures. More details on DHCS monitoring of TCS implementation will be forthcoming including TCS-specific requirements for pregnant and postpartum members. In addition, there will be a greater focus on service utilization in primary care, 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 (Updated July 2025)

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 reviews 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 is monitoring the implementation of the PHM Program include Children and Youth, Birthing Populations, and Individuals with Behavioral Health Needs, which align with the clinical focus areas in DHCS's CQS. DHCS may monitor the implementation of the PHM Program for seniors and dual-eligible members as a population of focus in the future. DHCS is also monitoring equity across all monitoring domains and categories. The monitoring domains and detailed categories are found in Table 4.

Table 4. PHM Monitoring Domains and Categories

Monitoring Domains	Categories
PHM Program Areas/Themes	Basic Population Health Management (BPHM)
	» Prevention Services
	» Primary Care Engagement/ Appropriate Utilization
	» Chronic Disease Management
	» CHW Integration
	» Risk Stratification Segmentation and Tiering (RSST)
	» Complex Care Management (CCM)
	» Enhanced Care Management (ECM)
	» Transitional Care Services (TCS)
	» Children and Youth

Monitoring Domains	Categories
Populations	» Birthing Populations
	» Individuals with Behavioral Health Needs
Cross Cutting Priorities	» Equity (include all stratified measures)

Within each category, DHCS has identified and is reviewing a set of quality measures, and where needed to supplement these quality measures, DHCS reviews key performance indicators (KPIs). Existing quality and performance improvement processes, such as the Medi-Cal Managed Care Accountability Set (MCAS), assess each measure individually and, as applicable, applies penalties against individual measure performance within a specific time period. For PHM monitoring, DHCS is reviewing 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 is 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 conducts routine engagement with MCPs on MCPs' PHM programs to ensure regular, bidirectional communication on implementation challenges and successes. DHCS will use these engagements 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 their own monitoring approaches to regularly assess their own PHM program.

The PHM monitoring approach will evolve over time. DHCS anticipates adding KPIs and quality measures to monitoring categories in the future. DHCS may also add additional populations or cross-cutting priorities. As Medi-Cal Connect continues to be implemented with greater capabilities, the monitoring strategy will evolve to further leverage its reporting and analytics functionalities.

A. 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 quality measures reported through the annual quality and performance improvement process as well data that are continually available via Medi-Cal Connect.

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 began in Q3 2023. MCPs submitted their first KPIs in August 2023 from Q1 and Q2 2023. While audited 2023 quality measure data was not available until 2024, DHCS began looking at quality measures in 2023, using 2022 data. Data collection was then paused while technical specifications were updated and resumed in 2026 using 2025 data. The reporting frequencies for different KPIs for PHM monitoring are as follows:

- » PHM Monitoring KPIs: Quarterly
- » MCAS measures: No additional reporting mechanisms or cadence are required.

DHCS anticipates that MCPs' MCAS measure performance will be available on a rolling basis within Medi-Cal Connect. At such a time, these data will be reviewed quarterly. Until this functionality is available, PHM Program Monitoring will utilize existing data sources on MCAS measure performance, and MCPs will have no additional PHM reporting requirements for MCAS measures.

Regardless of reporting frequency, DHCS expects MCPs to internally monitor all KPI performance more frequently (i.e., on a monthly basis) as part of continuous quality improvement.

1. Quality Measures

DHCS reviews existing data from a subset of MCAS quality measures reported through the existing annual quality and performance improvement process to monitor MCPs' PHM Programs. See Table 5 below for a list of the quality measures DHCS reviews for PHM monitoring; the table also indicates which quality measures are used for the children and youth, birthing populations, and individuals with behavioral health needs population-level analyses. MCPs do 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 reviews 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 level[133] in January-May, and audited measure data are released to DHCS in July for internal validation. For PHM monitoring, DHCS aggregates the existing data from the quality measures below 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 measures in the future.

Table 5. PHM Monitoring Quality Measures

Quality Measures to Be Reviewed for PHM Monitoring Starting in Q1 2026	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
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	✓·	✓·		

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[133] 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 Q1 2026	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
Colorectal Cancer Screening	✓·			
Breast Cancer Screening	✓·			
Cervical Cancer Screening	✓·		✓·	
Controlling High Blood Pressure	✓·			
Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9%)	✓·			
Follow-Up After ED Visit for Mental Illness – 30 days	✓·			✓·
Follow-Up after ED Visits for Substance Use – 30 days	✓·			✓·
Plan All-Cause Readmissions	✓·			

Quality Measures to Be Reviewed for PHM Monitoring Starting in Q1 2026	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: Postpartum Care	✓·		✓·	

2. KPIs

DHCS also reviews 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 as Medi-Cal Connect's functionalities increase. **MCPs are only required to report on six KPIs specific to PHM monitoring, including one KPI that was previously included as part of the Incentive Payment Program measure set.**

While MCPs are required to report the six 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 calculates the KPIs at a plan level using existing data from DHCS where possible and matches against what MCPs submit on a quarterly basis. If there are inconsistencies, DHCS probes further and requests county or member-level data from MCPs if needed.

See Table 6 below for a list of the KPIs DHCS reviews for PHM monitoring; the table also indicates which KPIs are 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 determined and implemented until the Medi-Cal

Connect RSST functionalities are available. MCPs are required to stratify and report these six KPIs by race, ethnicity, language, and age on a plan-level as specified in Appendix 5: PHM Monitoring KPI Technical Specifications:

PHM has developed a separate but complementary monitoring approach for Enhanced Care Management. Details and ECM measures can be found in the Enhanced Care Management Policy Guide[134] and are not included below.

Table 6. PHM Monitoring KPIs

PHM Monitoring Categories	KPIs to be Reported Starting in Q1 2026	For Children and Youth Population Analysis	For Birthing Population Analysis	For Individuals with Behavioral Health Needs Population Analysis
BPHM – Primary Care Engagement/ Appropriate Utilization	EDPC: Members Utilizing Emergency Department Care More than Primary Care	✓·		
	ENPC: Members Engaged in Primary Care	✓·		
	ENPC-A: Members Engaged in Primary Care at Assigned Primary Care Site	✓·		
Complex Care Management (CCM)	CCME: Complex Care Management Enrollment	✓·		
Transitional Care Services	CMHRD: Care Management for High-Risk Members after	✓·	✓	✓·

[134] ECM Policy Guide

PHM Monitoring Categories	KPIs to be Reported Starting in Q1 2026	For Children and Youth Population Analysis	For Birthing Population Analysis	For Individuals with Behavioral Health Needs Population Analysis
(TCS)	Discharge			
	FUAH: Follow-Up Ambulatory Visit After Hospital 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 for which DHCS has internal data (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 who had at least one primary care visit with their assigned primary care provider within a 12-month period), DHCS calculates stratifications using the same technical specifications in Appendix 5: List of KPIs for PHM Monitoring Approach. Then DHCS matches these internal stratifications with what MCPs submit on a quarterly basis. If there are inconsistencies, DHCS probes further and requests member-level data from MCPs if needed. Using Medi-Cal Connect, DHCS may also 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 and are fully implemented, such as providing Transitional Care Services for selected populations in 2024 or completing closed-loop referrals for ECM and Community Supports in 2025.

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

As stated above, DHCS reviews 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 reviews 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 but may consider doing so in the future.

If any concerns arise in any PHM monitoring category, DHCS engages 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:

o How does your PHM program support this monitoring category? What specific program initiatives address improvements in the category?

o What changes have you made to your PHM program in the last year?

o What internal monitoring do you have in place to manage your PHM program performance?

o What challenges does your MCP face in addressing members' health in this category?

o 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 does not change; PHM monitoring is 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.[135]

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

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[135] Welfare and Institutions Code, § 14197.7

IV. IMPLEMENTATION TIMELINE (Updated January 2026)

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 in the first two years of CalAIM, please refer to the DHCS [CalAIM Timelines](#) [webpage](#).

PHM Program Implementation Timeline

Q1 2023

» **DHCS Policy/Guidance**
- Elimination of IHEBA/SHA and Replacement of Initial Health Assessment with Initial Health Appointment(s)
- APLs 17-012 and 17-013 were superseded by [APL 22-024](#)

» **Program Go-Live Dates**
- January 1: PHM Program went live statewide
- January 1: ECM went live statewide for Long-Term Care (LTC) Populations of Focus

Q2 2023

» **DHCS Policy/Guidance**
- Publication of DHCS Monitoring Approach for Implementation of PHM Program

» **MCP Deliverables**
- May: PHM Policies and Procedures due for new plans to align with requirements in [APL 22-024](#)

Q3 2023

» **DHCS Policy/Guidance**
- August: APL 19- 011 is superseded by [APL 23-021](#) on new PNA/PHM Strategy deliverable requirements, which is accompanied by updates to the PHM Policy Guide with guidance on the PNA[136] and DHCS PHM Strategy Deliverable

» **MCP Deliverables**

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[136] As of January 2026, the PHM Policy Guide refers to PNA requirements as Local Planning requirements.

- o August: MCPs to submit first set of data on KPIs for PHM monitoring
  - » **Program Go-Live Dates**
    - o July 1: ECM went live statewide for Children and Youth Populations of Focus

Q4 2023
- » **DHCS Policy/Guidance**
  - o October: Updates to the Policy Guide with modified guidance on TCS policy and specific guidance on screening and assessments under the 2024 MCP Transition
  - o December: Updates to the Policy Guide with more detailed guidance on the modified PNA[137]
- » **MCP Deliverables**
  - o October: DHCS PHM Strategy Deliverable due for current plans under revised requirements. Annual submission thereafter

Q1 2024
- » **DHCS Policy/Guidance**
  - o January 1: New MCP Contract Goes Live
- » **Program Go-Live Dates**
  - o January 1: ECM went live statewide for Birth Equity Population of Focus

Q2 2024:
- » **DHCS Policy/Guidance**
  - o May: PHM Policy Guide updated

Q4 2024:
- » **MCP Deliverables**
  - o October: DHCS PHM Strategy Deliverable due for the first time for new plans and annually thereafter.

Q2 2025:
- » **DHCS Policy/Guidance**
  - o May: Updated CLR Implementation Guidance and new CLR FAQs released

Q3 2025:
- » **DHCS Policy/Guidance**
  - o July: PHM Policy Guide updated

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[137] As of January 2026, the PHM Policy Guide refers to PNA requirements as Local Planning requirements.

- » **Program Go-Live Dates**
  - o July 1: CLR requirements go live for ECM and Community Supports

Q4 2025:
- » **DHCS Policy/Guidance**
  - o October: [PHM Key Performance Indicator Technical Specifications Updates](#)

Q1 2026:
- » **DHCS Policy/Guidance**
  - o January: PHM Policy Guide Update
- » **MCP Deliverables**
  - o January: PHM KPI Data Reporting Due
  - o February: PHM Strategy Deliverable Due

APPENDICES

V. APPENDIX 1: KEY TERMINOLOGY (Updated July 2025)

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. **Closed-Loop Referral (CLR)** is a referral for specific services initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a known closure as outlined in Exhibit A, Attachment III, Subsection 4.3.8.A.12 Basic Population Health Management of the Medi-Cal Managed Care Plan (MCP) Contract.

7. **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.

8. **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.[138]

9. **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.

10. **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.[139]

11. **Health Risk Assessment (HRA)** is an assessment required for Seniors and Persons with Disabilities. Effective January 1, 2023, HRA assessment requirements for Seniors and Persons with Disabilities are simplified, while specific member protections are kept in place.

12. **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.[140]

13. **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).[141]

14. **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

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[138] EPSDT in Medicaid. Medicaid and CHIP Payment and Access Commission. DHCS specific requirements on EPSDT is outlined in APL 23-010.

[139] 42 CFR 438.208(b)(3)-(4)

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

[141] 2024 Re-Procurement. Exhibit A, Attachment I, Definitions and Acronyms

facility, or other institutional setting. LTSS includes both LTC and HCBS and includes carved-in and carved-out services. [142]

15. **Medi-Cal Connect, previously referred to as 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.

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. **DHCS Population Health Management Strategy (PHM) Deliverable** is an annual deliverable that MCPs submit to DHCS to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

18. **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.

19. **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.

20. **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.

21. **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.

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[142] 2024 Re-Procurement. Exhibit A, Attachment I, Definitions and Acronyms

22.**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).

23.**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.

VI. APPENDIX 2: RELEVANT ALL PLAN LETTERS (APLS) AND UPDATES (Updated January 2026)

Topic Within PHM Framework	Existing APLs	Upcoming Updates and Timing
Initial Health Appointment(s)	**APL 26-001 "Initial Health Appointment"**	Supersedes APL 22-030
Community Reinvestment	**APL 25-004 "Community Reinvestment Requirements"**	
Community Health Workers	**APL 24-006** "Community Health Worker Services Benefit"	Supersedes APL 22-016
PNA and PHM Strategy	**APL 23-021** "Population Needs Assessment [143] and PHM Strategy"	Supersedes APL 19-011.
HRA/Risk Stratification/Care Management Plans	**APL 22-024** "Population Health Management Policy Guide"	Supersedes APL 17-013 and APL 17-012.
Initial Health Appointment(s) and IHEBA/SHA	**APL 22-030** "Initial Health Appointment"	Supersedes PL 08-003, 13-001, and APL 13-017
Preventative Health	**APL 16-014** "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries"	This APL will be superseded to decouple requirements from outdated IHEBA/SHA requirement sometime in the future.

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[143] As of January 2026, the PHM Policy Guide refers to PNA requirements as Local Planning requirements.

Topic Within PHM Framework	Existing APLs	Upcoming Updates and Timing
	APL 18-004 Immunization Requirements"	No changes.
	APL 20-004 "Emergency Guidance for Medi-Cal Managed Care Plans in Response to COVID-19"	Retired.

VII. 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.

A. 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)

B. 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

VIII. APPENDIX 4: LIST OF QUALITY MEASURES AND DESCRIPTIONS FOR PHM MONITORING APPROACH (Updated July 2025)

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
1392 (W30-6+)	NCQA	**Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – 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 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.
1516 (WCV)	NCQA	**Child and Adolescent Well-Care Visits**	Assesses children 3–21years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.
0034 (COL- E)	NCQA	**Colorectal Cancer Screening**	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

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.
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: » 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.
(GSD)	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**	Assesses adults 18–85 years of age

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
		Pressure	who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).
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. 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,

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			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 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.
1517 (PPC-Pst)	NCQA	**Prenatal and Postpartum Care: Postpartum Care**	*Postpartum Care.* The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.

IX. APPENDIX 5: LIST OF KPIS FOR PHM MONITORING APPROACH (Updated July 2025)

The table below defines the six KPIs for which MCPs will be required to submit data. The accompanying technical specifications for these KPIs are forthcoming. Plans will not be expected to begin reporting on these KPIs until after the updated, finalized technical specifications have been issued.

KPIs to be reported starting in Q4 2025	PHM Program Area	Definitions
EDPC: Percentage of members who had more ED visits than primary care visits within a 12-month period	BPHM - Primary Care Engagement/ Appropriate Utilization	**Numerator:** The number of members who have more ED visits than primary care visits within a 12-month period. **Denominator:** The total number of enrolled members in the MCP.
ENPC: Percentage of members who had at least one primary care visit within a 12-month period	BPHM - Primary Care Engagement/ Appropriate Utilization	**Numerator:** The number of members who had at least one PCP visit within a 12-month period. **Denominator:** The total number of enrolled members in the MCP.
ENPC-A: Percentage of members who had at least one primary care visit with their assigned provider in a 12-month period.	BPHM - Primary Care Engagement/ Appropriate Utilization	**Numerator:** The number of members who had at least one primary care provider visit within a 12-month period at the primary care site where the member is assigned for primary care. **Denominator**: The total number of enrolled members in the MCP.
CCME: Percentage of members eligible for CCM who are successfully enrolled in	CCM	**Rate A Numerator:** The number of members who are enrolled in CCM for 1 or more days during the Measurement Period. **Rate A Denominator:** The number of members

KPIs to be reported starting in Q4 2025	PHM Program Area	Definitions
the CCM program		eligible for CCM for 1 or more days during the Measurement Period. **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. **Rate B Denominator:** The 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.
CMHRD: 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.
FUAH: 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.

X. APPENDIX 6: OVERVIEW OF KEY TRANSITIONAL CARE SERVICES (TCS) ELEMENTS BY CATEGORY (Updated January 2026)

Elements	High-Risk TCS (Not Pregnant or Postpartum)	Lower-Risk TCS (Not Pregnant or Postpartum)	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
Overview of TCS Category	▪ Any member that is not pregnant or postpartum member who meets high-risk criteria outlined in section II.F.2.c.	▪ Any member that is not pregnant, postpartum, or identified as high-risk per the criteria outlined in section II.F.2.c.	▪ Any pregnant or postpartum member who meets any one of the criteria outlined in section II.F.5.a.	▪ Any pregnant or postpartum member who does <u>not</u> meet the criteria for the high-intensity TCS outlined in section II.F.5.a.
MCP: Assignment for Care Coordination	▪ MCP to assign and notify the Single Point of Contact/Care Manager responsible for all TCS care management responsibilities	▪ MCPs to directly notify members about the dedicated TCS team/phone line and how to access it. ▪ MCP to support members as needed through the TCS Call Line	▪ MCP to assign and notify the Single Point of Contact/Care Manager responsible for all TCS care management responsibilities	▪ MCP to contract with a care coordination entity (e.g., doula group, perinatal provider's office) to complete TCS care coordination

Elements	High-Risk TCS (Not Pregnant or Postpartum)	Lower-Risk TCS (Not Pregnant or Postpartum)	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
	▪ MCP to provide additional support as needed through TCS Call Line		▪ Members reengaged in high-intensity TCS due to a post-pregnancy admission must be assigned the same care manager ▪ MCP to provide additional support as needed through the TCS Call Line	responsibilities as part of normal care ▪ MCP to provide additional support as needed through the TCS Call Line
Discharge Facility Coordinat-ion	▪ TCS care manager to coordinate with the discharge facility	▪ MCP to provide support to the discharge facility as needed through the TCS call line	▪ TCS care manager to coordinate with the discharge facility	▪ MCP to provide support to the discharge facility as needed through the TCS Call Line ▪ MCP to support care coordination entity in obtaining discharge summary and/or discharge

Elements	High-Risk TCS (Not Pregnant or Postpartum)	Lower-Risk TCS (Not Pregnant or Postpartum)	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
				instructions as needed • MCP to provide support as needed through the TCS Call Line
Follow-Up Care Coordination	• TCS care manager to ensure all needs are met, including those listed on the discharge summary and/or instructions and medication reconciliation	• MCP to support as needed through the TCS Call Line	• TCS care manager to review discharge summary and/or instructions from discharge facility with member • TCS care manager to ensure all needs are met, including those listed on the discharge summary and/or instructions and the TCS Birthing Supports Checklist	• TCS care coordination entity to review discharge summary and/or instructions from discharge facility with member • TCS care coordination entity to ensure all needs are met, including those listed on the discharge summary and/or instructions

Elements	High-Risk TCS (Not Pregnant or Postpartum)	Lower-Risk TCS (Not Pregnant or Postpartum)	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
				and the TCS Birthing Supports Checklist ■ MCP to provide support as needed through the TCS Call Line
Post-Discharge or Post-Pregnancy Outreach with Successful Connection to Member	■ TCS care manager to perform outreach with successful connection to member within 7 calendar days post-discharge	■ MCP to support as needed through the TCS Call Line	■ TCS care manager to perform member outreach with successful connection within 7 calendar days of discharge or following the end of pregnancy	■ TCS care coordination entity performs member outreach with successful connection within 21 calendar days of discharge or following the end of pregnancy (or sooner based on member needs)

Elements	High-Risk TCS (Not Pregnant or Postpartum)	Lower-Risk TCS (Not Pregnant or Postpartum)	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
Follow-Up Visit	• TCS care manager to ensure follow-up visit with medical provider occurs within 7 days post-discharge	• MCP must ensure follow-up visit with medical provider occurs within 30 days post-discharge	• Provider visits per ACOG guidelines and discharge instructions	• Provider visits per ACOG guidelines and discharge instructions
TCS Support Begins	• TCS support begins on admission	• TCS support begins on admission	• As soon as it is determined that the member meets high-intensity criteria, and no later than the beginning of the 3rd trimester[144]	• No later than the beginning of the 3rd trimester
TCS Support Ends	• TCS support ends when all needs are met, and a minimum	• TCS support ends at a minimum of 30 days post discharge	• No sooner than 60 days following end of pregnancy or 30 days post discharge	• No sooner than 60 days following end of pregnancy and must include the

[144] If the pregnancy status not known until later, then the MCP must engage as soon as pregnancy is known), or at the time of non-delivery admission (pre- or post-delivery)

Elements	High-Risk TCS (Not Pregnant or Postpartum)	Lower-Risk TCS (Not Pregnant or Postpartum)	High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
	of 30 days post discharge		(if the member is admitted for reasons other than delivery) (whichever is later) and must include the completion of the following three milestones: o Postpartum visit o Two-month well child visit o Completion of specific recommended follow-up visits identified in the discharge summary and/or instructions	completion of the following three milestones: o Postpartum visit o Two-month well child visit o Completion of specific recommended follow-up visits identified in the discharge summary and/or instructions