CALAIM: POPULATION HEALTH MANAGEMENT (PHM) KEY PERFORMANCE INDICATORS

Technical Specifications

Updated October 2025

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Summary of Changes to PHM KPI Technical Specifications

The list of measures and the technical specifications for the PHM KPIs have been revised from a total of five to now six. The original KPI 3 has been removed. Two additional KPIs have been added: one measure that was previously an Incentive Payment Plan (IPP) measure, and one new measure. To provide more clarity to the names, DHCS is now utilizing acronyms for each measure instead of numbers. DHCS have also made updates to the technical specifications for all KPIs to improve clarity and validity of the measures.

- **Measure Added:** Members Engaged in Primary Care at Assigned Primary Care Site (ENPC-A)
- **Measure Added:** Follow-up Ambulatory Visit After Hospital Discharge (FUAH). Previously an Incentive Payment Program (IPP) measure
- **Measure Removed:** Members Not Engaged in Ambulatory Care (previously PHM KPI 3)

Changes Applicable to all KPIs

- **Naming**: All KPIs are now identified with acronyms rather than numbers.
- **Measurement Period:** The measurement period is now standardized across all KPIs as "The 12-month period beginning 16 months prior to the time of reporting." Additionally, there is an allowable claims and encounter runout time for historical performance calculations.
- **Exclusions:** The following exclusions have been added for all KPIs:
  - Members who died during the measurement period.
  - Members with other primary health insurance coverage.
- **Inclusions:** The inclusion of members with Medi-Cal who also have other insurance limited to vision or dental services has been clarified.
- **Age Bands:** The age bands applicable to all KPIs have been revised with additional categories.
- **Race:** The race categories applicable to all KPIs have been revised.
- **Language:** The language categories applicable to all KPIs have been revised.

Instructions for all KPIs

- Please use the most recent available NCQA value sets.

EDPC: Members Utilizing Emergency Department Care More than Primary Care

Summary of Changes

- **Continuous Enrollment:** There is now a requirement for 6 months of continuous enrollment (CE) during the measurement period.
- **Emergency Department and Primary Care Visits**: The maximum number of visits for any one member in a given day is 1.
- **Primary Care Visit Identification**: All three steps for identifying primary care visits have been revised:
    - **Step 1:** The NCQA value sets used to identify ambulatory or preventive care visits, including prenatal and postpartum care were revised.
    - **Step 2**: The provider types and associated taxonomy codes were revised. A table demonstrating qualifying pathways using information on the billing and rendering provider of each encounter was included.
    - **Step 3**: The service setting and associated place of service codes were revised.
- **Emergency Department visits:** Denominator specifications were updated to exclude members who had only one ED visit during the measurement period.
- *See additional changes applicable to all KPIs on page 1.*

Description

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

Definitions

Measurement Period: The 12-months period beginning 16 months prior to the time of reporting. The measurement period always starts from the 1st of the start month to the end of the last month. For instance, if submitting on August 1, 2024, the measurement period would start on April 1, 2023, and end on March 31, 2024.

Allowable claims and encounter runout time: If this specification is used to calculate historical performance to allow trending over time (i.e. in periods prior to the publication of this updated technical specification), exclude any claims and encounter data for services provided during the measurement period but submitted more than 90 days after the last day of the Measurement Period. This approach is used to simulate

incomplete claims data that would have occurred in ongoing, regular reporting of this KPI.

Emergency Department Visit: An ED visit as defined by the NCQA ED Value Set. The maximum number of visits for any one member in a given day is 1.

Primary Care Provider: Primary care is defined by DHCS as care usually rendered in ambulatory settings by Primary Care Providers (PCP) and emphasizes the Member's preventive health needs, general health needs, and chronic disease management. The maximum number of visits for any one member in a given day is 1.

A PCP is a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN).

Primary Care Visit: A primary care visit is defined as an ambulatory or preventive visit delivered by a Primary Care Provider, as identified in the methodology below. For the purposes of this KPI, a primary care visit does not have to be with a member’s assigned PCP.

Eligible Population

Ages: Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.

Continuous Enrollment: There is a requirement for six months of continuous enrollment (CE) during the measurement period. The denominator and numerator for this measure should only include members who are continuously enrolled for any 6 continuous months during the measurement period.

When calculating CE, do not count any months during which members had any other primary insurance coverage, except for members enrolled in Medicare Medi-Cal Plans (MMPs), which were formally known as Exclusively Aligned Enrollment D-SNPs (EAE D-SNPs). For example, any months in which members had Medicare coverage outside of MMPs should be excluded from CE determinations. Months during which members have Medi-Cal coverage and other insurance limited to vision or dental services should remain included.

Required Exclusion: Members in hospice or using hospice services anytime during the Measurement Period; use the following NCQA value sets:

- Hospice Encounter Value Set
- Hospice Intervention Value Set

Members who died during the measurement period.

Members with other primary health insurance coverage are excluded, except for members enrolled in Medicare Medi-Cal Plans (MMPs), which were formally known as Exclusively Aligned Enrollment D-SNPs (EAE D-SNPs). Members with any form of Medicare coverage outside of MMPs should be excluded.

Exclusion based on other primary health insurance is for members with comprehensive insurance coverage. Members with Medi-Cal who also have other insurance limited to vision or dental services should remain included. Eligible Population

Administrative Specification

Denominator

The total cumulative and unduplicated number of enrolled members in the Managed Care Plan during the Measurement Period who meet inclusion criteria.

Numerator

The number of enrolled members who have had more ED visits than Primary Care Visits within a 12-month period.

For each member, determine:

ED Visits: Use the NCQA ED Value Set to calculate the number of ED visits in the Measurement Period for each member. The maximum number of visits for any one member in a given day is 1. This count should include all ED Visits regardless of whether they lead to an inpatient admission or transfer.

Primary Care Visits: Use the following steps to calculate the number of Primary Care Visits in Measurement Period for each member. Steps 1, 2, and 3 must all be passed to identify a primary care encounter.

Step 1: Visit Identification

Use the following NCQA value sets to identify ambulatory or primary care visits in the last 12 months for each member:

- Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Well Care Visit Value Set
- Encounter for Well Care Value Set

- Reason for Ambulatory Visit Value Set
- Prenatal Visit Value Set
- Stand Alone Prenatal Visit Value Set
- Postpartum Care Visit Value Set
- Encounter for Postpartum Care Value Set

The maximum number of visits for any one member in a given day is 1.

Step 2: Provider Identification

Of these visits, identify visits conducted by primary care providers based on criteria for both Plan contracting (Step 2a) and taxonomy (Step 2b).

Steps 2a and 2b must be independently true. For instance, if a visit meets Step 2a via a rendering provider and meets Step 2b via a billing provider, this is acceptable. See Table 2 for full pathways on how billing and rendering providers on a claim can meet Step 2.

Step 2a, Plan Contracting: The NPI of the rendering or billing provider on the qualifying claim or encounter is flagged in at least one of the monthly 274 Health Care Provider Directory File that the Managed Care Plan submits to DHCS during the Measurement Period as being a PCP. This flag is defined as a value of "3E" in field "2120DA TPB01" (site) or "2120EA TPB01" (provider) in the 274 Health Care Provider Directory File. This may appear as two separate tables.

AND

Step 2b, Provider Taxonomy: The NPI of the rendering or billing provider of the visit is identified within the taxonomy code list below. This taxonomy information should be pulled from the claim or encounter, when available. If no taxonomy information is available within the claim or encounter, the primary taxonomy code of the provider should be obtained from the National Plan and Provider Enumeration System (NPPES).

Table 1: Taxonomy Code List

Provider Type	Taxonomy
Family Medicine	207Q00000X
Family Medicine - Adolescent Medicine	207QA0000X
Family Medicine - Adult Medicine	207QA0505X
Family Medicine - Geriatric Medicine	207QG0300X
Internal Medicine	207R00000X
Internal Medicine - Adolescent Medicine	207RA0000X
Internal Medicine - Geriatric Medicine	207RG0300X
Obstetrics & Gynecology	207V00000X
Obstetrics & Gynecology – Gynecology	207VG0400X

Provider Type	Taxonomy
Pediatrics	208000000X
Pediatrics - Adolescent Medicine	2080A0000X
General Practice	208D00000X
Clinic/Center	261Q00000X
Clinic/Center - Critical Access Hospital	261QC0050X
Clinic/Center - Community Health	261QC1500X
Clinic/Center - Federally Qualified Health Center (FQHC)	261QF0400X
Clinic/Center - Health Service	261QH0100X
Clinic/Center - Migrant Health	261QM1000X
Clinic/Center - Multi-Specialty	261QM1300X
Clinic/Center - Public Health, Federal	261QP0904X
Clinic/Center - Public Health, State or Local	261QP0905X
Clinic/Center - Primary Care	261QP2300X
Clinic/Center - Rural Health	261QR1300X
Physician Assistant	363A00000X
Physician Assistant - Medical	363AM0700X
Nurse Practitioner	363L00000X
Nurse Practitioner - Adult Health	363LA2200X
Nurse Practitioner - Community Health	363LC1500X
Nurse Practitioner - Family	363LF0000X
Nurse Practitioner - Gerontology	363LG0600X
Nurse Practitioner - Pediatrics	363LP0200X
Nurse Practitioner - Primary Care	363LP2300X
Nurse Practitioner - Women's Health	363LW0102X
Nurse Practitioner - Obstetrics & Gynecology	363LX0001X

Table 2: Qualifying Pathways for Step 2, Combinations of Billing and Rendering Provider Characteristics

For Step 2a: Is a PC Site or Provider in 274 File? (Yes [Y]/No[N])

Qualifying Pathways	Billing Provider	Rendering Provider*
1	N	Y
2	N	Y
3	N	Y
4	Y	N
5	Y	Y
6	Y	N

Qualifying Pathways	Billing Provider	Rendering Provider*
7	Y	N
8	Y	Y
9	Y	Y

*If Rendering Provider is absent on an encounter, assume 'N.'

For Step2b: Provider's taxonomy code in Step 2b table? (Yes [Y]/No[N])

Qualifying Pathways	Billing Provider	Rendering Provider*
1	N	Y
2	Y	N
3	Y	Y
4	N	Y
5	N	Y
6	Y	N
7	Y	Y
8	Y	N
9	Y	Y

*If Rendering Provider is absent on an encounter, assume 'N'

Step 3: Service Setting Identification

Of these visits remaining, identify those visits with a Place of Service code on the claim or encounter included in the list below. If the Place of Service code is missing, Plans may use the "Type of Bill" field as described below.

Table 3: Place of Service Codes

Service Setting	Place of Service Code
Telehealth	02
Homeless Shelter	04
Indian Health Service Free-standing Facility	05
Tribal 638 Free-standing Facility	07
Prison/Correctional Facility	09
Telehealth Provided in Patient's Home	10
Office	11
Home	12
Mobile Unit	15

Service Setting	Place of Service Code
Temporary Lodging	16
Place of Employment-Worksite	18
Off Campus-Outpatient Hospital	19
On Campus-Outpatient Hospital	22
Outreach/Street Site	27
Independent Clinic	49
Federally Qualified Health Center	50
Public Health Clinic	71
Rural Health Clinic	72

OR

If encounter is missing place of service code, identify outpatient encounters that have X71X (Rural Health Center) or X77X (FQHC) on Type of Bill field (see box 4 in UB04 form for reference). X means a digit can vary.

Step 4

Sum the identified primary care visits meeting all of Steps 1, 2, and 3, representing the total number of Primary Care Visits during the measurement period for each member.

Step 5

Compare ED Visits and Primary Care Visits:

Step 5a: **Exclude members with only 1 ED visit during the Measurement Period.** This step identifies the number of members for whom the number of ED Visits is 2 or more during the Measurement Period.

Step 5b: Identify the number of members for whom the number of ED Visits is greater than the number of Primary Care Visits during the Measurement Period.

Data Elements for Reporting

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

Stratify data by:

(1) Age:
  a. 0 – 5 years,
  b. 6 – 11 years,
  c. 12 – 17 years,
  d. 18 – 20 years,
  e. 21 – 25 years,

f. 26 – 34 years
g. 35 – 49 years,
h. 50 – 64 years,
i. 65 – 74 years,
j. 75+

Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-17 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 10 categories for race:
  a. White
  b. Black or African American
  c. American Indian and Alaska Native
  d. Asian
  e. Native Hawaiian and Other Pacific Islander
  f. Some Other Race
  g. Two or More Races
  h. Asked but No Answer, with Ethnicity reported as Hispanic/Latino
  i. Asked but No Answer, with Ethnicity not reported as Hispanic/Latino
  j. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member:
  a. Hispanic/Latino
  b. Not Hispanic/Latino
  c. Asked but No Answer
  d. Unknown

(4) Language: Report on the member's primary spoken language (one language per member):
  a. Arabic
  b. Armenian
  c. Cambodian
  d. Chinese_Cantonese
  e. Chinese_Mandarin
  f. English
  g. Farsi
  h. Hmong
  i. Korean
  j. Laotian
  k. Portuguese
  l. Punjabi

m. Russian
n. Spanish
o. Tagalog
p. Vietnamese
q. Other languages
r. Unknown

Note: For stratifications based on race, ethnicity, and spoken language, stratify members based on reported demographic information as of the end of the measurement period. For example, if data on a member's race, ethnicity, or language are updated during the measurement period, stratify this member by whatever data are most up to date at the end of the measurement period.

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

Notes: Alignment with Other DHCS Reporting Initiatives

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

- Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Encounter for Well Care Values Set
- Well-Care Visit Value Set
- Reason for Ambulatory Visit
- Prenatal Visit Value Set
- Stand Alone Prenatal Visit Value Set
- Postpartum Care Visit Value Set
- Encounter for Postpartum Care Value Set

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

ENPC: Members Engaged in Primary Care

Summary of Changes

- **Continuous Enrollment:** There is now a requirement for 6 months of continuous enrollment (CE) during the measurement period.
- **Primary Care Visits:** The maximum number of visits for any one member in a given day is 1.
- **Primary Care Visit Identification:** All three steps for identifying primary care visits have been revised:
  - Step 1: The NCQA value sets used to identify ambulatory or preventive care visits was revised.
  - Step 2: The provider types and associated taxonomy codes were revised. A table demonstrating qualifying pathways using information on the billing and rendering provider of each encounter was included.
  - Step 3: The service setting and associated place of service codes were revised.
- See additional changes applicable to all KPIs on page 1.

Description

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

Definitions

Measurement Period: The 12-months period beginning 16 months prior to the time of reporting. The measurement period always starts from the 1st of the start month to the end of the last month. For instance, if submitting on August 1, 2024, the measurement period would start on April 1, 2023, and end on March 31, 2024.

Allowable claims and encounter runout time: If this specification is used to calculate historical performance to allow trending over time (i.e. in periods prior to the publication of this updated technical specification), exclude any claims and encounter data for services provided during the measurement period but submitted more than 90 days after the last day of the Measurement Period. This approach is used to simulate incomplete claims data that would have occurred in ongoing, regular reporting of this KPI.

Primary Care Provider: Primary care is defined by DHCS as care usually rendered in ambulatory settings by Primary Care Providers (PCP), and mid-level practitioners, and

emphasizes the Member's general health needs as opposed to Specialists focusing on specific needs. The maximum number of visits for any one member in a given day is 1.

A PCP is a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN).

Primary Care Visit: A primary care visit is defined as an ambulatory or preventive visit delivered by a Primary Care Provider, as identified in the methodology below. For the purposes of this KPI, a primary care visit does not have to be with a member's assigned PCP.

Eligible Population

Ages: Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.

Continuous Enrollment: There is a requirement for six months of continuous enrollment (CE) during the measurement period. The denominator and numerator for this measure should only include members who are continuously enrolled for **any 6 continuous months** during the measurement period.

When calculating CE, do not count any months during which members had any other primary insurance coverage, except for members enrolled in Medicare Medi-Cal Plans (MMPs), which were formally known as Exclusively Aligned Enrollment D-SNPs (EAE D-SNPs). For example, any months in which members had Medicare coverage outside of MMPs should be excluded from CE determinations. Months during which members have Medi-Cal coverage and other insurance limited to vision or dental services should remain included.

Required Exclusion: Members in hospice or using hospice services anytime during the Measurement Period; use the following NCQA value sets:

- Hospice Encounter Value Set
- Hospice Intervention Value Set

Members who died during the measurement period.

Members with other primary health insurance coverage are excluded, except for members enrolled in Medicare Medi-Cal Plans (MMPs), which were formally known as

Exclusively Aligned Enrollment D-SNPs (EAE D-SNPs). Members with any form of Medicare coverage outside of MMPs should be excluded.

Exclusion based on other primary health insurance is for members with comprehensive insurance coverage. Members with Medi-Cal who also have other insurance limited to vision or dental services should remain included.

Administrative Specification

Denominator

The total cumulative and unduplicated number of enrolled members in the Managed Care Plan during the Measurement Period who meet inclusion criteria.

Numerator

The number of members who had one or more Primary Care Visit(s) within a 12-month period.

Use the following steps to calculate the number of Primary Care Visits in Measurement Period for each member. Steps 1, 2, and 3 must all be passed to identify a primary care encounter.

Step 1

Use the following NCQA value sets to identify ambulatory or preventive care visits in the last 12 months for each member:

- Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Encounter for Well Care Values Set
- Well-Care Visit Value Set
- Reason for Ambulatory Visit
- Prenatal Visit Value Set
- Stand Alone Prenatal Visit Value Set
- Postpartum Care Visit Value Set
- Encounter for Postpartum Care Value Set

The maximum number of visits for any one member in a given day is 1.

Step 2: Provider Identification

Of these visits, identify those visits conducted by primary care providers based on criteria for both Plan contracting (Step 2a) **and** taxonomy (Step 2b).

Steps 2a and 2b must be independently true. For instance, if a visit meets Step 2a via a rendering provider and meets Step 2b via a billing provider, this is acceptable. See Table 2 for full pathways on how billing and rendering providers on a claim can meet Step 2.

Step 2a, Plan Contracting: The NPI of the rendering or billing provider on the qualifying claim or encounter is flagged in at least one of the monthly 274 Health Care Provider Directory File that the Managed Care Plan submits to DHCS during the Measurement Period as being a PCP. This flag is defined as a value of "3E" in field "2120DA TPB01" (site) or "2120EA TPB01" (provider) in the 274 Health Care Provider Directory File. This may appear as two separate tables.

AND

Step 2b, Provider Taxonomy: The NPI of the rendering or billing provider of the visit is identified within the taxonomy code list below. This taxonomy information should be pulled from the claim or encounter, when available. If no taxonomy information is available within the claim or encounter, the primary taxonomy code of the provider should be obtained from the National Plan and Provider Enumeration System (NPPES).

Table 1: Taxonomy Code List

Provider Type	Taxonomy
Family Medicine	207Q00000X
Family Medicine - Adolescent Medicine	207QA0000X
Family Medicine - Adult Medicine	207QA0505X
Family Medicine - Geriatric Medicine	207QG0300X
Internal Medicine	207R00000X
Internal Medicine - Adolescent Medicine	207RA0000X
Internal Medicine - Geriatric Medicine	207RG0300X
Obstetrics & Gynecology	207V00000X
Obstetrics & Gynecology – Gynecology	207VG0400X
Pediatrics	208000000X
Pediatrics - Adolescent Medicine	2080A0000X
General Practice	208D00000X
Clinic/Center	261Q00000X
Clinic/Center - Critical Access Hospital	261QC0050X
Clinic/Center - Community Health	261QC1500X
Clinic/Center - Federally Qualified Health Center (FQHC)	261QF0400X
Clinic/Center - Health Service	261QH0100X
Clinic/Center - Migrant Health	261QM1000X
Clinic/Center - Multi-Specialty	261QM1300X
Clinic/Center - Public Health, Federal	261QP0904X

Provider Type	Taxonomy
Clinic/Center - Public Health, State or Local	261QP0905X
Clinic/Center - Primary Care	261QP2300X
Clinic/Center - Rural Health	261QR1300X
Physician Assistant	363A00000X
Physician Assistant - Medical	363AM0700X
Nurse Practitioner	363L00000X
Nurse Practitioner - Adult Health	363LA2200X
Nurse Practitioner - Community Health	363LC1500X
Nurse Practitioner - Family	363LF0000X
Nurse Practitioner - Gerontology	363LG0600X
Nurse Practitioner - Pediatrics	363LP0200X
Nurse Practitioner - Primary Care	363LP2300X
Nurse Practitioner - Women's Health	363LW0102X
Nurse Practitioner - Obstetrics & Gynecology	363LX0001X

Table 2: Qualifying Pathways for Step 2, Combinations of Billing and Rendering Provider Characteristics

For Step 2a: Is a PC Site or Provider in 274 File? (Yes [Y]/No[N])

Qualifying Pathways	Billing Provider	Rendering Provider*
1	N	Y
2	N	Y
3	N	Y
4	Y	N
5	Y	Y
6	Y	N
7	Y	N
8	Y	Y
9	Y	Y

*If Rendering Provider is absent on an encounter, assume 'N.'

For Step2b: Provider's taxonomy code in Step 2b table? (Yes [Y]/No[N])

Qualifying Pathways	Billing Provider	Rendering Provider*
1	N	Y
2	Y	N

Qualifying Pathways	Billing Provider	Rendering Provider*
3	Y	Y
4	N	Y
5	N	Y
6	Y	N
7	Y	Y
8	Y	N
9	Y	Y

*If Rendering Provider is absent on an encounter, assume 'N'

Step 3: Service Setting Identification

Of these visits remaining, identify those visits with a Place of Service code on the claim or encounter included in the list below. If the Place of Service code is missing, Plans may use the "Type of Bill" field as described below.

Table 3: Place of Service Codes

Service Setting	Place of Service Code
Telehealth	02
Homeless Shelter	04
Indian Health Service Free-standing Facility	05
Tribal 638 Free-standing Facility	07
Prison/Correctional Facility	09
Telehealth Provided in Patient's Home	10
Office	11
Home	12
Mobile Unit	15
Temporary Lodging	16
Place of Employment-Worksite	18
Off Campus-Outpatient Hospital	19
On Campus-Outpatient Hospital	22
Outreach/Street Site	27
Independent Clinic	49
Federally Qualified Health Center	50
Public Health Clinic	71
Rural Health Clinic	72

OR

If encounter is missing place of service code, identify outpatient encounters that have X71X (Rural Health Center) or X77X (FQHC) on Type of Bill field (see box 4 in UB04 form for reference). X means a digit can vary.

Step 4

For each member, identify whether at least one primary care visit meeting all of steps 1, 2 and 3 occurred during the measurement period. If no primary care visits are identified, the member does not meet the criteria.

Data Elements for Reporting

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

Stratify data by:

Stratify data by:

(1) Age:

  a. 0 – 5 years,
  b. 6 – 11 years,
  c. 12 – 17 years,
  d. 18 – 20 years,
  e. 21 – 25 years,
  f. 26 – 34 years
  g. 35 – 49 years,
  h. 50 – 64 years,
  i. 65 – 74 years,
  j. 75+

  Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-17 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 10 categories for race:

  a. White
  b. Black or African American
  c. American Indian and Alaska Native
  d. Asian
  e. Native Hawaiian and Other Pacific Islander
  f. Some Other Race
  g. Two or More Races
  h. Asked but No Answer, with Ethnicity reported as Hispanic/Latino

   i. Asked but No Answer, with Ethnicity not reported as Hispanic/Latino
   j. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member:
   a. Hispanic/Latino
   b. Not Hispanic/Latino
   c. Asked but No Answer
   d. Unknown

(4) Language: Report on the member's primary spoken language (one language per member):
   a. Arabic
   b. Armenian
   c. Cambodian
   d. Chinese_Cantonese
   e. Chinese_Mandarin
   f. English
   g. Farsi
   h. Hmong
   i. Korean
   j. Laotian
   k. Portuguese
   l. Punjabi
   m. Russian
   n. Spanish
   o. Tagalog
   p. Vietnamese
   q. Other languages
   r. Unknown

Note: For stratifications based on race, ethnicity, and spoken language, stratify members based on reported demographic information as of the end of the measurement period. For example, if data on a member's race, ethnicity, or language are updated during the measurement period, stratify this member by whatever data are most up to date at the end of the measurement period.

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

Notes: Alignment with Other DHCS Reporting Initiatives

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

- Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Encounter for Well Care Values Set
- Well-Care Visit Value Set
- Reason for Ambulatory Visit
- Prenatal Visit Value Set
- Stand Alone Prenatal Visit Value Set
- Postpartum Care Visit Value Set
- Encounter for Postpartum Care Value Set

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

ENPC-A: Members Engaged in Primary Care at Assigned Primary Care Site

Summary of Changes

- This is a new measure.
- Definitions and technical specifications for this measure are distinct from Members Engaged in Primary Care (ENPC), as it seeks to measure engagement with assigned primary care provider (PCP) or site, as opposed to engagement with primary care overall. Additional definitions for this measure are:
  - Assigned Primary Care Site
  - Continuous Assignment
- See additional changes applicable to all KPIs on page 1.

Description

The number and percentage of members enrolled in a managed care plan that had at least one PCP visit within a specified 12-month period at the primary care site where the member is assigned for primary care.

Two rates are reported for this measure:

- Engaged in Primary Care – Plan Level
- Engaged in Primary Care – Site Level (for all site NPIs in the MCP's PCPA file at the time the report is run)

Definitions

Measurement Period: The 12-months period beginning 16 months prior to the time of reporting. The measurement period always starts from the 1st of the start month to the end of the last month. For instance, if submitting on August 1, 2024, the measurement period would start on April 1, 2023, and end on March 31, 2024.

Allowable claims and encounter runout time: If this specification is used to calculate historical performance to allow trending over time (i.e. in periods prior to the publication of this updated technical specification), exclude any claims and encounter data for services provided during the measurement period but submitted more than 90 days after the last day of the Measurement Period. This approach is used to simulate incomplete claims data that would have occurred in ongoing, regular reporting of this KPI.

Primary Care Provider: Primary care is defined by DHCS as care usually rendered in ambulatory settings by Primary Care Providers (PCP) and advanced practice clinicians (Nurse Practitioners and Physician Assistants). Primary care emphasizes the Member's general health needs as opposed to Specialists focusing on specific needs. The maximum number of visits for any one member can have in a given day is 1.

A PCP is a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN).

Primary Care Visit: A primary care visit is defined as an ambulatory or preventive visit delivered by a PCP, as identified in the methodology below.

Assigned Primary Care Site: A primary care site is defined as a single physical location that provides primary care, which may be composed one or more primary care providers. A site may also provide specialty care in addition to primary care.

For the purposes of this technical specification, each member's assigned primary care site is identified via a single NPI number provided by MCPs to DHCS via the monthly Primary Care Assignment File (PCPA).

Eligible Population

Ages: Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.

Continuous Enrollment: Members must be continuously enrolled with the managed care plan for at least the last 6 months of the measurement period. The last month of the measurement period serves as an anchor for enrollment. For example, if the measurement period is January 1 to December 31, then continuous enrollment should be calculated back from December, meaning the member must be enrolled with the MCP for at least July 1 to December 31 (with no gap).

Continuous Assignment: In addition to continuous enrollment, members must be continuously assigned for primary care to the same provider in the "Site NPI" field of the PCPA file for at least the last 6 months of the measurement period. The last month of the measurement period serves as an anchor for enrollment. For example, if the measurement period is January 1 to December 31, then continuous enrollment should be calculated back from December, meaning the member must be enrolled with the MCP for at least July 1 to December 31 (with no gap).

Required Exclusion: Members in hospice or using hospice services anytime during the Measurement Period, use the following NCQA value sets:

- Hospice Encounter Value Set
- Hospice Intervention Value Set

Members who died during the measurement period.

Members with other primary health insurance coverage are excluded, except for members enrolled in Medicare Medi-Cal Plans (MMPs), which were formally known as Exclusively Aligned Enrollment D-SNPs (EAE D-SNPs). Members with any form of Medicare coverage outside of MMPs should be excluded.

Exclusion based on other primary health insurance is for members with comprehensive insurance coverage. Members with Medi-Cal who also have other insurance limited to vision or dental services should remain included.

Administrative Specification

Engaged in Primary Care – Plan Level

Denominator

The total cumulative and unduplicated number of enrolled members in the Managed Care Plan during the Measurement Period that meet continuous enrollment and continuous assignment criteria.

Numerator

Of those members in the denominator, the number of members who had one or more Primary Care Visit(s) with their assigned site or provider as specified in the PCPA file within the 12-month measurement period.

The assigned primary care site is that "Site NPI" listed for the member in the PCPA file for the final month of the measurement period.

Engaged in Primary Care – Site Level (rates produced individually for each primary care site)

Denominator

As a subset of the "Primary Care Visit – Plan Level" denominator, the total cumulative and unduplicated number of members of the Managed Care Plan meeting continuous assignment criteria at a specific primary care site.

Numerator

Of those members in the denominator, the number of unduplicated members who had one or more Primary Care Visit(s) with any provider associated, in the PCPA file, with the member's assigned primary care site within the 12-month measurement period. The assigned primary care site is that "Site NPI" listed for the member in the PCPA file for the final month of the measurement period.

Technical Guidelines (both rates)

Use the following steps to calculate the eligible Primary Care Visits in Measurement Period for each member.

Step 1: Apply Value Sets

Use the following NCQA value sets to identify ambulatory or preventive care visits in the last 12 months for each member:

- Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Encounter for Well Care Values Set
- Well-Care Visit Value Set
- Reason for Ambulatory Visit
- Prenatal Visit Value Set
- Stand Alone Prenatal Visit Value Set
- Postpartum Care Visit Value Set
- Encounter for Postpartum Care Value Set

The maximum number of visits for any one member in a given day is 1.

Step 2: Service Setting Identification

Of these visits remaining, identify those visits with a Place of Service code on the claim or encounter included in the list below. If the Place of Service code is missing, Plans may use the "Type of Bill" field as described below.

Table 1: Place of Service Codes

Service Setting	Place of Service Code
Telehealth	02
Homeless Shelter	04
Indian Health Service Free-standing Facility	05
Tribal 638 Free-standing Facility	07
Prison/Correctional Facility	09
Telehealth Provided in Patient's Home	10

Service Setting	Place of Service Code
Office	11
Home	12
Mobile Unit	15
Temporary Lodging	16
Place of Employment-Worksite	18
Off Campus-Outpatient Hospital	19
On Campus-Outpatient Hospital	22
Outreach/Street Site	27
Independent Clinic	49
Federally Qualified Health Center	50
Public Health Clinic	71
Rural Health Clinic	72

OR

If encounter is missing place of service code, identify outpatient encounters that have X71X (Rural Health Center) or X77X (FQHC) on Type of Bill field (see box 4 in UB04 form for reference). X means a digit can vary.

Step 3: Identify Members for Denominator Inclusion and Designate PCP Anchoring to Final Month of Assignment

1) **To determine the initial "Plan Level" denominator,** each member meeting MCP continuous enrollment criteria should be evaluated to determine if the member had a PCP that met continuous assignment criteria. If yes, then that member meets inclusion criteria for "Plan Level" denominator. If no, then that member is excluded from the "Plan Level" denominator.
   a) To designate a PCP for each member in the "Plan Level" denominator, the "site NPI" PCPA file field (from the final month during the measurement period) is designated as each member's PCP for analysis. This step serves to anchor continuous assignment to the last month in the measurement period.
2) **To determine the initial "Site Level" denominator**, the members from step 3a should be attributed to each unique "site NPI" (from PCPA file) from step 3a. Then a sum of the count of members from Step 3a attributable to each "Site NPI" should be made. For example, if there are 1,000 members from the "Plan Level" denominator in Step 3a and 100 of those members are associated with "Site NPI" 12345678910, then site 12345678910 has a "Site Level" denominator of 100 members. Thus, there will be multiple "Site Level" denominators for each MCP to represent different primary care sites.

3) **To determine final “Plan Level” and “Site Level” denominators,** an additional step is needed for primary care sites where members are assigned to individual providers rather than only at the “Site NPI” level (for example, private practices where members are assigned to an individual provider rather than FQHCs where members are only assigned to the site). All MCP’s PCPA files for the measurement period (i.e. 12 months of files) must be used to map all individual providers to a “Site NPI”. For example, if individual Provider A and Provider B are both listed on the PCPA file associated with “Site NPI” Z, then these providers should be mapped to site Z. If a provider is associated with multiple sites in the PCPA file during the measurement period (for example, Dr. X shows as the PCP for two members but at different sites), then members assigned to this provider (regardless of the “Site NPI”) are excluded from both the “Plan Level” and “Site Level” denominators. This exclusion occurs even if the association with multiple sites is in different months in the measurement period. There are many scenarios in which the association of a single PCP to multiple sites in the PCPA file can occur. However, one example is the following: if Dr. X has members assigned exclusively at a single site in January and has members assigned exclusively at a different single site in February, Dr. X would be excluded from both the "Plan Level" and "Site Level" denominators.

Step 4: Determine Visit Attribution and Numerators

1) **Plan Level numerator:** for each member in the denominator at the “Plan Level” from Step 3, the member should be assessed to see if they had at least one primary care visit identified from Steps 1-2. If no visits are identified, numerator criteria are not met. If visits are identified, each member should have the NPIs listed on the claim for each visit cross referenced against the NPIs listed for that member in the PCPA file in the final month of the measurement period. If any NPI (billing or rendering provider) from the claims for any of the visits matches any NPI in the site level or provider level fields on the PCPA file, numerator criteria are met. If not, then numerator criteria are not met.
2) **Site Level numerator:** for each member identified in the denominator for a specific “Site NPI” in Step 3, the member should be assessed to see if they had at least one primary care visit identified from Steps 1-2. If no visits are identified, numerator criteria are not met. If visits are identified, each member should have the NPIs listed on the claim for each visit cross referenced against the NPIs listed for that member in the PCPA file in the final month of the measurement period. If any NPI (billing or rendering provider) from the claims for any of the visits matches any NPI in the site level or provider level fields on the PCPA file, numerator criteria are met. If not, then numerator criteria are not met.

Data Elements for Reporting

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

Stratify data by:

(1) Age:
  a. 0 – 5 years,
  b. 6 – 11 years,
  c. 12 – 17 years,
  d. 18 – 20 years,
  e. 21 – 25 years,
  f. 26 – 34 years
  g. 35 – 49 years,
  h. 50 – 64 years,
  i. 65 – 74 years,
  j. 75+

  Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-17 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 10 categories for race:
  a. White
  b. Black or African American
  c. American Indian and Alaska Native
  d. Asian
  e. Native Hawaiian and Other Pacific Islander
  f. Some Other Race
  g. Two or More Races
  h. Asked but No Answer, with Ethnicity reported as Hispanic/Latino
  i. Asked but No Answer, with Ethnicity not reported as Hispanic/Latino
  j. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member:
  a. Hispanic/Latino
  b. Not Hispanic/Latino
  c. Asked but No Answer
  d. Unknown

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

a. Arabic
b. Armenian
c. Cambodian
d. Chinese_Cantonese
e. Chinese_Mandarin
f. English
g. Farsi
h. Hmong
i. Korean
j. Laotian
k. Portuguese
l. Punjabi
m. Russian
n. Spanish
o. Tagalog
p. Vietnamese
q. Other languages
r. Unknown

Note: For stratifications based on race, ethnicity, and spoken language, stratify members based on reported demographic information as of the end of the measurement period. For example, if data on a member's race, ethnicity, or language are updated during the measurement period, stratify this member by whatever data are most up to date at the end of the measurement period.

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

Notes: Alignment with Other DHCS Reporting Initiatives

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

- Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Encounter for Well Care Values Set
- Well-Care Visit Value Set
- Reason for Ambulatory Visit
- Prenatal Visit Value Set
- Stand Alone Prenatal Visit Value Set

- Postpartum Care Visit Value Set
- Encounter for Postpartum Care Value Set

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

CCME: Complex Care Management Enrollment

Summary of Changes

- See additional changes applicable to all KPIs on page 1.
- No other changes specific to this measure.

Description

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

This measure has two rates:

- CCME Rate A: CCM enrollment among all eligible members.
- CCME Rate B: CCM enrollment among eligible members who were not already enrolled during the previous reporting period.

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

Definitions

Measurement Period: The 12-months period beginning 16 months prior to the time of reporting. The measurement period always starts from the 1st of the start month to the end of the last month. For instance, if submitting on August 1, 2024, the measurement period would start on April 1, 2023, and end on March 31, 2024.

Allowable claims and encounter runout time: If this specification is used to calculate historical performance to allow trending over time (i.e. in periods prior to the publication of this updated technical specification), exclude any claims and encounter data for services provided during the measurement period but submitted more than 90 days after the last day of the Measurement Period. This approach is used to simulate incomplete claims data that would have occurred in ongoing, regular reporting of this KPI.

Complex Care Management Program: Complex Care Management in this measure equates to "Complex Case Management," as defined by NCQA and described by Plans in their submissions to the Department of Health Care Services.

Eligible for Complex Care Management: Eligibility criteria for Complex Care Management varies by Managed Care Plan. Each Managed Care Plan should use its most current criteria when analyzing this measure.

Eligible Population

Ages: Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.

Continuous Enrollment: There are no continuous enrollment criteria for this measure. The count of members for the measure should be a point-in-time count at the time of submission.

Required Exclusion: Members in hospice or using hospice services anytime during the Measurement Period, use the following NCQA value sets:

- Hospice Encounter Value Set
- Hospice Intervention Value Set

Members who died during the measurement period.

Members with other primary health insurance coverage are excluded. Members with any form of Medicare coverage are excluded.

Exclusion based on other primary health insurance is for members with comprehensive insurance coverage. Members with Medi-Cal who also have other insurance limited to vision or dental services should remain included.

Administrative Specification

Rate A Specifications

Rate A Denominator

The total cumulative and unduplicated number of members eligible for CCM for 1 or more days during the Measurement Period.

Rate A Numerator

The number of members who are enrolled in CCM for 1 or more days during the Measurement Period.

Rate B Specifications

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

Rate B Denominator

The total cumulative and unduplicated number of members eligible for CCM for 1 or more days during the Measurement Period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period.

Rate B Numerator

The number of members who are enrolled in CCM for 1 or more days during the Measurement Period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period.

Data Elements for Reporting

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

Stratify data by:

(1) Age:

a. 0 – 5 years,
b. 6 – 11 years,
c. 12 – 17 years,
d. 18 – 20 years,
e. 21 – 25 years,
f. 26 – 34 years
g. 35 – 49 years,
h. 50 – 64 years,
i. 65 – 74 years,
j. 75+

Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-17 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 10 categories for race:

a. White
b. Black or African American
c. American Indian and Alaska Native
d. Asian
e. Native Hawaiian and Other Pacific Islander
f. Some Other Race
g. Two or More Races

h. Asked but No Answer, with Ethnicity reported as Hispanic/Latino
i. Asked but No Answer, with Ethnicity not reported as Hispanic/Latino
j. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member:
   a. Hispanic/Latino
   b. Not Hispanic/Latino
   c. Asked but No Answer
   d. Unknown

(4) Language: Report on the member's primary spoken language (one language per member):
   a. Arabic
   b. Armenian
   c. Cambodian
   d. Chinese_Cantonese
   e. Chinese_Mandarin
   f. English
   g. Farsi
   h. Hmong
   i. Korean
   j. Laotian
   k. Portuguese
   l. Punjabi
   m. Russian
   n. Spanish
   o. Tagalog
   p. Vietnamese
   q. Other languages
   r. Unknown

Note: For stratifications based on race, ethnicity, and spoken language, stratify members based on reported demographic information as of the end of the measurement period. For example, if data on a member's race, ethnicity, or language are updated during the measurement period, stratify this member by whatever data are most up to date at the end of the measurement period.

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

Notes: Alignment with Other DHCS Reporting Initiatives

DHCS requires current Managed Care Plans to submit Policies and Procedures on CCM Models of care to align with requirements in APL 22-024. Because CCM eligibility criteria

vary by Managed Care Plan, DHCS will compare submitted rates with each Managed Care Plan's eligibility criteria for context. Because CCM is not captured in claims and encounter data, DHCS reserves the right to ask Plans to submit member-level CCM enrollment in the future.

CMHRD: Care Management for High-Risk Members after Discharge

Summary of Changes

- **Transition:** The definition of "Transition" has been revised.
- **High Risk:** The definition of High-Risk Members was updated to align with the DHCS PHM Policy Guide, and the operationalized definition of "High Risk" for this specification was revised.
- **Enrollment criteria:** Enrollment criteria were updated to clarify that the member must be enrolled for the qualifying event plus 7 days.
- **Exclusions:** Denominator specifications were updated to exclude events that occurred in the last 7 days of the measurement period.
- **Enhanced Care Management**: Specifications related to members receiving Enhanced Care Management were added.
- See additional changes applicable to all KPIs on page 1.

Description

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

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

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

Definitions

Measurement Period: The 12-months period beginning 16 months prior to the time of reporting. The measurement period always starts from the 1st of the start month to the end of the last month. For instance, if submitting on August 1, 2024, the measurement period would start on April 1, 2023, and end on March 31, 2024.

Allowable claims and encounter runout time: If this specification is used to calculate historical performance to allow trending over time (i.e. in periods prior to the publication of this updated technical specification), exclude any claims and encounter data for services provided during the measurement period but submitted more than 90 days after the last day of the Measurement Period. This approach is used to simulate incomplete claims data that would have occurred in ongoing, regular reporting of this KPI.

Transition: Defined as the end of admissions including acute care inpatient, acute care observation stays, and nonacute inpatient stays through the NCQA Inpatient Stay Value Set and Observation Stay Value Set. If there are multiple admission (transfer or readmission) within a 7-day period, only the last inpatient stay should be used for denominator inclusion.

Assigned care manager: Defined as "the single point of contact responsible for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge." MCPs can assign members to a care manager either by using their own staff or contracting with other contracted entities (e.g., hospitals, ACOs, PCPs, etc.)."

Post discharge day: A post-discharge day occurs after the date of discharge, and a day is defined as a calendar day, irrespective of whether the day falls on a weekend or holiday. This definition excludes both interactions that occur while the member is still in an inpatient setting and interactions that occur on the same calendar day of discharge.

High-risk: Defined below in alignment with the Transitional Care Services requirements for "high-risk" members, effective January 1, 2024, in the DHCS PHM Policy Guide. A narrower, operationalized definition of high risk for the purposes of this measure is defined under "denominator."

Members defined as high-risk include members who are:

- Those with LTSS needs;
- Those in or entering ECM or CCM;
- Children with special health care needs (CSHCN);
- All Pregnant individuals: for the purposes of TCS, "pregnant individuals" includes any individual hospitalized during pregnancy or admitted during the 12-month period postpartum, including discharges related to the delivery
- Seniors and persons with disabilities who meet the definitions of "high-risk" established in existing APL requirements;
- 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 having a specialty mental health need or substance use disorder by the MCP or discharging facility;
- Any member transitioning to or from a SNF;
- Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS

- Members assessed to be high-risk through risk stratification methods, as defined below:
  - Prior to MCPs being required to use the DHCS PHM Service Risk Stratification and Segmentation Tiering (RSST) (expected in July 2026): Members identified by the Plan's chosen risk stratification and segmentation methods, with requirements outlined in the DHCS PHM Policy Guide, or members identified by DHCS' RSST methodology.
  - After the required implementation of the DHCS PHM Service RSST approach: Only those members identified by the DHCS RSST methodology to be high-risk. While Plans are allowed by DHCS Policy to use supplemental methodologies, for the purpose of this measure specification, limit the definition of high-risk members to those identified by the DHCS RSST methodology.

Interaction: An interaction is synchronous and involves the use of in-person, telephonic, text messaging, or audio-visual communication in real time with the member or authorized representative. This definition excludes asynchronous communication such as leaving voicemails, one-directional texts, or portal-based communications, and it excludes communication with the facility alone.

Long Term Services and Supports: Long Term Services and Supports (LTSS) are defined as services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) as well as carved-in and carved-out services. A narrower subset of these services are operationalized for this measure.

Eligible Population

Ages: Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.

Enrollment: Members must be enrolled with the managed care plan on the date of the denominator event and for at least 7 days after. For example, if the denominator event occurred on July 30, then the member must have been enrolled with the MCP at least by July 30 and through August 6.

Guidance: The day of discharge is considered Day 0.

Required Exclusion: Members in hospice or using hospice services anytime during the Measurement Period, use the following NCQA value sets:

- Hospice Encounter Value Set
- Hospice Intervention Value Set

Members who died during the measurement period.

Members who disenrolled during the 7-day period after the hospital discharge.

Members with other primary health insurance coverage are excluded. Members with any form of Medicare coverage are excluded.

Exclusion based on other primary health insurance is for members with comprehensive insurance coverage. Members with Medi-Cal who also have other insurance limited to vision or dental services should remain included.

Administrative Specification

Denominator

The number of transitions (inpatient and observation stays and nonacute inpatient stays) for members with high-risk during the Measurement Period. If another acute care admissions occur within the seven-day period following discharge, a 7-day period, only the last inpatient stay during that period will be counted.

To identify denominator-qualifying events, identify admissions in acute inpatient, observational, and non-acute inpatient admissions using the following NCQA Value Sets:

- Inpatient Stay Value Set
- Observation Stay Value Set

These value sets include admissions in acute inpatient, skilled nursing, and residential treatment settings. Among these events, include all discharges from day 1 through day 358 of the measurement year (seven days prior to the end of the measurement year: for example, if the measurement year is January 1 to December 31, then identify discharges occurring from January 1 to December 24).

Among these events, exclude any events not experienced by members who meet the operationalized definition of "High Risk" in the two following tables:

Table 1: High Risk Groups

High Risk Group	Data Source and Process
Enrolled in Complex Care Management; Authorized for Enhanced Care Management; or Enrolled in the California Children's Services Program	Internal Managed Care Plan Data and Identification Process. For guidance on Aid-Code-based methods on identifying youth currently or formerly engaged with the foster care system, see the Enhanced Care Management Policy Guide, pg. 97.
Seniors and persons with disabilities who meet the definitions of "high-risk" established in existing APL requirements;	Use the following MediCal Member Aid Codes: 10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6 and identify members who had these aid codes at any point during the measurement period.
Any member who has been served by county SMHS and/or DMC or DMC-ODS (if known) within the last 12 months.	Plans can receive these data through DHCS' plan data feed and/or through data sharing with county BH.
Any member transitioning to or from a SNF;	SNF stays are captured in value sets listed above.
Members who are pregnant including the 12-month period post pregnancy (irrespective of whether live or still birth delivery, or spontaneous or therapeutic abortion)	Use the NCQA Pregnancy Value Set, Live Birth Value Set, and Non-Live Birth Value Set to identify members who are pregnant or post-pregnancy during care episode of the discharge event or through any other care episode in the 12 months prior to the discharge event.

High Risk Group	Data Source and Process
Receiving Long Term Services and Supports	Internal Managed Care Plan Data and Identification Processes. LTSS is defined above, and Plans should only include the following groups: • Those who received Home Health (HH) services in the 30 days prior to the admission date of the discharge event, as identified by Vendor Code (44) • Those who received In-Home Supportive Services (IHSS) in the 30 days prior to the admission date of the discharge event (data as available to Plan) Those who had one or more long-term care (LTC) stays in the 30 days prior to the admission date of the discharge event

Members assessed to be high-risk through risk stratification methods, as defined below:

Table 2: High Risk Groups Defined by Risk Stratification

High Risk Group	Data Source and Process
Prior to MCPs being required to use the DHCS PHM Service Risk Stratification and Segmentation Tiering (RSST) (expected in July 2026): Members identified by the Plan's chosen risk stratification and segmentation methods, with requirements outlined in the DHCS PHM Policy Guide, or members identified by DHCS' RSST methodology.	Internal Managed Care Plan Data and Identification Process.

High Risk Group	Data Source and Process
After the required implementation of the DHCS PHM Service RSST approach, beginning no earlier than July 2026: Only those members identified by the DHCS RSST methodology to be high-risk. While Plans are allowed by DHCS Policy to use supplemental methodologies, for the purpose of this measure specification, limit the definition of high-risk members to those identified by the DHCS RSST methodology.	Medi-Cal Connect RSST methodology to identify high risk members.

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

Numerator

The number of transitions for high-risk members during the measurement period followed by at least one interaction with their assigned care manager within 7 days post discharge. Exclude interactions with the care manager that occur on the date of discharge.

For the purposes of measurement, transitional care services provided by ECM care teams are included in the numerator as care manager interactions with high-risk members. Use the HCPCS codes and all appropriate modifiers in the tables below for eligible inclusion. These codes include direct interactions between both clinical and non-clinical ECM team members for both telehealth and in-person modalities.

If members have multiple transitions of care involving discharge from an acute care setting, count these episodes separately if they fall outside the 7-day measurement period.

Table 3: ECM Provided by Clinical Staff

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
G9008	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1	Used with HCPCS code G9008 to indicate ECM services.
G9008	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	Used with HCPCS code G9008 to indicate ECM services.

Table 4: ECM Provided by Non-Clinical Staff

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
G9012	ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2	Used with HCPCS code G9012 to indicate ECM services.
G9012	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2, GQ	Used with HCPCS code G9012 to indicate ECM services.

For numerator compliance, evaluate each denominator-qualifying event using the following steps:

Step 1

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

Step 2

Count all synchronous post-discharge interactions between an Assigned Care Manager and the member experiencing the denominator-qualifying event occurring during the period starting on the calendar day after discharge and ending 7 calendar days after discharge.

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

Step 3

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

Data Elements for Reporting

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

Stratify data by:

(1) Age:

   a. 0 – 5 years,
   b. 6 – 11 years,
   c. 12 – 17 years,
   d. 18 – 20 years,
   e. 21 – 25 years,
   f. 26 – 34 years
   g. 35 – 49 years,
   h. 50 – 64 years,
   i. 65 – 74 years,
   j. 75+

   Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-17 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 10 categories for race:

   a. White
   b. Black or African American
   c. American Indian and Alaska Native
   d. Asian
   e. Native Hawaiian and Other Pacific Islander

f. Some Other Race
g. Two or More Races
h. Asked but No Answer, with Ethnicity reported as Hispanic/Latino
i. Asked but No Answer, with Ethnicity not reported as Hispanic/Latino
j. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member:
   a. Hispanic/Latino
   b. Not Hispanic/Latino
   c. Asked but No Answer
   d. Unknown

(4) Language: Report on the member's primary spoken language (one language per member):
   a. Arabic
   b. Armenian
   c. Cambodian
   d. Chinese_Cantonese
   e. Chinese_Mandarin
   f. English
   g. Farsi
   h. Hmong
   i. Korean
   j. Laotian
   k. Portuguese
   l. Punjabi
   m. Russian
   n. Spanish
   o. Tagalog
   p. Vietnamese
   q. Other languages
   r. Unknown

Note: For stratifications based on race, ethnicity, and spoken language, stratify members based on reported demographic information as of the end of the measurement period. For example, if data on a member's race, ethnicity, or language are updated during the measurement period, stratify this member by whatever data are most up to date at the end of the measurement period.

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

Notes: Alignment with Other DHCS Reporting Initiatives

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

FUAH: Follow-Up Ambulatory Visit After Hospital Discharge

Summary of Changes from Incentive Payment Program Technical Specifications

- **Target Population**: The Target Population was updated.
- **Description:** The Description was updated to align with the intent of the measure.
- **Enrollment**: Enrollment criteria were updated to clarify that the member must be enrolled for the qualifying event plus 7 days.
- **Exclusions**: Steps 1 – 3 of the Denominator calculation were revised to specify when readmissions and direct transfers should be excluded from the Denominator.
    - Each bullet of Step 4 of the Denominator was clarified to exclude "hospital stays" and not "individuals."
    - Step 4 was modified to exclude hospital stays for individuals who use hospice services and for individuals discharged to a long-term care or special needs facility.
    - Discharges related to pregnancy were excluded.
- The value sets for identifying ambulatory visits were revised.
- See additional changes application to all KPIs on page 1.

Measure-Specific Modifications from Source Specification: Note: This is a modification of the previous Incentive Payment Program (IPP) measure for MCP reporting and current Quality Incentive Pools (QIP) measure for QIP facility reporting. Target Populations differ for MCPs and QIP facilities; the target populations in this technical specification are intended for MCPs.

Description

The percentage of acute hospital stay discharges which had follow-up ambulatory visits within 7 days post-hospital discharge.

Definitions

Measurement Period: The 12-months period beginning 16 months prior to the time of reporting. The measurement period always starts from the 1st of the start month to the

end of the last month. For instance, if submitting on August 1, 2024, the measurement period would start on April 1, 2023, and end on March 31, 2024.

Allowable claims and encounter runout time: If this specification is used to calculate historical performance to allow trending over time (i.e. in periods prior to the publication of this updated technical specification), exclude any claims and encounter data for services provided during the measurement period but submitted more than 90 days after the last day of the Measurement Period. This approach is used to simulate incomplete claims data that would have occurred in ongoing, regular reporting of this KPI.

Acute Hospital Stay Discharge: An acute hospital stay discharge is a discharge event representing the end of an inpatient admission or admission for observation in an acute hospital setting, lasting at least 1 day. These events are identified using the value sets defined below.

Ambulatory Visit: DHCS defines an ambulatory visit as an outpatient encounter conducted by a primary care or specialty care provider using the value sets defined below.

Eligible Population

Ages: Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.

Enrollment: Members must be enrolled with the managed care plan on the date of the denominator event and for at least 7 days after. For example, if the denominator event occurred on July 30, then the member must have been enrolled with the MCP at least by July 30 and through August 6.

Guidance: The day of discharge is considered Day 0.

Required Exclusion: Exclude hospital stays where the admission date is the same as the discharge date. Exclude hospital stays for individuals who use hospice services:

- Hospice Encounter Value Set;
- Hospice Intervention Value Set
- or elect to use a hospice benefit any time during the measurement year.

Entities that use the Monthly Membership Detail Data File to identify these individuals must use only the run date of the file to determine if the individual elected to use a hospice benefit during the measurement year.

- Hospital stays for individuals who are discharged to a long-term care or special needs facility.
- Hospital stays for an individual who died during the stay.
- Hospital stays for individuals with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- Hospital stays for individuals with a principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Members who died during the measurement period.

Members who disenrolled during the 7-day period after the hospital discharge.

Members with other primary health insurance coverage are excluded Members with any form of Medicare coverage are excluded.

Exclusion based on other primary health insurance is for members with comprehensive insurance coverage. Members with Medi-Cal who also have other insurance limited to vision or dental services should remain included.

Administrative Specification

Denominator

The number of live discharges from hospital among individuals of all ages during the measurement year.

Follow the steps below to identify the denominator.

Step 1

Identify all acute inpatient and observation stay discharges from day 1 through day 358 of the measurement year (seven days prior to the end of the measurement year: for example, if the measurement year is January 1 to December 31, then identify discharges occurring from January 1 to December 24). To identify acute inpatient and observation stay discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The measure includes acute discharges from any type of hospital (including behavioral healthcare facilities).

Step 2

If there was one or more readmissions or direct transfers to an acute inpatient or observation setting during the 7 day follow up period, count only the discharge associated with the last readmission within the 7 day follow up period.

- For example: If an individual was discharged on August 15, then readmitted on August 20, and not discharged from that readmission until September 10, the entity would only count the September 10 discharge in the denominator.
- A direct transfer is when the discharge date from the first inpatient or observation stay setting precedes the admission date to a second inpatient or observation stay setting by one calendar day or less. For example:
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer and entities only count the last discharge.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer and entities only count the last discharge.

Whereas an inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is considered a readmission and entities only count the last discharge.

Step 3

Exclude hospital stays where the admission date is the same as the discharge date.

Step 4 – Required Exclusions:

Exclude hospital stays for the following reasons:

- Hospital stays for individuals who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year.
- Entities that use the Monthly Membership Detail Data File to identify these individuals must use only the run date of the file to determine if the individual elected to use a hospice benefit during the measurement year.
- Hospital stays for individuals who are discharged to a long-term care or special needs facility.
- Hospital stays for an individual who died during the stay.
- Hospital stays for individuals with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- Hospital stays for individuals with a principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Numerator

Of those denominator events, identify which had at least one ambulatory visit within 7 days post hospital discharge. Exclude visits that occur on the date of discharge. If one discharge resulted in more than one ambulatory visit within 7 days post hospital discharge, only count this event in the numerator one time.

Use the following value sets to identify ambulatory visits:

- Ambulatory Visits Value Set.
- Reason for Ambulatory Visit Value Set. Do not include laboratory claims (claims with POS code 81).
- Telephone Visits Value Set

Data Elements for Reporting

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

Stratify data by:

(1) Age:
   a. 0 – 5 years,
   b. 6 – 11 years,
   c. 12 – 17 years,
   d. 18 – 20 years,
   e. 21 – 25 years,
   f. 26 – 34 years
   g. 35 – 49 years,
   h. 50 – 64 years,
   i. 65 – 74 years,
   j. 75+

   Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-17 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 10 categories for race:
   a. White
   b. Black or African American
   c. American Indian and Alaska Native
   d. Asian
   e. Native Hawaiian and Other Pacific Islander

f. Some Other Race
g. Two or More Races
h. Asked but No Answer, with Ethnicity reported as Hispanic/Latino
i. Asked but No Answer, with Ethnicity not reported as Hispanic/Latino
j. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member:
   a. Hispanic/Latino
   b. Not Hispanic/Latino
   c. Asked but No Answer
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(4) Language: Report on the member's primary spoken language (one language per member):
   a. Arabic
   b. Armenian
   c. Cambodian
   d. Chinese_Cantonese
   e. Chinese_Mandarin
   f. English
   g. Farsi
   h. Hmong
   i. Korean
   j. Laotian
   k. Portuguese
   l. Punjabi
   m. Russian
   n. Spanish
   o. Tagalog
   p. Vietnamese
   q. Other languages
   r. Unknown

Note: For stratifications based on race, ethnicity, and spoken language, stratify members based on reported demographic information as of the end of the measurement period. For example, if data on a member's race, ethnicity, or language are updated during the measurement period, stratify this member by whatever data are most up to date at the end of the measurement period.

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

Notes: Alignment with Other DHCS Reporting Initiatives

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

- Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Encounter for Well Care Values Set
- Well-Care Visit Value Set
- Reason for Ambulatory Visit

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