DEPARTMENT OF HEALTH CARE SERVICES

COMPREHENSIVE QUALITY STRATEGY

2025

DHCS

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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EXECUTIVE SUMMARY

The Department of Health Care Services (DHCS) envisions a future where Medi-Cal helps people live longer, healthier, and happier lives. In this whole system, person-centered, and population health approach to care, health care services are only one element of supporting better health in the population. Partnerships with Medi-Cal members, communities, community-based organizations (CBO), schools, correctional facilities, public health agencies, counties, and health care systems will be essential to preventing illness, supporting needs, addressing health disparities, and reducing the effects of poor health.

Since the 2022 Comprehensive Quality Strategy (CQS), DHCS has made significant progress toward this vision. Through California Advancing and Innovating Medi-Cal (CalAIM) and broader Medi-Cal transformation efforts, Medi-Cal is providing more comprehensive preventive and personalized care that spans the physical and behavioral health needs of Californians. DHCS is strengthening mental health and substance use disorder services and better integrating them with physical health care. New benefits and services, such as Enhanced Care Management (ECM), community health worker, and Community Supports, are helping members with health-related social needs that can impact their health, like getting help with obtaining and keeping housing and accessing medically tailored meals to support a member's short-term recovery.

Importantly, DHCS has built upon the lessons learned from COVID-19 on the necessity of local partnerships and integration across sectors. Via the new Medi-Cal Managed Care Plan (MCP) contracts implemented in 2024, MCPs now have partnerships with a broad array of local partners, including local health jurisdictions, schools, county Behavioral Health Plans (BHP), child welfare entities, and others. DHCS' revised policy on how both MCPs and county BHPs conduct community assessments and partner with local health jurisdictions is strengthening and centering community and member voices in guiding policies and programs upon which they rely.

While DHCS has made significant progress, the recent enactment of HR1, along with other federal actions, makes sweeping changes to Medi-Cal, the public health system, and the health care safety net that have widespread impacts, including:

- Significant increase in the number of uninsured. Millions of Californians, as result, will lose access to health care coverage and other social supports.

- Significant cuts in federal funding leading to weakened health infrastructure (e.g., hospital closures in rural and underserved areas) leading to overcrowded emergency departments and longer wait times.
- Growing health disparities, leading to delays in diagnosis and treatment and preventable illness and death.

This, combined with significant state fiscal pressures that have already resulted in changes to Medi-Cal benefits and eligibility in 2025-2026, represent unprecedented challenges for the Medi-Cal program.

And yet, Medi-Cal, CalFresh and public health are not only lifelines for individuals and families. They are foundational pillars of local economies and healthcare infrastructure. Weakening them has the potential to weaken communities across California which is why—now more than ever—we must partner across sectors and with our communities to mitigate harm, optimize resources, foster innovative solutions and improve health outcomes. DHCS, working with the California Department of Public Health (CDPH) and other state partners, has already taken actions to strengthen and align community accountability mechanisms, planning, and investments across behavioral health, managed care and public health. California remains deeply committed to these issues and the work of advancing health equity and health outcomes. And in the face of federal changes, we will continue to push forward our vision for a more coordinated, person-centered and equitable health system that works for all Californians.

The 2025 CQS continues the Medi-Cal Transformation journey, which has become even more urgent and pressing in our current times. The revised CQS:

- Provides an overview of all DHCS health care, including managed care, fee-for-service (FFS), and other programs.
- Includes overarching quality and health equity goals, with program-specific objectives, including goals that are still in progress from the 2022 CQS.
- Reinforces DHCS' commitment to reducing health disparities in all program activities.

Section 1 of the CQS, in accordance with the 2016 Managed Care Final Rule, provides an overview of the Medi-Cal program and the quality management structure at DHCS, including the process for developing and reviewing the CQS.

Section 2 outlines DHCS' quality and health equity strategy. Based on fundamental quality assurance and performance improvement (QAPI) practices, the CQS identifies key drivers of health outcomes at the individual and system levels and proposes a comprehensive strategy to improve them. The CQS continues key quality efforts as outlined in the Medi-Cal Transformation policy framework, CalAIM, and incorporates newer initiatives, such as the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative and Behavioral Health Transformation, which further strengthen behavioral health services and advance whole-person care.

The CQS goals and guiding principles (summarized below) are a continuation of DHCS' goals in its 2022 CQS, which are continued as a part of DHCS' currently approved 1915b and 1115 waivers. These goals are built upon the Population Health Management (PHM) framework that is the cornerstone of Medi-Cal Transformation and aims to take a more comprehensive whole-person, upstream approach to achieving health outcomes. They also stress DHCS' commitment to improving health outcomes, addressing health disparities, member involvement, and accountability in all our programs and initiatives, and for all populations.

Section 2.3 of the CQS specifically outlines the implementation of PHM, which aims to help *all* members stay healthy via preventive and wellness services, identify and assess member risks to guide care management and care coordination needs, and identify and mitigate social drivers of health to reduce health care disparities. In the 2022 CQS, DHCS identified three clinical focus areas – children's preventive care, maternal outcomes and birth equity, and behavioral health integration – as foundational priorities and areas where significant improvement was needed. To further these priorities, DHCS launched the Bold Goals *50x2025* initiative, which has made significant progress on key measures in these clinical focus areas, but is not yet complete so are continued in this updated CQS. The 2025 CQS continues to emphasize these clinical focus areas and expands its population health approach to include behavioral health delivery systems, establishing 14 population-level outcomes for improvement. This behavioral population health work is also focused on key priority populations, which currently experience disproportionate health disparities and poor outcomes: individuals with behavioral health conditions who are chronically homeless and/or experiencing homelessness, those at risk of, or experiencing, justice system involvement, child-welfare involved youth, and individuals at high risk of institutionalization.

Section 2.4 of the CQS outlines specific clinical goals across the Medi-Cal program. Goals with measurable targets are included for each managed care delivery system (Medi-Cal managed care, behavioral health, and dental). These goals were identified to ensure a comprehensive quality approach across multiple populations. A complete set of all measures reported and tracked across Medi-Cal programs are available in **Appendix D**.

Similar to the 2022 CQS, DHCS recognizes that the Health Equity Roadmap and value-based payment (VBP) program initiatives, designed to address health disparities and improve outcomes while addressing costs, are critical levers to improving high quality care for *all* Medi-Cal members. In the 2025 CQS, **Section 2.5**, DHCS builds upon the work done in the last three years and outlines its strategy for community and member engagement in Medi-Cal policies and programs. In **Section 2.6,** DHCS furthers its VBP portfolio, especially around primary care spending and alternative payment models, in partnership with the Office of Health Care Affordability.

Section 3 of the CQS outlines significant changes at DHCS in terms of its quality management structure and managed care monitoring and oversight activities. Building upon the centralized Quality and Population Health Management (QPHM) program. which was created as part of the 2022 CQS, DHCS has significantly aligned and

standardized managed care policies across delivery systems, instituted standard, proactive monitoring strategies (including user-friendly public dashboards) to support transparency, and implemented standard accountability and enforcement measures, including financial sanctions.

DHCS is unwaveringly committed to addressing quality and health equity in Medi-Cal, as described in this strategy. We have made much progress in Medi-Cal Transformation over the past three years, but our work is not yet complete, and in these times of change and uncertainty, it is perhaps even more vital for our nearly 15 million members. The journey we have been on is already yielding measurable results, and our members, communities, and partners need us to complete it.

INTRODUCTION

1.1 Scope

The CQS provides a summary of the extensive work being done to assess and improve the quality and equity of health care covered by DHCS and its vision for the future of quality and health equity in Medi-Cal.

The CQS serves as an update to the 2022 Medi-Cal CQS Report, which was DHCS' overarching quality strategy to encompass all DHCS quality activities, while meeting the requirements of 42 Code of Federal Regulations (CFR) 438.340, as amended, under the 2016 Managed Care Final Rule. As this current CQS is being submitted in the middle of California's current Medi-Cal Transformation initiative (including its current 1115 CalAIM waiver), this revised CQS largely continues the same strategic priorities and areas of focus outlined in the 2022 CQS, but notably deepens the initiatives and work happening in population health, especially for members with behavioral health needs, VNP, and health equity activities.

1.2 Medi-Cal Program Overview

DHCS is the single state agency responsible for the administration of Medi-Cal, California's Medicaid program, and the Children's Health Insurance Program (CHIP), which provide comprehensive health care coverage at no or low cost for nearly 15 million individuals, or one in three Californians. With a total annual Medi-Cal budget of $196.7 billion, DHCS is the largest health care purchaser in California and the largest state Medicaid program.

Strategic Plan and Organizational Priorities

DHCS' organizational purpose is to provide equitable access to quality health care, leading to a healthy California for all. In order to achieve this, it has focused on a number of key strategic priorities, as described in its 2023-2027 Strategic Plan:

- Implementing CalAIM to strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory.
- Reimagining the role of Medi-Cal MCPs in providing equitable and quality coverage, while holding the plans to higher standards of care and accountability.

- Expanding comprehensive health coverage to all income-eligible Californians to strengthen our entire health system.
- Investing in the health workforce and adding doula services, Medi-Cal peer support services, and community health workers to serve Californians directly.
- Transforming our behavioral health system by scaling evidence-based and community-defined evidence practices, investing in infrastructure, and improving quality, accountability, and access while focusing on prevention, early intervention, and resiliency.

DHCS has identified six organizational goals as a part of its Strategic Plan, all of which align with its core values of Belonging, Equity, Innovation, Stewardship, and Sustainability.

1. **Be person centered**: Put people first and design programs and services in the community for the whole person.
2. **Increase meaningful access**: Ensure individuals get care when, where, and how they need it by strengthening health care coverage, benefits, and provider and service capacity
3. **Achieve excellence in health outcomes**: Improve quality outcomes, reduce health disparities, and transform the delivery system
4. **Be an employer of choice**: Attract, develop, and retain a diverse and talented team that is empowered and impactful
5. **Strengthen operations**: Enhance our organizational structures, processes, and systems to improve program administration
6. **Leverage data to improve outcomes**: Drive better decisions and results with meaningful information

As described in the DHCS Strategic Plan, achieving health equity, wellness, and excellence in health outcomes for all Medi-Cal members is the core purpose of the Medi-Cal program. The remainder of this section and the document provide an orientation to how that strategic vision is being put into action.

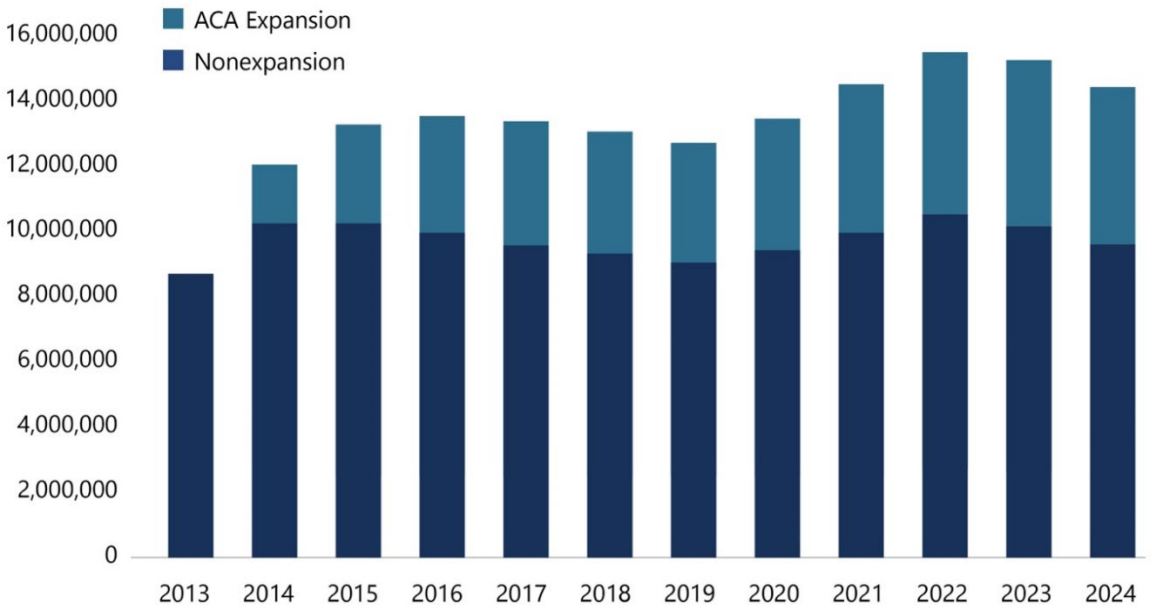
Medi-Cal Enrollment and Managed Care Structure

Thanks to the Affordable Care Act's Medicaid expansion, Medi-Cal enrollment has steadily grown over the last decade (see Figure 1), dramatically reducing the number of

uninsured Californians. Details of this expansion, by specific groups and federal requirements, are outlined in Figure 2. Additionally, DHCS provides state-funded full scope Medi-Cal to Californians who would otherwise be ineligible because of their immigration status. As of January 2024, DHCS has expanded full scope state-only Medi-Cal coverage to all adults, regardless of their immigration status, in addition to all children and young adults under age 26, and older adults over age 50 whom it had previously covered. Of note, changes to this state-only coverage will be implemented as a part of the recently enacted 2025-2026 California State Budget with an Adult Enrollment Freeze for undocumented individuals that are 19 years of age and older on January 1, 2026, elimination of the dental benefit and implementation of $30 monthly premiums for unsatisfactory immigration status individuals beginning July 1, 2026 and July 1, 2027 respectively.

During the unwinding of the Medi-Cal continuous coverage requirement, DHCS worked collaboratively with federal partners, counties, health plans, and community stakeholders to ensure a smooth transition for more than 15 million members. DHCS implemented 17 federal flexibilities, which gave the state the ability to streamline enrollment and support continued coverage for members in new ways. DHCS also launched a statewide media campaign and engaged more than 8,000 DHCS Coverage Ambassadors to raise awareness and guide members through the eligibility renewal process. As a result, a significant number of eligible members retained their Medi-Cal coverage, and the state earned national accolades for its efficiency and effectiveness during this historic challenge.

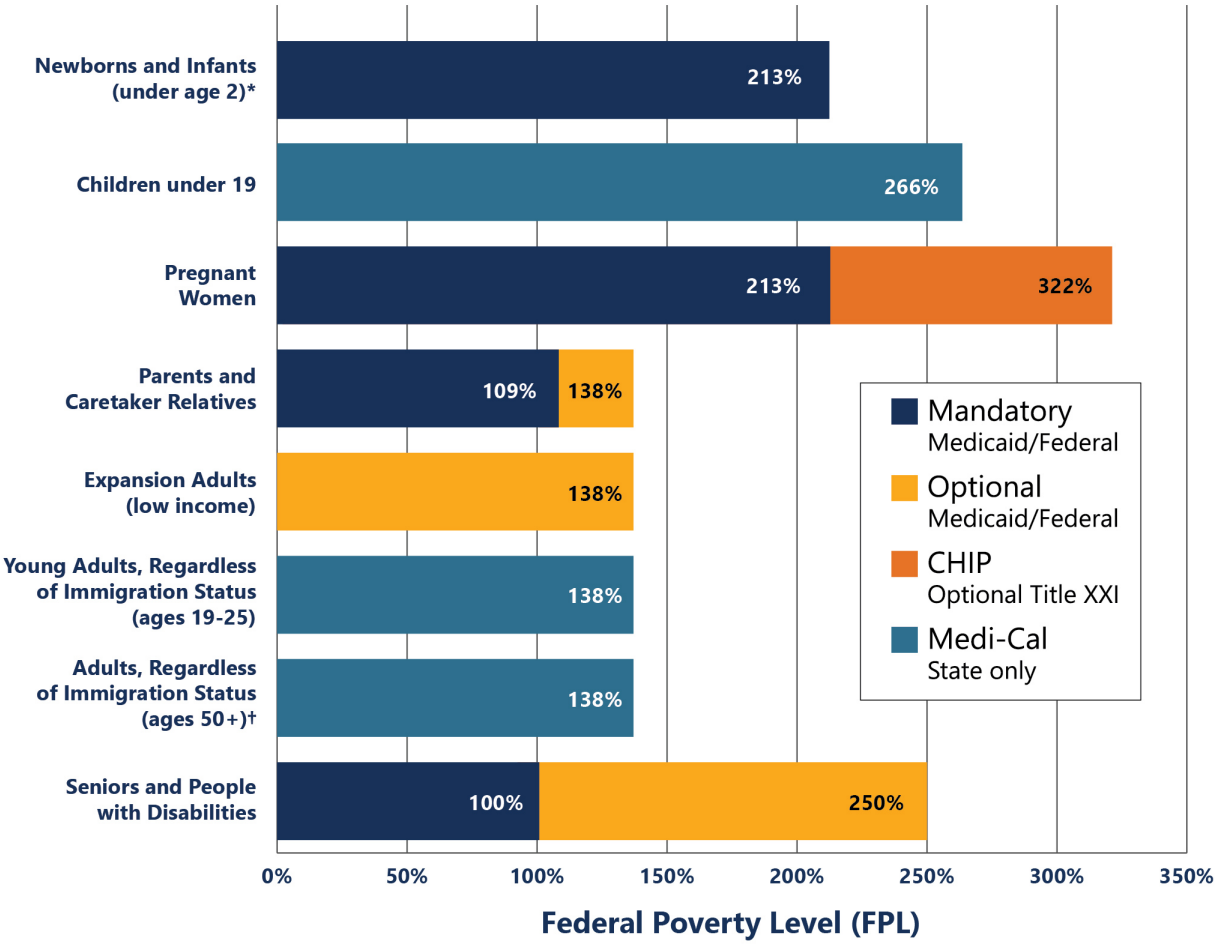
Figure 1: Medi-Cal Enrollment, 2010-2021[1]



1

Source: Statewide Medi-Cal Certified Eligible Individuals, by Aid Code, 2010 to the Most Recent Reportable Month, DHCS, January 2025. https://data.chhs.ca.gov/dataset/statewide-medi-cal-certified-eligible-individuals-by-aid-code-2013-2017.

Figure 2: Medi-Cal Income Thresholds[2]



[2] Source: Statewide Medi-Cal Certified Eligible Individuals, by Aid Code, 2010 to the Most Recent Reportable Month, DHCS, January 2025. https://data.chhs.ca.gov/dataset/statewide-medi-cal-certified-eligible-individuals-by-aid-code-2013-2017.

As of November 2024, there are nearly 15 million individuals, representing 96 percent of all Medi-Cal members covered through Medi-Cal's managed care delivery system[3], which consists of:

- Medi-Cal Managed Care (MCMC)
- Medicare Medi-Cal (Medi-Medi) Plans, California's aligned Dual Eligible Special Needs Plans (D-SNP)
- Dental Managed Care (Dental MC)
- Specialty Mental Health Services Program (SMHS)
- Drug Medi-Cal Organized Delivery System (DMC-ODS)

As a part of CalAIM, on June 30, 2021, DHCS submitted a 1915(b) waiver renewal to the Centers for Medicare & Medicaid Services (CMS) to consolidate Medi-Cal managed care delivery system programs currently authorized under California's Medi-Cal 2020 Section 1115(a) demonstration—MCMC, Dental MC, and DMC-ODS—with SMHS under the 1915(b) waiver in 2022. Also, under CalAIM, in 2023, DHCS transitioned the Cal MediConnect (CMC) duals integration plans to Medi-Medi Plans, which are D-SNPs aligned with MCMC plans to provide integrated care for dually eligible members. Alignment of all managed care authorities enabled DHCS to simplify California's Medi-Cal managed care delivery system and advance the goal of improving health outcomes and reducing health disparities for Medi-Cal members, as well as lay the groundwork for full integration plans that offer integrated physical, behavioral, and dental health benefits. Full details of each MCP are included in **Appendix B**.

In addition to managed care, Medi-Cal members also receive care through FFS Medi-Cal, Indian Health Services, the Drug Medi-Cal program, and several 1915(c) Home and Community-Based Services (HCBS) waiver programs tailored to meet specific population needs. DHCS has also developed programs to meet the specific health care needs of complex and vulnerable populations, including California Children's Services (CCS),

[3] For purposes of the 2016 Managed Care Final Rule requirements, MCMCs and Dental MC plans are Managed Care Organizations (MCO), and SMHS and DMC-ODS plans are Prepaid Inpatient Health Plans (PIHPs). COHS plans are considered Health Insuring Organizations (HIO) but are held to the same requirements as MCOs per the DHCS/MCMC contract.

which serves children with complex medical conditions, the Program of All-Inclusive Care for the Elderly (PACE), and In-Home Supportive Services (IHSS).

Medi-Cal Managed Care (MCMC)

MCMC is the foundational delivery system that provides coverage for physical health and non-specialty mental health services for approximately 96 percent of the Medi-Cal population through Medi-Cal MCPs. MCMC operates in all 58 counties in the state through five MCMC models that vary by county or region.

- **County Organized Health System (COHS) Model or Single Plan Model:** Members are served by a single plan that is created and administered by a county board of supervisors or a local health authority.
- **Two-Plan Model:** Members choose between a single publicly run entity, known as a local initiative plan, and a single commercial plan.
- **Geographic Managed Care (GMC) Model:** Members choose from multiple commercial plans.
- **Regional Model:** Members choose between two or more commercial plans operating in two or more contiguous counties as one service area.

DHCS restructured the MCMC contract, creating a standard contract for all plan model types. Using the same restructured contract for all plan models better enables DHCS to standardize requirements and monitoring processes across all counties and for all MCP model types.[4] The updated standard contract demonstrates a shift in requirements for the MCMCs and is a primary vehicle by which DHCS is ensuring quality, transparency, and accountability in the managed care program. The implementation date for the new contract was January 1, 2024. As a part of this contract, all Medi-Cal Managed Care Plans were required to obtain, and maintain, National Committee for Quality Assurance (NCQA) Health Plan Accreditation and to obtain NCQA Health Equity Accreditation, by January 1, 2026.

[4] MCMC boilerplate contracts are available on the MCMC Boilerplate Contracts webpage.

MCMC covers most Medi-Cal State Plan services, including primary and specialty care, as well as non-SMHS for members with mild-to-moderate functional impairments.[5]

Services not covered under MCMC include SMHS and most substance use disorder (SUD) and dental services. As part of CalAIM, in 2023, long-term care (LTC) skilled nursing facility services and dually eligible members (except those with non-LTC share of cost) were added to MCMC statewide.

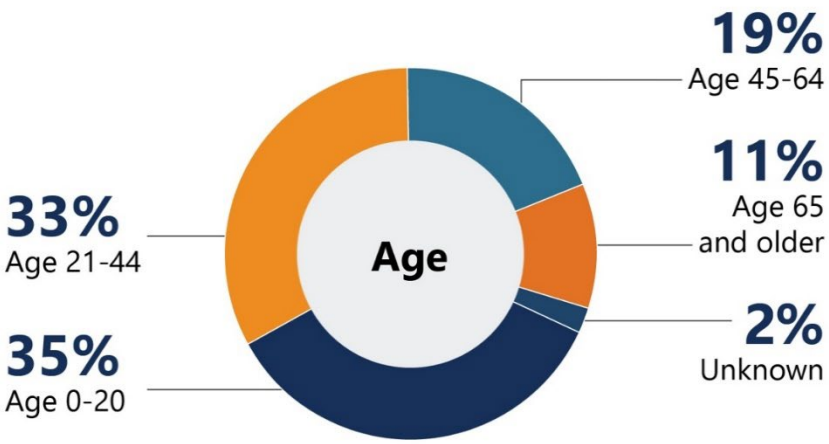
As of 2024, intermediate care facilities for the developmentally disabled and subacute care services were also added to MCMC, and dually eligible members in twelve counties have the option to enroll in Medi-Medi Plans. In 2026, the state intends to have Medi-Medi Plans available statewide. No sooner than 2028, DHCS intends to begin transitioning select 1915(c) HCBS waivers to statewide managed long-term services and supports (MLTSS) to advance its goals of whole-person care and aligned managed care delivery systems.

As of November 2024, there were approximately 15 million MCMC members.[6] This is an increase of almost 8 million members since 2013. The demographic breakdown of the managed care population is summarized below in Figures 3, 4, 5, and 6.

[5] Pursuant to Executive Order N-01-19, the state carved out pharmacy benefits from MCMCs as component of the Medi-Cal Rx initiative.

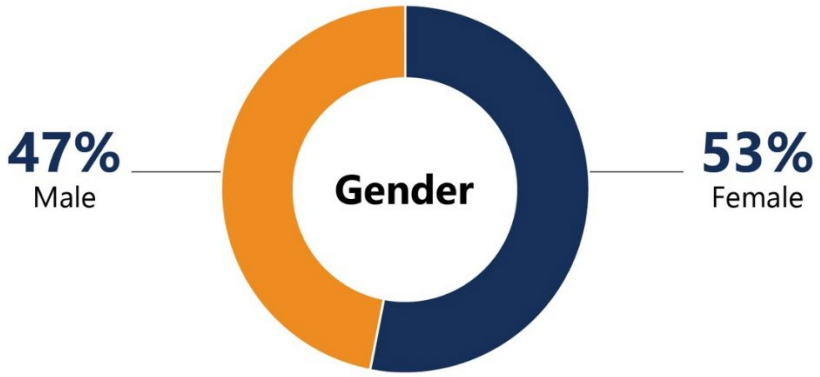
[6] Note: The counts presented are considered preliminary and subject to change. The certified eligible counts reflected in this chart incorporate three Medi-Cal eligibility updates and reflect roughly 96% of all Medi-Cal certified eligibles for the most recent month displayed. A specific month's certified eligible count is considered complete for statistical reporting purposes 12 months after the month's end. Source: DHCS/EDIM/DMAD/DTS. Data were extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

Figure 3: Medi-Cal Managed Care Demographics—Children and Adults



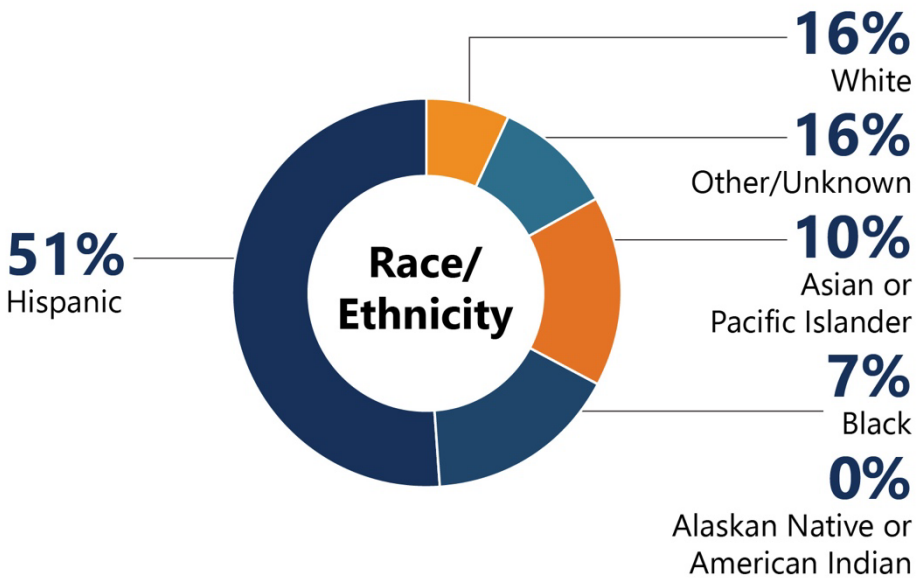
Source: DHCS/EDIM/DMAD/DTS. Data were extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

Figure 4: Medi-Cal Managed Care Demographics—Gender



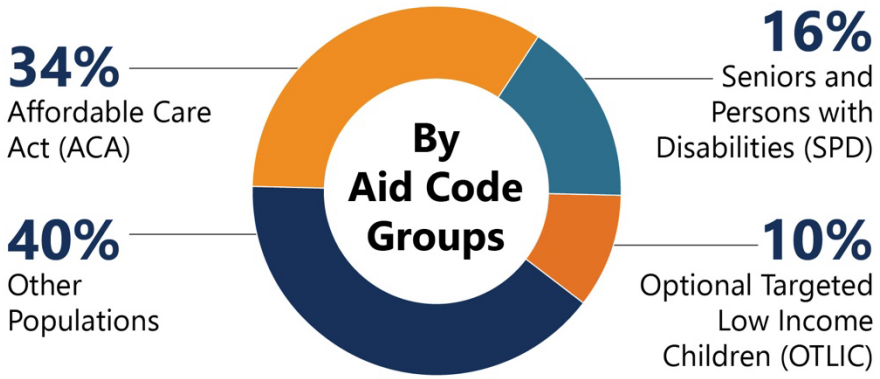
Source: DHCS/EDIM/DMAD/DTS. Data were extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

Figure 5: Medi-Cal Managed Care Demographics—Race/Ethnicity



Source: DHCS/EDIM/DMAD/DTS. Data were extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

Figure 6: Medi-Cal Managed Care Demographics—By Aid Code Groups



Source: DHCS/EDIM/DMAD/DTS. Data were extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

Additionally, as a part of CalAIM, DHCS' 1915(b) waiver renewal submission:

- Required additional populations to enroll in MCMC (as described above and including nearly all dual eligibles in 2023).
- Further standardized benefits offered across California's managed care delivery system.[7]

These enrollment changes were the foundation of the 2022 CQS, as reduced administrative complexity, integrated whole-person care, and improved care coordination through managed care are key drivers for quality and health equity efforts. This transition was particularly important for the vulnerable coverage groups that lacked adequate case management and care coordination services in the FFS delivery system. The standardization of benefits will ensure that regardless of the member's county of residence or the plan in which they are enrolled, they will have access to the same set of benefits through MCMC, a critical change to ensure continuity of health care, especially as members switch plans or move across county lines.

As DHCS has largely implemented many of these transitions, the focus of the 2025 CQS is to build upon this strengthened foundation of consistent enrollment and benefits, focusing on accountability, transparency, and ensuring all eligible members are receiving the services to which they are entitled.

Medi-Medi Plans, California's Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (D-SNPs)

Members dually eligible for Medicare and Medi-Cal have disproportionately high rates of chronic conditions and are generally high utilizers of inpatient care and long-term services and supports, across both Medicare and Medi-Cal. Dually eligible members must also navigate multiple sets of rules, benefits, insurance cards, and providers (Medicare Parts A and B, Part D, and Medicaid).

[7] DHCS carved into the MCMC benefit package statewide major organ transplants and institutional LTC services (e.g., skilled nursing facilities, pediatric/adult subacute care, and disabled/rehabilitative/nursing services).

To support these members through better care coordination and management of health and LTSS, DHCS established the Medi-Medi Plan model. Medi-Medi Plans comprise Medicare Advantage D-SNPs with aligned MCMC plans, under the same parent organization, that qualify as applicable integrated plans as defined in 42 CFR 422.561. Medi-Medi Plans provide integrated member materials, an integrated grievance and appeals process, and integrated provider billing, and they are responsible for care coordination across all Medicare and Medi-Cal benefits. Medi-Medi Plans must meet federal D-SNP Model of Care requirements, as reviewed by the National Committee for Quality Assurance (NCQA), as well as state-specific Model of Care requirements that California has established, including alignment with CalAIM ECM, palliative care, and dementia care.

Medi-Medi Plans must report Medicare D-SNP quality measures to CMS, which are used for Medicare Star Ratings. Medi-Medi Plans must also report on state-specific quality measures to DHCS. Further, beginning in 2024, DHCS requires all Medi-Medi Plans to have a D-SNP only H-contract, as authorized under 42 CFR 422.107(e). This change enables reporting of quality measures and calculation of Star Ratings specific to each D-SNP only contract, thereby providing the state and public with greater transparency on outcomes and experiences specific to dually eligible members in the state.

Enrollment in Medi-Medi Plans is voluntary for members. As of 2024, 12 MCMC plans offer Medi-Medi Plans, and those plans serve approximately 300,000 dually eligible members across 12 counties (Fresno, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Clara, and Tulare). DHCS is requiring all MCMC plans to establish Medi-Medi Plans, across all 58 counties by 2026.

In addition to Medi-Medi Plans, dually eligible members in three counties (Los Angeles, Riverside, and San Bernardino) can enroll in the state's Fully Integrated D-SNP (FIDE-SNP), operated by SCAN Health Plan. The FIDE-SNP includes all Medicare and Medi-Cal benefits and must meet all Medi-Medi Plan integrated care and quality requirements. Approximately 20,000 members were enrolled in the FIDE-SNP in 2024.

Dental Managed Care (Dental MC)

Dental services have been provided through Dental MC in two California counties since 1995—Sacramento (mandatory enrollment, authorized under a 1915(b) waiver) and Los Angeles (voluntary enrollment, subject to the STCs of the 1915(b) waiver). Historically, members have the option of choosing from three Dental MC plans in each county. Apart

from San Mateo County, where Health Plan of San Mateo is operating a pilot that integrates dental care in the health plan's benefits, dental services are available to most members through Dental FFS. Members receive dental services from dentists within the plan's provider network and are eligible for at least the same scope of benefits as members who access services through the dental FFS delivery system. As of January 2024, approximately 962,820 Medi-Cal members are enrolled in Dental MC.[8]

Behavioral Health Plans

DHCS administers Medi-Cal Specialty Mental Health (SMHS), and substance use disorder (SUD) treatment services through separate, unique delivery systems administered by California's 58 counties. SMHS is administered by County Mental Health Plans (MHP) and SUD is administered by Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans. These programs are collectively referred to as county Behavioral Health Plans (SMHS and DMC-ODS) or county Behavioral Health Delivery Systems (inclusive of DMC).[9]

DHCS is undertaking a multi-year effort, CalAIM Behavioral Health Administrative Integration, that requires counties to combine the administration of SMHS and SUD through one integrated BHP contract by January 1, 2027. Whereas counties currently execute two separate contracts with DHCS for the provision of SMHS and SUD services, this CalAIM initiative will result in counties adopting a single integrated contract for the delivery of Medi-Cal specialty behavioral health services (in DMC counties, DMC benefits will be included in this contract but remain outside of managed care authority). Behavioral Health Administrative Integration is being implemented through multiple phases, including an Early Implementers Workgroup, consisting of 17 counties[10] that have opted in early to pilot integrated plans and contracts in advance of mandatory integration in January 2027.

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[8] Data Source: DHCS Data Warehouse as of January 9, 2025.

[9] Counties contract with DHCS to administer SMHS and DMC-ODS benefits as MCPs (Prepaid Inpatient Health Plans). In a minority of counties, SUD treatment services are not covered under DMC-ODS managed care authority; instead, a core set of benefits is administered by counties and referred to simply as DMC. The CQS will frequently refer to "Behavioral Health Plans" given many quality-related requirements are implemented primarily through SMHS and DMC-ODS managed care authority.

[10] Counties piloting integrated SMHS/DMC-ODS contracts: Fresno, Lake, Marin, Nevada, Orange, Riverside, Sacramento, San Joaquin, San Luis Obispo, Santa Barbara, Stanislaus, Tulare, and Ventura. Counties piloting integrated SMHS/DMC: Calaveras, Madera, Plumas, and Tuolumne.

Specialty Mental Health Services (SMHS)

SMHS are currently provided by 57 MHPs covering all 58 counties, including one joint-county arrangement in Sutter/Yuba. This model has been in place since 1995 under the authority of a 1915(b) waiver. County MHPs are required to provide or arrange for the provision of SMHS to adult and child members in their counties who meet SMHS access criteria, consistent with the members' mental health treatment needs and goals.[11] The SMHS program has evolved through numerous renewals and policy changes described in the state's current 1915(b) waiver for SMHS.

SMHS include:[12]

- Mental Health Services
- Medication Support Services
- Day Treatment Intensive
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Mobile Crisis Services
- Adult Residential Treatment
- Crisis Residential Treatment Services
- Psychiatric Health Facility Services
- Intensive Care Coordination
- Intensive Home-Based Services
- Therapeutic Foster Care Services
- Therapeutic Behavioral Services
- Functional Family Therapy
- Parent-Child Interaction Therapy
- Multisystemic Therapy

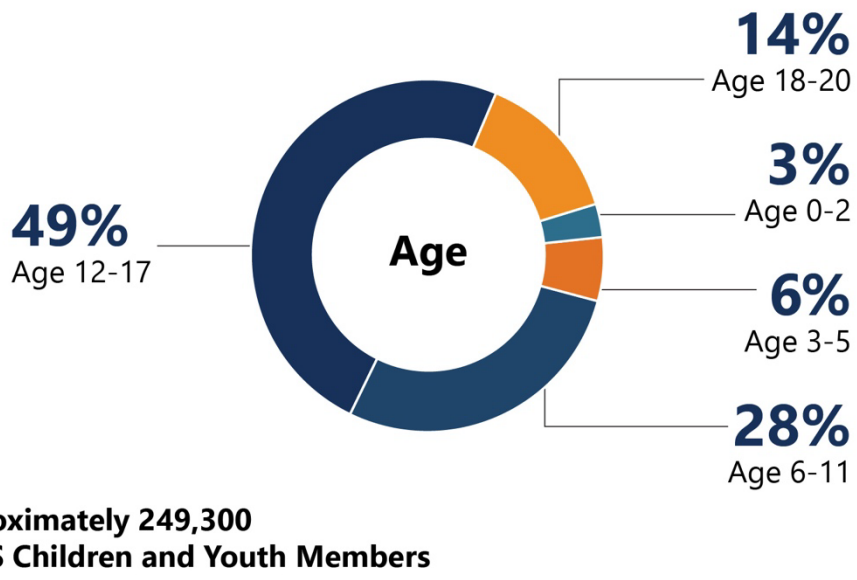
[11] BHIN 21-073: Criteria for beneficiary access to SMHS, medical necessity, and other coverage requirements. December 10, 2021.

[12] In accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under Section 1905(r) of the Social Security Act, all counties shall ensure that all members under age 21 receive SMHS needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act. Certain SMHS are not Medicaid State Plan Services, as services provided through Medicaid EPSDT are covered, whether they are included in the Medicaid State Plan. Intensive Care Coordination, Intensive Home-Based Services, Therapeutic Foster Care Services, Therapeutic Behavioral Services, Functional Family Therapy, Parent-Child Interaction Therapy, Multisystemic Therapy, and High-Fidelity Wraparound, among other services and supports, are available to Medi-Cal members up to age 21 if medically necessary and not included in the State Plan.

- High-Fidelity Wraparound
- Targeted Case Management
- Psychiatric Inpatient Hospital Services
- Peer Support Services (optional)
- Assertive Community Treatment/Forensic Assertive Community Treatment (optional)
- Coordinated Specialty Care for First Episode Psychosis (optional)
- Individual Placement and Support (IPS) Model of Supported Employment (optional)
- Clubhouse Services (optional)
- Enhanced Community Health Worker Services (optional)
- Community Transition In-Reach Services (optional, approved on a demonstration basis from 2025-2029)

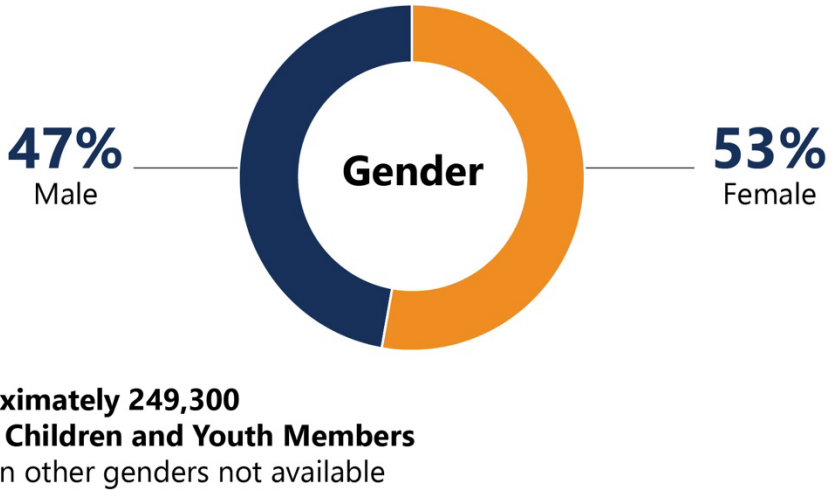
Nearly 249,000 children and youth received SMHS between July 2022 and June 2023. The demographics of these children and youth are summarized below in Figures 7, 8, and 9:

Figure 7: Medi-Cal SMHS Demographics—Children by Age



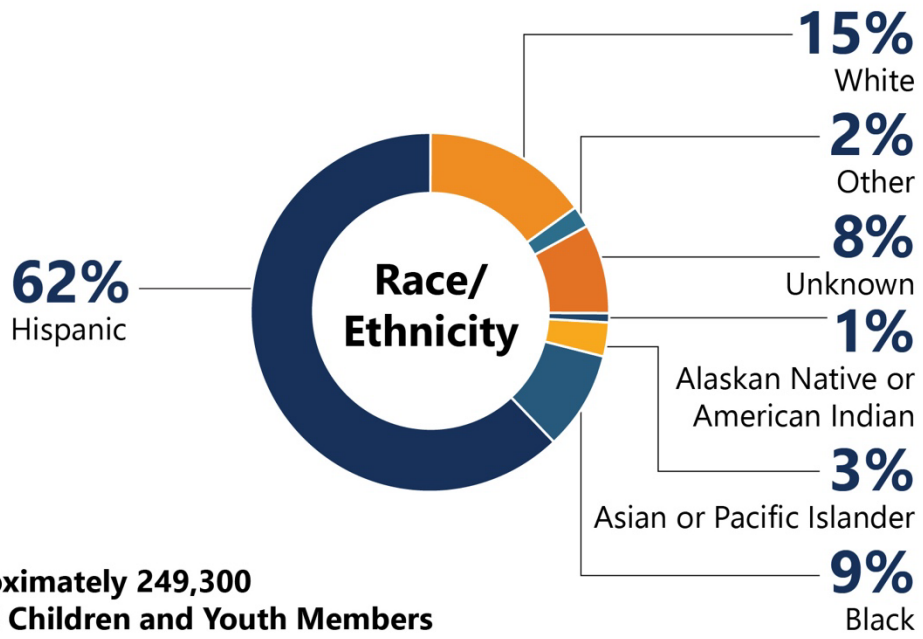
Source: DHCS/EDIM/DMAD/DTS. Data was extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

Figure 8: Medi-Cal SMHS Demographics—Children by Gender



Source: DHCS/EDIM/DMAD/DTS. Data was extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

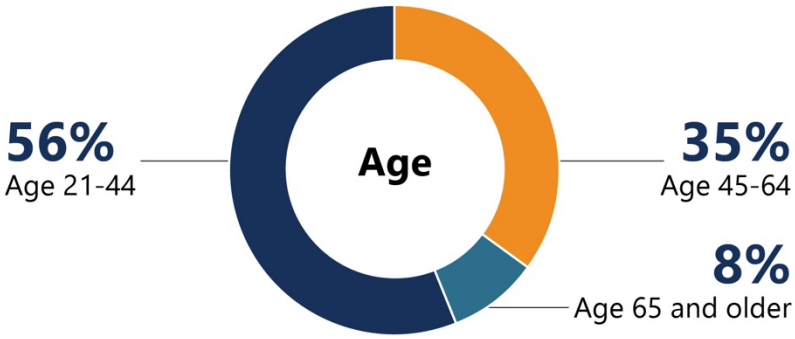
Figure 9: Medi-Cal SMHS Demographics—Children by Race/Ethnicity



Source: DHCS/EDIM/DMAD/DTS. Data was extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

Nearly 346,200 adults received SMHS between July 2022 and June 2023. The demographics of these adults are summarized below in Figures 10, 11, and 12:

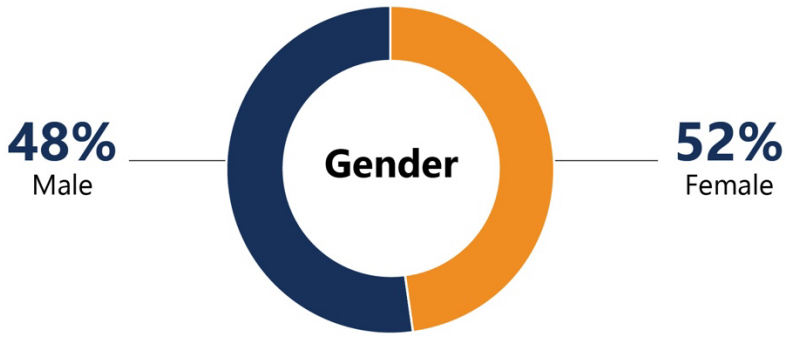
Figure 10: Medi-Cal SMHS Demographics—Adults by Age



Approximately 346,200
SMHS Adult Members

Source: DHCS/EDIM/DMAD/DTS. Data were extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

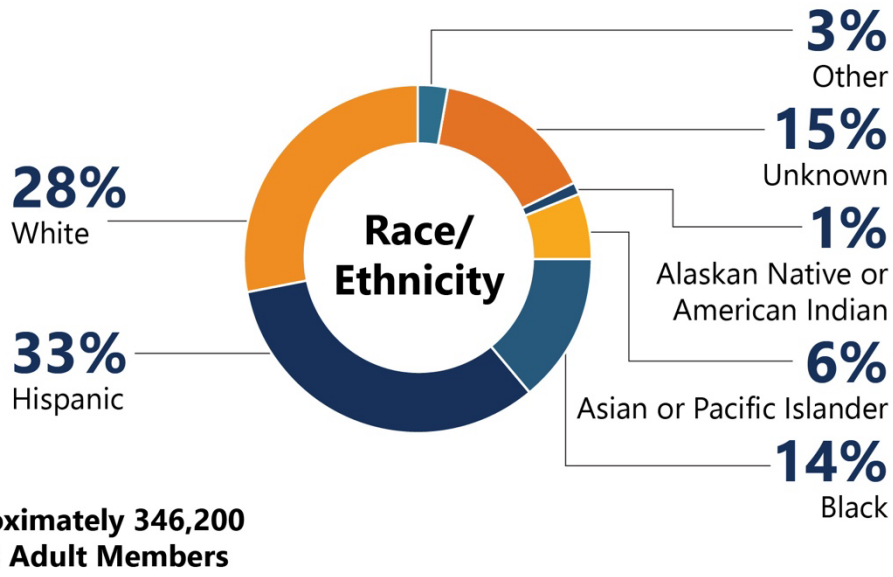
Figure 11: Medi-Cal SMHS Demographics—Adults by Gender



Approximately 346,200
SMHS Adult members
Data on other genders not available

Source: DHCS/EDIM/DMAD/DTS. Data were extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

Figure 12: Medi-Cal SMHS Demographics—Adults by Race/Ethnicity



Source: DHCS/EDIM/DMAD/DTS. Data were extracted on January 1, 2025, from the DHCS Management Information System/Decision Support System (MIS/DSS data warehouse).

Following approval of the 1915(b) renewal, DHCS added Peer Support Services, effective July 1, 2022, as a new SMHS to promote client recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Peer Support Specialists promote health equity by providing culturally competent services to support recovery and enhanced access to care across a diverse population, including race/ethnicity, gender identity, sexual orientation, generation, and geographic regions.

As part of broader Medi-Cal Transformation efforts, DHCS made programmatic changes to improve access to care through a "no wrong door" approach to ensure members receive needed services, regardless of where they enter the delivery system.[13] DHCS has clarified that treatment services are reimbursable prior to formal diagnosis and in the presence of an SUD; streamlined screening and transitions between delivery systems;[14]

[13] BHIN 22-011: No Wrong Door for Mental Health Services Policy. March 31, 2022. APL 22-055: No Wrong Door for Mental Health Services Policy. March 30, 2022.

[14] BHIN 22-065: Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services. December 22, 2022.

updated and simplified documentation requirements[15]; operationalized mobile crisis services statewide[16]; and implemented behavioral health payment reform, moving from a cost-based to a rate-based reimbursement approach to support improved quality reporting and future alternative payment models. The SMHS boilerplate contract is available on the DHCS website.

As described below, the BH-CONNECT initiative also includes new options for counties to cover evidence-based practices for members who need SMHS.

Drug Medi-Cal Organized Delivery System (DMC-ODS)

From 2015-2021, California counties had the option to participate in the DMC-ODS (under the Section 1115 demonstration) to provide Medi-Cal members who reside in their county with a range of evidence-based SUD treatment services. To date, 40 of California's 58 counties have implemented DMC-ODS, covering more than 96 percent of the total Medi-Cal population statewide. DHCS is engaging with prospective new counties to participate in DMC-ODS, with the goal of eventually expanding DMC-ODS services to Medi-Cal members in all counties, and has transitioned most waiver authorities of this program to the 1915(b) waiver in its most recent renewal, effective 2022-2026. The demographics of these members are summarized below in Figures 13, 14, and 15.[17] The DMC-ODS boilerplate contract, Behavioral Health Information Notice (BHIN) containing comprehensive policy guidance, and other information is available on the DHCS website.

The DMC-ODS covers a comprehensive continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for SUD treatment services. Providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psychoeducation. Medications for addiction treatment, also known as medication-assisted treatment (MAT), are available at all levels of care as a component of covered services listed below.

[15] BHIN 23-068: Updates to Documentation Requirements for all SMHS, DMC, and DMC-ODS. November 20, 2023.

[16] BHIN 23-025: Medi-Cal Mobile Crisis Services Benefit Implementation. June 19, 2023.

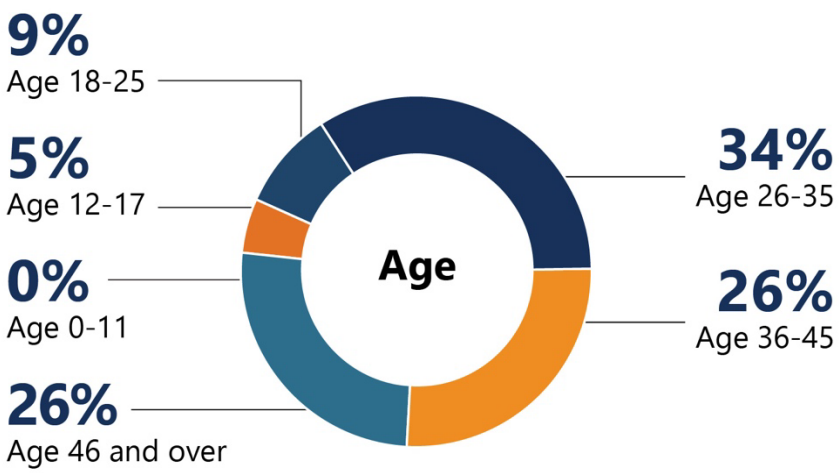
[17] Source: Short Doyle Medi-Cal II system

DMC-ODS services include:[18]

- Early Intervention Services (for members under age 21)
- Outpatient Treatment Services
- Intensive Outpatient Treatment Services
- Residential Treatment and Inpatient Services (ASAM Levels 3.7 and 4.0 optional
- Partial Hospitalization (optional)
- Narcotic Treatment Program (NTP)
- Withdrawal Management Services
- Medications for Addiction Treatment (MAT)
- Care Coordination
- Clinician Consultation
- Traditional Health Care Practices (Traditional Healers and Natural Helpers)
- Recovery Services
- Mobile Crisis Services
- Peer Support Services (optional)
- Contingency Management (optional)
- Enhanced Community Health Worker Services (optional)
- Individual Placement and Support Model of Supported Employment (optional)

[18] In accordance with the EPSDT mandate under Section 1905(r) of the Social Security Act, all counties, regardless of their participation in the DMC-ODS program, will ensure that all members under age 21 receive all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act. As with SMHS, EPSDT coverage of members under age 21 is not limited to services that appear in California's Medicaid State Plan, and other services may be covered.

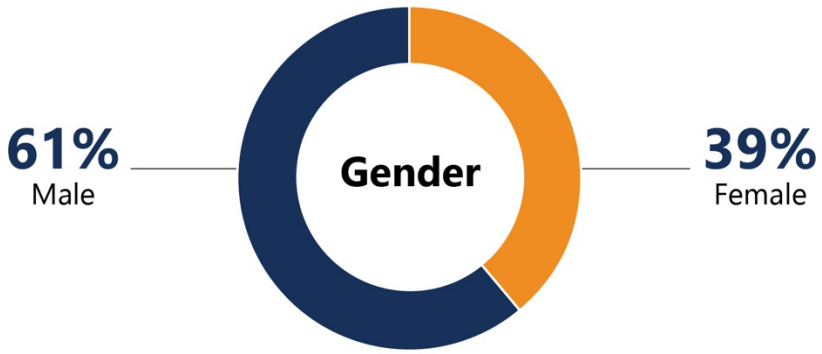
Figure 13: Medi-Cal DMC-ODS Demographics—Age



Approximately 117,300 DMC-ODS Members

Source: Data was extracted on August 1, 2024, for the unique count of members served between July 2022 to June 2023 from the Short Doyle Medi-Cal II system

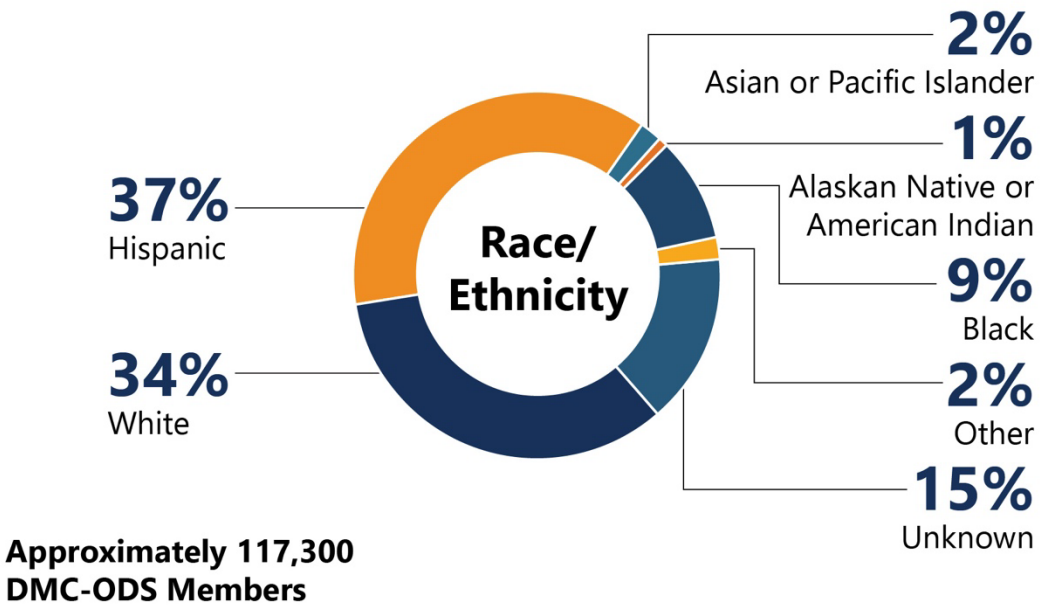
Figure 14: Medi-Cal DMC-ODS Demographics—Gender



Approximately 117,300 DMC-ODS Members

Source: Data was extracted on August 1, 2024, for the unique count of members served between July 2022 to June 2023 from the Short Doyle Medi-Cal II system Short Doyle Medi-Cal II system

Figure 15: Medi-Cal DMC-ODS Demographics—Race/Ethnicity



Source: Data was extracted on August 1, 2024, for the unique count of members served between July 2022 to June 2023 from the Short Doyle Medi-Cal II system Short Doyle Medi-Cal II system

As part of CalAIM, DHCS is implementing or has recently operationalized several policy improvements to DMC-ODS, including:

- **Behavioral Health Administrative Integration:** a multi-year effort requiring counties to combine the administration of SMHS and SUD services into one, integrated specialty behavioral health contract by January 1, 2027.
- **Recovery Incentives Program**[19]**:** The Recovery Incentives Program is California's Contingency Management benefit, which is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery. Twenty-four DMC-ODS Plans have opted into the program, with the first county and site receiving approval to begin operations in March 2023.

[19] BHIN 24-031: Updated Guidance for the Recovery Incentives Program: California's Contingency Management Benefit. August 22, 2024.

- **Traditional Health Care Practices:** In late 2024, California was one of four states to receive approval to cover Traditional Health Care Practices in Medicaid. Beginning in 2025, the state is piloting this coverage through the DMC-ODS by offering Traditional Healer and Natural Helper services to members who receive coverage from DMC-ODS counties, meet DMC-ODS access criteria, and receive care from a participating Indian Health Service (IHS) facility, a facility operated by Tribes or Tribal organizations (Tribal Facilities), or a facility operated by urban Indian organizations (UIO facilities).
    - Traditional health care practices are expected to improve access to culturally responsive care; support these facilities' ability to serve their patients; maintain and sustain health; improve health outcomes and the quality and experience of care; and reduce existing disparities in access to care.
- **Mobile Crisis Services[20]:** Mobile crisis services are a community-based intervention designed to provide de-escalation and relief to individuals experiencing a behavioral health crisis wherever they are, including at home, work, school, or in the community. DHCS submitted State Plan Amendment (SPA) 22-0043 to add community-based mobile crisis intervention services as a Medi-Cal benefit, receiving approval of its SPA, effective January 1, 2023. DHCS released BHIN 23-025 in June 2023, specifying implementation requirements of the benefit. Cohort I counties were required to implement by December 31, 2023, and Cohort II counties were required to implement by June 30, 2024.

As described below, the BH-CONNECT initiative also includes new options for counties to cover IPS Supported Employment and Enhanced Community Health Worker Services under DMC-ODS.

BH-CONNECT

Beginning January 1, 2025, DHCS is implementing the BH-CONNECT initiative, which is designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT is comprised of a new five-year Medicaid section 1115 demonstration, SPAs to expand coverage of Evidence-Based Practices (EBP) available

[20] BHIN 23-025: Medi-Cal Mobile Crisis Services Benefit Implementation. June 19, 2023.

under Medi-Cal, and complementary guidance and policies to strengthen behavioral health services statewide. BH-CONNECT aims to expand access to care, improve outcomes, and address long-standing gaps in mental health and SUD services across California. BH-CONNECT addresses the behavioral health needs of Medi-Cal members by focusing on:

- Adults and children with the most significant behavioral health needs.
- Children and youth involved in child welfare.
- People involved in the justice system.
- Individuals and families experiencing or at risk of homelessness.

BH-CONNECT will:

- **Enhance the continuum of care:** Offer a broader range of community-based services to meet diverse individual needs.
- **Standardize and scale EBPs:** Use proven treatment methods to improve recovery outcomes.
- **Increase access:** Direct resources to populations and communities that have historically faced barriers to accessing care.

BH-CONNECT also includes up to $1.9 billion in state and federal funds available over the five-year demonstration to expand the behavioral health workforce, and up to $1.9 billion in state and federal funds for quality incentive payments to qualifying BHPs that meet performance targets in three categories: 1) Improved access to behavioral health services; 2) Improved health outcomes and quality of life; and 3) Targeted behavioral health delivery system reforms.

Indian Health Services

California is home to more people of American Indian/Alaska Native heritage than any other state in the country, with 109 federally recognized Indian Tribes.[21] The health status of American Indian/Alaska Natives in California is recognized as among the lowest of any racial group in the state, with higher prevalence rates of infant mortality, asthma,

[21] Tribal FAQs

poor perinatal outcomes, SUDs, diabetes, and other chronic diseases, compared to that of the general population, as well as having a disproportionate impact from COVID-19.

DHCS follows a robust Tribal consultation process that includes quarterly meetings that provide Tribes and Indian health program representatives an opportunity to learn more about DHCS initiatives in development and provide input on other DHCS activities on a consistent basis. DHCS also seeks advice from designees of Indian Health Programs (IHP) and UIO on matters having a direct effect on American Indians, IHPs, or UIOs, as required by the American Recovery and Reinvestment Act of 2009 (ARRA) through a federally approved process.

DHCS' Office of Tribal Affairs (OTA) serves as the principal entity to facilitate early and ongoing engagement on policy initiatives and to collaborate in addressing significant health disparities in this population.

DHCS administers the MCMC program in accordance with federal and state laws and regulations,[22] which includes special protections for American Indians/Alaska Natives in managed care. DHCS issued All Plan Letter (APL) 24-002 to summarize and clarify existing federal and state protections for American Indian/Alaska Native members enrolled in MCPs. Effective January 1, 2024, MCPs are required to have an identified Tribal liaison to work with Indian health care providers (IHCP) in its service area. The MCP Tribal liaison is responsible for coordinating referrals and payment for services, including, but not limited to, coordinating care for American Indian/Alaska Native members, ensuring access to in- and out-of-network IHCPs, aiding with transportation, case management, and assisting IHCPs with contracting issues, claims, grievances, and credentialing issues. The roles and responsibilities of the MCP liaisons are described in APL 24-002 and were developed in collaboration with Tribal partners.

FFS and Other Programs

There are several Medi-Cal delivery systems and other programs that operate outside of managed care and instead operate on a FFS basis, governed by Section 1902(a)(30)(A)

[22] 42 CFR 438 State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval. Medi-Cal FFS and other programs are not required to be included in the CQS by 42 CFR 438.340, as amended, under the 2016 Managed Care Final Rule, but are incorporated given their vital role in the Medi-Cal program and impact on quality and health equity.

of the Social Security Act. These programs are critical to DHCS' overall approach to quality and health equity for our members and are described briefly below.

These FFS programs include:

- **FFS Medi-Cal**: As of January 2024, approximately 1 percent of Medi-Cal members remain in FFS. Those populations include foster youth and former foster youth (note: this group has voluntary managed care, so some will still choose to stay in FFS), justice-involved individuals, share-of-cost individuals, Trafficking and Crime Victims Assistance Program members, diagnosis-specific groups (end state renal dialysis, tuberculous), minor consent, and individuals enrolled in presumptive eligibility programs.
- **Dental FFS**: As of June 1, 2024, approximately 92 percent of Medi-Cal members remain in FFS. Dental FFS is offered statewide (except in Sacramento and San Mateo counties). Dental FFS delivery is supported by a contracted fiscal intermediary that supports the dental business operations and a fiscal intermediary that supports the system maintenance and operations for the provision of dental benefits and payments.
- **Outpatient pharmacy services**: As of January 1, 2022, all outpatient pharmacy services were carved out of MCMC to FFS to achieve cost-savings for state drug purchases made, standardize the pharmacy benefit statewide for all Medi-Cal members, and increase overall access by allowing members to receive pharmacy services from the broader FFS pharmacy network.
- **DMC State Plan**: For counties not participating in DMC-ODS, this program provides a more limited set of SUD treatment services.
- **Services currently carved out of MCMC to FFS**[23].
- **California Children's Services (CCS)** (unless Whole Child Model counties; details below)
- **Home and Community Based Services (HCBS)** (except for Community-Based Adult Services)

DHCS also supports several other programs that provide high-quality, equitable care, especially to specific populations, including:

[23] Of note, SMHS and DMC-ODS services are carved out of MCMC and, instead, delivered through their respective county behavioral health delivery systems, as described in the MCMC section above.

- **California Children's Services (CCS):** A program for children and youth under 21 years of age with specific CCS-eligible medical conditions (e.g., cancer, diabetes, cerebral palsy, congenital heart defect, sickle cell disease, hearing loss, and cystic fibrosis) that provides coverage for medical diagnosis and treatment services, medical case management, private duty nursing, and physical and occupational therapy.
- **Program of All-Inclusive Care for the Elderly (PACE):** A comprehensive medical and social service delivery system using an interdisciplinary team approach that provides, and coordinates all needed preventive, primary, acute, and LTC services. PACE primarily serves dually eligible members and provides all Medicare- and Medi-Cal-covered services. In 2024, PACE enrollment in California was approximately 20,000 across 26 counties. The PACE model enables eligible individuals to remain independent and in their homes for as long as possible. To be eligible, a person must be 55 years of age or older, reside in a PACE service area, be determined eligible at the nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment.
- **California Community Transitions (CCT)** is California's Money Follows the Person (MFP) Rebalancing Demonstration program. CCT provides residents of LTC institutions, who want to return to live and receive LTSS at home or in a community-based setting, with transition and care planning services from experienced transition coordination staff employed by CCT lead organizations. Under CCT, members who are transitioned to the community receive 365 days of post-transition follow-up care to ensure the care plan meets their nursing facility level of care needs in the community.
- **In-Home Supportive Services (IHSS):** A personal care services program for approximately 780,000 recipients who need assistance with activities of daily living. IHSS is an alternative to out-of-home care, enabling recipients to remain safely in their own homes. IHSS is administered by county human service agencies and is available in all 58 counties.
- **1915(c) HCBS Waivers:** Provide long-term, community-based services and supports to Medi-Cal-eligible members in the home or community setting of their choice. Medically necessary services are identified within a person-centered plan of care to maintain the health and safety of an individual with at least

nursing level of care needs in a community setting instead of an institution. While DHCS is currently working towards a long-term Managed LTSS strategy as described above, it currently administers six 1915(c) waiver programs serving different populations.

- **Assisted Living Waiver (ALW)** provides 24-hour care, 7 days a week, to adults (21+ years of age) with disabilities, living in community care settings or public subsidized housing within 15 counties.
- **Medi-Cal Waiver Program (MCWP)** provides long-term services and supports to individuals diagnosed with HIV or AIDS (all ages) who require at least a nursing facility level of care. Services are provided in a community-based setting.
- **Home and Community-Based Alternatives (HCBA)** waiver provides LTSS to individuals (all ages) who require at least a nursing facility level of care in their own home or community setting of choice.
- **HCBS Waiver for Individuals with Developmental Disabilities (HCBS-DD)** provides LTSS to individuals (all ages) with intellectual or developmental disabilities who require at least a nursing facility level of care.
- **Multipurpose Senior Services Program (MSSP)** waiver provides LTSS to individuals who are at least 60 years of age who require at least a nursing facility level of care.
- **Self-Determination Program (SDP) Waiver for Californians with Developmental Disabilities** provides LTSS to individuals (all ages with intellectual or developmental disabilities) who require at least a nursing facility level of care.

» **School-Based Services:**

- **Local Educational Agency Billing Option Program (LEABOP)** reimburses local education agencies (e.g., school districts, county office of education, public charter schools, community colleges, and public universities) the federal share of costs incurred for qualified practitioners to provide approved health and behavioral health-related services to students enrolled in Medi-Cal.

- **Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule program)** requires Medi-Cal managed care plans, commercial health plans, and disability insurers to reimburse local educational agencies, institutions of higher education and school-linked providers for the provision of covered outpatient mental health and substance use disorder services to students under the age of 26 who are enrollees of the plan.
- **Additional programs for specific populations:**
    - Newborn Hearing Screening Program
    - Genetically Handicapped Persons Program
    - Health Care Program for Children in Foster Care
    - Every Woman Counts
    - Prostate Cancer Treatment Program
    - Family Planning, Access, Care, and Treatment Program (Family PACT)
    - Breast and Cervical Cancer Treatment Program

Behavioral Health Grant and Other Programs

Behavioral Health Grant Programs:

- Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Use Block Grant and Mental Health Block Grant to support the full behavioral health continuum of care, from prevention and early intervention through treatment and recovery services, including the coverage of services that are not Medi-Cal benefits.
- SAMHSA State Opioid Response (SOR) grant opioid funding has been used to expand access to MAT and to build capacity to integrate MAT into the entire delivery system, including primary care, mental health care, emergency departments, hospitals, jails, prisons, diversion courts, tribal health care, and the full spectrum of SUD treatment services, including harm reduction programs (e.g., syringe services). Funding is also deployed to support administration initiatives, such as building out mobile crisis response services.

- Naloxone Distribution Program combats opioid overdose-related deaths throughout California by reducing opioid overdose deaths through the provision of free naloxone. As of November 2024, more than 313,000 overdose reversals have been reported through the NDP.
- California Opioid Settlement funds have final and proposed agreements with a set of manufacturers, distributors, and pharmacies. The State and Participating Subdivisions receive payments from the settlements each year. DHCS provides oversight and state-level grant funding for opioid remediation activities.
- Behavioral Health Bridge Housing (BHBH) funding to county behavioral health agencies and Tribal entities to operate bridge housing settings to address the immediate housing needs of people experiencing homelessness who have serious behavioral health conditions, including serious mental illness and/or SUD. DHCS has awarded more than $1.1 billion in BHBH grant funding.
- Behavioral Health Continuum Infrastructure Program (BHCIP) provides funding to award competitive grants to construct, acquire, and rehabilitate real estate assets to expand the behavioral health continuum of treatment and service resources in settings that serve Medi-Cal members. To date, DHCS has awarded 225 grants, totaling $1.7 billion through five rounds of BHCIP grant funding. In addition, DHCS is distributing up to $4.4 billion in competitive Bond BHCIP funding, including $3.3 billion for Round 1: Launch Ready grants as part of Behavioral Health Transformation, DHCS' work to implement Proposition 1.
- Proposition 64 for Elevate Youth California (EYC), a statewide program that has provided more than $323 million through 460 grant awards across 56 counties. These grants address SUD by investing in youth leadership and civic engagement for youth of color and 2S/LGBTQIA+ youth ages 12 to 26 living in communities disproportionately impacted by the war on drugs.
- Children and Youth Behavioral Health Initiative (CYBHI), a cornerstone of Governor Newsom's Master Plan for Kids Mental Health, is an over $4 billion investment by the State of California that takes a "whole child approach" to address that factors that contribute to the mental health and well-being of children, youth, young adults and families in California. In total, over 1.300 California organizations have been awarded more than $2 billion to conduct more than 1,800 activities that advance behavioral health supports and services across the state. DHCS' statewide investments include but are not limited to: a

$381.9 million grant program to scale evidence-based and community-defined evidence practices; over $800 million in grants to support county offices of education and local educational agencies to expand school-based behavioral health services; BrightLife Kids and Soluna, mobile and app-based telehealth coaching services programs that provide free, on-demand telehealth and chat-based support, peer communities, health and wellness tools, and care navigation services to children, youth, and families in California; and, the California Child and Adolescent Mental Health Access Portal, Cal-MAP, a pediatric mental health care access program designed to increase timely access to mental health care for youth throughout California's communities, especially in the state's most underserved and rural areas.

Behavioral Health Services Act

Under Governor Gavin Newsom, California is modernizing the behavioral health delivery system to improve accountability, increase transparency, and expand the capacity of behavioral health care facilities for Californians.

Proposition 1, which was passed by voters in March 2024, includes a $6.4 billion Behavioral Health Infrastructure Bond Act for treatment settings and housing with services, and historic reform of the Behavioral Health Services Act to focus on people with the most serious mental health conditions, SUDs, and housing needs. DHCS is implementing Proposition 1, including the Behavioral Health Services Act, through several initiatives that will transform behavioral health to improve services for Californians.

The Behavioral Health Services Act:

- Reforms behavioral health care funding to include treatment, housing interventions, and behavioral health workforce and prioritizes services for people with the most significant behavioral health needs, including those with mental health only, SUD only, and co-occurring mental health and SUD conditions.
- Expands services to promote prevention, early intervention, and treatment for California's diverse population, with investments in innovative pilot programs.
- Focuses on outcomes, accountability, and equity

The Behavioral Health Infrastructure Bond Act authorizes $6.4 billion in bonds to finance behavioral health treatment facilities, residential care, supportive housing, and housing for veterans with behavioral health needs:

- $4.4 billion will be grants to public and private entities for behavioral health treatment and residential settings.
- $1.5 billion of the $4.4 billion will be awarded only to cities, counties, and Tribal entities, with $30 million set aside for Tribal communities.
- The remaining $1.972 billion will be administered by the Department of Housing and Community Development to support permanent supportive housing for individuals at risk of or experiencing homelessness and behavioral health challenges. Of that amount, $1.065 billion will be for veterans.

1.3 Quality Management Structure at DHCS

DHCS' Medi-Cal Transformation, building upon CalAIM, aims to transform DHCS' Medi-Cal program to achieve health equity, population health, and excellence in quality outcomes. To achieve these goals, DHCS has significantly changed its quality management and data infrastructure and invested in leveraging data-driven improvement, workforce diversity, equity, and inclusion efforts, and more robust member engagement as key pillars in its quality improvement efforts. Each of these is described in more detail in this section.

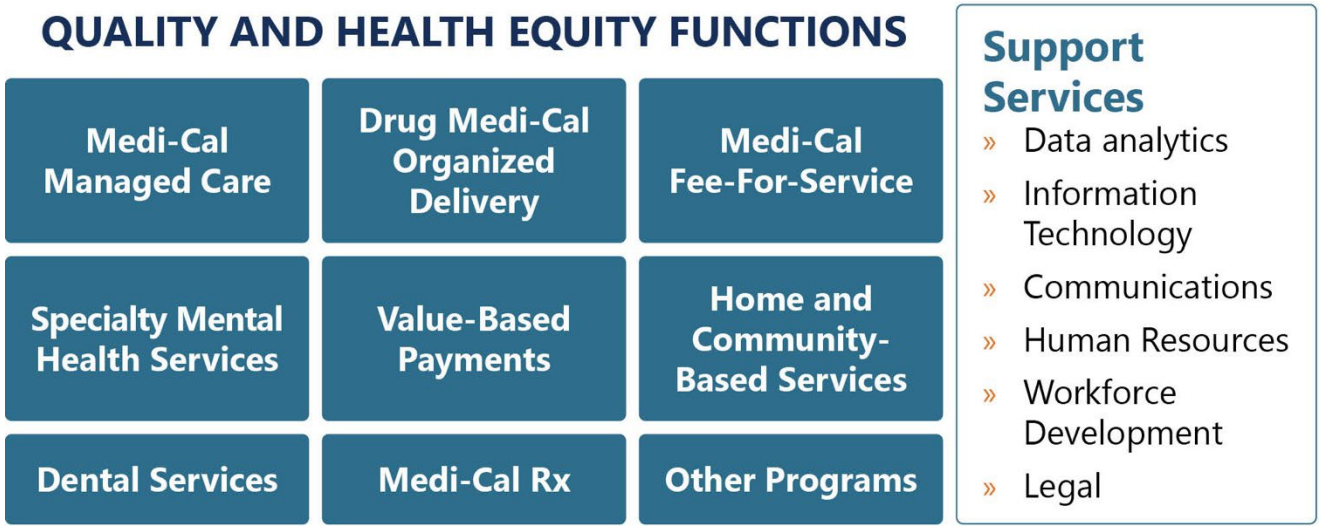
Centralization and Reorganization of Quality and Health Equity Management

Recognizing the centrality of quality and health equity to this agenda, DHCS created a new executive position, Chief Quality and Medical Officer (CQO and CMO) and Deputy Director for QPHM, and since 2021, has centralized and standardized all health equity, quality, and PHM functions across DHCS. The QPHM program also serves as a hub of technical expertise in quality assurance (including enforcement) and data-driven monitoring, performance improvement, health equity, and program evaluation. To further develop this expertise, QPHM is being trained specifically in Lean methodology as a foundational improvement framework that QPHM will leverage in all its activities.

Lean is a customer-centric approach that focuses on maximizing value while minimizing waste in organizational processes.

QPHM, in partnership with health care programs and other support services, helps to elevate and address quality and health equity across all DHCS delivery systems. This partnership is summarized in the functional organizational structure in Figure 16 below.

Figure 16: Quality and Health Equity Functions

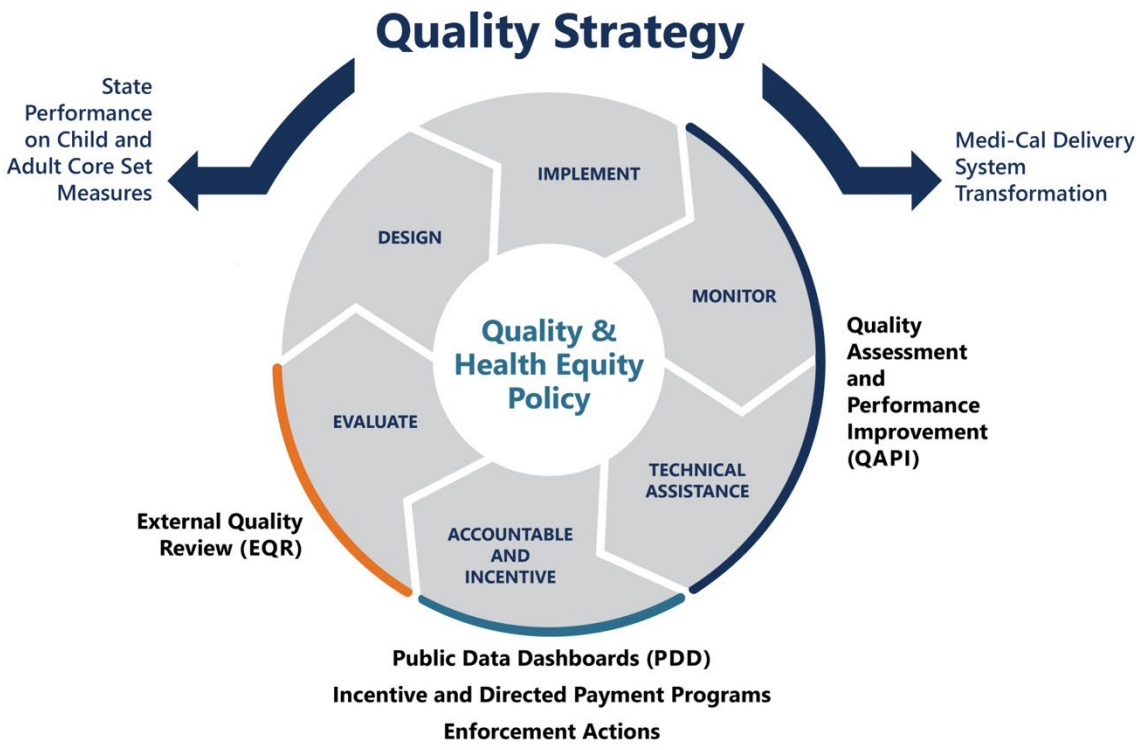


Within this new structure, the QPHM team has led quality and health equity policy for all DHCS programs (managed care, FFS, and other programs, as described previously). DHCS' CQS serves as the Department's strategic plan for quality and health equity. DHCS will leverage this strategy to inform all health care transformation efforts, including efforts to advance strategic directed payments, VBP programs, and managed care contracts. The strategy will also directly inform DHCS' approach to quality assessment and performance improvement focus areas as well as improvements to public dashboards.

The recent centralization of the External Quality Review (EQR) process across delivery systems has helped to improve the assessment of these activities. Additionally, as of July 1, 2024, DHCS has contracted with a single EQR vendor to provide EQR services across all managed care delivery systems, further creating synergies and alignment of managed care quality and health equity expectations across MCMC, SMHS, DMC-ODS, and Dental

MC delivery systems. This feedback loop of continuous improvement based on the quality strategy, improvement activities, public data, and EQR assessment is outlined in Figure 17.

Figure 17: DHCS Continuous Quality Improvement Cycle



Critical parts of this continuous improvement loop are the transparency and accountability provided by accurate, data-driven monitoring and public data dashboards. DHCS, its contracted MCPs, and stakeholders currently use a variety of dashboards to drive continuous quality improvement. Since 2021, DHCS, with key partners, has been steadily improving the amount and timeliness of publicly available data across key Medi-Cal Transformation initiatives to support improved transparency and accountability and enable local implementers to use data for action. Further details are available on DHCS' Dashboard Initiative website. Currently available dashboards, by program, include:

Medi-Cal Transformation

- The Medi-Cal Transformation Dashboard: Published quarterly with updates on key performance indicators for most CalAIM initiatives.
- ECM and Community Supports Implementation Report: Published quarterly with comprehensive ECM and Community Supports uptake and network data, including stratification by key demographics and MCP and county-level information.
- LTSS Dashboard: Published annually with utilization data on a wide range of LTSS, including stratification by key demographics and MCP and county-level information.

Medi-Cal Managed Care (MCMC)

- The Managed Care Performance Dashboard: Published quarterly with comprehensive data on a variety of metrics, including MCP enrollment, health care utilization, member grievances, network adequacy, and quality of care.
- D-SNP Performance Dashboard: Published quarterly to provide data on the key aspects of coordinated care through Medi-Medi Plans, as well as legacy D-SNPs not aligned with MCMC plans.
- Managed Care WCM Dashboard: Published quarterly with comprehensive WCM program data on select metrics for children and youth eligible for CCS and enrolled in a qualifying plan.

Specialty Mental Health Services (SMHS)

- All behavioral health dashboards published annually at the county and statewide level that include outcomes for children and adults.
- Children and Youth Performance Dashboard - All children and youth under age 21 receiving SMHS.
- Adult Performance Dashboard - All adults ages 21 and older receiving SHMS

Aggregate Mental Health Reporting (N-SMHS and SMHS):

- Children and Youth Demographic Datasets and Report Tool.[24]
- Adult Demographic Datasets and Report Tool. [25]

Reports specific to child welfare:

- Children and Youth in Foster Care.
- Children and Youth with an Open Child Welfare Case.
- Katie A. Specialty Mental Health Datasets.

Drug Medi-Cal Organized Delivery Systems (DMC-ODS)

- SUD DMC-ODS Penetration Dashboard

Dental Managed Care (Dental MC)

- Dental Data Reports are published quarterly to monitor utilization through 13 performance measures for both Dental MC and FFS, and annual complaints and grievances reports.
- Other dental data reports that monitor utilization are published monthly.

Medi-Cal Program Overall

- Eligibility data published monthly to provide Medi-Cal Enrollment Trends.
- Pediatric Dashboard published quarterly with pediatric-specific data across DHCS delivery systems.

[24] Children and youth under age 21-member population. These datasets consist of aggregate mental health services data derived from Medi-Cal claims, encounters, and eligibility systems and were developed in accordance with California Welfare and Institutions Code (WIC) § 14707.5, added as part of Assembly Bill 470 (Arambula, Chapter 550, Statutes of 2017).

[25] Adults aged 21 and older member population. Data include aggregate MHS data from claims, encounters, and eligibility systems, developed in accordance with California WIC § 14707.5 added as part of Assembly Bill 470.

Enabling Data-Driven Improvement

Using actionable data to identify gaps in quality and health equity and informing improvement efforts are at the foundation of DHCS' CQS. Recognizing this need, and like the restructuring of QPHM, DHCS has centralized data analytic functions under the Chief Data Officer (CDO) and Deputy Director for Enterprise Data and Information Management (EDIM). EDIM is leading several department-wide initiatives to improve data quality and reporting. These initiatives include:

- Transformed Medicaid Statistical Information System (TMSIS), which transmits Medi-Cal data to CMS.
- Implementation of the CMS Interoperability and Patient Access Rule and the CMS Interoperability and Prior Authorization Rule, which will allow Medi-Cal members greater access to their health care data.
- Partnering with the California Department of Health Care Access and Information to implement the Data Exchange Framework.
- Improving public access to data by sharing DHCS data on the CalAIM Dashboard as well as via the CalHHS Open Data Portal.
- Partnering with other state agencies to share data for improvement. For example, sharing data with the California Department of Public Health (CDPH) to leverage registries, such as the Vital Records Registry, California Immunization Registry (CAIR), Childhood Blood Lead Registry, the Infectious Disease Reporting Registry, and the HIV/AIDS registry, to improve quality reporting. Similar efforts are underway with the California Department of Social Services (CDSS) to assess children in foster care and child welfare.

External Stakeholder and Medi-Cal Member Engagement

Stakeholder participation and feedback are vital to the success of the Medi-Cal program and our quality and health equity efforts. Stakeholders are engaged in several formal forums, advisory groups, and other types of outreach as described in Figure 18. DHCS Stakeholder Advisory Committee materials, including agendas and presentations, are publicly available. Recent discussion topics have included DHCS' numerous initiatives designed to support Medi-Cal's most complex members, including people experiencing

homelessness, involved in the justice system, and eligible for ECM and Community Supports.

Additionally, as described in DHCS' 2022 CQS, central to DHCS' vision for quality and health equity is the belief that Medi-Cal members are at the center of our policy design and programs. Since 2022, DHCS has launched several venues by which it engages with, listens to, and centers member voices in its quality and health equity work. These include, but are not limited to:

Health Equity Roadmap: The Health Equity Roadmap outlines DHCS' plan to reduce health disparities by collecting data, identifying care gaps, and creating targeted interventions for high-risk groups. A statewide listening tour gathered member feedback directly from communities experiencing disparities to help shape this roadmap, which aims to build transparency and trust among diverse members.

Medi-Cal Member Advisory Committee (MMAC): Launched in 2023, the MMAC continues to serve as a dedicated forum for Medi-Cal members to provide direct feedback to DHCS' Director and executive leadership. The committee is composed entirely of Medi-Cal members and family caregivers, representing the diverse demographics and geography that Medi-Cal covers. In 2025, MMAC members played a key role in testing and refining the new Medi-Cal member digital experience, a simplified, mobile-first web platform designed to improve access to Medi-Cal information and services. During breakout sessions, MMAC participants evaluated the site's usability, offering critical feedback on accessibility features such as screen reader compatibility and translation options. Their insights directly informed improvements to the site's content and functionality.

Medi-Cal Voices and Vision Council: Established in 2025, the Voices and Vision Council brings together diverse stakeholders, including clinical providers, public health leaders, Tribal representatives, consumer advocates, and community partners, to inform DHCS policy and program design. To ensure authentic member representation, the Council includes seats for MMAC participants. In its first year, three MMAC members joined the Council, contributing firsthand insights into the lived experiences of Medi-Cal members. Their input has shaped maternal health outreach strategies and culturally responsive communications.

Birthing Care Pathway: As a part of DHCS' Birthing Care Pathway policy initiative to transform prenatal and postpartum care for members, DHCS engaged directly with Medi-Cal members who had been or were currently pregnant to understand their lived

experiences accessing care while on the Medi-Cal program. These experiences directly informed DHCS' policy work in this area.

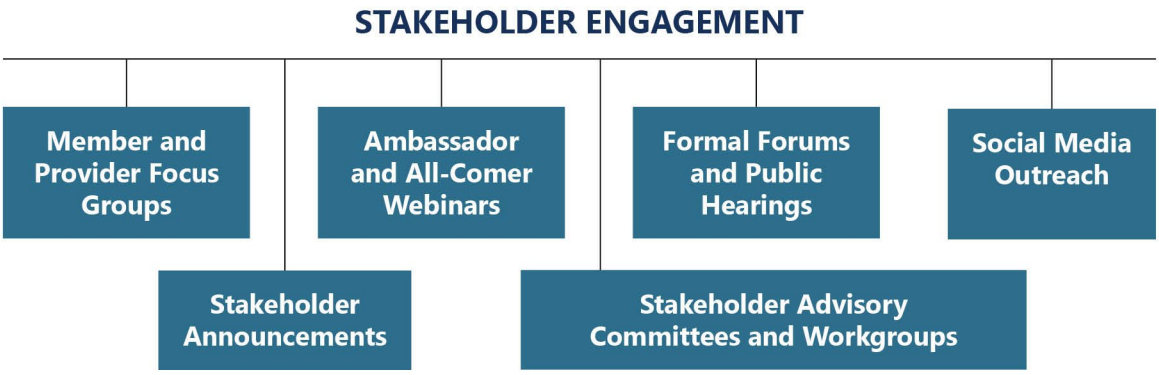
Ethnic Media Campaign: DHCS continues to partner with American Community Media and California Black Media (CBM) to increase awareness of Medi-Cal's transformation through targeted ethnic media outreach. The campaign includes webinar briefings, community forums, reporting fellowships, and regional Lunch & Learn events, collectively reaching millions of Californians and producing more than 300 stories. This year's topics include maternal health, midwife services, and behavioral health.

Efforts have been instrumental in amplifying member voices and ensuring that policy changes are communicated in culturally and linguistically appropriate ways.

Virtual Member Feedback Forums: Facilitated virtual discussion boards with Medi-Cal members and caregivers to explore topics, such as perceptions of Medi-Cal services, challenges with accessing care, and reactions to new programs like Medi-Medi Plans and Community Supports. These forums provided critical insights to refine communication strategies and ensure member-focused messaging.

Coverage Ambassadors: The Coverage Ambassador program has grown to include over 8,000 community-based messengers who serve as trusted sources of information in their local communities. These Ambassadors, ranging from promotors, Covered California Enrollment Counselors, clinic staff, providers, and other community partners, play a critical role in helping Medi-Cal members understand their coverage, access benefits, and navigate the system. In 2025, DHCS expanded the program to support H.R.1 implementation, equipping Ambassadors with multilingual toolkits, flyers, FAQs, and social media content to educate members about upcoming changes. By leveraging their community connections and cultural competency, Ambassadors reduce confusion, build trust, and amplify outreach. Their feedback also informs DHCS' communication strategies, ensuring materials are responsive to member needs.

Figure 18: DHCS and Stakeholder Engagement



1.4 Development and Review of the CQS

With this CQS, DHCS meets the requirements for its development, evaluation, revision, and availability of the CQS as described in 42 CFR 438.340(b), (c), and (d) and has addressed feedback already received by CMS on its draft CQS.DHCS followed the following steps to revise this CQS:

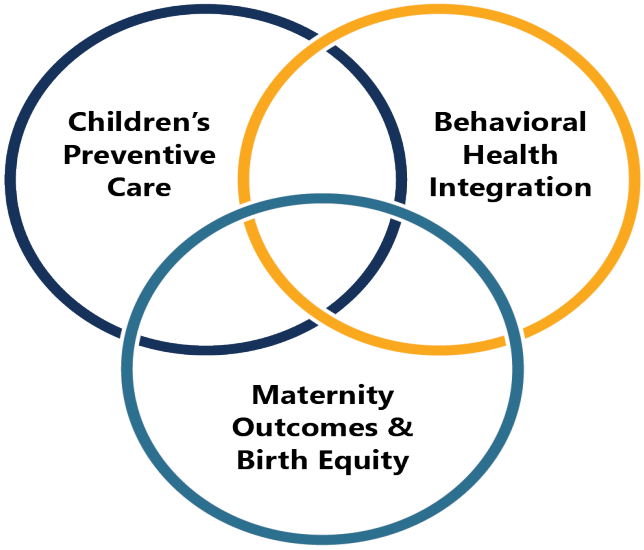
- QPHM led an interdisciplinary team to work with all relevant DHCS areas to review materials and update the quality strategy. DHCS posted the draft strategy for public review in July 2025, presented at stakeholder meetings and consulted with Tribal partners and incorporated stakeholder feedback
- DHCS has reviewed the effectiveness of the 2022 Comprehensive Quality Strategy and has included this evaluation in Appendix E
- DHCS has reviewed all recent EQRO reports and addressed them; in addition, overarching themes have been incorporated in this revised CQS
- DHCS has posted the final report on the DHCS CQS website

QUALITY AND HEALTH EQUITY IMPROVEMENT STRATEGY

2.1 DHCS' Vision for Medi-Cal

DHCS' vision for Medi-Cal is that people served by our programs should have longer, healthier, and happier lives. In this whole-system, person-centered, and population health approach to health and social care, health care services are only one element of supporting people to have better health. Partnerships with communities, members, CBOs, and public health, in addition to the health care system, will help support and anticipate health needs, prevent illness, and reduce the impact of poor health.

Figure 19: DHCS Clinical Focus Areas



The whole-system, person-centered approach will be equitable, reducing health inequities within the Medi-Cal program and between Medi-Cal and other insurance programs. It will improve health (physical, behavioral, developmental, oral, and LTSS) throughout lives, from birth to a dignified end of life, allowing people to access a range of seamless services as close to home as possible, whenever needed. Services will be tailored to the individual and around groups of people, based on their unique needs and what matters to them, as well as quality, equity, and safety outcomes.

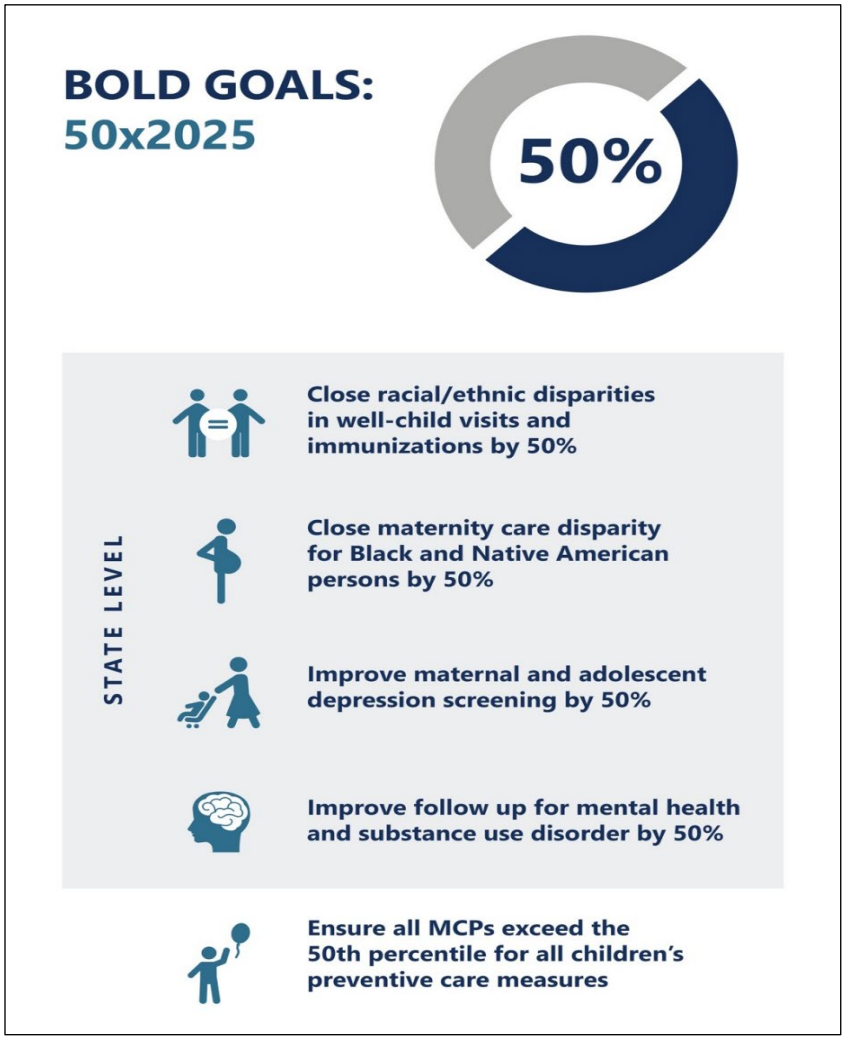
Even prior to the COVID-19 pandemic, DHCS recognized opportunities to improve care for specific vulnerable populations—people experiencing homelessness, foster children, justice-involved, dual-eligibles, seniors and persons with disabilities (SPD), individuals receiving LTSS, adults with multiple chronic conditions, and people utilizing the behavioral health care system. The CalAIM initiatives were designed to transform these programs to improve member access, experience, and outcomes.

Since its 2022 CQS, DHCS has only deepened and strengthened its whole-person approach, expanding it to the behavioral health care realm through its BH-CONNECT and Behavioral Health Transformation initiatives, which continue prioritizing integrated, whole-person care for the populations identified above.

In addition, as a part of its previous 2022 CQS, DHCS identified three key clinical focus areas: children's preventive care, maternity outcomes, and birth equity and behavioral

health integration, which served as the foundation of its Bold Goals 50x2025 campaign. While DHCS has made marked progress towards its Bold Goals and key 2022 CQS priorities, the work is only partially done. The 2025 DHCS CQS aims to strengthen and build upon these efforts previously initiated efforts, maintaining the key clinical focus areas described above, adding significant programming on maternity care and behavioral health as described below, and ensuring the successful achievement of its Bold Goals. Additional details on progress towards Bold Goals 50x2025 are described below in Section 2.4 and in the formal 2022 CQS Evaluation (Appendix E).

Figure 20: Bold Goals 50x2025 Initiative[26]

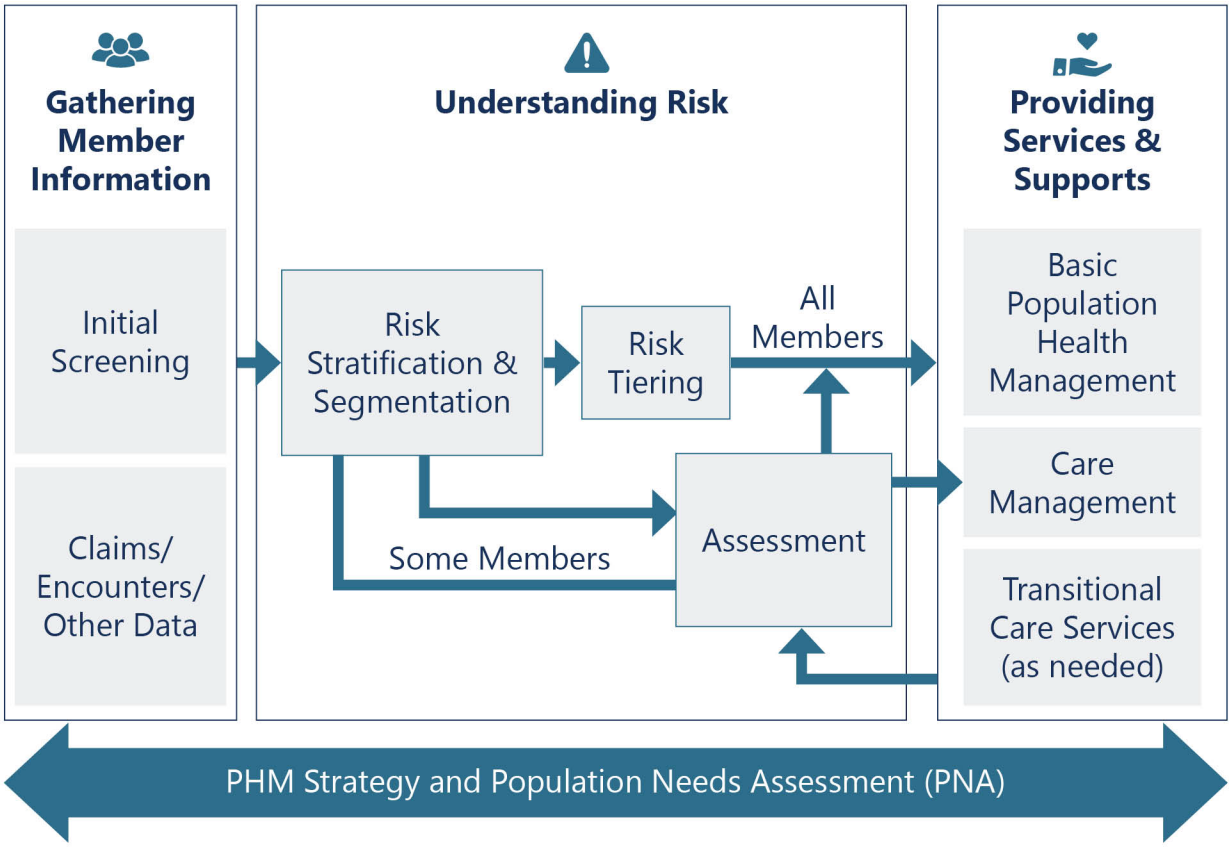


[26] As described, the Bold Goals 50x2025 were submitted to CMS as a part of its 2022 CQS and are expected to go through at least December 2025. Results of these goals will not be available until Q3 2026 so DHCS is carrying forward these specific objectives until data and results are available and will extend as necessary until objectives are met.

2.2 Population Health Management (PHM)

On January 1, 2023, DHCS launched its comprehensive PHM program for all Medi-Cal MCPs as part of CalAIM. PHM aims to address members' clinical and non-clinical needs through a person-centered approach that emphasizes health equity and social drivers of health (SDOH). While PHM programs are required for MCMCs, the PHM Framework (Figure 21) can serve as a blueprint for meaningful health promotion and collaboration in DHCS and for other MCPs and delivery systems. More information on population health management can be found on DHCS's PHM website and in the PHM Policy Guide.

Figure 21: PHM Framework



Gathering Member Information

An effective PHM approach begins with gathering accurate and robust information to understand members' health and social needs, as well as their health goals, attitudes,

and behaviors, to ensure that DHCS, MCPs, and other Medi-Cal delivery system partners can address these needs as effectively as possible.

Member data should ideally be collected through existing sources, including, but not limited to, screenings and assessments, social services reports, electronic health records, referrals and authorizations, claims and encounters, laboratory data, demographic data, and information on SDOH.

Further, delivery systems should have initial screening processes and requirements for clinical evaluations or appointments to gather comprehensive and up-to-date member information on a timely basis. Examples of these policies include MCP requirements for a Health Information Form (HIF)/Member Evaluation Tool (MET) within 90 days and Initial Health Appointment(s) to start within 120 days of enrolling as a member.

Understanding Risk

Members' risks for poorer health and underutilization of services should be analyzed systematically and comprehensively through processes, including risk stratification, segmentation, and tiering (RSST) and standard assessments, including those that evaluate members' exposure to the upstream SDOH that are critical to health outcomes. These methods must account for potential biases, including those driven by data gaps due to under-engagement and underutilization. RSST results in the categorization of all members according to their care and risk needs at all levels and intensities, followed by assigning members to standardized risk tiers.

DHCS is committed to creating a statewide, transparent, and comprehensive RSST process within its PHM service, Medi-Cal Connect[27]. This RSST process will set a statewide standard for classifying members into risk tiers, implicitly identifying members who require different levels and types of health and social services. In addition to predicting risk for adverse outcomes, DHCS's RSST processes aims to address structural biases by systematically considering what data may be missing due to underutilization of services because of mistrust or other barriers to services. This effort also strives to predict outcomes in a broad range of domains, including physical health, behavioral health, and social services. Prior to the launch of RSST within Medi-Cal Connect, MCPs must implement risk stratification processes that meet NCQA accreditation standards, with further requirements to account for potential bias added by DHCS.

[27] Fact sheet: What is Medi-Cal Connect?

Assessments vary in length and scope, and some are mandated by federal and/or state law, by NCQA, or by DHCS' PHM requirements. For instance, people with LTSS needs have requirements for annual assessments and reassessments, and DHCS policy requires every member enrolled in ECM to receive an assessment. RSST processes can identify members who may benefit from assessments for clinical and non-clinical needs, but are missed by other approaches, revealing high-impact opportunities to promote health, improve use of available services, and address SDOH.

Providing Services and Supports

Medi-Cal delivery system partners may use the understanding of member health risk to design and drive Medi-Cal member engagement in programs designed to have the greatest possible impact on members' health outcomes and reduction of disparities. Different levels of PHM, including care management, are described below. These efforts may range from preventive services provided to the whole population, such as Basic PHM (BPHM), to intensive in-person services designed to address upstream SDOH and complex medical and behavioral health needs, such as ECM.

BPHM is an approach to care that ensures all members have access to necessary programs and services, regardless of their risk tier, at the right time and in the right setting. BPHM replaces the previous "Basic Case Management" requirements for MCPs and includes several key components, such as access to primary care, care coordination, integration of community health workers, programs focused on wellness, prevention, and social needs, and chronic disease management.

Complex Care Management (CCM). Members with more complex needs and risks may benefit from care management programs that provide additional services and supports. CCM is an MCP requirement that meets "Complex Case Management" program requirements as defined by NCQA. CCM is a service for MCP members who are at medium-to-high risk and need extra support but do not qualify for ECM. CCM may address both ongoing chronic care coordination and interventions for episodic or temporary needs, aiming to help members regain optimum health or improve their functional capabilities. MCPs' CCM programs must have clear eligibility criteria, core components including comprehensive assessments and a Care Management Plan, standard services and interventions, and a well-defined care manager role.

ECM is a statewide managed care benefit that was launched in January 2022. ECM addresses the clinical and nonclinical needs of Medi-Cal's highest-need members through intensive coordination of health and health-related services. ECM is

community-based, interdisciplinary, high-touch, person-centered, and provided primarily through in-person interactions. MCPs are required to contract with community-based providers, such as Federally Qualified Health Centers (FQHC), counties, county behavioral health providers, Local Health Jurisdictions (LHJ), and others to deliver ECM.

ECM eligibility is based on members meeting specific "Populations of Focus" criteria as detailed in DHCS' ECM Policy Guide. ECM includes seven core services: outreach and engagement, comprehensive assessment and care management plan, enhanced care coordination, health promotion, comprehensive transitional care, member and family support, and coordination of and referral to community and social support services. Each ECM provider is required to 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.

Transitional Care Services (TCS) are designed to support members as they transition from one care setting to another, particularly for high-risk individuals who require additional coordination to ensure continuity of care. These services involve a comprehensive approach that includes ensuring medication reconciliation, scheduling follow-up appointments, and connecting members to necessary community resources and supports post-discharge. The TCS framework aims to provide support for at least 30 days after discharge, aiming to ensure that all transitions are managed effectively to enhance member health outcomes.

DHCS requires MCPs to match the scope of TCS to the needs and risks of members. More intensive TCS are required for high-risk members, such as members receiving LTSS, eligible for ECM, and determined to be in a high-risk tier via RSST. High-risk members' TCS must include a dedicated care manager and single point of contact, with clear communication of care management assignment and responsibilities. In contrast, lower-risk TCS focuses on members who do not meet high-risk criteria but still require some level of support during their transition, involving access to a specialized team rather than a dedicated care manager.

Population Needs Assessment (PNA)

The PNA is a vital mechanism used by MCPs to assess and identify the priority needs of their local communities and members, particularly focusing on health disparities. As outlined in the updated PHM Policy Guide, MCPs are to fulfill their PNA requirement by actively participating in the Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) developed by LHJs. This participation aims to foster

collaboration among MCPs, LHJs, and community stakeholders to gain a comprehensive understanding of the health and social needs within their shared communities.

Integrating the PNA with the CHA/CHIP ensures a unified approach to identifying and addressing these needs, aligning MCP priorities with those of the LHJ and avoiding duplication of efforts. The PNA/CHA/CHIP process draws on diverse data sources and community input to understand and address community needs. It also reduces siloed approaches to population assessments and interventions. Additionally, MCPs must submit an annual DHCS PHM Strategy Deliverable to report on their engagement progress and updates regarding the PHM Program.

As part of meaningful participation in LHJs' CHAs/CHIPs, MCPs are required to contribute resources to support LHJs' CHAs/CHIPs in the service areas where they operate, in the form of funding and/or in-kind staffing, starting on January 1, 2025. MCPs are strongly encouraged to contribute resources at least proportionately with the number of Medi-Cal members they serve in each LHJ jurisdiction. MCPs are further expected to attend key CHA/CHIP meetings as requested by LHJs and serve on CHA/CHIP governance structures, including subcommittees, as requested by LHJs.

Medi-Cal Connect, the DHCS PHM Service

Medi-Cal Connect is the name of the PHM analytics service that will aggregate, link, and analyze data across multiple sectors to provide Medi-Cal plans and providers with whole-person data. This service consolidates information from various sources, including historical administrative, medical, behavioral, dental, and social service data, to enhance the ability to conduct RSST and facilitate assessment, screening, analytics, and policy and program design by risk tier and/or population subgroup.

Empowering Medi-Cal providers and plans with whole-person data will increase Medi-Cal members' health care engagement, utilization, and outcomes. Medi-Cal Connect has already completed its Phase 1 and Phase 2 launches for DHCS users. In September and November 2025, MCPs and BHPs, respectively, will be onboarded on the platform. Additional details can be found on the PHM website.

PHM Monitoring

DHCS has developed a monitoring approach to assess the implementation, operations, and effectiveness of its policies and benefits and MCPs' PHM programs. This approach involves a comprehensive review of areas in the PHM Framework (Figure 21). Specific populations, such as children and youth, birthing populations, and individuals with behavioral health needs, are monitored to ensure equitable access to services and

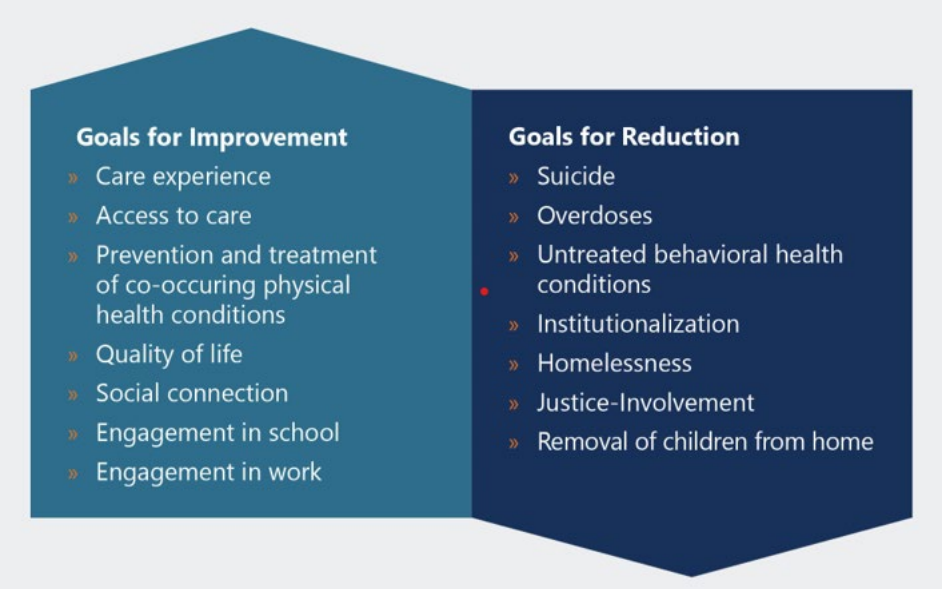
improved health outcomes. The monitoring framework also emphasizes the importance of health equity across all domains and categories within the PHM program.

DHCS leverages existing quality measures and new Key Performance Indicators (KPI) that are reported quarterly in PHM monitoring. The KPIs are designed to track key areas, such engagement in primary care, use of the emergency department without other usual sources of care, and care management interactions for high-risk members' post-discharge. MCPs are required to report these KPIs at the plan level, and DHCS expects them to conduct internal monitoring on a regular basis to ensure continuous quality improvement. If any significant issues arise, DHCS will engage with MCPs for further investigation and may implement corrective actions as needed.

Expanding DHCS' PHM Framework to Behavioral Health

As a part of DHCS' broader behavioral health transformation efforts, and to support implementation of state statutory mandates included in SB 326 (Eggman, Chapter 790, Statutes of 2023), also known as the Behavioral Health Services Act, DHCS has established, for the first time, statewide population health goals across relevant delivery systems. These goals, outlined below, expand the existing whole-person care approach to quality and equity established in MCMC to the broader behavioral health system.

Figure 22: Statewide Behavioral Health Goals



2.3 Goals, Guiding Principles, and Objectives for the Quality Strategy

The goals of and guiding principles for DHCS' CQS (summarized in Figure 24 and described in this section), are designed to build upon the overarching Medi-Cal Transformation and PHM goals and principles to achieve population health. The subsequent specific objectives for each program and DHCS' **50x2025** Bold Goals initiative are in service of these overarching goals. Several of these specific objectives and goals are a continuation of the 2022 CQS, including the 50x2025 Bold Goals, which run through December 31, 2025, as well as numerous goals tied to CalAIM, which continue through the end of DHCS' current 1115 waiver (December 31, 2026). The goals below represent strategic priorities for DHCS with accompanying narrative of the various efforts designed to advance this priority.

Figure 23: DHCS Quality Strategy Goals and Guiding Principles

Goal 1: Engaging Members in their Care

Improving Member Experience

Medi-Cal members currently experience a fragmented health care system where they may have to access six or more separate delivery systems (for example, spanning across managed care, FFS pharmacy, specialty mental health, SUD, dental, developmental, IHSS) to address their needs. Services also vary from county to county, which can lead to significant disruptions in care for members if they move. This administrative complexity and variation can significantly impact care coordination needs and clinical outcomes, especially for members who may already be experiencing barriers due to socioeconomic factors, limited English proficiency, or greater clinical complexity.

These barriers are also reflected in patient experience survey scores, with many California health plans scoring below the 25th percentile nationally. Members also experience disparities in how they can access care, with communities of color significantly more likely to face barriers to broadband and video visits while experiencing higher utilization of audio-only visits during the pandemic, and rural regions facing numerous gaps in provider network and access. While behavioral health member experience surveys, such as the Consumer Perception Survey and Treatment Perception Survey, generally show positive results, they are limited in methodology and do not have national benchmarks for comparison. Anecdotal evidence such as this narrative and video report from the California Health Care Foundation provides vivid examples of the challenges people face when trying to access care when they struggle with mental illness, SUD, and/or homelessness, suggesting there may be similar challenges among behavioral health plans as well.

The 2025 DHCS CQS aims to continue existing efforts to improve member experience and empower members to own their care and to inform Medi-Cal programs and policy through several efforts:

- Incorporating Medi-Cal members into DHCS policy processes as described in Section 1, and especially through the Medi-Cal Member Advisory Committee and Voices and Vision Council, ensuring that policy decisions reflect lived experiences.
- Requiring MCPs, as a part of their PHM Strategy and their Community Advisory Council, to engage members and local communities to inform community health needs and MCP services.

- Integrating behavioral health administration to provide a more seamless experience for members accessing mental health and SUD services.
- Incorporating member experiences survey results into the Quality Withhold Incentive program to further incentivize improvements in member experience.
- Exploring opportunities to improve the response rates and utilization of member experience surveys across delivery systems, in addition to now collecting such data annually.
- Partnering with ethnic media outlets to deliver culturally relevant, in-language information through webinars, community forums, and media placements to expand awareness of Medi-Cal services.
- Supporting over 8,000 Coverage Ambassadors statewide who serve as trusted messengers, helping members understand their coverage, access benefits, and navigate the Medi-Cal system.

Goal 2: Keeping Families and Communities Healthy

The critical necessity of effective primary care, preventive services, and close collaboration with public health was seen throughout the COVID-19 pandemic and in the years since. It was highlighted even further by the National Academies of Sciences, Engineering, and Medicine report on implementing high-quality primary care. The foundation of DHCS' CQS, as mentioned previously, is a shift to population health and a renewed emphasis on prevention, especially in collaboration with public health authorities to address prevention at the member, population, and community levels. Primary care is critical in achieving quality and equity, and yet, Medi-Cal members are more likely than commercial populations to report having no usual source of care. To achieve its CQS goals, DHCS must increase member engagement with primary care and support primary care practices in transformation efforts so they can truly serve as the backbone of the delivery system.

DHCS will utilize this lens in establishing or evaluating financial strategies and payment methodologies. As an example, DHCS has required MCPs to report on primary care spending as a percentage of total spending as well as the percentage of primary care contracts that are in alternative payment models. As part of the 2025 CQS, and in partnership with the Office of Health Care Affordability (OCHA), Covered California, and CalPERS, DHCS will further this work with three specific goals:

- Establishing a utilization metric to measure primary care engagement for children and adults (including continuity with their primary care provider) and setting a threshold for all MCPs.
- Establishing a primary care spending target for all MCPs, consistent with OCHA's Primary Care Spending targets.
- Establishing an Alternative Payment Model (APM) target for all MCPs, consistent with OCHA's APM targets.

Goal 3: Providing Early Interventions for Rising Risk

To help preserve health and quality of life for Medi-Cal members, it is critical that Medi-Cal programs effectively manage chronic conditions and identify changes in health status as early as possible. In addition, communities have different levels of access to support structures that help them lead healthier lives (e.g., safe neighborhood parks, fresh fruits and vegetables, and clean air and water), leading to significant health disparities in rates of chronic diseases, such as hypertension, asthma, and diabetes. In addition to the population health efforts described above, there are many new DHCS initiatives that aim to target rising risk for specific populations, including:

- **Children and Youth Behavioral Health Initiative (CYBHI)**: Improving early access to behavioral health for children and youth to prevent the development of serious mental illness and SUDs. CYBHI supports strengthening behavioral health partnerships and capacity within California schools, scales evidence-based practices across the state, and implements a service and supports platform for behavioral health to allow all youth in California to access early behavioral health interventions. In January 2024, DHCS launched two free behavioral health virtual services platforms, web- and app-based applications that support two distinct groups: BrightLife Kids is for parents, caregivers, and kids 0-12 years old, and Soluna is for teens and young adults ages 13-25. For more information, please visit the BrightLife Kids and Soluna webpage.
- **Behavioral Health Service Act Funds for Early Intervention:** As of July 1, 2026, County Behavioral Health Delivery Systems will be required to dedicate a portion of Behavioral Health Services Act funds to early intervention programs. Within that Early Intervention allocation, at least 51% of funds will be dedicated to services for individuals 25 years of age or younger to provide upstream

interventions for behavioral health conditions that too often go undiagnosed and untreated. While Behavioral Health Services Act funds and services are not limited to Medi-Cal-eligible individuals, funds can and should be used to serve the Medi-Cal population.

- **The Birthing Care Pathway:** Like the rest of the nation, California is facing a maternal health crisis. Every five days, a Californian loses their life to pregnancy-related complications. Although the state's pregnancy-related mortality ratio is lower than the national ratio, it has been rising in recent years, and the majority of these deaths are preventable. The severe maternal morbidity rate in California has also been rising and is higher than the national rate. This crisis is disproportionately impacting Black, American Indian/Alaska Native, and Pacific Islander individuals.

  With Medi-Cal covering 40 percent of births statewide, DHCS is uniquely positioned to drive significant improvements in maternal health and birth equity. DHCS began developing a comprehensive policy and care model roadmap called the Birthing Care Pathway in 2023 to cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum. The Birthing Care Pathway is designed to be a strategic roadmap for state entities, MCPs, counties, providers, social service entities, philanthropy, and other key partners serving pregnant and postpartum Medi-Cal members. The goals of the Birthing Care Pathway, which is generously supported by the California Health Care Foundation (CHCF) and the David & Lucile Packard Foundation, are to reduce maternal morbidity and mortality and address racial and ethnic disparities that disproportionately affect Black, American Indian/Alaska Native, and Pacific Islander individuals.

  On February 4, 2025, DHCS released the Birthing Care Pathway report, a comprehensive plan to improve maternity care for Medi-Cal members. The report details policies DHCS has implemented or is in the process of implementing to support all pregnant and postpartum members enrolled in Medi-Cal. Additionally, the report identifies opportunities for future exploration.

Goal 4: Providing Whole-Person Care for High-Risk Populations

High-risk populations in Medi-Cal, including older adults, persons with disabilities, dual eligibles, members needing LTSS, people with significant diseases, mental illness, SUD, housing instability, foster children, or justice system-involvement, often suffer from

fragmented care that worsens their health and their ability to lead long, healthy, and happy lives. CalAIM, BH CONNECT, and Behavioral Health Transformation aim to actively support these populations and address known health care gaps through targeted interventions that will support non-medical services that drive clinical outcomes, care management and transition services, workforce initiatives, and behavioral health integration. Select interventions that will be key for addressing high-risk populations include:

ECM and Community Supports

As part of CalAIM, DHCS established ECM (as described above) as a statewide benefit in managed care to provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Since the launch of ECM in 2022, the program has served more than 279,800 unique members, and 143,200 unique members received ECM services in Q3 2024 (the most recent quarter for which data are publicly available).

ECM is now provided to all nine populations of focus (POF) statewide with a phased launch between January 1, 2022, and January 1, 2024. The nine POFs are:

- Individuals Experiencing Homelessness
- Individuals At Risk for Avoidable Hospital or Emergency Department (ED) Utilization
- Individuals with Serious Mental Health and/or SUD Needs
- Individuals Transitioning from Incarceration
- Adults Living in the Community and At Risk for LTC Institutionalization
- Adult Nursing Facility Residents Transitioning to the Community
- Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition
- Children and Youth Involved in Child Welfare
- Birth Equity

To better address the needs of these high-risk populations and recognizing that SDOH contribute to avoidable health outcomes and health inequities in these populations, DHCS also implemented Community Supports, which are optional wraparound services

that are provided as a substitute for, or to avoid, other services, such as hospitalization.[28] The current list of Community Supports includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Assisted Living Facility (ALF) Transitions (formerly known as Nursing Facility Transition/Diversion to Assisted Living Facilities)
- Community or Home Transition Services (formerly known as Community Transition Services/Nursing Facility Transition to a Home)
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals/Medically Supportive Food
- Sobering Centers
- Asthma Remediation
- Transitional Rent (effective January 1, 2026)

Community Supports are optional for MCPs and members, apart from Transitional Rent, which becomes a mandatory service for MCPs to cover on January 1, 2026. As of December 31, 2024, all MCPs had opted in, with every county offering at least 8 services. Twenty-three counties offered all 14 Community Supports. Overall, 41 percent of Medi-Cal members had access to all 14, and nearly 91 percent had access to at least 10.

Since the launch of Community Supports in 2022, the program has served more than 368,400 unique members, and more than 148,800 unique members received Community Supports services in Q4 2024 (the most recent quarter for which data are publicly available). More than 59 percent of members utilizing Community Supports in Q4 2024 accessed Medically Tailored Meals/Medically Supportive Foods, and approximately 40

[28] 12 Community Supports are authorized under California's Section 1915(b) waiver and 42 CFR section 438.3(e)(2). Short-Term Post-Hospitalization Housing and Recuperative Care are authorized under Section 1115 waiver authority. Transitional Rent is authorized under BH_CONNECT Section 1115(a) Demonstration and will become a mandatory benefit for all Medi-Cal MCPs starting on January 1, 2026.

percent of members accessed one or more of the Housing Trio (Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services). More than 920,000 Community Supports services have been utilized and delivered to members since they launched in January 2022.

Strengthened Behavioral Health Interventions

As described above, DHCS submitted and received approval of its new 1115 demonstration waiver, BH CONNECT, to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT includes interventions focused on improving outcomes for high-risk populations with complex needs, including children and youth (particularly those with multi-system involvement); justice-involved individuals; and people experiencing homelessness. For example, county BHPs may elect to cover Assertive Community Treatment and Forensic Assertive Community Treatment (ACT/FACT). ACT/FACT is an intensive, community-based care model that has been shown to reduce inpatient and emergency department admissions[29] and justice-system involvement,[30] among other positive outcomes. Similarly, under BH-CONNECT, BHPs will adopt updated practice standards for EBPs for children and youth, including High-Fidelity Wraparound (HFW). HFW is correlated with numerous improved outcomes for children and youth with behavioral health needs, including improved child behavior, mental health functioning, caregiver satisfaction, and reduced school absences and suspensions.[31,32] HFW is also linked to cost savings through reduced claims expenses for emergency room and inpatient psychiatry visits.[33]

The Behavioral Health Services Act also identifies priority populations, including individuals with behavioral health conditions who are chronically homeless and/or experiencing homelessness, those at risk of, or experiencing, justice system involvement, child-welfare involved youth, and individuals at high risk of institutionalization,[34] and

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[29] Aagard et. al (2017)

[30] Cusack et. al (2010)

[31] National Wraparound Initiative, Wraparound Basics: Frequently Asked Questions

[32] Bruns, E. (2008). The evidence base and wraparound. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

[33] Suter, J. C., & Bruns, E. J. (2009). Effectiveness of the wraparound process for children with emotional and behavioral disorders: a meta-analysis. *Clinical Child and Family Psychology Review*, 12(4), 336–351.

[34] California Welfare and Institutions Code, Section 5892(d)

requires counties to dedicate Behavioral Health Services Act funds to corresponding interventions. Under the Behavioral Health Services Act, counties must dedicate 35% of available funds to Full-Service Partnership programs for individuals with the most complex and significant behavioral health needs, including those with mental health, SUD, and co-occurring needs, and must offer evidence-based practices, including ACT and HFW to improve outcomes for this population. Thirty percent of available Behavioral Health Services Act funds must be dedicated to an array of housing interventions for people with behavioral health needs who are homeless or at risk of experiencing homelessness. Thirty percent of available funds must be dedicated to Behavioral Health Services and Supports, including early intervention and outreach and engagement. The Behavioral Health Infrastructure Bond Act enacted as part of Proposition 1 will make $4.4 billion in grant funds available to public and private entities for behavioral health treatment settings to expand the available continuum of care for people with significant behavioral health needs across the state.

Justice-Involved Populations

On January 26, 2023, California became the first state in the nation to receive federal approval to offer a targeted set of Medicaid services to Medi-Cal-eligible youth and adults in state prisons, county jails, and youth correctional facilities (YCFs) for up to 90 days prior to release. Through a federal Medicaid 1115 demonstration waiver[35] approved by the Centers for Medicare & Medicaid Services (CMS), DHCS is partnering with state agencies, counties, providers, and community-based organizations (CBOs) to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release and reentering their communities. The initiative is helping California address the unique and considerable health care needs of justice-involved (JI) individuals, improve health outcomes, deliver care more efficiently, and advance health equity across the state.

By providing pre-release and reentry services to individuals who are incarcerated, DHCS aims to improve health outcomes and reduce health disparities. Pre-release services will be anchored in comprehensive care management and include physical and behavioral health clinical consultation, medication-assisted treatment (MAT) (also referred to as medications for substance use disorders (SUD)), medications and medication

[35] California's approved CalAIM 1115 Demonstration, CMS, January 2023. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf

administration, lab and radiology services, community health worker (CHW) services, and provision of medications and durable medical equipment (DME) upon release. For people receiving these services, a care manager will be assigned-– either on-site in the carceral setting or via telehealth–to establish a relationship with the individual, understand their health needs, coordinate vital services, and plan for community transition, including connecting the individual to a community-based care manager they can work with upon their release.

In October 2024, three California counties[36]were the first in the nation to go-live with Medi-Cal pre-release services. Since October 2024, ten additional counties and the 31 state prisons, operated by the California Department of Corrections and Rehabilitation and California Correctional Health Care Services, went live under the demonstration. Between October 1, 2024, and September 2025, over more than 35,000 Medi-Cal members incarcerated in state prisons, county jails and YCFs were determined to be eligible for pre-release services. All California counties are required to implement this initiative before October 1, 2026.

Providing Access and Transforming Health (PATH)

PATH funds are supporting a multi-year effort to shift delivery systems upstream to community-based interventions and advance the coordination and delivery of quality care and services authorized under DHCS' Section 1115 and 1915(b) waivers by maintaining, building, and scaling the capacity and infrastructure necessary for health care providers and CBOs to deliver ECM and Community Supports. These capacity-building efforts are critical for helping to provide whole-person care and enhancing community-based interventions. PATH funding enabled the transition of services from the Whole Person Care pilot and Health Homes Program demonstrations to statewide availability under CalAIM and includes support for maintaining and building justice-involved services ahead of the implementation of the full suite of statewide CalAIM justice-involved initiatives in 2023.

Addressing Homelessness

DHCS has executed a suite of initiatives – in collaboration with other sister departments or on its own – that target homelessness and associated health care consequences. This effort focuses on California's steady increase in individuals experiencing homelessness

[36] Inyo, Santa Clara and Yuba

who are disproportionately impacted by systemic racism and discrimination throughout the state.

These initiatives to address homelessness and housing instability are designed to: expand statewide access to housing services; provide funding for CBOs to expand services and programs; improve access to coordinated health and social services, including housing; reduce avoidable use of costly health care services; and, most importantly, improve whole-person health for Medi-Cal members. This suite notably included a $1.3 billion Housing and Homelessness Incentive Program (HHIP) through the HCBS Spending Plan to support MCPs and their local partners to make investments and progress in addressing homelessness and keeping people housed.

Additionally, ECM and Community Supports are ambitious reforms to address Medi-Cal members' needs through coordinated and community-based whole-person care.

Housing-related Community Supports include:

- **Housing Transition/Navigation Services:** Assistance with finding and securing safe and stable housing.
- **Housing Tenancy and Sustaining Services:** Support in maintaining safe and stable tenancy once housing is secured.
- **Housing Deposits:** Assistance with identifying, coordinating, securing, or funding one-time services, including first and last rent payments, and making necessary modifications to enable a person to establish a basic household.
- **Short-Term Post-Hospitalization Housing:** A recovery setting after institutional care for people who do not have a secure place to stay and who have high medical or behavioral health needs.
- **Recuperative Care (Medical Respite):** Short-term residential care for individuals without stable housing who no longer require hospitalization but still need to heal from an injury or illness.

Effective July 1, 2025, MCMC plans may offer Transitional Rent as an optional benefit. It will become a mandatory benefit for the behavioral health POF starting on January 1, 2026.

- **Transitional Rent:** Temporary rental assistance for individuals experiencing or at risk of experiencing homelessness and with other specific qualifying conditions.

2.4 Quality Performance Measures and Specific Objectives

DHCS selects performance measures to drive continuous quality improvement.[37] In order to reduce unnecessary reporting burden and to align priorities and incentives, QPHM leads a cross-division Quality Metric Workgroup that evaluates metrics for all program areas and makes recommendations about which metrics to include for monitoring and accountability.[38] DHCS is also coordinating metric selection efforts with its public purchaser partners, Covered California and the California Public Employees Retirement System (CalPERS), to help increase alignment, especially for health plans and provider networks that serve multiple populations.

As described in Section 2.1, DHCS' Bold Goals 50x2025 initiative was launched as a part of the 2022 CQS and aligns with broader goals in Medi-Cal Transformation as outlined in DHCS' currently authorized waivers. In addition to these ambitious statewide goals to improve clinical outcomes in key clinical focus areas, DHCS has identified key high-priority metrics for each managed care delivery system, with measurable targets for performance which are published as Managed Care and Behavioral Health Accountability Sets on an annual basis. DHCS aims to maintain consistency in these accountability sets for the three-year duration of each Quality Strategy to support sustained performance improvement efforts in these priority areas. As this CQS will cover MY 2026-2028, DHCS intends to keep the 2026 Managed Care and Behavioral Health Accountability Sets stable through 2028. DHCS will partner with plans to help meet these targets, as well as foster cross-plan communication and partnership across delivery systems. A comprehensive list of program-level specific objectives for all programs (those with specific targets and others used for monitoring only) can be found in **Appendix D**. As described previously, DHCS' 4 CQS Goals (engaging members in their care, keeping families and communities healthy, providing early interventions for rising risk and providing whole-person care for high-risk populations) are overarching strategic priorities for Medi-Cal. The specific objectives outlined below represent actionable, measurable targets for each delivery system which relate back to each of the 4 goals. Measures that specifically address gaps and needs informed by Medi-Cal

[37] 42 CFR 438.340(b)(3)(i)

[38] Metrics are evaluated based on guiding principles. The metrics must: be clinically meaningful; have a high population impact; align with other national and state priority areas and initiatives and other public purchasers; have an availability of standardized measures and data; be evidence based; and promote health equity.

member engagement through DHCS' member engagement efforts are additionally tied to Goal 1 as they were directly informed by member feedback and priorities.

Bold Goals 50x2025: Progress from MY 2021 to MY 2023

As part of DHCS' mission to improve health care quality and equity, the updated CQS will continue to focus on measuring progress towards meeting DHCS' ambitious Bold Goals 50x2025 that it outlined in its 2022 CQS. By 2025, the five Bold Goals are to (1) reduce racial and ethnic disparities in well-child visits and immunizations by 50% with respect to statewide performance, (2) close maternity care disparities for Black and Native American persons by half with respect to statewide performance, (3) improve maternal and adolescent depression screening by 50%, (4) improve follow-up for mental health and substance use disorder (SUD) by 50%, and (5) ensure all health plans exceed the 50th percentile for all children's preventive care measures. An interim assessment of DHCS' progress towards the bold goals from MY 2021 to MY 2023 (including baseline data and final targets) is included in Appendix E.

Overall, Bold Goals 1, 2, and 3 are on track to be achieved by MY 2025, with more than half of the underlying outcomes of each goal already achieved or showed improvements over time. Due to underlying data issues associated with changes in policy for behavioral health payment, data for Goal 4 for MY 2023 was impacted and showed mixed results in terms of progress. Bold Goal 5, while demonstrating slight increase over time, indicates a key area for improvement by MY 2025 with most plans still failing to meet the MPL for all children's health measures.

MCMC Specific Objectives

For MCMC plans, DHCS releases a Managed Care Accountability Set (MCAS) of clinical quality measures annually. For Measurement Years (MY) 2023 to 2025, DHCS modified this measure set (see Table 2 below) to include key metrics for the clinical focus areas, as well as identified a subset of metrics that will be stratified by race and ethnicity to inform future health disparity reduction targets (indicated by *' in Table 2). While the MCMC plans will report on all the following measures, DHCS will hold the MCMC plans to a benchmark on only some of the measures, specifically those for which a numerical target is displayed in Table 2.

Table 2: MCAS Rate Year (RY) 2026/MY 2025

#	Measure Name	Measure Steward	Target Minimum Performance Level (MPL) (MY2024)	Target Met in MY 2024 (statewide) (Yes, No, NA)	Associated CQS Goal
1	Asthma Medication Ratio*	NCQA	66.24	No	Goal 3
2	Breast Cancer Screening*[ii]	NCQA	52.68	Yes	Goal 2
3	Cervical Cancer Screening	NCQA	57.18	Yes	Goal 2
4	Child and Adolescent Well-Care Visits*	NCQA	51.81	Yes	Goal 1, Goal 2
F5	Childhood Immunization Status: Combination 10*	NCQA	27.49	Yes	Goal 2
6	Chlamydia Screening in Women	NCQA	55.95	Yes	Goal 2
7	Controlling High Blood Pressure*[iv]	NCQA	64.48	Yes	Goal 3
8	Developmental Screening in the First Three Years of Life	CMS	35.70	Yes[iii]	Goal 2
9	Follow-Up After ED Visit for Substance Use – 30 days*	NCQA	36.18	Yes	Goal 4

#	Measure Name	Measure Steward	Target Minimum Performance Level (MPL) (MY2024)	Target Met in MY 2024 (statewide) (Yes, No, NA)	Associated CQS Goal
10	Follow-Up After ED Visit for Mental Illness – 30 days*[iv]	NCQA	53.82	No	Goal 4
11	Glycemic Status Assessment for Patients with Diabetes (>9)*	NCQA	33.33[v]	Yes	Goal 3
12	Immunization for Adolescents: Combination 2*	NCQA	34.30	Yes	Goal 2
13	Lead Screening in Children	NCQA	63.84	Yes	Goal 2
14	Prenatal and Postpartum Care: Postpartum Care*	NCQA	80.23	Yes	Goal 1, Goal 2
15	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	NCQA	84.55	Yes	Goal 1, Goal 2
16	Topical Fluoride for Children	DQA	19.00	Yes[iii]	Goal 2
17	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months	NCQA	60.38	Yes	Goal 1, Goal 2

#	Measure Name	Measure Steward	Target Minimum Performance Level (MPL) (MY2024)	Target Met in MY 2024 (statewide) (Yes, No, NA)	Associated CQS Goal
18	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	NCQA	69.43	Yes	Goal 1, Goal 2

i. MCPs held to the MPL for the HEDIS© total rates only; the NCQA Quality Compass© Medicaid HMO 50th and 90th percentiles represent the MPLs and high-performance levels (HPLs), respectively

ii. Stratified by SPDs

iii. CMS calculated national median is considered the MPL

iv. If applicable, stratify by Members dually enrolled in Medi-Cal and Medicare with the same MCP

v. MPL is reflective of performance under the previous version of this measure (Hemoglobin A1c Control for Patients with Diabetes). A lower number indicates higher quality.

* Measures stratified by race and ethnicity will inform future health disparity reduction targets.

Dental MC Specific Objectives

For Dental MC, based on areas of improvement identified from previous data, DHCS has set improvement targets on key utilization and quality measures (summarized in Table 3 below) to be achieved over a three-year period. These targets will also apply to Dental FFS, which serves most Medi-Cal members.

Table 3: Dental MC Priority Measures RY 2025/MY 2024

#	Measure Name	Measure Steward	Target MPL	Target Met in MY 2024 (Yes, No, NA)	Associated CQS Goals
1	Annual Dental Visits for Children Ages 1-20	NA	**Rates by Plan:** **Access GMC:** 35.13% **Access PHP:** 45.55%	**Results by Plan:** **Access GMC:** Yes **Access PHP:** No	Goal 1, Goal 2

			Health Net GMC: 47.27% **Health Net PHP:** 40.98% **Liberty GMC:** 51.39% **Liberty PHP:** 44.45%	**Health Net GMC:** Yes **Health Net PHP:** No **Liberty GMC:** No **Liberty PHP:** No	
2	Annual Dental Visits for Adults Ages 21+	NA	**Rates by Plan:** **Access GMC:** 24.40% **Access PHP:** 25.64% **Health Net GMC:** 26.80% **Health Net PHP:** 27.08% **Liberty GMC:** 27.99% **Liberty PHP:** 27.88%	**Results by Plan:** **Access GMC:** No **Access PHP:** Yes **Health Net GMC:** No **Health Net PHP:** No **Liberty GMC:** No **Liberty PHP:** Yes	Goal 1, Goal 2
3	Use of Dental Preventive Services for Children Ages 1-20	NA	**Rates by Plan:** **Access GMC:** 28.33% **Access PHP:** 40.72% **Health Net GMC:** 42.65% **Health Net PHP:** 36.08% **Liberty GMC:** 44.53% **Liberty PHP:** 39.30%	**Results by Plan:** **Access GMC:** Yes **Access PHP:** No **Health Net GMC:** Yes **Health Net PHP:** No **Liberty GMC:** Yes **Liberty PHP:** No	Goal 1, Goal 2

4	Use of Dental Preventive Services for Adults Ages 21+	NA	**Rates by Plan:** **Access GMC:** 13.97% **Access PHP:** 15.31% **Health Net GMC:** 17.25% **Health Net PHP:** 16.75% **Liberty GMC:** 17.61% **Liberty PHP:** 17.86%	**Results by Plan:** **Access GMC:** No **Access PHP:** No **Health Net GMC:** No **Health Net PHP:** No **Liberty GMC:** No **Liberty PHP:** No	Goal 1, Goal 2
5	Use of Sealants Ages 6-9	NA	**Rates by Plan:** **Access GMC:** 12.09% **Access PHP:** 20.40% **Health Net GMC:** 16.31% **Health Net PHP:** 17.00% **Liberty GMC:** 15.17% **Liberty PHP:** 17.64%	**Results by Plan:** **Access GMC:** No **Access PHP:** No **Health Net GMC:** No **Health Net PHP:** No **Liberty GMC:** No **Liberty PHP:** No	Goal 1, Goal 2
6	Use of Sealants Ages 10-14	NA	**Rates by Plan:** **Access GMC:** 9.20% **Access PHP:** 13.66% **Health Net GMC:** 11.07%	**Results by Plan:** **Access GMC:** No **Access PHP:** No **Health Net GMC:** No	

			Health Net PHP: 11.72% **Liberty GMC:** 10.88% **Liberty PHP:** 11.35%	**Health Net PHP:** No **Liberty GMC:** No **Liberty PHP:** No	Goal 1, Goal 2

SMHS and DMC-ODS Specific Objectives

For county MHPs and DMC-ODS, many CalAIM initiatives are designed to improve capacity for accurate quality data reporting and support process improvement. Recognizing this infrastructure need, DHCS has identified the following high-priority metrics to drive annual improvements in quality outcomes. Over the next year, DHCS will work with stakeholders to identify a dedicated roadmap for additional high-priority quality measures and quality improvement in our behavioral health programs, building upon the critical infrastructure developments in CalAIM.

Table 4: County MHP Priority Measures RY 2026/MY 2025[i]

#	Measure Name	Measure Steward	Target MPL (MY 2024)[ii]	Target Met in MY 2024 (Yes, No, NA)	Associated CQS Goal
1	Follow-Up After ED Visit for Mental Illness – 30 days*	NCQA	53.82	No	Goal 4

2	Follow-Up After Hospitalization for Mental Illness – 30 days	NCQA	59.85	No	Goal 4
3	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	60.22	No	Goal 4
4	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA	62.56	Yes	Goal 4

Table 5: DMC-ODS Priority Measures RY 2026/MY 2025

#	Measure Name	Measure Steward	Target MPL (MY 2024) [ii]	Target Met in MY 2024 (Yes, No, NA)	Associated CQS Goal
1	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 30 days*	NCQA	36.18	No	Goal 4

2	Pharmacotherapy of Opioid Use Disorder*	NCQA	25.28	No	Goal 4
3	Use of Pharmacotherapy for Opioid Use Disorder	CMS	60.20	Yes	Goal 4
4	Initiation and Engagement of SUD Treatment – Initiation of SUD Treatment	NCQA	44.51	No	Goal 4
5	Initiation and Engagement of SUD Treatment – Engagement of SUD Treatment	NCQA	14.39	No	Goal 4

i. For BHPs that are integrated or will be during MY 2025, both MHP and DMC-ODS measure sets are required.

ii. MCPs held to the 50th percentile as established by the NCQA Quality Compass© Medicaid HMO or CMS calculated national medians. If a county plan's rate is below the 50th percentile, then the plan must achieve at least a 5 percent increase from the MY's baseline rate.

* Measures must be stratified by race/ethnicity per NCQA categorizations.

MLTSS and D-SNP Performance Measures

DHCS contracts with D-SNPs, known as State Medicaid Agency Contracts (SMAC), require Medi-Medi Plans and all other D-SNPs to report on state-specific measures, in addition to the federal measures that D-SNPs are required to report to CMS. State-specific D-SNP reporting measures are outlined in **Appendix D**. DHCS has worked with stakeholders, plans, and CMS to identify the range of quality and reporting results that D-SNPs report to DHCS.

To support improvements in quality and health equity for recipients of LTSS, which includes institutional LTC services as well as HCBS, DHCS launched the LTSS Dashboard. The dashboard includes data on LTSS utilization, quality of care, length of facility stays and cost, by demographics, counties, and MCPs. It also provides a view of LTC versus HCBS to provide transparency on comparative utilization.[39]

In addition, DHCS began using the National Core Indicators- Aging and Disabilities (NCI-AD) Adult Consumer Survey in 2025 to better capture person-reported information on quality of life, community integration, and satisfaction among individuals who receive Medi-Cal HCBS. DHCS will use the data collected to track consumer experience on a statewide basis and compare California's survey results against national benchmarks.

2.5 Health Disparity Reduction Framework

As articulated in the 2022 CQS, and as required by 42 C.F.R. § 438.340(b)(6), DHCS created a health disparity reduction framework to identify, evaluate and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status.

This framework incorporates data collection and stratification to identify inequities, addressing workforce issues to ensure cultural responsiveness and language access, and targeted initiatives to reduce disparities across Medi-Cal populations. Central to the

[39] The LTSS Dashboard

evolution of this strategy is the inclusion of member and community engagement, which serves as the foundation for addressing systemic inequities:

- **Data collection and stratification:** Complete, accurate data on race, ethnicity, disability, and language and SOGI (Sexual Orientation and Gender Identity) information for Medi-Cal members will be utilized to illuminate and address health care inequities across DHCS programs.
- **Workforce diversity and cultural responsiveness:** Medi-Cal workforce, at all levels, should reflect the diversity of the Medi-Cal population and always provide culturally and linguistically appropriate care.
- **Eliminating health care disparities:** Eliminate disparities based on age, race, ethnicity, sex, primary language, disability status[40] and other demographic factors within the Medi-Cal population and support policy efforts to eliminate disparities, driven by SDOH, between Medi-Cal members and commercial or other Medicare populations.
- **Member and Community Engagement:** DHCS has launched several venues for engaging with, listening to, and centering member voices in its quality and health equity work.

[40]The state defines "disability status" in accordance with Title 22, California Code of Regulations §50223. This includes individuals who meet the federal definitions of disability under Title II or Title XVI of the Social Security Act, as well as those previously eligible under SSI/SSP who continue to experience the qualifying impairment despite engaging in substantial gainful activity. Children are considered disabled if they have a medically determinable impairment of comparable severity.

- Managed Care/FFS (including CCS)
- Dental
- Behavioral Health
- School Based Services
- HCBS/1915c Delivery System
- CalAIM & Quality Strategy
- Alignment With Public Health

Health Equity Roadmap Overview

In 2023, DHCS launched the Health Equity Roadmap initiative, which represents a vital part of Medi-Cal Transformation. The Health Equity Roadmap represents a process to center the experience of Medi-Cal members while engaging CBOs, health plans, counties, providers, and other stakeholders to collectively identify gaps, needs and co-design solutions to make Medi-Cal a more equitable health care delivery system for members.

The Health Equity Roadmap includes three phases and is a multi-year initiative to transform Medi-Cal into a more equitable health care delivery system.

- Phase 1 – DHCS conducted statewide member feedback listening tour (details below) to hear directly from Medi-Cal members living in historically marginalized and underserved communities.
- Phase 2 is the co-design phase using feedback from members, experts, advocates, providers, and stakeholders to ensure their important voices and experiences are heard and included in the conversation.
- Phase 3 – will use what DHCS learned from the first two phases to build a Health Equity Roadmap, which will outline specific, actionable items to reach mutual goals.

Healthy Equity Roadmap Member Feedback Sessions

- **September 29, 2023**
  Statewide Session - Everyday Impact Consulting (Virtual)
- **November 16, 2023**
  Bakersfield American Indian Health Center in Bakersfield
- **January 24, 2024**
  Choice in Aging - Bedford Center in Antioch
- **January 26, 2024**
  The Cambodian Family Center in Santa Ana
- **January 27, 2024**
  Latino Health Access in Santa Ana
- **February 6, 2024**
  Statewide Session - California Alliance of YMCAs (Virtual)
- **February 7, 2024**
  Statewide Session - Everyday Impact Consulting (Virtual)
- **February 13, 2024**
  Members with Disabilities & Caregivers -
  California Alliance of YMCAs and Choice in Aging (Virtual)
- **February 15, 2024**
  Statewide Session - Everyday Impact Consulting (Virtual)
- **February 28, 2024**
  Greater Mt. Sinai Missionary Baptist Church of Compton
  in Compton
- **March 1, 2024**
  Cultiva La Salud in Fresno

What We Learned: Medi-Cal Members' Priorities

Through a series of 11 listening sessions conducted throughout the state, nearly 250 Medi-Cal members shared their experiences and perspectives on the health care system. These insights, gathered through partnerships with CBOs, will play a crucial role in shaping the final Health Equity Roadmap. Medi-Cal members consistently raised concerns across several key areas that significantly impact their health care experiences:

1. **Respect and Equity:** Members highlighted the importance of feeling respected and heard by health care providers. Many reported instances of discrimination and emphasized the need for respectful treatment and equitable interactions across the health care delivery system.
2. **Racially/Culturally Concordant Care:** Some members noted that receiving care from a provider from the same racial/ethnic background or community was instrumental in feeling comfortable accessing and utilizing needed health care.
3. **Navigation and Communication:** Members expressed frustration with the complexity of navigating their coverage and coordinating care independently. Many were unclear about the benefits available to them and advocated for easier-to-maintain coverage and simplified communication.
4. **Access and Timeliness:** Members identified the need for higher-quality care, faster referrals and approvals, shorter wait times for appointments, and fewer delays in treatment as critical improvements.
5. **Coverage and Benefits:** Members called for broader coverage and improved usability of benefits, with dental care services consistently raised as an area of need.
6. **Language and Accessibility*:*** Addressing language barriers through enhanced interpretation services was seen as essential. Members also highlighted the need for a more robust access infrastructure, including transportation, online scheduling portals, text reminders, and expanded telehealth services.

What We Learned – Incorporating the Process of Advancing Equity

Direct engagement with Medi-Cal members and communities reinforced several critical lessons to advancing equity in DHCS' work:

- Achieving health equity is both a process and an outcome, requiring collaboration with trusted community partners to connect with Medi-Cal members and elevate their voices in decision-making.
- It is essential to recognize and uplift participants as experts in their own experiences while reducing barriers to participation.
- Creating inclusive, welcoming spaces that respect community traditions and rituals fosters meaningful engagement.

Next Steps: The Co-Design Phase and Informing DHCS Health Disparity Reduction Priorities

Feedback collected during the listening tour will guide the next phase of the Health Equity Roadmap. This phase will involve diverse Medi-Cal members, CBOs, Tribal representatives, and other stakeholders in co-designing actionable strategies to create a more equitable health care system. The roadmap will outline specific steps to improve access, quality, and outcomes for Medi-Cal members, with a focus on addressing longstanding inequities.

DHCS will work with Medi-Cal members and other implementation partners to identify priority areas of focus for future efforts to advance health equity in Medi-Cal based on needs and solutions identified through the listening tour; alignment with DHCS CQS clinical priorities and health equity framework; and impact of potential changes on advancing health equity for the Medi-Cal population. Potential broad areas of focus include:

- Making Medi-Cal coverage easier for people to use, maintain, and navigate.
- Improve access to benefits to address specific inequities (e.g., dental care).
- Supporting workforce development of new provider types (e.g., community health workers, doulas) to enable participation as Medi-Cal providers and to increase workforce diversity.
- Supporting health care delivery models that center the needs of Black, Indigenous, and people of color and that address geographic disparities.
- Formalizing consistent engagement of Medi-Cal members and communities across Medi-Cal policy and program development and informing health care delivery implementation.

The Health Equity Roadmap represents a transformative opportunity for Medi-Cal, leveraging input from members and community partners to build a health care system that reflects their needs and experiences. Through this process, Medi-Cal aims to ensure equitable access to high-quality care for all Californians, continuing to adapt and evolve in collaboration with the communities it serves.

2.6 Value-Based Payment (VBP) Roadmap

Covering more than one in three Californians and almost half of all children and annual births, DHCS will leverage its role as the largest public purchaser of health care in California to drive value for its members. DHCS can pursue further effects through strategic alignment with non-Medicaid payors, both public and private, in California and in fact has aligned many of its programs with Covered CA and CalPERS, other state public purchasers. Under the prior CQS, DHCS began efforts to tie payments and reimbursements to clinical quality measures, health disparity reduction, and member experience through a variety of mechanisms. The roadmap below provides a broad overview of DHCS' next steps in strengthening value in existing programs and increasing value-based purchasing (see Figure 26).

DHCS will continue to operate and strengthen existing payment programs that are tied to quality outcomes, such as the following programs:

- **Quality Incentive Pool (QIP) program**: This Directed Payment Program provides payments to public, district, and municipal hospitals for achieving improvements in quality and health equity outcomes. This program is being reshaped to better link to DHCS' population health goals.
- **Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP)**: This Directed Payment Program pays skilled nursing facilities based on quality and workforce metrics. Although SNF WQIP is sunset effective December 31, 2025, pursuant to the 2025 Budget Act, DHCS is interested in carrying lessons learned into the SNF Value Strategy work effort to reauthorize SNF financing methodologies for dates of service on or after January 1, 2027.
- **Equity and Practice Transformation (EPT) program**: This Directed Payment Program pays primary care practices for milestones that improve population health, quality, and health equity; practices are also incentivized to develop plans for VBP contracts.

DHCS has also focused on expanding its value-based payment approaches to both Medi-Cal Managed Care Plans and Behavioral Health Plans through the following programs:

- **BH-CONNECT** Access, Reform, and Outcomes Incentive Program: This program incentivizes county BHPs to improve access to behavioral health services; improve

outcomes among Medi-Cal members living with significant behavioral health needs; and make targeted behavioral health delivery system reforms.

- **County Behavioral Health Plan Payment Reform**: starting in 2023, DHCS began reimbursing Behavioral Health Plans via a fee-for-service methodology, rather than the prior cost-based reimbursement approach. This change allows BHPs more flexibility to push their provider network to provide higher value services, rather than focusing solely on volume of services.
- **Quality Withhold and Incentive Program:** Starting in 2024, DHCS implemented a hybrid Quality Withhold and Incentive Program that uses MCMC performance on the key measures (including high priority clinical quality measures, health equity measures, and member experience) to withhold a portion of base capitation payments (0.5% in 2024, 1% in 2025) and reinvest withheld amounts that are unearned into statewide managed care incentive payments to improve well-child visits.
- **Auto Assignment Incentive Program:** A program that adjusts MCMC member assignment algorithms based on performance on key quality measures to reward higher performing plans with greater default members (i.e. members who do not proactively choose a health plan and are assigned to a plan by DHCS' auto-assignment process). In 2025, DHCS updated the quality measures methodology used in the Auto Assignment Incentive Program to better align with the CQS Clinical Focus Areas.

Primary Care Spending and Alternative Payment Model Requirements: Starting in 2025, DHCS will require all Medi-Cal MCPs to report on primary care spend (as a percentage of total spend), with stratifications by various demographic factors, and will explore setting targets for minimum primary care spend. In 2023, DHCS began to require that MCPs report on the percentage of their provider contracts (especially primary care) by VBP category in the HCP-LAN APM framework. This is consistent with the new statewide Office of Health Care Affordability regulations and DHCS anticipates issuing an APL no later than Q1 2026. DHCS, along with state partners Covered California and CalPERS, participated in the State Transformation Collaborative, with the Center for Medicare and Medicaid Innovation (CMMI) and CMS, which supported multi-payor APMs and earlier versions of this work effort.

DHCS also acknowledges the significant impact that H.R.1 will have on its numerous value-based payment programs and State Directed Payment (SDP) programs, globally requiring much more focus and accountability for value-based payments. Additionally, the strengthened provisions of SDPs to require robust evaluations and demonstration of improvement in quality outcomes as well as requiring more MCP risk and oversight of these programs will require DHCS to re-imagine many of its current SDPs to comply with these new changes by 2027. DHCS will be standing up working groups in several venues throughout 2026 to engage with stakeholders to inform these program re-designs.

Figure 26: Value-Based Roadmap

2025

- Implement a head-to-head achievement methodology for the MCMC Auto Assignment Incentive Program
- Increase performance expectations in the MCMC Quality Withhold and Incentive Program
- Begin BH-CONNECT Incentive Program implementation
- Begin discussions with stakeholders on the development of the Hospital Value Strategy and SNF Value Strategy.

2026

- Under H.R.1, new SDPs cannot exceed published Medicare payment rates
- Implement changes to QIP to better align with strategic priorities
- Set and implement VBP contracting and primary care spend targets for MCMCs
- Full implementation of BH-CONNECT Access, Reform, and Outcomes Incentive Program
- Continue development of Hospital Value Strategy and SNF Value Strategy with stakeholders and begin preparing to implement some value-based payment changes.
- Expand measures of cost containment, efficiency, productivity, and access to EPP, a large currently utilization-

based directed payment program for Designated Public Hospitals (DPHs)

2027

- Under the 2024 CMS Managed Care Access, Finance, and Quality Final Rule, SDP evaluation plans must explicitly link to the Comprehensive Quality Strategy
- Implement additional changes to QIP
- Continue implementing hospital value-based payment changes
- Finalize development of the Hospital Value Strategy and SNF Value Strategy and continue to implement value-based payment changes.

2028

- Under H.R.1, existing SDPs above Medicare rates must start reducing payments by 10 percentage points per year
- Continue to implement value-based payment changes aligned with the Hospital Value Strategy and SNF Value Strategy over a multi-year roadmap.

2025

- Implement a head-to-head achievement methodology for the MCMC Auto Assignment Incentive Program
- Increase performance expectations in the MCMC Quality Withhold and Incentive Program
- Begin BH-CONNECT Incentive Program implementation
- Subject to appropriation, begin discussions with stakeholders on value-based payment changes for hospitals and Long-Term Care (LTC) facilities as well as payment methods that promote appropriate rebalancing of home and community based services (HCBS) and institutional long-term care.

2026

- Implement changes to QIP to better align with strategic priorities
- Set and implement VBP contracting and primary care spend targets for MCMCs
- Full implementation of BH-CONNECT Access, Reform, and Outcomes Incentive Program
- Implement some hospital value-based payment changes, as feasible, and continue discussion of hospital and LTC value-based payment changes as well as payment methods that promote appropriate rebalancing of HCBS and institutional LTC. HCBS rebalancing will be reflected in a forthcoming "Multi-Year Roadmap of Medi-Cal Home and Community-Based Services and Managed Long-Term Services and Supports Programs" that is under development.
- Expand measures of cost containment, efficiency, productivity, and access to EPP, a large currently utilization-based directed payment program for Designated Public Hospitals (DPHs)

2027

- Implement additional changes to QIP
- Continue implementing hospital value-based payment changes
- Implement LTC value-based payment changes and begin implementation efforts for HCBS and MLTSS Roadmap

2.7 Medi-Cal's Strategy to Support Health and Opportunity for Children and Families

DHCS is responsible for the health care of more than 50 percent of California's children and is committed to improving their health, supporting their families, and reducing barriers and disparities in care. In alignment with the goals of Medi-Cal Transformation and the prioritization of children's preventive care as a key clinical focus area in the 2022 DHCS CQS, in 2022, DHCS launched Medi-Cal's Strategy to Support Health and Opportunity for Children and Families, a comprehensive strategy to support the health and well-being of children and families enrolled in Medi-Cal.

Through both existing and new initiatives in the strategy, DHCS has made significant strides towards laying a strong foundation for strengthening health care coverage, enhancing preventive and primary care, advancing whole-child and family-based care, increasing accountability, and implementing EBPs to promote high-quality care and equitable health outcomes for children and families. In alignment with advancing the CQS strategies to improve children's health outcomes, with a particular emphasis on improving children's preventive care, DHCS will focus on the following priority areas to continue to advance gains in prioritizing the health of children and families:

Increase Medi-Cal Member Engagement to Address Child and Family Health

DHCS is prioritizing consistent engagement with Medi-Cal members, families, and communities to create pathways for their inclusion in policy and program development processes to ensure that initiatives reflect the needs and lived experiences of those they serve. This focus aligns with DHCS' emerging focus in this area through the MMAC and Birthing Care Pathway and Health Equity Roadmap initiatives, which have centered member engagement in informing policy and program directions.

Fortify the Pediatric Preventive and Primary Care Foundation

EPSDT Outreach/Education: Building on the existing Medi-Cal for Kids and Teens EPSDT outreach and awareness campaign, DHCS will continue to work with child health stakeholders to increase awareness of EPSDT benefits, as well as explore opportunities highlighted in the recent CMS state health officer letter on Best Practices for Adhering to EPSDT Requirements to improve awareness and utilization of EPSDT benefits with a particular focus on improving preventive care.

Enhance Accountability for High-Quality, Equitable Care for Children and Families

MCP Learning Collaboratives to Improve Accountability for Child Health Outcomes: In partnership with the Institute for Healthcare Improvement (IHI), DHCS is fostering statewide learning collaboratives to promote equity-driven care improvements among MCPs. Continued focus on a learning collaborative approach to improve MCP capacity to contract and collaborate with child-serving providers would support MCPs in increasing accountability for child and maternal health outcomes.

Support Ongoing Implementation of Family-Centered Benefits

Workforce Development for Doulas and Community Health Workers: Medi-Cal added doula services as a covered benefit on January 1, 2023. Doula services include personal support to individuals and families throughout pregnancy and one year postpartum. Doula services help reduce racial and ethnic disparities in birth outcomes, prevent perinatal complications, and improve health outcomes for birthing parents and infants. Medi-Cal added community health worker services as a covered benefit on July 1, 2022. Community health workers are skilled and trained health educators and may include promotors, community health representatives, navigators, and other non-licensed public health workers, such as violence prevention professionals, who work directly with individuals who may have difficulty understanding or interacting with providers due to cultural or language barriers. Consideration of workforce development and technical assistance strategies to increase participation of doulas and community health workers as Medi-Cal providers would contribute to supporting a workforce that reflects the diversity of the Medi-Cal population and that can provide culturally and linguistically appropriate care to Medi-Cal children and families.

Support Ongoing Implementation of ECM for Children and Youth POFs

Support for learning collaboratives among MCPs, providers, and other child health stakeholders could assist with identifying challenges and solutions to coordinating care for children and youth with specialized needs to enhance effective implementation of ECM benefits for the children and youth POF.

Cross Department Collaboration to Improve Access to Child and Family Benefits

Maximize Medi-Cal Member Enrollment in Women, Infants, and Children (WIC) and CalFresh: DHCS plans to partner with MCPs to test outreach and enrollment strategies to maximize enrollment of eligible Medi-Cal children and families into WIC and CalFresh. Strategies center on targeted outreach process improvement and improved coordination between MCPs and county WIC and social services agencies. In spring 2025, MCPs and providers will be able to use Medi-Cal Connect to view member-level data on WIC and CalFresh enrollment as well as Medi-Cal data across delivery systems.

Home Visiting: Collaborate with CDPH, CDSS, and MCPs to promote home visiting for Medi-Cal members and ensure eligible members can access home visiting programs. DHCS is collaborating with CDPH and CDSS to identify opportunities to further promote home visiting programs to pregnant and postpartum Medi-Cal members. DHCS will consider requiring closed-loop referrals for referrals to home visiting programs in the future, after the initial phase of closed-loop referrals goes live for ECM and Community Supports in July 2025.

Improve Perinatal Health Outcomes through the Birthing Care Pathway

DHCS is undertaking a comprehensive overhaul of maternity care in Medi-Cal as a part of the Birthing Care Pathway. The Birthing Care Pathway is envisioned as a care model with related benefit and payment strategies in Medi-Cal to reduce maternal morbidity and mortality and address significant racial and ethnic disparities in maternal health outcomes among Black, American Indian/Alaska Native, and Pacific Islander individuals. Through extensive stakeholder engagement with key partners and Medi-Cal members, DHCS will identify policy opportunities to improve maternal outcomes and advance birth equity.

Address the Child and Adolescent Behavioral Health Crisis through the CYBHI:

Continued support for online behavioral health services platforms: BrightLife Kids and Soluna offer free telehealth coaching services with certified and highly-trained wellness coaches. Each program also offers a library of multimedia resources, wellness exercises, and peer communities moderated by trained behavioral health professionals, as well as critical care navigation support to assist children, youth and families with

identifying and accessing community-based behavioral health resources. Ongoing support for these platforms is critical for extending capacity to meet the behavioral health support needs of children and families. More than half of all users of BrightLife Kids and Soluna report that their experience using these programs is their first and only interaction with the behavioral health delivery system in California. As of May 2025, DHCS reached more than 319,000 children (and their parents/caregivers), teens, young adults and the programs continue to grow. By delivering early and consistent support from trained professionals, BrightLife Kids and Soluna can help address young people's concerns before they escalate into crisis.

Expansion of school-based behavioral health services: California schools have long worked to meet student mental health needs, and the CYBHI Fee Schedule program aims to ensure they have sustainable funding resources to continue providing services. DHCS' CYBHI Fee Schedule program requires Medi-Cal MCPs, commercial health care services plans, and disability insurers to reimburse local educational agencies (LEAs), institutions of higher education and school-linked providers for the provision of covered outpatient mental health and substance use disorder services to students under the age of 26 who are enrollees of the plan. As of December 2025, DHCS has enrolled more than 500 public K-12 schools, colleges and universities to receive reimbursement for mental health screenings, treatment, and case management services. This innovative, first-of-its-kind, multi-payer program breaks down barriers and puts students first, creating a more seamless experience for youth seeking help with mental health.

In addition, as part of the MCP contract, by January 1, 2027, MCPs must execute a memorandum of understanding (MOU) with LEAs to enhance coordination between LEAs and MCPs. This effort will build upon the CYBHI Fee Schedule program and open the door to expanding access to a larger array of Medi-Cal services in schools.

Dyadic Services Implementation Support: Implemented in January 2023, dyadic services are a family and caregiver-focused model of care intended to address developmental and behavioral health conditions of children and includes services provided to parent(s)/caregiver(s). Dyadic services help improve access to preventive care for children and rates of immunization completion, as well as address coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health. Dyadic services include behavioral health visits, access to Community Supports services, psychoeducational services, and family training

and counseling for child development. As part of the CYBHI, DHCS, through a partnership with UCSF Dyadic Services Technical Assistance Center, is launching an implementation grant funding opportunity to incentivize clinics to implement the Medi-Cal dyadic services benefit. Continued support and technical assistance for implementation of dyadic services will extend provider capacity to implement these services and allow more children and families to benefit from this support.

Improve Care Coordination and Services for Foster Youth

The BH-CONNECT 1115 initiative proposes elements designed to improve outcomes for children and youth with significant behavioral health needs, particularly those involved in child welfare. BH-CONNECT includes efforts to strengthen statewide, cross-agency coordination for youth involved in child welfare by implementing:

- A County Child Welfare Liaison within each Medi-Cal MCP (2024). The Child Welfare Liaison is designed to be the point of contact for child welfare departments and to advocate on behalf of members involved in child welfare to ensure the needs of members involved with child welfare and foster care are met.
- Alignment of the Child and Adolescent Needs and Strengths (CANS) tool and procedures to ensure both child welfare and behavioral health providers are using the same CANS tool in the same way (2025 and 2026).[41]
- Activity Funds for children and youth involved in child welfare to promote social and emotional well-being (2026).
- Expanded access to evidence-based practices like Multisystemic Therapy, Functional Family Therapy, Parent-Child Interaction Therapy, and HFW (with HFW updates taking effect in 2026).

DHCS is unwaveringly committed to improving quality and advancing health equity for children and families in Medi-Cal. These initiatives represent a bold commitment to advancing equity and improving outcomes for California's children and families,

[41] CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for monitoring of outcomes of services.

ensuring that Medi-Cal delivers on its promise of comprehensive, high-quality care for all.

MANAGED CARE ASSESSMENT EVALUATION AND STATE STANDARDS

3.1 Revised Managed Care Monitoring and Oversight Framework

Since 2022, DHCS has made significant progress in improving transparency, accountability, and monitoring across its programs, especially its managed care delivery systems, which were all authorized in 2022 under a single federal authority under the 1915(b) waiver.[42] This single authority has enabled DHCS to begin implementing a Managed Care Monitoring and Oversight Framework. The goal of this framework is to standardize and strengthen monitoring and oversight across all delivery systems.

Notable achievements include:

- **Aligning requirements and standardizing DHCS managed care monitoring**: Starting with MCMC contracts, DHCS standardized contracts across all plan county model types with a new 2024 MCP contract with significantly strengthened requirements around quality, health equity, increased transparency and compliance, and oversight, including for network providers as well as for delegated subcontractors. Many of the key provisions from these contracts have been/will be carried over to the SMHS, DMC-ODS, and Dental MC delivery systems.

  DHCS has begun reviewing key managed care monitoring, oversight, and enforcement provisions to align approaches across all delivery systems, including standardizing approaches to network adequacy, quality enforcement, publishing quality score results for MCMC, SMHS, and DMC-ODS delivery systems, and issuing sanctions for MCPs that failed to meet the MPL in MY 2021, MY 2022, and MY 2023.

  DHCS is updating its Audit Program to reflect the updated requirements of the 2024 MCP contract as well as subsequent All Plan Letters and policy guidance (i.e., PHM Policy Guide). This effort will result in updated Technical Assistance Guides for various domains of the contract, including those pertaining to PHM and Coordination of Care, Quality Improvement and Health Equity Transformation Program, and Network and Access to Care

[42] CalAIM 1915b waiver proposal

- **Creating a proactive monitoring structure to assess managed care performance:** DHCS has begun creating dashboards for key initiatives, such as ECM, Community Supports, and the PHM program to provide quarterly data inputs to inform monitoring and accountability for MCP contracts. This timely data has enabled DHCS to detect trends and ensure accountability with program requirements, and are being expanded to most new programs

  Medi-Cal Connect, DHCS' PHM service, will enable further monthly data refreshes of key utilization and quality measures across delivery systems. This was already launched for DHCS internal users in 2024 and will be expanded to other key partners, including MCPs, in 2025

  In 2024, DHCS completed a Statewide Access Assessment to understand access across numerous provider types and across all managed care delivery systems to inform improvements and improved access for members, and is in the process of launching an internal dashboard to help support network adequacy and timely access accountability efforts

  Consolidating the External Quality Review Organization (EQRO) vendor contract to have a single EQR perform EQR functions across all delivery systems to improve consistency and oversight

  DHCS is also better leveraging all required reports, including program evaluations and EQRO technical reports, to inform policy and program revisions and ensure continuous program performance improvement.

- **Establishing an effective monitoring governance structure:** Building on DHCS' centralized quality, compliance, and data and analytics functions, described in the 2022 CQS, DHCS has launched numerous interdisciplinary workgroups to address key aspects of quality monitoring and oversight, including standardized approaches to measurement, data-driven monitoring, and enforcement.

  An internal DHCS Enforcement Committee was established in 2023 with two primary goals: 1) Provide a forum to review and assess MCP performance globally and provide the necessary context, information, and data to make decisions on enforcement actions; and 2) Enable programs to establish policies to support consistent enforcement actions in a manner that is fair, robust, and in

alignment with DHCS authorities. The Enforcement Committee meets every other month to discuss MCP non-compliance issues across various domains (i.e., contract compliance, data quality, quality performance, etc.) and assess consequent actions as authorized under Welfare and Institutions Code (WIC) 14197.7(g) and monetary sanctions under WIC section 14197.7(e). DHCS has established and continues to update Enforcement Standard Operating Procedures (SOP) to outline general guidelines for how DHCS will escalate enforcement activity once policies are established and technical assistance and guidance are provided.

The DHCS Data Governance structure was established to help provide oversight, authority, control, and shared decision-making over the management of enterprise data assets. This data management is driven by enterprise business needs and supports the development of technology. As a result, many aspects of data governance cross both the business and technical sides and require close coordination throughout the enterprise. To accomplish this coordination, DHCS has established enterprise-level data governance, which includes representatives from across the enterprise. Each level of participation in data governance supports a decrease of data duplication, improves cost-effectiveness of data sharing throughout the enterprise, and increases data quality.

One of the key roles within the enterprise data governance structure is the Data Owner, who authorizes access to information in accordance with the classification of the information and the need for access to it (SAM 5300). In addition, the data owners also monitor and ensure compliance with applicable laws, security policies, and procedures affecting the information. Finally, the Data Owner group establishes enterprise data management standards, reviews and approves data governance decision proposals, and prioritizes data management work efforts.

DHCS recognizes there are similar opportunities to improve monitoring and accountability outside of the managed care delivery system and has two CalAIM initiatives focused on additional areas:

- **Enhancing oversight and monitoring of Medi-Cal eligibility:** DHCS will utilize a phased-in approach to working with counties to improve Medi-Cal eligibility processes. This includes reinstating county performance standards, developing an updated process for monitoring and reporting county performance

standards, fostering collaboration and open communication between DHCS and counties, creating a tiered corrective action approach (including financial penalties), and incorporating findings and actions in public facing dashboards.

- **Enhancing oversight and monitoring of CCS:** To improve consistency and oversight to support improved quality and health equity outcomes for children in these programs, DHCS is working with all 58 counties to voluntarily enter in a Memorandum of Understanding to clarify roles and responsibilities, along with expectations to ensure program compliance. In addition, DHCS undertook an effort to measure certain key indicators based on recommendations by the CCS Redesign Performance Measure Quality Subcommittee

For the subsequent sections on quality assessment, evaluation, and state standards, in addition to the narrative provided, a full description of regulatory requirements, activities by MCP type, and links to all reports can be found in **Appendix C**, Managed Care Entity Program Reporting Requirements.

3.2 Quality Assessment and Performance Improvement (QAPI)

Continuous performance improvement in collaboration with MCPs and provider networks is critical to addressing quality and health disparities and has informed the 2025 CQS and the broader Medi-Cal Transformation framework. Each of the managed care and other programs have previously had their own QAPI programs that met federal requirements, identified performance metrics, utilized quality improvement formats, and held regular meetings with plans. However, the strategy mapped out in 2022 created a coordinated and standardized report. For overlapping delivery networks, these numerous, sometimes uncoordinated programs added administrative burdens without yielding sustainable results. An evaluation of the 2022 Quality Strategy and its QAPI strategy is available in Appendix E.

With the continued efforts to centralize and coordinate quality efforts, DHCS standardized the QAPI across all programs to use similar methods and align them with DHCS priorities. DHCS leverages the considerable infrastructure already in place across programs, such as the robust MCMC Quality Improvement (QI) toolkit that was designed to support training and capacity building with managed care plans.

DHCS' Quality and Health Equity Improvement Framework balances creating a strong, standard foundation of quality across the state with supporting local

innovation. Some of the ways DHCS is working to build a strong statewide foundation and local innovations include, but are not limited to:

- Close collaboration with the Institute for Healthcare Improvement (IHI) to facilitate two Learning Collaboratives. The Behavioral Health Demonstration Collaborative focuses on improving transitions of care across delivery systems for people experiencing behavioral health conditions. The Medi-Cal Child Health Equity Collaborative focuses on increasing access to well-child visits by building partnerships between MCPs and providers.
- Implementation of a Regional Learning Collaborative framework that brings delivery systems together to share best practices and address quality improvement and health equity topics specific to geographically similar regions of the state. In addition, DHCS shares best practices identified by the Regional Learning Collaboratives through statewide dissemination of best practices.
- Beginning in 2025, DHCS will combine member incentive efforts with Medi-Cal member experience surveys to bring members' experiences to the forefront of quality improvement and health equity efforts at both the plan level and statewide.
- DHCS assesses member experience measures, such as timely access to services, provider communication skills, and health plan rating, across delivery systems and will embed them within quality and equity improvement efforts, partnering closely with delivery systems.

DHCS will continue to leverage required, standardized quality standards (defined as exceeding the 50th percentile nationally) to ensure that all delivery systems are providing a necessary level of care to all Medi-Cal members, independent of where the member lives or their individual demographics. A variety of penalties, including corrective action plans (CAP), non-monetary and monetary sanctions, and liquidated damages, may be levied if targets are not met, as described in more detail in the state standards section. However, DHCS cannot accept the national 50th percentile, or "average," as our goal. This foundation must be coupled with opportunities for incentives that can support local innovation and transformation efforts and achieve our vision of achieving greater than the 90th percentile on key measures, or "excellent care" across programs. DHCS has aligned metrics across programs to minimize provider administrative burden and maximize the impact of current measures. Focused initiatives with innovative

metrics and incentives will help support care transformation and new priorities and help California achieve the quality and equity outcomes its members deserve.

Performance Improvement Project (PIP) and PIP Interventions

DHCS requires all 21 MCPs and two MCMC specialty plans to conduct and/or participate in two PIPs annually, in alignment with federal requirements. MCPs have been required to have one clinical PIP and one non-clinical PIP, one of which has been focused on a health equity topic since 2017. SMHS and DMC-ODS plans complete one clinical and one non-clinical PIP. Dental MC plans complete one state-level and one individual PIP. Details by plan type and PIP are provided below (see Table 3). Based on its review of previous Managed Care Quality Strategy, DHCS continues to better coordinate PIP areas of focus across the state and across delivery systems to support statewide learning, improvement, and scaling of best practices. Based on experiences from DHCS' Infant Well Child Visit Affinity Group and statewide learning collaboratives, DHCS has more broadly scaled learnings across the state regarding best practices, data analytics, and communication efforts.

Table 6: PIPs and Interventions

Managed Care Program	PIP Topic	PIP Aim	PIP Intervention
SMHS: The EQRO validates PIP information on 56 MHPs. Each SMHS submits one clinical and one non-clinical PIP.	See BH EQR page for general information about PIPs and the BH EQR page for specific examples.	Each MHP has two unique PIPs specific to their populations, with distinct aims; see the BH EQR page for a list of PIPs.	Each MHP has two unique PIPs specific to their populations, with distinct interventions; see the BH EQR page for a list of PIPs.

Managed Care Program	PIP Topic	PIP Aim	PIP Intervention
MCMC: The EQRO validates PIP information on 23 plans (MCMCs + Population Specific Health Plans (PSP). Each MCMC and PSP submits one health equity and one clinical PIP.	Specific information regarding MCMC plan PIPs can be found within published EQR Technical Reports.	There are several aims, as each MCMC plan has a unique PIP supported by DHCS and its EQRO; see EQRO links for details.	There are several interventions, as each MCMC plan has a unique PIP supported by DHCS and Health Services Advisory Group (HSAG). Please see the Plan Specific Evaluation Reports (PSER) page provided for details.
DMC-ODS: The EQRO validates PIP information for DMC-ODS counties. Each county is required to submit one clinical and one non-clinical PIP.	See the BH EQR page for general information about DMC-ODS PIPs, and the BH EQR page for specific examples.	Each DMC-ODS plan has two unique PIPs specific to their populations, with distinct aims; see the BH EQR page for a list of PIPs.	Each DMC-ODS plan has two unique PIPs specific to their populations, with distinct interventions; see the BH EQR page for a list of PIPs.

Managed Care Program	PIP Topic	PIP Aim	PIP Intervention
Dental MC	Improving Annual Dental Visits (ADV) Rates for Children	Increase ADV performance for children ages 1-20, enrolled in a Dental MC plan for at least 90 continuous days, by 3.33% annual percentage points.	Robocall outreach to inform members or guardians on how to utilize their dental benefits or what to do if they require assistance with scheduling a dental benefit. Provider letters and provider portal communications to address providers not understanding performance expectations and inform which members need services.

Managed Care Program	PIP Topic	PIP Aim	PIP Intervention
Dental MC	Improving Oral Health Risk Assessments (OHRA)	Increase OHRA completion rates for all members within 90 days of enrollment.	Live agent telephone outreach to inform members on the necessity and benefit of completing OHRA, as well as assist members with how to complete the OHRA. Oral Health Intake Form (OHIF) reminder call campaign to members who have not responded to the mailed OHIF.

Corrective Action Plans and Intermediate Sanctions

The 2016 Managed Care Final Rule requires the 2025 CQS to include the state's appropriate use of enforcement actions, including intermediate sanctions for managed care organizations (MCO). DHCS has enforcement policies in place for MCMC, MHPs, DMC-ODS plans, and Dental MC plans.

For MCMC plans, DHCS released APL 25-007 in April 2025 to review existing law and policy authorizing DHCS to impose enforcement actions, including CAPs and administrative and financial sanctions, on MCMCs, as well as informing plans of sanction calculation methodology. Sanctions may be imposed on actions that violate applicable California Medi-Cal and federal Medicaid laws, the Knox-Keene Health Care Services Act of 1975 (Knox-Keene Act) standards, or the terms of

their MCMC contract with DHCS; this also ensures that MCMC delegates similarly comply with all state and federal laws and regulations and other contract requirements.

In 2022, DHCS sanctioned 22 MCMC plans for not meeting required MPLs on MCAS measures in MY 2021. This was the first year that monetary sanctions were applied to MCMC plans for not meeting established performance levels. Of these plans, seven were placed on CAPs to collaborate with DHCS leadership, identify issues, and work toward improving performance in needed areas.

In 2023, DHCS sanctioned 18 MCMC plans for not meeting required MPLs on MCAS measures in MY 2022. The number of sanctioned plans decreased from the previous year, but the overall sanction amount increased by nearly $1.4 million due to the high population not served numbers. This was despite the inclusion of a reduction factor in the sanction calculation methodology to account for MCMCs serving members in underserved areas that face additional underlying challenges. A total of three MCMCs were placed on a CAP for MY 2022 performance.

In 2024, DHCS sanctioned 20 MCMC plans for not meeting or exceeding required MPLs on MCAS measures in MY 2023. The number of sanctioned plans increased from the previous year, but the overall sanction amount decreased by nearly 8 percent due to improvement in some MCMC plan performance rates. A total of three MCMCs were placed on CAP for MY 2023 performance.

In fall 2024, five MCMC plans were identified as out of compliance with network certification requirements and placed on a CAP. All MCMC plans were able to supply documentation demonstrating the resolution of their identified deficiencies. These findings are published on the DHCS Network Adequacy webpage.

DHCS also maintains a process for conducting Audits for all MCMC and imposes CAPs to remediate findings. These are available on the DHCS' website: For SMHS and DMC-ODS, DHCS released BHIN 25-023 ("Enforcement Actions: Administrative and Monetary Sanctions and Contract Termination for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans") in June 2025, providing clarification about its authority to impose sanctions on county MHPs and DMC-ODS plan for violating applicable federal and state laws, regulations, or contractual obligations, or failing to comply with the State Plan, approved waivers, or for good cause, and notification of enforcement tiers that DHCS will use when determining whether to take

enforcement action specific to network adequacy and timely access to care. Additionally, the authority of DHCS to impose administrative and monetary sanctions is strengthened by its inclusion in the executed contracts between DHCS and county MHPs and DMC-ODS plans.

For the FY 2023-24 certification year, 49 county MHPs and 27 DMC-ODS plans were identified as out of compliance with network certification requirements and subsequently placed on a CAP. DHCS assesses whether the county MHPs and DMC-ODS plans met the CAP requirements and publishes this information on the DHCS Network Adequacy webpage.

For SMHS and DMC-ODS, DHCS is assessing the results of CAPs for the FY 2023-24 certification period and anticipates the publication of these results in summer 2025. CAPs for deficiencies identified for the FY 2024-25 certification period are also anticipated to be issued in summer 2025. Based on DHCS' experience, many CAPs issued to MHPs and DMC-ODS plans are promptly resolved through addressing data reporting issues; such CAPs are not indicative of bona fide network deficiencies. DHCS anticipates that many CAPs issued to the MHPs and DMC-ODS Plans for FY 2023-24 and 2024-25 will be similarly resolved. Plans that fail to resolve CAPs may be subject to monetary sanctions.

For Dental MC, DHCS released APL 22-009 (Enforcement Actions: Administrative and Monetary Sanctions) in August 2022, providing clarification of administrative and monetary sanctions to enforce compliance with Dental MC contractual provisions and applicable state and federal laws. Sanctions may be imposed on actions that violate applicable California Medi-Cal and federal Medicaid laws, Knox-Keene Act standards, or the terms of their Dental MC contract with DHCS.

In 2023, DHCS sanctioned and placed two CAPs on one Dental MC plan for not meeting minimum contractual requirements. Additionally, DHCS closed four CAPs that were placed on three Dental MC plans due to deficiencies assessed in DHCS audits. The Dental MC plans identified root cause, worked toward improvement in needed areas, and demonstrated resolution of their deficiencies.

3.3 EQR Arrangements

The following table provides a description of DHCS' EQR arrangements for annual, external, and independent review of quality outcomes and timeliness of

access to services covered under each MCP, Prepaid Inpatient Health Plan (PIHP), and Prepaid Ambulatory Health Plan (PAHP), in accordance with 42 CFR 438.250. DHCS has made strides in the consolidation and standardization of EQR activities across managed care delivery systems. As of July 1, 2024, DHCS has entered an EQRO contract that will deliver EQR services across all DHCS systems of care. Although DHCS continues to have no applicable arrangements to report regarding non-duplication of mandatory EQR activities (according to 42 CFR 438.360 (c)), non-duplication has been included in the new EQR scope of work and will look to pursue these efforts should the need arise. Below are EQR arrangements for 2025-2028.

Table 7: EQR Arrangements

Program	Name of Organization	Activities To Be Conducted 2025 - 2028	
MCMC	HSAG, Inc., (base contract through 2027.)	» Assessment of the 2025 MCMC quality strategy » Inclusion of Compliance reviews of MCMCs in EQR Technical Reports, including follow-up on audits and CAPs » Assessment of PIPs » Calculation, validation, and trend assessment of performance measures for MCMCs » Follow-up on the EQRO's recommendations,	» Validation of encounter data submitted by MCMCs » Conducted at least every three years » Administration and validation of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys » Administration of focused studies (active studies in 2025 include: Health Disparities; Statewide Network Analysis; Network » Technical assistance to MCMCs on quality improvement topics through calls, webinars, email support, and annual quality conference

		both to DHCS and MCMCs » The EQRO is also contracted to validate network adequacy as specified under 42 CFR 438.358(b)(1)(iv); pending issuance of protocols from CMS » The state also mandates the following EQR activities: » Alternative Access Standards (Network Adequacy) California WIC § 14197.05(a)(b) and (d) » Skilled Nursing Facility/Intermediate Care Facility (Network Adequacy) CA WIC §14197.05(c) and (d)	» EQRO contracted to aid with the quality rating of MCMCs consistent with 42 CFR 438.334 pending issuance of protocols from CMS

Program	Name of Organization	Activities To Be Conducted 2022 - 2026	
		Mandatory Activities	Optional Activities
Dental MC	HSAG, Inc., (contract through 2027).	» Validation of PIPs » Calculation and validation of Dental MC plan performance measures » Inclusion of Dental MC plan compliance reviews in EQR Technical Report » Validation of Dental MC plan network adequacy	
MHPs	HSAG, Inc., (contract through 2027).	» Validation of PIPs » Validation of MHP performance measures » Inclusion of MHP compliance reviews in EQR Technical Report » Validation of MHP network adequacy	» Inclusion of Consumer Perception Surveys results in EQR Technical Reports » Technical assistance to MHPs through participation in statewide QI coordinator meetings » Conduct additional PIPs or focused studies
DMC-ODS	HSAG, Inc., (contract through 2027).	» Validation of PIPs » Validation of DMC- ODS plan performance measures » Inclusion of DMC-ODS plan compliance reviews in EQR Technical Report » Validation of DMC- ODS plan network adequacy	» Validation of encounter data reported by DMC-ODS plan » Inclusion of Treatment Perception Surveys results in EQR Technical Reports » Conduct additional PIPs or focused studies » Technical assistance for DMC-ODS plans

3.4 State Standards

Network adequacy and availability of services

DHCS published its network adequacy standards in July 2017 to comply with the network adequacy provisions of the 2016 Managed Care Final Rule. The DHCS network adequacy standards document was subsequently amended in March 2018 to reflect changes under Assembly Bill 205 (Wood, Chapter 738, Statutes of 2017), which was codified in WIC §14197 and amended California's network adequacy standards to base the standards on the population density of each county, rather than population size. DHCS is actively planning and implementing policy and operations to achieve compliance with the 2024 Managed Care Access, Finance, and Quality Final Rule (2024 Managed Care Final Rule) network adequacy and availability of services requirements which include appointment wait time standards, network adequacy exceptions, secret shopper surveys, provider directory reviews, and remedy plan submissions. The 2024 Managed Care Final Rule is effective July 9, 2024, with provisions having applicability dates that extend to 2028. DHCS will align its approach in achieving compliance with the 2024 Final Rule to the goals and vision of the CQS.

DHCS certifies managed care networks on an annual basis through the Annual Network Certification (ANC) process and submits the Network Adequacy and Assurances Report (NAAAR) to CMS annually. DHCS posts the results of the NAAAR for all delivery systems at the following link: Network Adequacy. As a part of the CalAIM Special Terms and Conditions (STCs), DHCS is undertaking a comprehensive evaluation of the Medi-Cal managed care delivery system in comparison to other health care lines of business (e.g. commercial or Medicare) . The STCs also require DHCS to submit the 2024 Interim Access Report, which identifies a number of best practices but also 14 discrete opportunities for DHCS to improve its monitoring and oversight of access across delivery systems in Medi-Cal, inclusive of physical and behavioral health services. These opportunities include substantive improvements in network data accuracy in addition to improved accountability and are as follows:

Measure and data alignment

1. Continue to standardize provider network files across service delivery systems.
2. Align secret shopper and revealed caller studies across service delivery systems.
3. Align member surveys across survey delivery systems.

4. Standardize and expand use of member-to-provider ratio logic across service delivery systems.

Data improvements and measure refinement

5. Require plans to report plan-county rates.
6. Improve provider data for enhanced subcontractor monitoring.
7. Improve provider data to accurately collect providers' spoken languages.
8. Improve data on provider network for each plan.
9. Capture the SMHS and DMC-ODS population more accurately.

Alignment with strategic initiatives

10. Further align with DHCS Health Equity Roadmap.
11. Expand measures that address Culturally and Linguistically Appropriate Services standards.

Enhancements to performance standards

12. Consider expansion of minimum performance standards and goals for individual performance measures.
13. Revisit minimum performance standards and goals based on current performance.

Performance improvement activities

14. Conduct targeted performance improvement initiatives informed by key findings on access to care.

DHCS has already implemented some of the findings recommended above and is exploring feasibility of addressing the remaining recommendations. A final State Access Assessment will be submitted to CMS in December 2026.

MCMC

As part of ANC, MCPs are required to meet specified time or distance standards according to county population density. MCPs unable to meet these standards are required to submit alternative access standard (AAS) requests to DHCS by zip code and provider type. AAS approval is reserved only for those geographic areas with provider shortages. MCPs must demonstrate good faith efforts, reviewed by DHCS, to contract with the closest available Medi-Cal enrolled providers before receiving AAS approval. DHCS will also require MCPs to reach out to closely located providers that are not enrolled in Medi-Cal to recruit them to enroll in Medi-Cal, if applicable.

For the 2023 ANC, DHCS made the decision to implement systemic changes to improve monitoring of member access and align with the Department of Managed Health Care (DMHC) in standardizing network adequacy data. The

strengthened methodology better reflects the member experience and applies a consistent approach across all populations in the state. The new methodology reveals true gaps in member access, facilitating more meaningful oversight and compliance. DMHC licenses and regulates nearly all MCPs in California, 19 of which are also Medi-Cal MCPs. While DHCS and DMHC have different jurisdictions and responsibilities, they collaborate and align their efforts where possible to promote consistent network adequacy standards for MCPs in California and minimize administrative burden for health plans and the delivery system.

Also commencing with the 2023 ANC, DHCS migrated from non-standard MCP-driven geocaches mapping to ArcGIS. In prior years, MCPs conducted their own geographic mapping using various platforms, which was derived from the "100 points of light" methodology that DMHC also utilized. These platforms required each MCP to independently create 100 population points in each zip code in their service area(s). Population points serve as a proxy for where members could potentially reside. The new methodology required each individual MCP to map the DHCS-defined population points to specific locations in their service area based on the population density of habitable areas in each zip code.

Each MCP's methodology was not standardized, resulting in variation of time or distance mapping results within the same county. Often the variation among MCPs in the same county with overlapping delivery systems led to different results. It was difficult to ascertain whether variations were reflective of true differences in travel time or distance or merely attributable to variation in methodology. The strengthened methodology results in a consistent analysis across the state, enabling DHCS to better target resources to those areas with true gaps in access.

MHPs and DMC-ODS Plans

Since FY 2021-22, to monitor compliance with time or distance standards, DHCS has prepared geographic access maps for MHPs and DMC-ODS plans based upon Medi-Cal member and provider location data. DHCS applies an enhancement within ArcGIS created by the Environmental Systems Research Institute (ESRI) to run the driving times or driving distances. DHCS plotted time or distance for all network providers, stratified by service type and geographic location, for both adults and children/youth. DHCS will grant exceptions to time or distance standards if a plan cannot meet them. Plans

unable to meet time or distance can submit an AAS request to DHCS; however, DHCS will only consider requests for AAS if the MHP or DMC-ODS plan has exhausted all other reasonable options to obtain providers to meet the applicable standard, or if DHCS determines that the MHP or DMC-ODS plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

DHCS is currently exploring the ability to align the time or distance methodology for MHPs and DMC-ODS plans with MCPs and DMHC's methodology with the use of Population Points instead of member addresses.

In a continuous quality improvement process, DHCS continues to strengthen and refine the timely access reporting and analysis methodology for analysis annually, with the goal of improving the validity of initial and follow-up appointment time data and strengthening DHCS' monitoring and compliance enforcement with network adequacy standards for MHP and DMC-ODS networks. Consequently, DHCS provides updated templates and reporting guidance for each annual network certification.

For 2023, DHCS included compliance thresholds for new MHP members being offered appointments within established timeframes by age group (0-20 for children/youth and 21+ for adults).

In addition, DHCS made significant updates to the Timely Access Data Tool (TADT), which is an Excel-based template that DHCS requires MHPs, DMC-ODS plans, and DMC counties to submit data on member appointment requests. This method is valuable because it captures detailed appointment time data from the MHPs, DMC-ODS plans, and DMC counties and their providers for Medi-Cal members who request services during the annual reporting period. The updates made to the TADT allowed DHCS to expand and improve timely access monitoring. These changes included:

- Revisions of terminology and instructions to align with DHCS' CalAIM policy changes and clarify that an array of appointment types should be tracked.
- Replacement of the County Client Numbers (CCN) with the collection of Client Index Numbers (CIN), which sought to further ensure protection of protected health information (PHI) and facilitate more detailed data analysis by enabling DHCS to perform data matching with demographic data already available to the department.
- Addition of appointment data to align with updates to Senate Bill (SB) 221, which revised California Health and Safety Code §1367.03 to explicitly apply

appointment time standards to follow-up appointments with a non-physician mental health provider or SUD provider, as applicable.

- The addition of out-of-network provider referral appointment data to ensure BHPs are following access to care requirements as specified in the MHP
- or DMC-ODS intergovernmental agreement.

DHCS is also moving to a single standard for MHPs and DMC-ODS Plans to submit network and program data to DHCS monthly using the X12 274 Health Care Provider Directory standard (274), in alignment with how MCPs report provider network data today. The 274 replaced the use of the Excel-based template, the Network Adequacy Certification Tool for Mental Health Plans in FY 24-25 and for DMC-ODS Plans in FY 25-26. The implementation of the 274 will help to ensure plans' provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. It will also support expanded tracking and monitoring of the full array of services provided by plans and increased frequency of analyses.

DHCS also plans to standardize its process to use its independent EQRO to perform validation of timely and provider network data across all Medi-Cal managed care delivery systems through "secret shopper" surveys. Until then, DHCS intends to conduct a limited-scope secret shopper process in 2025 for DMC-ODS and MHP providers. Additionally, DHCS will be developing additional validation activities to verify the accuracy of DMC-ODS and MHP provider network directories.

DHCS also requires managed care networks[43] (MCMC, Dental MC) to report within 60 business days whenever there is a significant change that would affect the adequacy of capacity and services as defined by DHCS. For MHPs and DMC-ODS plans, they are required to inform DHCS any time there has been a change in the operations of the county that affects the adequacy of their capacity and services within 10 business days.

A significant change is a change in the composition of the MCP's network, services, benefits, geographic service area, or enrollment of a new population. The significant change may occur because of a termination, suspension, or decertification of a network provider or subcontractor impacting 2,000 or more members, or because the network is out of compliance with network adequacy standards. For BHPs any operational changes that would affect the adequacy of capacity and services. If DHCS' review of significant changes results in a county and/or managed care plan being out of compliance with any

[43] Network Adequacy Certification Materials for MCMC, Dental, SMHS, DMC-ODS

standard, DHCS will issue a CAP. DHCS makes available to CMS, upon request, all documentation collected due to the annual network certification. DHCS has aligned its network adequacy certification process across all delivery systems, including managed care, behavioral health, and dental.

In addition to certifying for network adequacy for Dental MC as described, DHCS has included similar network requirements in its dental FFS delivery system contract with its delegated Administrative Services Organization (ASO). The ASO must submit annual plans, describing strategic approaches to increase the number of providers and access to care, with an emphasis on areas and subpopulations with low utilization. Performance measures must also be tied to the plan contract. The ASO must conduct annual surveys to receive data for participating providers about their satisfaction with the Medi-Cal Dental Program, and for unenrolled providers to gauge their interest in the program. Additionally, an annual Provider Capacity Survey[30] is conducted to gauge how enrolled offices serve Medi-Cal members, and to learn about issues providers encounter in serving the Medi-Cal population.

Evidence-Based Clinical Guidelines

The 2016 Managed Care Final Rule requires the CQS to include examples of evidence-based clinical practice guidelines the state requires in accordance with 42 CFR 438.236. It further requires the MCMC, SMHS, DMC-ODS, and Dental MC plans to adopt and disseminate these clinical practice guidelines to plan providers and Medi-Cal members.

DHCS requires all contracted managed care entities to develop and implement processes that reflect evidence-based clinical practice guidelines. Clinical practice guidelines are based on medical evidence and allow managed care entities to monitor the safety and effectiveness of provider services. DHCS and its contractors review and update clinical practice guidelines regularly to provide consistency with best practices. For behavioral health programs, DHCS provides guidance through various avenues, such as the annual Substance Use Disorder Integrated Care Conference, technical assistance on clinical PIPs via the EQRO, and through ASAM-based assessment tools for DMC-ODS. Specific clinical guidelines are provided below.

MCMC and MMPs

Through its contracts with MCMC plans, DHCS requires that they develop and implement a process to provide information to providers and to train providers on a

continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS-developed cultural awareness and sensitivity instruction for seniors and persons with disabilities or chronic conditions. DHCS also requires, through its contracts, that MCMC plans ensure that their pre-authorization, concurrent review, and retrospective review decisions are based on a set of written criteria or guidelines for utilization review (UR) that are based on sound medical evidence and are consistently applied, regularly reviewed, and updated as needed. MCMC plans must utilize evaluation criteria and standards to approve, modify, defer, or deny services, and must document the way providers are involved in the development and or adoption of specific criteria used by the MCMC plan. Additionally, DHCS requires, through its contracts, that MCMC plans ensure that the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adults (age 21 or older). All preventive services identified as USPSTF "A" and "B" recommendations must be provided. Further, DHCS contracts specify that MCMC plans must follow the most recent American Academy of Pediatrics (AAP) Bright Futures guidelines for the provision of preventive services to children, and the most recent American College of Obstetrics and Gynecology (ACOG) guidelines for the care of pregnant members.

MCMC plans must submit policies and procedures to ensure providers receive training on a continuing basis regarding clinical protocols and evidence-based practice guidelines. MCMC plans are audited on their utilization management practices, including the application of evidence-based guidelines, and provider training protocols as part of the annual medical compliance audits conducted by DHCS on all MCMC plans. Similar provisions apply to MMPs, in conjunction with related federal Medicare requirements.

MHPs

Through its contracts with MHPs, DHCS requires the adoption and dissemination of clinical practices and guidelines as specified in 42 CFR 438.236. DHCS' contract with MHPs specifies access criteria for SMHS and other SMHS requirements. MHPs must have processes in place to disseminate this information to providers and members upon request. MHPs submit their policies and procedures to DHCS during triennial compliance reviews.

DHCS holds MHPs accountable to all contract components; if there are deficiencies, DHCS may impose a CAP and will meet with the MHP at least monthly until the deficiencies are resolved.

Furthermore, as with MCMCs, DHCS requires MHPs to base their authorization decisions on written UR criteria grounded in clinical practice standards, which must be applied consistently, regularly reviewed, and updated as needed. Each MHP is required to implement mechanisms to monitor the safety and effectiveness of medication practices at least annually. As such, a majority of MHPs have adopted clinical practice guidelines pertaining to clinical monitoring practices for psychotropic medications, consistent with the best practices in the California guidelines for the use of Psychotropic Medication with Children and Youth in Foster Care.

DHCS and CDSS jointly issue the California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care. In December 2024, the department released the 2024 Edition, which supersedes the previous 2018 Edition. The interdepartmental guidelines offer best practices for treating mental health conditions in children and youth in out-of-home care and have contributed to a decline in psychotropic medication use in this population. The guidelines cover principles and values, expectations about treatment monitoring, and options for non-pharmacologic treatment, safety, and informed consent. They are intended to be used by SMHS providers when prescribing psychotropic medication to children and youth in foster care. DHCS conducts compliance reviews to ensure that MHPs implement the guidelines in accordance with state and federal requirements.

DMC-ODS

Counties that implement the DMC-ODS are required to use the ASAM criteria to ensure that eligible members receive clinically appropriate services. The ASAM criteria are the result of a collaboration of experts that began in the 1980s to develop a national standard for proving outcome-oriented and results-based care in the treatment of a SUD. The ASAM criteria are a proven model in the SUD field and the most widely used comprehensive set of guidelines for assessing patient needs and optimizing placement into SUD treatment. Counties are responsible for ensuring their network providers are trained and conduct ASAM assessments on members seeking SUD services.

DMC-ODS counties are required by DHCS to adopt clinical practices and guidelines per 42 CFR 438.236. DHCS conducts compliance reviews to ensure that DMC-ODS counties

implement contractual requirements in accordance with state and federal requirements. DMC-ODS counties must also ensure that authorization decisions have written criteria for UR based on clinical standards, which are consistent and updated.

DMC-ODS counties must also identify and train their network providers to use two or more of the five following evidence-based practices:

- **Cognitive-Behavioral Therapy**: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
- **Motivational Interviewing**: A member-centered, empathic but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on a member's past successes.
- **Relapse Prevention**: A behavioral coping-focused process that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a standalone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
- **Psycho-education**: Psycho-education groups are designed to educate members about substance abuse and related behaviors and consequences. Psycho-education groups provide information designed to have a direct application to members' lives. These groups instill self-awareness, suggest options for growth and change, identify community resources that can assist members in recovery, develop an understanding of the recovery process, and prompt people using substances to act on their own behalf.
- **Trauma-informed Treatment**: Services that consider an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.

Effective March 2023, DHCS began piloting a new evidence-based practice, contingency management for treatment of stimulant use disorders. As of October 2024, 98 sites across 19 counties were providing contingency management; 80 percent of Medi-Cal members now reside in a county with at least one site offering this service. In addition, DHCS requires all treatment providers to offer or refer to MAT to ensure this service is available at all levels of care and is accessible to members whether they are in residential

or outpatient care. MAT is also available in Narcotic Treatment Programs (NTPs), and all DMC-ODS counties are required to cover and ensure access to NTP services.

Dental MC

Through its contracts with Dental MC plans, DHCS requires them to abide by the clinical criteria outlined in the Medi-Cal Dental Program Provider Handbook inclusive of Section 5 – Manual of Criteria (MOC). The MOC provides dental clinical parameters for providers treating Medi-Cal members, setting forth program benefits and clearly defining limitations, exclusions, and special documentation requirements. The MOC outlines DHCS policy for procedures offered through the program that Dental MC plans are required to adopt and disseminate to providers. The handbook serves as a reference guide for all Medi-Cal dental providers, in addition to being available to members and the public. The handbook contains criteria for dental services, program benefits and policies, and instructions for completing forms used in the dental FFS program. The Dental MC contract also requires plans to maintain their own provider manual that, following DHCS approval, should be disseminated to providers and, upon request, to members and potential members. The plan-specific provider manual must rely on clinical evidence and specific clinical practice guidelines to which providers must adhere.

The Dental MC contract requires plans to provide dental services in accordance with intervals that meet reasonable standards of dental practice, including the American Academy of Pediatric Dentistry periodicity schedule for dental services to children. DHCS has also provided Dental MC plans and dental providers with information regarding intravenous sedation and general anesthesia services, as well as services for pregnant women and postpartum individuals. The contract also states that services must be furnished in an amount, duration, and scope that is no less than the same services furnished to members under the dental FFS program.

Transitions of Care Policy

The 2016 Managed Care Final Rule requires the CQS to include the state's managed care transition of care policy. Effective July 1, 2018, 42 CFR 438.62 requires the state to have in effect a transition of care policy to ensure continued access to services during a member's transition from Medi-Cal FFS to an MCP, or transition from one managed care entity to another, when the member, in the absence of continued services, would suffer

serious detriment to their health or be at risk of hospitalization or institutionalization. Each MCP has developed specific transition-of-care policies, detailed in the sections below.

MCMC Plans

DHCS released APL 23-022 in August 2023, which clarified Continuity of Care requirements for Medi-Cal members who transition into MCMC. Medi-Cal members who transition from Medi-Cal FFS to enroll as members in an MCP on or after January 1, 2023, have the right to request Continuity of Care in accordance with state law and the MCMC contracts, with some exceptions. All eligible MCMC members with pre-existing provider relationships who make a Continuity of Care request to an MCMC plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider, subject to the MCMC plan and the provider coming to an agreement. The Medi-Cal Continuity of Care policy for MCMC plans also applies to dual eligible members enrolled in Medi-Medi Plans.

On January 1, 2024, MCPs were subjected to new requirements to advance health equity, quality, access, accountability and transparency to improve the Medi-Cal health care delivery system. As part of this transformation, approximately 10 percent of Medi-Cal members transitioned to a new health plan on January 1, 2024. DHCS implemented policy in July 2023 using the 2024 Managed Care Plan Transition Policy Guide (2024 MCP Transition Policy Guide) to ensure transitioning members experienced minimal disruption in their health care services during the transition to new MCMC plans in 2024. The 2024 MCP Transition Policy Guide set enhanced transition of care and Continuity of Care policies, including expanded protections for particularly vulnerable populations, referred to as "Special Populations". The key provisions included:

- **Continuity of Care for Covered Services**: Members were able to continue an active course of treatment as well as receive services authorized by the previous MCP for six months. To further minimize disruptions for Special Populations members, the new MCPs were required to continue honoring the prior authorizations and active courses of treatment for the full six-month Continuity of Care for Covered Services period and until the new MCP assessed medical necessity for ongoing services.

- **Continuity of Care for Providers**: Members required to transition to a new MCP were able to request to continue seeing a provider with whom they had a pre-existing relationship, for up to 12 months, even if the provider was out-of-network with their new MCP, subject to the new MCP and the provider reaching an agreement. Special Populations members were not required to take any action to continue seeing their prior provider as their new MCP was required to identify and proactively contact all eligible out-of-network providers with whom Special Population members had pre-existing relationships to initiate a Network Provider Agreement or a Continuity of Care for Providers agreement.
- **Continuity of Care Coordination and Management Information**: DHCS recognized the importance of sharing supportive information to avoid member disruption and to enable the new Care Manager to continue the member's care management services without interruption. The previous MCP was required to share supportive information that included, but was not limited to, rendering provider contact information, national provider identifiers, member demographics, special population(s) identifiers, active service authorizations, including transportation service authorizations, results of available member screening and assessment, and member Care Management Plans as applicable.
- **Continuity of Durable Medical Equipment (DME) Rentals and Supplies**: MCPs were required to allow members to keep their existing DME rentals and medical supplies from their existing DME providers without further authorization for six months after the 2024 MCP Transition and until reassessment.

MHPs

DHCS issued Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 18-059, which established a Continuity of Care policy for the SMHS delivery system. To ensure compliance with CMS' Parity in Mental Health and SUD Final Rule (Parity Rule) in the Federal Register (81. Fed. Reg. 18390), DHCS' transition of care policy for MHPs is consistent with its policy for MCMC, and all eligible Medi-Cal members receiving SMHS have the right to request Continuity of Care. Members with pre-existing provider relationships making Continuity of Care requests to the MHP must be given the option to continue treatment with an out-of-network Medi-Cal provider or a terminated network provider, including employees of the MHP or a contracted organizational provider, provider group, or individual practitioner. If a member requests Continuity of

Care, any SMHS necessary to complete a course of treatment will be provided for a period of no longer than 12 months, and the MHP will arrange for a safe transfer to another provider as determined by the MHP, in consultation with the member and provider, and consistent with good professional practice.

DMC-ODS

The transition of care policy for DMC-ODS counties (MHSUDS Information Notice No. 18-051) ensures a member has continued access to the same provider during a county's transition from a State Plan DMC network into a DMC-ODS network, or a member's move from one DMC-ODS county to another DMC. Counties are required to allow a member to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the member would suffer serious harm to their health or be at risk of hospitalization or institutionalization. SUD treatment services with the existing provider will continue for a period of no more than 90 days unless medical necessity requires the services to continue for a longer period, not exceeding 12 months.

Dental MC

In April 2018, DHCS released Dental APL 17-011A, which provided Dental MC plans with updated policy guidance regarding transition of care requirements for individuals who transition to Dental MC plans from Dental FFS or other Dental MC plans. Medi-Cal members mandatorily enrolled in Dental MC and who are transitioning from FFS into a Medi-Cal Dental MC plan have the right to request Continuity of Care in accordance with state law and the Dental MC contracts, with some exceptions. All Dental MC members with pre-existing provider relationships who make a Continuity of Care request to a Dental MC plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal dental FFS provider. These eligible members may require Continuity of Care for services they have been receiving through Medi-Cal dental FFS or through another Dental MC plan.

Continuity of Primary Care and Coordination of Care

DHCS requires, in accordance with 42 CFR 438.208, that managed care plans must support coordinated care by ensuring that enrollees have an ongoing source of primary

care appropriate to their needs, a person or entity is formally designated as primarily responsible for coordinating the services accessed by the enrollee, and timely and coordinated access to all medically necessary services is provided to all members. In 2024, DHCS launched processes to understand existing barriers and to improve data on primary care assignments and to assess Medi-Cal member engagement in primary care, with a new APL on Primary Care assignment reconciliation expected in 2026. DHCS also requires that contracted plans provide appropriate continuity of care for members to ensure uninterrupted access to services and to minimize the disruption of care.

To ensure the state's compliance with the Medicaid Mental Health Parity Rule, DHCS adopted continuity of care policies for SMHS and SUD services that are consistent with the requirements in place for MCMCs. DHCS' Continuity of Care policy for MCMC plans includes non-participating physician providers.

MCMC Plans

DHCS has issued several APLs addressing Continuity of Care requirements specific to populations. In 2017, DHCS released APL 17-12[44], which addresses care coordination requirements for MLTSS, as well as APL 17-017, which addresses long-term care coordination, disenrollment and continuity of care. In 2018, DHCS released APL 18-008, which addresses Continuity of Care requirements for Medi-Cal members who transition from FFS into managed care. In 2023, DHCS released APL 23-022, which clarified Continuity of Care requirements for Medi-Cal members who newly enrolled in Medi-Cal managed care from FFS on or after January 1, 2024.

MCMC members with pre-existing provider relationships who make a Continuity of Care request to an MCMC plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. APL 18-008 clarifies the requirements of Continuity of Care services. APL 23-022 imposed additional Continuity of Care protections for the 2024 transition as described in the above section.

Similar to the MCMC population, members enrolled in Medi-Medi plans are afforded the same Medi-Cal Continuity of Care provisions.

MCMCs meet their contractual requirements for the reporting of Continuity of Care request data to DHCS by utilizing a standardized monthly Java Script Object Notation

[44] As a part of its PHM program, D-SNP transition and HCBS initiatives, DHCS is reviewing this APL and intends to issue updated guidance.

(JSON) reporting format. This allows DHCS to capture Medical Exemption Request (MER) denial reports and other continuity of care request data in much finer detail, allows for automated processing and validation of this data, and provides near real time feedback to submitters regarding data deficiencies.

DHCS' contracts with MCMCs also address care coordination requirements, including care management, person-centered planning for seniors and persons with disabilities, transitional care management, and out-of-network case management and coordination of care. The contracts also outline the requirements for MOUs between the MCMCs and several external partners, including, but not limited to, CCS, local public health departments, county mental health providers, and local education agencies, to coordinate care for members

MHPs

MHPs are required to coordinate care for all Medi-Cal members receiving SMHS, in accordance with 42 CFR 438.208, and the terms of the SMHS contract. MHPs are responsible for coordination and continuity of care for their enrolled members. The MHP is required to ensure that each member has an ongoing source of care appropriate to their needs, and a person or entity is formally designated as primarily responsible for coordinating the services accessed by the member. Information on how to contact their designated person or entity at enrollment must be provided to members.

To facilitate care coordination and the exchange of information necessary to improve referral processes between parties, MHPs are required to enter into a MOU with any MCP that enrolls members served by the MHP, per the MHP Contract, Title 9 of the California Code of Regulations (CCR) §1810.370 and BHIN 23-056. MHPs, through executed MOUs, establish processes for coordinating member access to care including the policies and procedures the parties will use to coordinate care between the parties, addressing barriers to care coordination, and ensuring the ongoing monitoring and improving of such care coordination. MOUs additionally include requirements for parties to coordinate provision of medically necessary services, treatment planning, clinical consultation, ECM, Community Supports, and prescription drugs.

DMC-ODS

DMC-ODS Plans are responsible for coordination and continuity of care for their enrolled members. The plan is required to ensure that each member has an ongoing

source of care appropriate to their needs, and a person or entity is formally designated as primarily responsible for coordinating the services accessed by the member. Information on how to contact their designated person or entity at enrollment must be provided to members.

To facilitate care coordination and the exchange of information necessary to improve referral processes between parties, counties are required to enter into a MOU with any MCP that enrolls members served by the DMC-ODS, per the DMC-ODS contract and BHIN 23-057. DMC-ODS plans, through executed MOUs establish processes for coordinating member access to care including the policies and procedures the parties will use to coordinate care between the parties, addressing barriers to care coordination, and ensuring the ongoing monitoring and improving of such care coordination. MOUs include requirements for parties to coordinate provision of medically necessary services, treatment planning, clinical consultation, ECM, Community Supports, and prescription drugs.

Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the member with linkages to services and supports designed to restore the member to their best possible functional level. Care coordination shall be provided to a member in conjunction with all levels of treatment. It may also be delivered and claimed to be a standalone service. DMC-ODS plans, through executed MOUs, shall implement care coordination services with other SUD, physical, and/or mental health services to ensure a member-centered and whole-person approach to wellness.

Through this coordination process, continuity of care is achieved, reducing fragmentation of services.

Dental MC

Dental MC plans are responsible for coordinating the care of their members. DHCS issued Dental APL 18-007 and amended the Dental MC contracts to ensure plans: 1) conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful; and 2) share with DHCS or other managed care plans serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities.

In addition, for members with Special Health Care Needs (SHCN), each Dental MC plan is required to: 1) implement mechanisms to comprehensively assess members identified as having SHCN to identify any ongoing special conditions that require a course of treatment or regular care monitoring; and 2) produce a member-specific treatment or service plan for those members that are determined through assessment to need a course of treatment or regular monitoring. Please note that "a member-specific treatment or service plan" is statutorily required language that means the same as "a care plan." Dental APL 18-007 establishes a definition for members with SHCN to assist Dental MC plans in identifying members with SHCN for the purpose of conducting assessments and developing treatment plans.

In July 2018, DHCS reviewed and approved all Dental MC plans' submitted policies and procedures and oral health information forms to confirm that Dental MC plans have effective processes in place to demonstrate compliance with these requirements.

Identification of Persons Who Need LTSS or Persons with Special Health Care Needs

The 2016 Managed Care Final Rule requires the CQS to include the mechanisms implemented by the state to comply with 42 CFR §438.208(c)(1), relating to the identification of persons who need LTSS or people with SHCN.

In California, some Medicaid LTSS benefits are provided through managed care and others through 1915(c) and other waiver and State Plan programs that are carved out of managed care. Medicaid LTSS in California includes SNF care, IHSS, and several other HCBS waiver programs authorized under Section 1115, 1915(b), and 1915(c) waivers.

The LTSS programs included in MCMC include Community-Based Adult Services (CBAS) and LTC as described below.

Under CalAIM, MCMC plans began covering and coordinating Medi-Cal institutional LTC in all counties starting in 2023 in a phased approach by benefit type. The transition to managed care provides all LTC residents with access to coordinated and integrated care within Medi-Cal managed care and makes coverage consistent across California. The goal of the Medi-Cal LTC Carve-In is to better integrate care across institutional and community-based settings as well as to make the LTC delivery system consistent across all counties in California. MCMC plans can offer complete care management, and provide a broader array of services, including ECM and Community Supports. Effective

January 1, 2023, all MCMC plans became responsible for covering the skilled nursing facility benefit in 31 counties where SNF coverage newly transitioned from Medi-Cal FFS to Medi-Cal managed care: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, and Yuba.

Effective January 1, 2024, all MCMC plans became responsible for covering the following LTC benefits:

- Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home
- Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H) Home
- Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N) Home
- Adult Subacute Care
- Pediatric Subacute Care

DHCS has developed policies and resources to support the transition of SNF, ICF/DD, and subacute care coverage from FFS Medi-Cal to Medi-Cal managed care. All resources can be found at Long-Term Care (LTC) Carve-In Transition.

Identification of members who need LTSS is accomplished through several processes:

- For MCMC, including the Medi-Medi plans and Dental MC, the state provides MCMCs and Dental MC plans with enrollment files that include the aid codes associated with each newly enrolled member. For members enrolling in managed care from FFS, the MCMCs and Dental MC plans also receive the member's FFS utilization data, including certain HCBS waiver enrollment data. The aid code and FFS utilization data, if provided, are used by plans to identify individuals utilizing LTSS, or persons with other SHCNs. Further details are provided in **Appendix D.**
- CalAIM initiatives on PHM have strengthened MCMC health risk assessments and risk stratification, including identification of members who need LTSS. MCMC and Medi-Medi plans are required to conduct an initial health assessment of the member's health needs to identify those members whose health needs require coordination with appropriate community resources and

other agencies, including LTSS as well as those who might benefit from care management services.

- In addition to the initial health assessment that identifies any need for LTC services, MCMC plans to conduct regular assessments to monitor changes in the number of members' health status, which help identify any new or emerging needs for LTC services. MCMC plans also use data analytics to identify patterns and trends that may indicate a need for LTC services, such as analyzing claims data, utilization patterns, and other health indicators.
- Each MCMC (and Medi-Medi Plans) must also identify newly enrolled older adults and people with disabilities with higher risk and more complex health care needs as required by 42 CFR 438.208(c)(1), using a state-approved process, that might benefit from care management services This process is outlined in the Screening and Assessments section of the PHM Policy Guide.
- For LTSS not included in MCMC, identification processes are determined based on federally approved waiver and state plan provisions, which generally indicate that local HCBS waiver agencies or counties contracted with the state will conduct assessments to determine individuals needing LTSS. For example, IHSS assessments are conducted by county staff, and HCBA assessments are conducted by local waiver agencies.
- Each MCMC is required to implement and maintain a program for Children with SHCN (CSHCN), who are defined by the state as having, or being at an increased risk for, 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 MCMC'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 MCMC must implement methods for monitoring and improving the quality and appropriateness of care for CSHCN. Dental MC plans are required to implement and maintain a program for CSHCN, which includes standardized procedures, such as dental care provider training for the identification of CSHCN at and after enrollment. Members identified as CSHCN receive comprehensive oral assessments and a written dental treatment plan.

CONCLUSION

DHCS envisions a future of Medi-Cal that enables all members to lead longer, healthier, and happier lives via a whole-system, person-centered approach to health and social care.

DHCS is unwaveringly committed to addressing quality and health equity in Medi-Cal, as described in this strategy. We have made much progress in Medi-Cal Transformation over the past three years, but our work is not yet complete, and in these times of change and uncertainty, it is even more vital for our nearly 15 million members.

Given the significant changes occurring in the Medicaid program, both in California and nationally, it is understandable that there is an impulse to back away from the ambitious goals of advancing quality and health equity and transforming Medi-Cal into the system that our members need and deserve. And yet, this is precisely the moment where we cannot allow the incredible multi-sector progress we have made as a state to crumble. We can continue to advance our shared vision by centering Medi-Cal Members, strengthening accountability, and fostering innovative solutions through cross-sector collaboration and reaching out across our silos. Our journey is grounded in transparency, public engagement, and a shared vision for a more coordinated, whole-person care.

By working together—across managed care, behavioral health, public health, and our communities—we can build a stronger, more resilient health infrastructure for all Californians, even during these challenging times.

The journey we have been on is already yielding measurable results, and our members, communities, and partners need us to complete it.

APPENDICES

APPENDIX A: COMMONLY USED ACRONYMS

AAP	American Academy of Pediatrics
ACA	Affordable Care Act
ACE	Adverse Childhood Experiences
ACOG	American College of Obstetrics and Gynecology
ALW	Assisted Living Waiver
APL	All-Plan Letter
ARF	Adult Residential Facilities
ARRA	American Recovery and Reinvestment Act
APM	Alternative Payment Method
ASAM	American Society of Addiction Medicine
BH	Behavioral Health
BHBH	Behavioral Health Bridge Housing
BHCIP	Behavioral Health Continuum Infrastructure Program
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BH-QIP	Behavioral Health Quality Improvement Program
BHIN	Behavioral Health Information Notice
CalAIM	California Advancing and Innovating Medi-Cal
Cal HOPE	California Hope
CalPERS	California Public Employees' Retirement System
CalHHS	California Health and Human Services Agency
CANS	Child and Adolescent Needs and Strengths Scale
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAIR	California Immunization Registry
CBAS	Community-Based Adult Services
CBO	Community-Based Organization

CCT	California Community Transitions
CCP	Cultural Competency Plan
CCS	California Children's Services
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CFR	Code of Federal Regulations
CHDP	Child Health & Disability Program
CHIP	Children's Health Insurance Program
CMHEP	Community Mental Health Equity Project
CMS	Centers for Medicare & Medicaid Services
COHS	County Organized Health System
CP	Commercial Plan
CPS	Consumer Perception Survey
CQS	Comprehensive Quality Strategy
CSHCN	Children with Special Health Care Needs
CY	Calendar Year
DEI	Diversity, Equity, and Inclusion
Dental MC	Dental Managed Care
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DMHC	Department of Managed Health Care
D-SNP	Dual Eligible Special Needs Plan
DTI	Dental Transformation Initiative
EBP	Evidence-Based Practice
ECM	Enhanced Care Management

ED	Emergency Department
EDIM	Enterprise Data and Information Management
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-for-Services
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GMC	Geographic Managed Care
HCBA	Home and Community Based Alternatives
HCBS	Home and Community Based Services
HCBS-DD	Home and Community Based Services Waiver for Individuals with Development Disabilities
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIO	Health Insurance Organization
ICF/DD	Intermediate Care Facilities for the Developmentally Disabled
IHSS	In-Home Supportive Services
IHP	Indian Health Program
IHI	Institute for Healthcare Improvement
LCD	Licensing and Certification Division
LEA-BOP	Local Education Agency-Billing Option Program
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MCAS	Managed Care Accountability Set
MCMC	Medi-Cal Managed Care

MCO	Managed Care Organization
MCP	Medi-Cal Managed Care Plan
MCWP	Medi-Cal Waiver Program
Medi-Cal	California's Medicaid Program
MFP	Money Follows the Person
MHP	Mental Health Plan
MIS/DSS	Management Information System/Decision Support System
MLTSS	Managed Long-Term Supports and Services
MOC	Manual of Criteria
MOU	Memorandum of Understanding
MPL	Minimum Performance Level
MSSP	Multipurpose Senior Services Program
MY	Measurement Year
NTP	Narcotic Treatment Program
OHRA	Oral Health Risk Assessments
OTA	Office of Tribal Affairs
PACE	Programs of All-Inclusive Care for the Elderly
PAHP	Prepaid Ambulatory Health Plan
PATH	Providing Access and Transforming Health
PHE	Public Health Emergency
PHM	Population Health Management
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPS	Protective Payment System
PSER	Plan Specific Evaluation Report
PSP	Population Specific Health Plan

QAIP	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIP	Quality Incentive Pool
QPHM	Quality and Population Health Management
RCFE	Residential Care Facilities for Elderly
REAL	Race, Ethnicity, and Language
RFP	Request for Proposal
RY	Reporting Year
SAMHSA	Substance Abuse and Mental Health Services Administration
SDP	Self-Determination Program
SDP	State Directed Payment
SMAC	Statewide Medicaid Agency Contracts
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SOGI	Sexual Orientation and Gender Identity
SOR	State Opioid Response
SPA	State Plan Amendment
SPD	Seniors and Persons with Disabilities
SUD	Substance Use Disorder
TMSIS	Transformed Medicaid Statistical Information System
UR	Utilization Review
USPSTF	U.S. Preventive Services Task Force
VBP	Value-Based Payment Program
WIC	Women, Infants, and Children or Welfare and Institutions Code
WCM	Whole Child Model

WPC Whole Person Care

APPENDIX B: MANAGED CARE PROGRAM STRUCTURE

Table 1: MCMC Plan Information[45]

County	Managed Care Model	Type of Program	MC Authority[46]	Name of Plan
Alameda	Single	MCO	1915(b)	Alameda Alliance for Health; Kaiser Permanente
Alpine	Two Plan	MCO	1915(b)	ABC; Mountain Valley Health Plan
Amador	Regional	MCO	1915(b)	ABC; Health Net; Kaiser Permanente
Butte	COHS	MCO	1915(b)	Partnership
Calaveras	Regional	MCO	1915(b)	ABC; Health Net
Colusa	COHS	MCO	1915(b)	Partnership
Contra Costa	Single Plan	MCO	1915(b)	Contra Costa Health Plan; Kaiser Permanente

[45] All MCMC plans listed serve the same population of patients: low-income children and adults, pregnant women, and families.

[46] Current authority for managed care plans is under the 1115 waiver but is included in DHCS' 1915(b) submission to CMS that is under review.

County	Managed Care Model	Type of Program	MC Authority[46]	Name of Plan
Del Norte	COHS	HIO	1915(b)	Partnership HealthPlan of California (PHC)
El Dorado	Two Plan	MCO	1915(b)	ABC; Mountain Valley Health Plan; Kaiser Permanente
Fresno	Two-Plan	MCO	1915(b)	ABC; CalViva Health; Kaiser Permanente
Glenn	COHS	MCO	1915(b)	PHC
Humboldt	COHS	HIO	1915(b)	PHC
Imperial	Single Plan	MCO	1915(b)	Community Health Plan of Imperial Valley; Kaiser Permanente
Inyo	Regional	MCO	1915(b)	ABC; Health Net
Kern	Two-Plan	MCO	1915(b)	Anthem Blue Cross; Kern Family Health Care; Kaiser Permanente
Kings	Two-Plan	MCO	1915(b)	ABC; CalViva Health; Kaiser Permanente
Lake	COHS	HIO	1915(b)	PHC
Lassen	COHS	HIO	1915(b)	PHC

County	Managed Care Model	Type of Program	MC Authority[46]	Name of Plan
Los Angeles	Two-Plan	MCO	1915(b)	Health Net; L.A. Care Health Plan; Kaiser Permanente
Madera	Two-Plan	MCO	1915(b)	ABC; CalViva Health; Kaiser Permanente
Marin	COHS	HIO	1915(b)	PHC; Kaiser Permanente
Mariposa	COHS	MCO	1915(b)	Central California Alliance for Health; Kaiser Permanente
Mendocino	COHS	HIO	1915(b)	PHC
Merced	COHS	HIO	1915(b)	Central California Alliance for Health
Modoc	COHS	HIO	1915(b)	PHC
Mono	Regional	MCO	1915(b)	ABC; Health Net
Monterey	COHS	HIO	1915(b)	Central California Alliance for Health
Napa	COHS	HIO	1915(b)	PHC; Kaiser Permanente
Nevada	COHS	MCO	1915(b)	PHC

County	Managed Care Model	Type of Program	MC Authority[46]	Name of Plan
Orange	COHS	HIO	1915(b)	CalOptima; Kaiser Permanente
Placer	COHS	MCO	1915(b)	PHC; Kaiser Permanente
Plumas	COHS	MCO	1915(b)	PHC
Riverside	Two Plan	MCO	1915(b)	Inland Empire Health Plan (IEHP); Molina; Kaiser Permanente
Sacramento	GMC	MCO	1915(b)	ABC; Health Net; Kaiser Permanente; Molina
San Benito	COHS	MCO	1915(b)	Central California Alliance for Health
San Bernardino	Two Plan	MCO	1915(b)	IEHP; Molina; Kaiser Permanente
San Diego	GMC	MCO	1915(b)	Blue Shield of California Promise Health Plan; Community Health Group Partnership Plan; Kaiser Permanente; Molina;

County	Managed Care Model	Type of Program	MC Authority[46]	Name of Plan
San Francisco	Two Plan	MCO	1915(b)	ABC; San Francisco Health Plan; Kaiser Permanente
San Joaquin	Two Plan	MCO	1915(b)	Health Net; Health Plan of San Joaquin; Kaiser Permanente
San Luis Obispo	COHS	HIO	1915(b)	CenCal Health
San Mateo	COHS	HIO/MCO[47]	1915(b)	Health Plan of San Mateo (HPSM); Kaiser Permanente
Santa Barbara	COHS	HIO	1915(b)	CenCal Health
Santa Clara	Two Plan	MCO	1915(b)	ABC; Santa Clara Family Health Plan; Kaiser Permanente
Santa Cruz	COHS	HIO	1915(b)	Central California Alliance for Health; Kaiser Permanente

[47] As previously approved in the Bridge to Reform (2010) and Medi-Cal 2020 Section 1115 demonstrations, HPSM is considered a COHS even if it is not considered an HIO by federal standards because it became operational after January 1, 1986.

County	Managed Care Model	Type of Program	MC Authority[46]	Name of Plan
Shasta	COHS	HIO	1915(b)	PHC
Sierra	COHS	MCO	1915(b)	PHC
Siskiyou	COHS	HIO	1915(b)	PHC
Solano	COHS	HIO	1915(b)	PHC; Kaiser Permanente
Sonoma	COHS	HIO	1915(b)	PHC; Kaiser Permanente
Stanislaus	Two Plan	HIO	1915(b)	Health Plan of San Joaquin; Health Net; Kaiser Permanente
Sutter	COHS	MCO	1915(b)	PHC; Kaiser Permanente
Tehama	COHS	MCO	1915(b)	PHC
Trinity	COHS	HIO	1915(b)	PHC
Tulare	Two Plan	MCO	1915(b)	ABC; Health Net; Kaiser Permanente
Tuolumne	Regional	MCO	1915(b)	ABC; Health Net

County	Managed Care Model	Type of Program	MC Authority[46]	Name of Plan
Ventura	COHS	HIO	1915(b)	Gold Coast Health Plan; Kaiser Permanente
Yolo	COHS	HIO	1915(b)	PHC; Kaiser Permanente
Yuba	COHS	MCO	1915(b)	PHC; Kaiser Permanente

Table 2: Dental MC Plans[48]

County	Type of Program	MC Authority	Name of Plan
Sacramento	PAHP	1915(b)	California Dental Network dba DentaQuest ; Health Net of California, Inc.; Liberty Dental Plan of California, Inc.
Los Angeles	PAHP	1915(b)	California Dental Network dba DentaQuest ; Health Net of California, Inc.; Liberty Dental Plan of California, Inc.

Table 3: Medi-Medi Plans[49]

County	Type of Plan	MC Authority	Name of Plan
Los Angeles	Medi-Medi Plans	42 CFR 422.561	ABC, Blue Shield of California; Health Net; Kaiser Permanente; L.A. Care Health Plan; Molina
Orange	Medi-Medi Plans	42 CFR 422.561	CalOptima, Kaiser Permanente
Riverside	Medi-Medi Plans	42 CFR 422.561	IEHP; Molina, Kaiser Permanente
San Bernardino	Medi-Medi Plans	42 CFR 422.561	IEHP; Molina Kaiser Permanente
San Diego	Medi-Medi Plans	42 CFR 422.561	Blue Shield of California; Community Health Group; Molina; Kaiser Permanente
San Mateo	Medi-Medi Plans	42 CFR 422.561	Health Plan of San Mateo, Kaiser Permanente

[48] All Dental MC plans listed serve the same population: Medicaid children without disabilities, and parents and expansion adults, ages 20-64. Current authority for the Sacramento and Los Angeles Dental MC plans is under the Section 1115 waiver but is included in DHCS' 1915(b) submission to CMS that is under review.

[49] All Medi-Medi plans listed serve the same population: dual eligibles (individuals eligible for Medicare and Medi-Cal) older than age 21.

County	Type of Plan	MC Authority	Name of Plan
Santa Clara	Medi-Medi Plans	42 CFR 422.561	ABC; Santa Clara Family Health Plan Kaiser Permanente
Fresno	Medi-Medi Plans	42 CFR 422.561	ABC; CalViva, Kaiser Permanente
Kings	Medi-Medi Plans	42 CFR 422.561	ABC; CalViva, Kaiser Permanente
Madera	Medi-Medi Plans	42 CFR 422.561	ABC; CalViva, Kaiser Permanente
Sacramento	Medi-Medi Plans	42 CFR 422.561	ABC; Health Net; Kaiser Permanente
Tulare	Medi-Medi Plans	42 CFR 422.561	ABC; Health Net

Table 4: County MHPs[50]

County	Type of Program	MC Authority	Name of Plan
Alameda	PIHP	1915(b)	Alameda County Behavioral Health Care Services
Alpine	PIHP	1915(b)	Alpine County Behavioral Health Services
Amador	PIHP	1915(b)	Amador County Behavioral Health
Butte	PIHP	1915(b)	Butte County Department of Behavioral Health
Calaveras	PIHP	1915(b)	Calaveras Health and Human Services Agency
Colusa	PIHP	1915(b)	Colusa County Department of Behavioral Health
Contra Costa	PIHP	1915(b)	Contra Costa County Behavioral Health Services

[50] All listed MHPs serve the same population: Medicaid members meeting criteria for SMHS.

County	Type of Program	MC Authority	Name of Plan
Del Norte	PIHP	1915(b)	Del Norte County Health and Human Services
El Dorado	PIHP	1915(b)	El Dorado County Health and Human Services Agency
Fresno	PIHP	1915(b)	Fresno County Department of Behavioral Health
Glenn	PIHP	1915(b)	Glenn County Health & Human Services Agency
Humboldt	PIHP	1915(b)	Humboldt County Department of Health and Human Services
Imperial	PIHP	1915(b)	Imperial County Behavioral Health Services
Inyo	PIHP	1915(b)	Inyo County Department of Health and Human Services
Kern	PIHP	1915(b)	Kern Behavioral Health & Recovery Services
Kings	PIHP	1915(b)	Kings County Behavioral Health
Lake	PIHP	1915(b)	Lake County Behavioral Health Services
Lassen	PIHP	1915(b)	Lassen County Health and Social Services
Los Angeles	PIHP	1915(b)	Los Angeles County Department of Mental Health
Madera	PIHP	1915(b)	Madera County Department of Behavioral Health Services
Marin	PIHP	1915(b)	Marin County Department of Health & Human Services
Mariposa	PIHP	1915(b)	Mariposa County Health & Human Services Agency
Mendocino	PIHP	1915(b)	Mendocino County Health and Human Services Agency
Merced	PIHP	1915(b)	Merced County Behavioral Health and Recovery Services

County	Type of Program	MC Authority	Name of Plan
Modoc	PIHP	1915(b)	Modoc County Health Services
Mono	PIHP	1915(b)	Mono County Behavioral Health
Monterey	PIHP	1915(b)	Monterey County Behavioral Health
Napa	PIHP	1915(b)	Napa County Health & Human Services Agency
Nevada	PIHP	1915(b)	Nevada County Behavioral Health
Orange	PIHP	1915(b)	Orange County Health Care Agency
Placer/Sierra	PIHP	1915(b)	Placer County Health and Human Services
Plumas	PIHP	1915(b)	Plumas County Behavioral Health Department
Riverside	PIHP	1915(b)	Riverside University Health System - Behavioral Health
Sacramento	PIHP	1915(b)	Sacramento County Behavioral Health Services
San Benito	PIHP	1915(b)	San Benito County Behavioral Health
San Bernardino	PIHP	1915(b)	San Bernardino County Department of Behavioral Health
San Diego	PIHP	1915(b)	San Diego County Behavioral Health Services
San Francisco	PIHP	1915(b)	San Francisco Department of Public Health - Behavioral Health Services
San Joaquin	PIHP	1915(b)	San Joaquin County Behavioral Health Services
San Luis Obispo	PIHP	1915(b)	San Luis Obispo County Behavioral Health Department
San Mateo	PIHP	1915(b)	San Mateo County Behavioral Health and Recovery Services

County	Type of Program	MC Authority	Name of Plan
Santa Barbara	PIHP	1915(b)	Santa Barbara County Department of Behavioral Wellness
Santa Clara	PIHP	1915(b)	Santa Clara County Behavioral Health Services Department
Santa Cruz	PIHP	1915(b)	Santa Cruz County Behavioral Health and Substance Use Disorder Services
Shasta	PIHP	1915(b)	Shasta County Behavioral Health
Sierra	PIHP	1915(b)	Sierra County Health and Human Services
Siskiyou	PIHP	1915(b)	Siskiyou County Health and Human Services Agency
Solano	PIHP	1915(b)	Solano County Department of Health & Social Services
Sonoma	PIHP	1915(b)	Sonoma County Department of Health Services
Stanislaus	PIHP	1915(b)	Stanislaus County Behavioral Health & Recovery Services
Sutter/Yuba	PIHP	1915(b)	Sutter and Yuba Behavioral Health Services
Tehama	PIHP	1915(b)	Tehama County Health Services Agency
Trinity	PIHP	1915(b)	Trinity County Behavioral Health Services
Tulare	PIHP	1915(b)	Tulare County Health & Human Services Agency
Tuolumne	PIHP	1915(b)	Tuolumne County Behavioral Health Department
Ventura	PIHP	1915(b)	Ventura County Health Care Agency
Yolo	PIHP	1915(b)	Yolo County Health and Human Services Agency

Table 5: DMC-ODS Plans[51]

County	Type of Program	MC Authority[41]	Name of Plan
Alameda	PIHP	1915(b)	County of Alameda
Contra Costa	PIHP	1915(b)	County of Contra Costa
El Dorado	PIHP	1915(b)	County of El Dorado
Fresno	PIHP	1915(b)	County of Fresno
Humboldt	Regional	1915(b)	County of Humboldt
Imperial	PIHP	1915(b)	County of Imperial
Kern	PIHP	1915(b)	County of Kern
Lake	PIHP	1915(b)	County of Lake
Lassen	Regional	1915(b)	County of Lassen
Los Angeles	PIHP	1915(b)	County of Los Angeles
Marin	PIHP	1915(b)	County of Marin
Mariposa	PIHP	1915(b)	County of Mariposa
Mendocino	Regional	1915(b)	County of Mendocino
Merced	PIHP	1915(b)	County of Merced
Modoc	Regional	1915(b)	County of Modoc
Monterey	PIHP	1915(b)	County of Monterey
Napa	PIHP	1915(b)	County of Napa
Nevada	PIHP	1915(b)	County of Nevada
Orange	PIHP	1915(b)	County of Orange
Placer	PIHP	1915(b)	County of Placer
Riverside	PIHP	1915(b)	County of Riverside

[51] All DMC-ODS plans listed serve the same population: Medicaid members meeting criteria for SUD treatment.

County	Type of Program	MC Authority[52]	Name of Entity
Sacramento	PIHP	1915(b)	County of Sacramento
San Bernardino	PIHP	1915(b)	County of San Bernardino
San Benito	PIIHP	1915(b)	County of San Benito
San Diego	PIHP	1915(b)	County of San Diego
San Francisco	PIHP	1915(b)	County of San Francisco
San Joaquin	PIHP	1915(b)	County of San Joaquin
San Luis Obispo	PIHP	1915(b)	County of San Luis Obispo
San Mateo	PIHP	1915(b)	County of San Mateo
Santa Barbara	PIHP	1915(b)	County of Santa Barbara
Santa Clara	PIHP	1915(b)	County of Santa Clara
Santa Cruz	PIHP	1915(b)	County of Santa Cruz
Shasta	Regional	1915(b)	County of Shasta
Siskiyou	Regional	1915(b)	County of Siskiyou
Solano	Regional	1915(b)	County of Solano
Stanislaus	PIHP	1915(b)	County of Stanislaus
Tulare	PIHP	1915(b)	County of Tulare
Ventura	PIHP	1915(b)	County of Ventura
Yolo	PIHP	1915(b)	County of Yolo

[52] Current authority for DMC-ODS is under the Section 1115 waiver but is included in DHCS' 1915(b) submission to CMS that is under review.

APPENDIX C: MANAGED CARE ENTITY PROGRAM REPORTING REQUIREMENTS

DHCS meets the requirements for developing, evaluating, revising, and making available the CQS as described in 42 CFR §438.340(b), (c), and (d). This section includes examples of the reporting requirements for entities covered by the CQS. Reporting requirements are subject to change.

42 CFR	Summary of Requirement	DHCS Strategy Details
438.340 (b)	Requires state to include, at a minimum, the following: 1. Defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs. 2. Examples of evidence-based clinical practice guidelines; goals and objectives for continuous quality improvement that must be measurable. 3. A description of the quality metrics and performance targets, PIPs, and a description of interventions if required. 4. Arrangements for external independent review. 5. Description of the transition of care policy. 6. Plan to identify health disparities and disability status. 7. Intermediate sanctions (MCOs). 8. Identification/support for those who need LTSS and persons with SHCN. 9. Non-duplication of EQR activities; and	Interdisciplinary team led by QPHM collaborated with all relevant DHCS areas to review materials and update the quality strategy (programs, admin, EDIM, technology, and CalAIM leads). Reviewed all available documentation and previous public comments from 2019, as outlined in CMS Quality Strategy Toolkit. DHCS defines a significant change as: » Significant restructuring of the quality management within DHCS » Significant change in the numbers, types or timeframes of quality reporting. » A significant change to the managed care population.

42 CFR	Summary of Requirement	DHCS Strategy Details
	10. Definition of "significant changes."	» Changes to quality standards or reporting requirements by state or federal regulations.
438.340 (c)	The State must: 1. Make the strategy available for public comment before submitting the strategy to CMS for review. 2. Review and update the quality strategy as needed, but no less than once every three years; review of the quality strategy must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years. The state must ensure that updates to the quality strategy consider the recommendations provided by an EQRO and should describe how updates to the quality strategy take those recommendations into consideration. 3. Submit a copy of the initial strategy for CMS comment/feedback prior to adopting it in final and submit a copy of the revised strategy whenever significant changes are made to the document.	» DHCS posted the draft strategy for public review in July 2025, presented it at stakeholder meetings, sought Tribal consultation, and incorporated feedback. » Please see stakeholder engagement and key partnerships section for additional entities that have provided input over time. » DHCS acknowledges that it will update its CQS at least every three years, or sooner due to significant change. » This revision is the three-year update, although it incorporates some significant changes in the quality structure at DHCS. » DHCS has reviewed the effectiveness of the 2022 Managed Care Quality Strategy and has summarized the results in **Appendix E**. » DHCS has reviewed all recent EQRO reports and addressed them; in addition, overarching themes have been incorporated in this revised CQS. EQRO

42 CFR	Summary of Requirement	DHCS Strategy Details
		Reports can be found at Calor. And Managed Care Quality Performance EQRTR.
438.340 (d)	The State must make the final quality strategy available on the DHCS website.	» DHCS posts the final report on the DHCS CQS website.

Network Adequacy and Availability of Services

(42 CFR 438.68 – Network Adequacy Standards; 42 CFR 438.206 – Availability of Services)

Program	Report Title	Description
MCMC	Time or Distance Accessibility Analysis	Annual report, and any time there is a significant change to the MCMC plan's network, which assesses the MCMC plan's compliance with time or distance standards for all provider types by service area required by WIC 14197.
	Alternative Access Standard Requests	Annual report, and any time there is a significant change to the MCMC plan's network, that details the exception request of the plan for provider-specific network standards.
	X12 274 Provider Network File	Monthly report detailing the MCMC plans provider network.
	Provider Network Report	Quarterly report in which the MCMC plan reports network provider additions and terminations during the previous quarter.

Program	Report Title	Description
	Quarterly Monitoring Response Template	Quarterly report in which the MCMC plans report on their compliance with DHCS policies, covering grievances, appeals, state fair hearings, Continuity of Care requests, and out-of-network access requests.
	Provider-to-Member Ratios	Annual report, and any time there is a significant change to the MCMC plan's network, assessing the MCMC plan's compliance with provider-to-member ratios
	Mandatory Provider Type	Annual report assessing the MCMC plan's compliance with mandatory provider type requirements
	Significant Changes in Provider Network	Immediate notice of significant changes in the plan's provider network that will affect the adequacy and capacity of services
	Provider Suspensions and Termination Notification	Immediate notice of any independent action taken by the plan to suspend or terminate a network provider
	Timely Access Survey	Quarterly revealed shopper survey assessing MCMC plan compliance with timely access standards

Program	Report Title	Description
Medi-Medi Plans MHPs	Network Overlap	**Aligned Networks:** EAE D-SNPs must submit a report to DHCS detailing the percent and number of contracted Medi-Cal physicians and facilities for the D-SNPs aligned Medi-Cal MCP that are also contracted Medicare physicians and facilities with the EAE D-SNP. Aligned Network Language Gap Assessment: EAE D-SNPs must submit an analysis of their linguistic services, which includes languages offered (American Sign Language inclusive) by the plan or by a skilled medical interpreter at the provider's office. This analysis is in respect to differences between Medicare network providers and the specified Medi-Cal network providers. **Medicare Provider Network File**: EAE and non-EAE D-SNP plans must submit a report with their contracted Medicare provider network to DHCS.
	Annual Network Certification Report	Annual report of BHPs compliance/non-compliance with network adequacy standards

Program	Report Title	Description
	X12 274 Provider Network Data Report	Annual submission of plan provider network data to certify the BHP's provider network.
	Time or Distance Standards	Annual report, and any time there is a significant change to the BHP's network, which includes the plan's geographic access assessment for all provider types by service area required by WIC 14197.
	Approved Alternative Access Standards	Annual report of BHPs meeting time and distance standards with an Alternative Access Standards request
	Capacity and Composition	Annual report of the BHP's compliance with capacity and composition standards.
	Timely Access	Annual report of the BHP's compliance with timely access standards.
	Mandatory Provider Type	Annual report of the BHP's compliance with mandatory provider type standards.
	Annual Network Certification CAP Report	Annual report on the status of BHPs found out of compliance with network adequacy standards.

Program	Report Title	Description
DMC-ODS	Annual Network Certification Report	Annual report of BHP compliance/non-compliance with network adequacy standards.
	X12 274 Provider Network Data Report	Annual submission of plan provider network data to certify the BHP's provider network.
	Time or Distance Standards	Annual report, and any time there is a significant change to the BHP's network, which includes the plan's geographic access assessment for all provider types by service area required by WIC 14197.
	Approved Alternative Access Standards	Annual report of BHPs meeting time and distance standards with an Alternative Access Standards request.
	Capacity and Composition	Annual report of the BHP's compliance with capacity and composition standards.
	Timely Access	Annual report of the BHP's compliance with timely access standards.
	Mandatory Provider Type	Annual report of the BHP's compliance with mandatory provider type standards.

Program	Report Title	Description
	Annual Network Certification CAP Report	Annual report on the status of BHPs found out of compliance with network adequacy standards.
Dental MC	X12 274 Provider Network Data Report	Monthly submission of plan provider network data.
	Plan Provider Network Report	Monthly reporting of all direct subcontracting providers, specialists and provider groups, including FQHCs and Rural Health Clinics (RHC).
	Time or Distance Analysis	Annual report, and any time there is a significant change to the plan's network, which includes the plans' geographic access assessment for all provider types by service area as required by WIC 14197.
	Alternative Access Standard Request	Annual report, and any time there is a significant change to the plan's network that details the exception request of the plan for provider-specific network standards.

Program	Report Title	Description
	Timely Access and Specialty Referral Report	Quarterly reporting of the average amount of time for members to obtain initial primary care dentist appointments, routine appointments, specialist appointments/referrals, emergency appointments, percentage of "no show" appointments, and other requirements. Quarterly reporting on the plan's compliance with the provider-to-member ratio standard.
	Provider-to-Member Ratios	Annual report on the plan's compliance with the provider-to-member ratio standards.
	Timely Access Survey Results	Quarterly report to the plans containing the results of DHCS' Timely Access Survey.
	Attestation of Network Certification	Annual attestation of network certification letter.
	Network Certification Report	Annual report of Dental MC plan compliance with network adequacy standards.

Coordination and Continuity of Care

(42 CFR 438.208(c)(1) - Additional services for enrollees with SHCNs or who need LTSS

Program	Report Title	Description
Medi-Medi Plans	Health Risk Assessment (HRA)	DHCS requires all Medi-Medi plans to conduct an HRA for all members to identify persons who need LTSS or persons with SHCN. This requirement is included in state-specific D-SNP Model of Care requirements. DHCS provides a regular data feed to all Medi-Medi plans and all MCMCs with LTSS and related program utilization.
	Managed Care Program Data (MCPD)	MCMC plans submit a monthly report detailing: Grievances, Appeals, State Fair Hearings, and Continuity of Care and Out of Network Access requests.
MHP	N/A	
DMC-ODS	N/A	
Dental MC	Timely Access and Specialty Referral Report	Quarterly reporting of average amount of time for members to obtain initial PCD appointments, routine appointments, specialist appointments/referrals, emergency appointments, percentage of “no show” appointments, and other requirements.
	Case Management	Quarterly reporting of case management cases received during the quarter.

Program	Report Title	Description
	Dental APL 17-011E: Errata to Transition of Care Policy	Medi-Cal members assigned a mandatory Dental MC aid code and who are transitioning from Medi-Cal Dental FFS into a Dental MC plan have the right to request Continuity of Care in accordance with state law and the Dental MC contracts. Dental APL 17-011E provides Dental MC plans with clarification on Transition of Care requirements.
	Transition of Care Policy	Annual reporting of the plan's Transition of Care policy.
	Initial Health Appointment(s) and Oral Health Information Form (OHIF) Annual Screening Policy	Dental MC plans must ensure that a member has an Initial Health Appointment(s) within 90 days. The Initial Health Appointment must include a history of the transition member's oral health, an identification of risks, an assessment of needs for preventive screens or services and health education, and the diagnosis or plan for treatment of any diseases. The OHIF is a screening tool that is required to be completed within 90 days of Dental MC plan enrollment for new members and fulfills the federal initial screening requirement, as outlined in APL 18-007. Dental MC plans must submit their Initial Screening Policy to DHCS for approval annually.

Practice Guidelines

(42 CFR 438.236 - Practice Guidelines)

Program	Report Title	Description
MCMC	DHCS Provider Manual	Manual of required covered services, including certain applicable clinical parameters, which all managed care and FFS providers must follow, including MCMCs.
	DHCS Boilerplate Managed Care Contracts	Require MCMCs and providers to follow all current recommendations from the AAP Bright Futures, USPSTF and ACOG, as well as develop and implement a process to provide information to providers and to train network providers on a continuing basis regarding clinical protocols and evidence-based practice guidelines.
	2025 MCP Evidence of Coverage (EOC) Member Handbook	Each health plan has a member handbook. It gives you more details about your health plan benefits and services. It includes the benefits and services that the health plan offers.
Medi-Medi Plans	State Medicaid Agency Contract Dual Special Needs Plans (D-SNP) Contract and Program Guide	DHCS and CMS contract with Medi-Medi plans to coordinate the delivery of and be accountable for covered Medicare and Medicaid services for dual eligible enrollees. These plans are required to offer quality, accessible care; improve care coordination among medical care, behavioral health, and LTSS; and further the goals of the Olmstead Decision.

Program	Report Title	Description
MHP	Behavioral Health Information Notices	Information notices clarify criteria for SMHS and other program requirements.
	DHCS Boilerplate MHP Contracts	Require MHPs and providers to adopt, follow, and disseminate current practice guidelines, which (1) must be based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field; (2) consider the needs of the members; (3) are adopted in consultation with contracting health care professionals; and (4) are reviewed and updated periodically as appropriate.
DMC-ODS	Behavioral Health Information Notices	Information notices clarify criteria for SUD treatment services and other program requirements
	DHCS DMC-ODS County Contracts	Require DMC-ODS county plans and providers to adopt, follow, and disseminate current practice guidelines, which (1) must be based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field; (2) consider the needs of the members; (3) are adopted in consultation with contracting health care professionals; and (4) are reviewed and updated periodically as appropriate.
Dental MC	DHCS Boilerplate DMC Contracts	Require Dental MC plans and providers to follow and provide all medically necessary dental services as identified in the Medi-Cal Dental MOC, as well as create written criteria or guidelines based on dental standards of care that are regularly reviewed and updated.

Program	Report Title	Description
	Manual of Criteria	Manual of required medically necessary dental covered services that all Dental MC and FFS dental providers must follow.
	Medi-Cal Dental Provider Handbook	Manual of required covered services, including certain applicable clinical parameters, which all managed care and FFS providers must follow, including Dental MCs.

Quality Assessment and Performance Improvement Program:

(42 CFR 438.330(c) – Performance Measurement; 42 CFE 438.330(d) – Performance Improvement Projects)

Program	Report Title	Description
MCMC	EQR Technical Report, including Performance Measure Validation (PMV) reporting	An annual report that analyzes and evaluates aggregated information on the healthcare services provided by MCMCs, using standard performance measures such as HEDIS and CMS Core Set measures for PMV.
	CAHPS Report	An annual report on results from the CAHPS Survey.
	PIP reporting as a part of the PSERs	Annual reporting on the PIPs occurs in the PSERs, which are a part of the annual EQR Technical Report. The PSERs contain information about each MCMC's PIPs, including the validity and reliability of PIP submissions to draw conclusions about the quality and timeliness of and access to care furnished by these plans.
	Health Disparities Report	Annual report that stratifies performance measures by demographic characteristics and conducts disparity analyses to better identify health disparities and create targeted interventions to improve the quality of and access to care.

Program	Report Title	Description
MHP	Annual MHP Report for 56 MHPs	DHCS contracts with 56 MHPs and the EQRO reviews annual performance relating to access to services, timely access, quality metrics and outcomes. The reports capture information specific to children and youth in foster care, as well as member satisfaction with services using consumer focus groups. The reports can be found on the CalEQRO website.
	Annual Statewide Aggregate Technical Report	As a result of annual MHP reviews, the EQRO annually summarizes aggregate key findings, supporting data, examples, and recommendations for all 56 MHPs' performance on access, timeliness, quality, and outcomes. The reports can be found on the CalEQRO website.
	PIP Reports	Quarterly reports with information regarding MHPs' performance using specific time-limited projects that address clinical and non-clinical areas within the SMHS delivery system. The reports can be found on the CalEQRO website.
DMC-ODS	Annual Technical DMC-ODS County report for 37 counties	DHCS currently contracts with 37 counties operating under the DMC-ODS through the 1115 waiver. The EQRO annually reviews county performance regarding access, timeliness, quality and outcomes. The reports can be found on the CalEQRO website.

Program	Report Title	Description
	Annual Statewide Aggregate Technical Report	As a result of annual DMC-ODS county reviews, the EQRO annually summarizes aggregate key findings, supporting data, examples, and recommendations for all 37 counties' performance on access, timeliness, quality, and outcomes. The reports can be found on the CalEQRO website.
	PIP Reports	Quarterly reports that contain information regarding DMC-ODS counties' performance using specific time limited projects that address clinical and non-clinical areas within the DMC-ODS delivery system. The reports can be found on the CalEQRO website.
	UCLA: Annual DMC-ODS Evaluation Report	Annual submission of 1115 waiver DMC-ODS evaluation data, including summaries of client experience surveys. In collaboration with the EQRO, UCLA's Evaluation Report focuses on access to care, quality of care, cost, and the integration and coordination of SUD care, both within the SUD system and with medical and mental health services. The reports can be found on the California DMC-ODS Evaluation website.
Dental MC	QIP Reports	Quarterly reporting on required QIPs.
	PIPs	Annual reporting on the PIPs is included in the EQR Technical Report.
	Consumer Satisfaction Survey	Annual reporting on consumer satisfaction survey results.
	EQRO Performance Measure Audit	Annual reporting of audit report conducted by an EQRO.

Program	Report Title	Description
	Performance Measures	Quarterly self-reported performance measures.

External Quality Review

(42 CFR 438.350 – External Quality Review)

Program	Report Title	Description
MCMC	EQR Technical Report with Plan-Specific Evaluation Reports (PSER)	Annual, independent technical report that meets external quality review mandates and summarizes findings on access and quality of care related to the health care services provided by MCMC plans, including opportunities for quality improvement.
MHP	MHP Report for 56 MHPs	DHCS contracts with an EQRO to conduct annual reviews on 56 MHPs to assess their capability in terms of access, timeliness, quality, and outcomes to maintain an adequate mental health service delivery system for members. Findings are obtained using approved methodologies and protocols. These findings are summarized in reports found on the CalEQRO website.
	Annual Statewide Aggregate Technical Report	Annual report that summarizes key findings as well as recommendations for all 56 MHPs' performance on access, timeliness, quality, and outcomes. The report contains specific data and information regarding consumer satisfaction with the provision of services. The reports are posted on the CalEQRO website.

Program	Report Title	Description
DMC ODS	Annual Technical DMC-ODS county report for 40 counties	DHCS contracts with an EQRO to conduct annual reviews of 40 counties operating under the DMC-ODS, through the 1115 waiver, to assess their capability in terms of access, timeliness, quality, and outcomes to maintain an adequate SUD service delivery system for members. Findings are obtained using approved methodologies and protocols. These findings are summarized in reports found on the CalEQRO website.
	Annual Statewide Aggregate Report	Annual report that summarizes key findings as well as recommendations for all 40 counties operating under the DMC-ODS, through the 1115 waiver, on access, timeliness, quality, and outcomes. The reports include member satisfaction with services and are published on the CalEQRO website.
Dental MC	EQR Technical Report with PSER	Annual, independent technical report that meets external quality review mandates and summarizes findings on timeliness, access, and quality of care related to the dental services provided by Dental MC plans, including opportunities for quality improvement.

Nonduplication of Mandatory Activities with Medicare or Accreditation Review

(CFR Section: 42 CFR 438.360(c) – Nonduplication of Mandatory EQR Activities)

Program	Report Title	Description
MCMC	Not applicable to MCMC	Not applicable to MCMC
Medi-Medi plans	Not applicable	Not applicable
MHP	Not applicable to BH	Not applicable to BH
DMC-ODS	Not applicable to BH	Not applicable to BH
Dental MC	Not applicable to Dental MC	Not applicable to Dental MC

External Quality Review Results

(42 CFR 438.364(a)(4) – Recommendations for improving the quality of health care)

Program	Report Title	Description
MCMC	EQR Technical Report and PSER	Annual, independent, technical report that draws conclusions from findings on the quality and accessibility of healthcare services provided by MCMC plans, which provides recommendations based on those findings to DHCS and MCMCs for improving quality of care. DHCS and MCMCs respond to the recommendations in the following year's Technical Report and PSERs.
Medi-Medi Plans	EQR	The external quality review activities for D-SNPs are conducted by the CMS EQRO.
MHP	Annual Statewide Aggregate Technical Report	Annual report that summarizes key findings as well as recommendations for all 56 MHPs' performance on access, timeliness, quality, and outcomes. The fiscal year 2019-20 report showed expanded access through telehealth services and new services for children and youth. The report, as well as previous versions, is posted on the CalEQRO website.
DMC-ODS	Annual Statewide Aggregate Report	Annual report that summarizes key findings as well as recommendations for all 40 counties operating under the DMC-ODS 1115 waiver regarding their performance on access, timeliness, quality, and outcomes. The fiscal year 2019-20 report found that the 1115 waiver is improving members' overall access to treatment and timeliness of service, as well as improving outcomes in terms of SUD recovery. The report as well as previous reports are posted on the CalEQRO website.

Program	Report Title	Description
Dental MC	EQR Technical Report and PSER	Annual, independent, technical report that formulates conclusions from findings on the timeliness, quality, and accessibility of dental services provided by Dental MC plans, which provides recommendations based on those findings to DHCS and Dental MCs for improving quality of care. DHCS and Dental MCs are provided with the opportunity to respond to the recommendations in the following year's Technical Report and PSER.

Continued Services to Enrollees

(42 CFR 438.62(b)(3) – Transition of Care)

Program	APL/Policy Title	Description
MCMC	APL 23-018: 2024 MCP Transition Policy Guide	DHCS implemented enhanced transition of care and continuity of care policies, including expanded protections for particularly vulnerable populations, referred to as "Special Populations" to minimize potential disruptions in care as part of the 2024 MCP Transition.
	APL 23-022: Continuity of Care for Medi-Cal Members who Transition into MCMC	Clarification of Continuity of Care requirements for Medi-Cal members who transition into MCMC from FFS. This APL requires MCMC plans to provide Continuity of Care for members transitioning into managed care, with their FFS provider, if requested.
	APL 17-007: Continuity of Care for New Enrollees Transitioned to Managed Care after Requesting a Medical Exemption	This APL requires MCMC plans to consider each denied MER to managed care enrollment as an indication for automatic Continuity of Care with the member's FFS provider.

Program	APL/Policy Title	Description
	APL 05-002: New Process for Transmitting Enrollment/Disenrollment Data APL 25-001	The process DHCS uses to transmit weekly plan enrollment/disenrollment data to MCMCs operating in the Two-Plan Model, GMC, and PHP plans which assists the health plans with identifying members new to managed care.
	Monthly FFS Data Share with MCMCs	DHCS shares member FFS data with the MCMC plans every month to assist them with better care coordination for their members. This data includes pharmacy data on carved out medications, behavioral health, and dental data.
SMHS	MHSUDS Information Notice 18-059. Federal Continuity of Care Requirements for MHPs	This information notice informs MHPs that all eligible Medi-Cal members receiving SMHS have the right to request Continuity of Care, with the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider.
DMC-ODS	MHSUDS Information Notice No. 18-051 and BHIN 24-001	This information notice addresses county responsibility to ensure that members receive continued services during transition from State Plan Drug Medi-Cal to DMC-ODS or transition from one DMC-ODS county to another DMC-ODS county when a member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
Dental	Transition of Care Policy	Annual reporting of the plan's transition of care policy.

Program	APL/Policy Title	Description
MC	Dental APL 17-011E: Errata to Transition of Care Policy	Medi-Cal members assigned a mandatory Dental MC aid code and who are transitioning from Medi-Cal Dental FFS into a Dental MC plan have the right to request Continuity of Care in accordance with state law and the Dental MC contracts. Dental APL 17-011E provides Dental MC plans with clarification on transition of care requirements.

Sanctions

(42 CFR 438.700 - .730 – Sanctions)

Program	Report Title	Description
MCMC	Sanction policy outlined in APL 25-007. Sanction notices to health plans are posted on the DHCS website.	Sanctions levied on MCMCs are made public by posting the sanction notices on the DHCS website.
MHP	Sanction policy outlined in BHIN 25-023	In the event sanctions are levied on an MHP, information regarding the sanctions and appropriate notices would be posted on the DHCS website.
DMC-ODS	Sanction policy outlined in BHIN 25-023	In the event sanctions are levied on a DMC-ODS Plan, information regarding the sanctions and appropriate notices would be posted on the DHCS website.
Dental MC	Sanction policy outlined in APL 22-009	Sanctions levied on Dental MCs are made public by posting the sanction notices on the DHCS website. DHCS works with the DMHC to conduct dental surveys. In the event sanctions are levied on a Dental MC plan, information regarding sanctions would be posted on the Dental MC webpage.

APPENDIX D: PERFORMANCE MEASURES

The following table summarizes performance measures collected across programs. Additional measures are also collected for ongoing monitoring and quality assurance purposes. Note: The CMS Medicare program collects several quality measures from D-SNPs, which apply to Medi-Medi Plans and SCAN in California. DHCS accesses the Medicare quality measure reporting for Medi-Medi Plans and SCAN and collects additional state-specific measures from those plans.

Managed Care Accountability Set Measurement Year 2023 (MCAS MY23)

Measure	Steward	MCO/ HIO[53]	PSP[54]	PIHP[55]	PAHP[56]	Medi-Medi Plans	Baseline Performance MY 2023	Target
Asthma Medication Ratio[57]	NCQA	X					64.28%	MPL
Breast Cancer Screening	NCQA	X	SCAN			CMS Medicare	58.00%	MPL[58]
Cervical Cancer Screening	NCQA	X					58.27%	MPL
Child and Adolescent Well-Care Visits	NCQA	X					49.50%	MPL

[53] Medi-Cal Managed Care (MCMC) are MCOs and HIOs.

[54] Population Specific Health Plans (PSPs): AIDS HealthCare Foundation (AHF), Senior Care Action Network (SCAN) and Radys Children's Hospital (Radys). Note Rady's contract with DHCS ended December 31, 2021, and was not renewed.

[55] The Specialty Mental Health Services (SMHS) Program and the DMC-ODS are PIHPs.

[56] Dental MC are PAHPs.

[57] Ibid.

[58] The MPL (minimum performance level) for MCMC plans is defined as the 50th percentile using national or state-calculated benchmarks (if national benchmarks not available) and vary from year to year as benchmarks are updated.

Measure	Steward	MCO/ HIO[53]	PSP[54]	PIHP[55]	PAHP[56]	Medi-Medi Plans	Baseline Performance MY 2023	Target
Childhood Immunization Status: Combination 10	NCQA	X					30.64%	MPL
Chlamydia Screening in Women	NCQA	X					65.79%	MPL
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)[59]	NCQA	X	AHF/ SCAN			CMS Medicare	32.94%	MPL
Controlling High Blood Pressure	NCQA	X	AHF/ SCAN			CMS Medicare	66.72%	MPL
Developmental Screening in the First Three Years of Life	OHSU	X					40.34%	MPL
Immunization for Adolescents: Combination 2	NCQA	X					41.36%	MPL

[59] In MY 2024, this measure is being replaced with "Glycemic Status Assessment for Patients with Diabetes (>9 percent)".

Measure	Steward	MCO/ HIO[53]	PSP[54]	PIHP[55]	PAHP[56]	Medi-Medi Plans	Baseline Performance MY 2023	Target
Lead Screening in Children	NCQA	X					58.46%	MPL
Prenatal and Postpartum Care: Postpartum Care	NCQA	X					82.62%	MPL
Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA	X					87.99%	MPL
Topical Fluoride for Children	DQA	X					18.17%	MPL
Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months	NCQA	X					53.56%	MPL

Measure	Steward	MCO/ HIO[53]	PSP[54]	PIHP[55]	PAHP[56]	Medi-Medi Plans	Baseline Performance MY 2023	Target
Well-Child Visits in the First 30 Months of Life – Well-Child Visits for Age 15 Months – 30 Months	NCQA	X					66.65%	MPL
Colorectal Cancer Screening	NCQA	X	AHF/ SCAN			CMS Medicare	40.46%	Reporting only
Prenatal Immunization Status	NCQA	X					27.05%	Reporting only
Adults' Access to Preventive/ Ambulatory Health Services	NCQA	X	AHF/ SCAN			DHCS	65.31%	Reporting only
Ambulatory Care: ED Visits[60]	NCQA	X					461.63	Reporting only

[60] DHCS does not set a target for this measure because it is a measure of utilization only and difficult to interpret if increased or decreased.

Measure	Steward	MCO/ HIO[53]	PSP[54]	PIHP[55]	PAHP[56]	Medi-Medi Plans	Baseline Performance MY 2023	Target
Antidepressant Medication Management: Acute Phase Treatment[61]	NCQA	X		X			73.48%	Reporting only
Antidepressant Medication Management: Continuation Phase Treatment[62]	NCQA	X		X			57.72%	Reporting only
Contraceptive Care – All Women: Most or Moderately Effective Contraception	OPA	X	AHF				Age 15-20: 11.67% Age 21-44: 20.49%	Reporting only

[61] Due to the proposed implementation date of Medi-Cal Rx on January 1, 2021, DHCS had moved this measure to" report only" for measurement year 2021. Medi-Cal Rx was ultimately pushed back to January 1, 2022.

[62] Ibid

Measure	Steward	MCO/ HIO[53]	PSP[54]	PIHP[55]	PAHP[56]	Medi-Medi Plans	Baseline Performance MY 2023	Target
Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	OPA	X					Age 15-20: 45.25% Age 21-44: 41.19%	Reporting only – no benchmark available
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[63]	NCQA	X					81.63%	Reporting Only

[63] Due to the proposed implementation date of Medi-Cal Rx on January 1, 2021, DHCS had moved this measure to" report only" for measurement year 2021. Medi-Cal Rx was ultimately pushed back to January 1, 2022.

Measure	Steward	MCO/ HIO[53]	PSP[54]	PIHP[55]	PAHP[56]	Medi-Medi Plans	Baseline Performance MY 2023	Target
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 30 days	NCQA	X	AHF/ SCAN	X			29.17%	MPL
Follow-Up After ED Visit for Mental Illness – 30 days	NCQA	X	AHF/ SCAN	X		DHCS	38.15%	MPL
Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	NCQA	X					48.99%	Reporting only

Measure	Steward	MCO/ HIO[53]	PSP[54]	PIHP[55]	PAHP[56]	Medi-Medi Plans	Baseline Performance MY 2023	Target
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	X					46.80%	Reporting only
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	X					39.78% (total rate)	Reporting Only
Low-Risk Cesarean Delivery	CMS	X					New measure for MY 2024	Reporting only
Depression Remission and Response	NCQA	X	AHF/ SCAN				44.99% (Follow-up PHQ-9), 8.94% (Remission),15.72% (Response)	Reporting only
Pharmacotherapy of Opioid Use Disorder	NCQA	X	AHF/ SCAN	x			21.34%	Reporting only
Plan All-Cause Readmissions	NCQA	X	SCAN			CMS Medicare	0.9676	Reporting only

Measure	Steward	MCO/ HIO[53]	PSP[54]	PIHP[55]	PAHP[56]	Medi-Medi Plans	Baseline Performance MY 2023	Target
Screening for Depression and Follow-up Plan	NCQA	X	AHF/ SCAN				8.78% (Screening), 71.70% (Follow-up)	Reporting only
Prenatal Depression Screening and Follow Up	NCQA	X					17.16% (Screening), 53.75% (Follow-up)	Reporting only
Postpartum Depression Screening and Follow Up	NCQA	X					13.11% (Screening), 71.13% (Follow-up)	Reporting only

Behavioral Health Accountability Set Measurement Year 2023 (BHAS MY23)

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Follow-Up After ED Visit for Mental Illness – 7 days	NCQA	X	AHF/ SCAN	X			38.09%	Reporting only (PIHP)
Follow-Up After ED Visit for Mental Illness – 30 days	NCQA	X	AHF/ SCAN	X			52.36%	Reporting only (PIHP)
Follow-Up After Hospitalization for Mental Illness – 7 days	NCQA			X			41.94%	Reporting only (PIHP)
Follow-Up After Hospitalization for Mental Illness – 30 days	NCQA		SCAN	X		CMS Medicare	64.35%	Reporting only (PIHP)
Antidepressant Medication Management: Acute Phase Treatment	NCQA	X		X		CMS Medicare	58.42%	Reporting only (PIHP)

[64] These represent California state averages across Behavioral Health Plans (BHPs).

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Antidepressant Medication Management: Continuation Phase Treatment	NCQA	X		X			33.97%	Reporting only (PIHP)
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	X		X			61.60%	Reporting only (PIHP)
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA			X			63.20%	Reporting only (PIHP)
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 7 days	NCQA	X	AHF/ SCAN	X			18.85%	Reporting only (PIHP)

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 30 days	NCQA	X	AHF/ SCAN	X			27.65%	Reporting only (PIHP)
Pharmacotherapy of Opioid Use Disorder	NCQA	X	AHF/ SCAN	X			13.24%	Reporting only (PIHP)
Use of Pharmacotherapy for Opioid Use Disorder	CMS			X			60.46%	Reporting only (PIHP)
Initiation and Engagement of SUD Treatment- Initiation	NCQA		SCAN	X		CMS Medicare	16.32%	Reporting only (PIHP)
Initiation and Engagement of SUD Treatment- Engagement	NCQA			X			6.58%	Reporting only (PIHP)

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Received five or more SMHS visits: proportion of members eligible for SMHS who received five or more SMHS visits				X			Youth: 196,130, 2.8% Adults: 216,331, 2.7%	No MPL exists; targets in development
Time between Inpatients Discharge and Step Down Service				X			Youth: 10.3 days Adults: 15.4 days	No MPL exists; targets in development
Median Time Adult Residential Treatment Services Utilized (Adults)				X			103.4 Days	No MPL exists; targets in development
Median Time Case Management/Brokerage Utilized (Adults)				X			431.1 Minutes	No MPL exists; targets in development
Median Time Crisis Intervention Utilized (Adults)				X			219.6 Minutes	No MPL exists; targets in development

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Median Time Crisis Residential Treatment Services Utilized (Adults)				X			21 Days	No MPL exists; targets in development
Median Time Crisis Stabilization Utilized (Adults)				X			24.1 Hours	No MPL exists; targets in development
Median Time FFS Inpatient Utilized (Adults)				X			9.2 Days	No MPL exists; targets in development
Median Time Full-Day Rehabilitation Utilized (Adults)				X			149.9 Hours	No MPL exists; targets in development
Median Time Full-Day Treatment Intensive Utilized (Adults)				X			126.3 Hours	No MPL exists; targets in development
Median Time Intensive Care Coordination Utilized (Adults)				X			331.8 Minutes	No MPL exists; targets in development

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Median Time Intensive Home-Based Services Utilized (Adults)				X			835.2 Minutes	No MPL exists; targets in development
Median Time Inpatient Administrative Utilized (Adults)				X			15.4 Minutes	No MPL exists; targets in development
Median Time Medication Support Services Utilized (Adults)				X			282.9 Minutes	No MPL exists; targets in development
Median Time Mental Health Services Utilized (Adults)				X			741.6 Minutes	No MPL exists; targets in development
Median Time Psychiatric Health Facility Utilized (Adults)				X			12.9 Days	No MPL exists; targets in development

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Median Time Short Doyle/Medi-Cal Hospital Inpatient Utilized (Adults)				X			5.6 Days	No MPL exists; targets in development
Median Time Therapeutic Behavioral Services Utilized (Adults)				X			2,194.6 Minutes	No MPL exists; targets in development
General Satisfaction (Youth and Adult Surveys)				X			Youth 4.2% Adults 4.4%	Reporting only
Perception of Participation in Treatment Planning (Youth and Adult Surveys)				X			Youth 4.1% Adults 4.3%	Reporting only
Perception of Access (Youth and Adult Surveys)				X			Youth 4% Adults 4.3%	Reporting only

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Perception of Cultural Sensitivity (Youth and Adult Surveys)				X			Youth 4.2% Adults 4.3%	Reporting only
Perception of Quality and Appropriateness (Adult Surveys)				X			Adults 4.3%	Reporting only
Perception of Outcomes of Services (Youth and Adult Surveys)				X			Youth 3.8% Adults 3.9%	Reporting only
Perception of Functioning (Youth and Adult Surveys)				X			Youth 3.9% Adults 3.9%	Reporting only
Perception of Social Connectedness (Youth and Adult Surveys)				X			Youth 4.1% Adults 3.9%	Reporting only
AMB-ED (MLTSSPs)	NCQA			X			40.36%	Reporting only

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
PCR (MLTSSPs)	NCQA			X			0.969	Reporting only
Follow-Up After ED Visit for Mental Illness – 7 days	NCQA			X			NA	First year baseline reporting followed by 5% increase per year or >MPL
Follow-Up After Hospitalization for Mental Illness – 30 days	NCQA			X			NA	First year baseline reporting followed by 5% increase per year or >MPL
Antidepressant Medication Management	NCQA			X			NA	First year baseline reporting followed by 5% increase per year or >MPL
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA			X			NA	First year baseline reporting followed by 5% increase per year or >MPL

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA			X			NA	First year baseline reporting followed by 5% increase per year or >MPL
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	NCQA			X			NA	First year baseline reporting followed by 5% increase per year or >MPL
Pharmacotherapy of Opioid Use Disorder	NCQA			X			NA	First year baseline reporting followed by 5% increase per year or >MPL
Use of Pharmacotherapy for Opioid Use Disorder	CMS			X			NA	First year baseline reporting followed by 5% increase per year or >MPL

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[64]	Target
Initiation and Engagement of SUD – Treatment	NCQA			X			NA	First year baseline reporting followed by 5% increase per year or >MPL
Number of children and adults that received SMHS[65]				X			Youth: 259,159 Adults: 338,324	No MPL exists; targets in development
Received one or more SMHS visits: proportion of members eligible for SMHS who received one or more SMHS visits				X			Youth: 259,159, 4% Adults: 338,324, 4.2%	No MPL exists; targets in development

[65] The behavioral health measures were created through the work of the Performance Outcomes System/Performance Dashboards (POS) as mandated by Welfare and Institutions Code - WIC § 14707.5 and are new, so there is no research with which to compare them.

Dental Managed Care Performance Measures

Measure	Steward	MCO/ HIO[42]	PSP[43]	PIHP[44]	PAHP[45]	Medi-Medi Plans	Baseline Performance MY 2023[66]	Target
Use of Preventive Services: Children (0 – 20)					**X**		**Rates by Plan:** Access GMC Plan: **25%** Access PHP: **37.39%** Health Net GMC: **39.32%** Health Net PHP: **32.75%** Liberty GMC: **41.2%** Liberty PHP: **35.97%**	**Targets by Plan: 3.33% absolute increase per plan per year**

[66] These represent California state averages across Behavioral Health Plans (BHPs).

Use of Preventive Services: Adults (21+)	**NA**				**X**		**Rates by Plan:** Access GMC Plan: **10.64%** Access PHP: **11.98%** Health Net GMC: **13.92%** Health Net PHP: **13.42%** Liberty GMC: **14.28%** Liberty PHP: **14.53%**	**Targets by Plan: 3.33% absolute increase per plan per year**

Measure	Steward	MCO/ HIO	PSP	PIHP	PAHP	Medi-Medi Plans	Baseline Performance MY 2023	Target
Annual Dental Visit: Children (0-20)					X		Rates by Plan: **Access GMC Plan:** 31.8% **Access PHP:** 42.22% **Health Net GMC:** 43.94% **Health Net PHP:** 37.65% **Liberty GMC:** 48.06% **Liberty PHP:** 41.12%	Targets by Plan: 3.33% increase per plan per year

Measure	Steward	MCO/ HIO	PSP	PIHP	PAHP	Medi-Medi Plans	Baseline Performance MY 2023	Target
Annual Dental Visit: Adult (21+)					X		Rates by Plan: **Access GMC Plan:** 21.07% **Access PHP:** 22.31% **Health Net GMC:** 23.47% **Health Net PHP:** 23.75% **Liberty GMC:** 24.66% **Liberty PHP:** 24.55%	Targets by Plan: 3.33% increase per plan per year

Measure	Steward	MCO/ HIO	PSP	PIHP	PAHP	Medi-Medi Plans	Baseline Performance MY 2023	Target
Use of Sealants (6-9)					X		Rates by Plan: **Access GMC Plan:** 8.76% **Access PHP:** 17.07% **Health Net GMC:** 12.98% **Health Net PHP:** 13.67% **Liberty GMC:** 11.84% **Liberty PHP:** 14.31%	Targets by Plan: 3.33% increase per plan per year

Measure	Steward	MCO/ HIO	PSP	PIHP	PAHP	Medi-Medi Plans	Baseline Performance MY 2023	Target
Use of Sealants (10-14)					X		Rates by Plan: **Access GMC Plan:** 5.87% **Access PHP:** 10.33% **Health Net GMC:** 7.74% **Health Net PHP:** 8.39% **Liberty GMC:** 7.55% **Liberty PHP:** 8.02%	Targets by Plan: 3.33% increase per plan per year
Caries Risk Documentation and Education Bundle (0-6)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*

Measure	Steward	MCO/ HIO	PSP	PIHP	PAHP	Medi-Medi Plans	Baseline Performance MY 2023	Target
Fluoride Applications within Reporting Year in Dental Office (0-20)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*
Fluoride Applications within Reporting Year in Medical Office (Not Weighted) (0-20)							New Measure in 2025	Reporting only
Dental Office Follow-Up Following Medical Fluoride Application (0-20)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*

Measure	Steward	MCO/ HIO	PSP	PIHP	PAHP	Medi-Medi Plans	Baseline Performance MY 2023	Target
Care Continuity Same Office for Two or More Consecutive Years (0-20)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*
Emergency Visits (Under Threshold) (0-20)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*
Emergency Visits Follow Up Services (0-20)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*
Care Continuity Same Office for Two or More Consecutive Years (21+)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*
Emergency Visits (Under Threshold) (21+)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*

Measure	Steward	MCO/ HIO	PSP	PIHP	PAHP	Medi-Medi Plans	Baseline Performance MY 2023	Target
Emergency Visits Follow Up Services (21+)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*
At Least One Fluoride Application within Reporting Year (21+)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*
Primary Care Provider's Office Follow-Up Services (21+)					X		New measure in 2025. Baseline will be determined in 2026*	Target increase will be determined in 2026*
Treatment/ Prevention of Caries					X			Reporting only**
Exams/Oral Health Evaluations					X			Reporting only**

Measure	Steward	MCO/ HIO	PSP	PIHP	PAHP	Medi-Medi Plans	Baseline Performance MY 2023	Target
Use of Dental Treatment Services					X			Reporting only**
Preventive Services to Fillings Ratio					X			Reporting only**
Overall Utilization of Dental Services (one year)					X			Reporting only**
Usual Source of Care					X			Reporting only**
General Anesthesia					X			Reporting only**
Sealant to Restoration Ratio (Surface) 6-14					X			Reporting only**

Measure	Steward	MCO/ HIO	PSP	PIHP	PAHP	Medi-Medi Plans	Baseline Performance MY 2023	Target
*A new Den Managed Care contract with three Dental MC plans, including a new plan, will be effective July 01, 2025. Baseline Perormance Measures and Target increases will be established beginning in MY 2026 and provided to the Plans via AP. **Some Perrmance Measures are collected for reporting purposes only because there is not a way to develop an actuarily sond baseline measure. These measures are specific to unique situations and not universally available or medically ncessary services.								

APPENDIX E:
EVALUATION REPORT FOR THE 2022-24 COMPREHENSIVE QUALITY STRATEGY

December 2025

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EXECUTIVE SUMMARY

The Department of Health Care Services (DHCS) developed the 2022 Comprehensive Quality Strategy (CQS) to advance health equity and improve healthcare delivery across California. The 2022 CQS report outlined multifaceted aims across DHCS to strengthen clinical outcomes, eliminate healthcare inequities, promote continuous quality improvement, and ensure compliance across Medi-Cal health plans. To target three key clinical focus areas of children's preventive care, birth equity, and behavioral health—guided by three core frameworks (Health Equity Roadmap, Value-Based Payment Roadmap, and Population Health Framework)—DHCS identified the root causes of healthcare inequities and sought to elevate the performance of healthcare services for Medi-Cal members.

Using a mixed methods approach, this evaluation provides an overview of DHCS activities since the release of the 2022-24 CQS and its progress on key DHCS initiatives and priority measures. The initial sections examine quantitative outcomes of clinical measures, namely, those listed in the 2025 DHCS Bold Goals and the 2023-2024 Medi-Cal Managed Care Accountability Set (MCAS), comparing changes in rates from baseline in measurement year (MY) 2021 to the most recent data in MY 2023. The next section focuses on qualitative advancements towards meeting the CQS criteria. It highlights key programmatic revisions that were tied to the Health Equity Framework, as well as initiatives related to value-based payments (VBP) and population health.

Key findings revealed that more than half of the MCAS measures showed significant improvement since the baseline year. Measures with a fixed target rate demonstrated greater improvement than those focused on reporting only, suggesting that defined benchmarks and associated sanctions, if benchmarks were not met, generally encouraged measure progress. Notable initiatives, such as the DHCS Health Equity Roadmap Listening Tour, value-based incentive programs, and the implementation of a Population Health Management program, played critical roles in achieving the 2022 CQS objectives. Revisions to Medi-Cal data collection methods, including enhanced collection of Medi-Cal member demographic information, were also key components of the strategy.

The Bold Goals were five specific quality improvement targets set as a part of the 2022 CQS to improve health care quality and equity in Medi-Cal by 2025. The five goals included: (1) reduce racial and ethnic disparities in well-child visits and immunizations by 50% with respect to statewide performance, (2) close maternity care disparities for Black

and Native American persons by half with respect to statewide performance, (3) improve maternal and adolescent depression screening by 50%, (4) improve follow-up for mental health and substance use disorder (SUD) by 50%, and (5) ensure all health plans exceed the 50th percentile for all children's preventive care measures.

More than half of the underlying outcome measures within three of the five Bold Goals (Goals 1,2, and 3) were already achieved or showed improvements between 2021 and 2023. The largest improvement was reducing the gaps in access inequity for Native Hawaiian or other Pacific Islander members in the first 15 months of life to receive well-child visits, with a 24% increase between MY 2021 to MY 2023. Two of the five outcomes measured for Bold Goal 4 showed improvement over time, two outcomes did not demonstrate any change, and one outcome decreased over time. Roughly 33% of unique county-MCP combinations met the Bold Goal 5 in MY 2023.

It is worth noting that some measures used a hybrid technique in MY 2022 and switched to the administrative method in MY 2023, leading to bigger denominators than in prior years. As a result, compared to MY 2021 and MY 2022, some measures, including childhood immunization status, had much larger sample sizes in MY 2023. Due to the differences in the data collection methodologies between those periods, the rates for those measures are not comparable with the MY 2023 data. Despite data limitations, improvements in all Bold Goals are needed to meet target rates with key opportunity areas for the CQS 2025 in Bold Goals 4 and 5.

In summary, the updates since the 2022 CQS reflect meaningful progress toward the vision outlined by DHCS. At the halfway point of its implementation period, the strategy has supported major achievements while offering valuable insights for future improvements.

QUALITY PERFORMANCE

The Medi-Cal Accountability Set (MCAS) for health care delivery systems is a collection of performance measures chosen by DHCS to assess the quality of service delivery across Medi-Cal managed care plans (MCPs). Many of these measures are reflective of Centers for Medicare & Medicaid Services Adult and Child Core Set measures (CMS Core Set). Each year, MCPs also report their performance on MCAS measures through the External Quality Review process.

Beginning in 2022, DHCS introduced significant changes to MCP requirements to enhance performance improvement and strengthen accountability. DHCS established clear, equity-focused benchmarks known as Bold Goals. These targets were designed to reduce racial and ethnic disparities in care, with a particular focus on birth equity and children's preventive health. DHCS required MCPs to build and execute quality improvement plans to work towards these targets, and the quality improvement team at DHCS coached MCPs on this work and facilitated exchange of relevant regional and statewide best practices to advance quality performance improvement.

In addition, DHCS implemented a more robust accountability framework. MCPs are now held accountable to meet specific performance targets on a defined subset of MCAS measures. If plans fail to meet these benchmarks, they may face corrective action plans and/or sanctions.

The new measures introduced in MY 2022 and stratification guidelines aimed to increase MCP accountability for improving health outcomes and quality of care, particularly among Medi-Cal subpopulations facing inequities in preventive health outcomes and primary care. The MCAS measures fall under various health domains including children's health, chronic disease management, behavioral health outcomes, and birth equity. These measures are assessed annually to inform MCPs of priority outcomes and reporting requirements for that year. DHCS has also aimed to preserve some degree of consistency in these measures, so that they are able to effectively highlight trends over time, hold plans accountable and provide useful information about DHCS initiatives.

The analysis of the MCAS reporting year (RY) is an evaluation of the data collected during the preceding MY. This section focuses on the most recent reporting year, RY 2024, which corresponds to data from MY 2023. Baseline findings from MY 2021 are included, along with an analysis of measures introduced in MY 2022. For measures with available data, trends between MY 2021 and MY 2023 were examined.

Supplementary Table S1 of this evaluation provides a detailed crosswalk of all the measures that were listed in both the 2022 CQS Appendix D and MY 2023 MCAS reports. A condensed version of the crosswalk results is displayed in Table1 of this evaluation, which summarizes the number of measures that appeared in the 2022 CQS, the 2023 MCAS reports, and both publications. The purpose of comparing measures from these sources was to demonstrate how the CQS strategy aimed to maintain a relatively consistent set of measures related to managed care accountability. Most measures that were included in the MY 2023 MCAS aligned with those that were found in Appendix D of the CQS report for 2022.

The 2022 CQS listed a total of 112 measures, with 37 of the measures overlapping with those highlighted in the 2023 MCAS report. The remaining measures included those used in the Behavioral Health Accountability Set (BHAS), the now-sunset Cal Medi-Connect initiative, and other programs offered by AIDS Healthcare Foundation (AHF) and Senior Care Action Network (SCAN). The MCAS report had a total of 42 measures. Only five MCAS measures were not part of the 2022 CQS: Follow-Up After ED Visit for Mental Illness – 7 days (FUM_7), Follow-Up After ED Visit for Substance Use – 7 days (FUA_7), Number of Outpatient ED Visits per 1,000 Long Stay Resident Days (HFS), Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization (SNF_HAI), and Potentially Preventable 30-day Post-Discharge Readmission (PPR). Two behavioral health measures, FUM_30 and FUA_30, were measures similar to FUM_7 and FUA_7 that were included in both reports but measured the same outcome for follow-ups of 30 days instead of seven days. All 18 measures that aligned with the 2025 CalAIM Bold Goals were included in the CQS and the MCAS reports.

Table 1: Crosswalk of measures available in the 2021-2023 Medi-Cal Accountability Sets (MCAS) and the 2022 Comprehensive Quality Strategy (CQS) Appendix D.

Number of measures listed in the 2022 CQS report	Number of measures listed in the MY 2023 MCAS report	Number of measures that overlap between the 2022 CQS and MY 2023 MCAS reports	Number of 2025 Bold Goals measures
112	42	37	18

Not all measures had data available from MY 2021 (the baseline year) through MY 2023 (the most current year with available data). In MY 2022, DHCS updated reporting requirements to incorporate 18 new measures into the MCAS dataset.

Tracking the progress of the MCAS rates

Overview of MCAS measures

Table 2 illustrates the rates and trends from MY 2021 through MY 2023 for the MCAS measures. Some targets were determined by the California State Minimum Performance Level (MPL) or High-Performance Level (HPL). DHCS establishes a MPL on performance measures based on the national Medicaid median—National Committee for Quality Assurance's (NCQA) Medicaid 50th percentile for Healthcare Effectiveness Data and Information Set (HEDIS) measures and the CMS 50th percentile for non-HEDIS measures. The MPL represents a quality standard that MCPs are required to meet or exceed, while the HPL, set at the 90th percentile nationally, is the ultimate quality goal for all contracted MCPs. A total of 50 measures is presented in Table 2, including subsets of composite measures (such as blood glucose testing, cholesterol testing, and a combined measure for blood glucose and cholesterol testing) and 16 measures from the 2025 Bold Goals.

Only 18 out of the 50 measures in Table 2 had specific MPL targets set for all three measurement years. The MPL and percentiles of those measure rates across the reporting units are available in Table 3. The remaining 32 measures that had no specific target were reported only, which meant that MCPs were required by DHCS to track outcomes for those measures but were not held to meet certain MPL thresholds. Other measures, such as ambulatory care, were exempt from meeting DHCS target requirements because an increase or decrease in this type of health care utilization does

not accurately reflect improvements or enhanced quality of care for this outcome. Lastly, 18 new measures were introduced in MY 2022, and therefore, did not have baseline data during MY 2021.

Findings from MY 2023

Most measure rates improved between the baseline year and their most current measurement years. Out of the 50 measures, 41 exhibited statistically significant improvements ($p<0.01$), whereas eight had statistically significant rate reductions (in measures where a rate decrease suggests a decline in progress). The remaining measures revealed no substantial change in rates between their respective baselines and the most recent measurement year. Measures with targets held to MPL showed a generally better rate of improvement than the measures under the reporting only requirement. This difference might suggest that measures with set benchmarks and associated sanctions, if benchmarks were not met, generally supported better progress toward measure improvement than reporting only measures with no specified targets.

Of the 18 measures held to the MPL, 16 of them demonstrated a significant increase ($p<0.01$) during that timeframe (89%). Among the reporting only measures, 16 of the 32 measures (50%) had significantly higher rates during the most recent measurement year than at baseline. Measures, such as well-child visits, birth equity, cancer screenings, antidepressant medication management, and most types of depression screenings (adult/adolescent, prenatal, postpartum) represented clinical areas that exhibited the greatest rate increases. Conversely, the measures that had the largest rate reductions included metabolic monitoring for children on antipsychotics and contraceptive care for all women of reproductive age. Childhood immunization status demonstrated the largest decline from 36.6% in MY 2021 to 30.6% in MY 2023. During this same period, the national median for the childhood immunization status declined from 32.9% to 28.6% between MY 2021 and MY 2022. The shift in the reporting requirements from a

hybrid reporting approach[67] in MY 2021 to an administrative[68] or hybrid approach in MY 2022 dramatically boosted response rates for that measure and several others, including controlling high blood pressure and cervical cancer screenings. However, these methodological changes resulted in less reliable data comparisons with the baseline year. For example, the additional use of the administrative approach increased response rates in MY 2022 by adding auditor-approved supplemental data sources to estimate the numerator (i.e., services provided to members in the eligible population). This equates to a larger numerator and consequently a lower measure rate that may be attributed partly to the change in measures.

[67] *Method which requires that MCPs identify the eligible population using administrative data, then extract a systematic sample of members from the eligible population, which becomes the denominator. MCPs use administrative data to identify services provided to these members. When administrative data do not show evidence that MCPs provided the service, MCPs review medical records for those members to derive the numerator.*

[68] *Method which requires that MCPs identify the eligible population (i.e., the denominator) using administrative data such as enrollment, claims, and encounters. Additionally, MCPs derive the numerator (services provided to members in the eligible population) from administrative data sources and auditor-approved supplemental data sources. MCPs may not use medical records to retrieve information. When using the administrative method, MCPs use the entire eligible population as the denominator.*

Table 2. Statewide MCAS measures, rates, and targets* by measurement year (MY)

Measure name	MY 2021 Rats %	MY 2022 Rate %	MY 2023 Rats %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Behavioral Health Domain Measures					
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	34.77% MPL: N/A HPL: N/A	46.81% MPL: 54.51% HPL: 72.01%	38.15% MPL: 54.87% HPL: 73.26%	+3.38	<0.001
Follow-Up After Emergency Department Visit for Substance Abuse—30-Day Follow-Up***	8.56%[+] MPL: N/A HPL: N/A	28.61% MPL: 21.24% HPL: 32.38%	29.17% MPL: 36.34% HPL: 53.44%	+20.61	<0.001
Children's Health Domain Measures					
Child and Adolescent Well-Care Visits***	47.51% MPL: 45.31% HPL: 61.97%	47.02% MPL: 48.93% HPL: 62.70%	49.50% MPL: 48.07% HPL: 61.15%	+1.99	<0.001

Measure name	MY 2021 Rates %	MY 2022 Rate %	MY 2023 Rats %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Children's Health Domain Measures					
Childhood Immunization Status—Combination 10***	36.63% MPL: 38.20% HPL: 53.66%	34.69% MPL: 34.79% HPL: 49.76%	30.64% MPL: 30.90% HPL: 45.26%	-5.99	<0.001
Developmental Screening in the First Three Years of Life**	28.83% MPL: N/A HPL: N/A	32.33% MPL: N/A HPL: N/A	40.34% MPL: 34.70% HPL: N/A	+11.51	<0.001
Immunizations for Adolescents—Combination 2***	39.23% MPL: 36.74% HPL: 50.61%	39.97% MPL: 35.04% HPL: 48.42%	41.36% MPL: 34.31% HPL: 48.80%	+2.13	<0.001
Lead Screening in Children***	New measure fo MY 2022	54.57% MPL: 63.99% HPL: 79.57%	58.46% MPL: 62.79% HPL: 79.26%	+3.89	<0.001

Measure name	MY 2021 Rates %	MY 2022 Rate %	MY 2023 Rats %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Children's Health Domain Measures					
Topical Fluoride for Children—Dental or Oral Health Services***	New measure fo MY 2022	9.75% MPL: N/A HPL: N/A	18.17% MPL:19.30% HPL: N/A	+8.42	<0.001
Topical Fluoride for Children—Dental Servic	New measure fo MY 2022	7.42%	12.56%	+5.14	<0.001
Topical Fluoride for Children—Oral Health Services	New measure fo MY 2022	0.57%	0.70%	+0.13	<0.001
Well-Child Visits in the Firt 15 Months—Six or More Well-Child Visits***	40.23% MPL: 54.92% HPL: 68.33%	49.56% MPL: 55.72% HPL: 67.56%	53.56% MPL: 58.38% HPL: 68.09%	+13.33	<0.001

Measure name	MY 2021 Rats %	MY 2022 Rate %	MY 2023 Rats %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Children's Health Domain Measures					
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits***	60.28% MPL: 70.67% HPL: 82.82%	64.33% MPL: 65.83% HPL: 78.07%	66.65% MPL: 66.76% HPL: 77.78%	+6.37	<0.001
Chronic Disease Management Domain Measures					
Asthma Medication Ratio	65.04% MPL: N/A HPL: N/A	67.43% MPL: N/A HPL: N/A	64.28% MPL: 65.61% HPL: 75.92%	-0.76	<0.001
Controlling High Blood Pressure	60.25% MPL: 55.35% HPL: 66.79%	62.93% MPL: 59.85% HPL: 69.19%	66.72% MPL: 61.31% HPL: 72.22%	+6.47	<0.001

Measure name	MY 2021 Rats %	MY 2022 Rates %	MY 2023 Rats %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Chronic Disease Management Domain Measures					
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes—HbA1c Poor Control (>9.0 Percent). ***Lower rates suggest better outcomes.***	37.50% MPL: 43.19% HPL: 34.06%	35.60% MPL: 39.90% HPL: 30.90%	32.94% MPL: 37.96% HPL: 29.44%	-4.56	<0.001
Reproductive Health Domain Measures					
Chlamydia Screening in Women***	63.61% MPL: 54.91 HPL: 66.15	63.56% MPL: 55.32% HPL: 67.84%	65.79% MPL: 56.04% HPL: 67.39%	+2.18	<0.001
Prenatal and Postpartum Care—Postpartum Care***	81.39% MPL: 76.40% HPL: 83.70%	81.90% MPL: 77.378.10% HPL: 84.18%	82.62% MPL: 78.10% HPL: 84.59%	+1.23	<0.001

Measure name	MY 2021 Rats %	MY 2022 Rate %	MY 2023 Rats %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Reproductive Health Domain Measures					
Prenatal and Postpartum Care—Timeliness of Prenatal Care***	87.57% MPL: 85.89% HPL: 92.21%	88.55% MPL: 85.40% HPL: 91.89%	87.99% MPL: 84.23% HPL: 91.07%	+0.42	<0.001
Cancer Prevention Domain Measures					
Breast Cancer Screening	53.99% MPL: 53.93% HPL: 63.77%	55.73% MPL: 50.95 HPL: 61.27	58.00% MPL: 52.60% HPL: 62.67%	+4.01	<0.001
Cervical Cancer Screenin	58.18% MPL: 59.12% HPL: 67.99%	56.80% MPL: 57.64% HPL: 66.88%	58.27% MPL: 57.11% HPL: 66.48%	+0.09	0.042

Measure name	MY 2021 Rates %	MY 2022 Rtes %	MY 2023 Rtes %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Report Only Measures to DHCS					
Adults' Access to Preventive/Ambulatory Health Services	New measure fo MY 2022	64.43%	65.31%	+0.88	<0.001
Ambulatory Care—Emergency Departmen (ED) Visits per 1,000 Member Months (Total)	N/A	458.06	461.63	N/A	N/A
Antidepressant Medicatin Management—Effectiv Acute Phase Treatmen	65.15%	66.10%	73.48%	+8.33	<0.001
Antidepressant Medicatin Management—Effectiv Continuation Phase Treatment	48.52%	49.52%	57.72%	+9.20	<0.001

Measure name	MY 2021 Rates %	MY 2022 Rates %	MY 2023 Rates %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Report Only Measures to DHCS					
Colorectal Cancer Screening	New measure fo MY 2022	36.72%	40.46%	+3.74	<0.001
Contraceptive Care—All Women ages 15-44 yes : Most or Moderatel Effective Contraceptio	Age 15-20 years 13.89% Age 21-44 years 23.21%	Age 15-20 years: 12.69% Age 21-44 years: 21.22%	Age 15-20 years: 11.67% Age 21-44 years: 20.49%	Age 15-20 years: -2.22 Age 21-44 years: -2.72	Age 15-20 years: <0.001 Age 21-44 years: <0.001
Contraceptive Care—Postpartum Women: Mst or Moderately Effectie Contraception (60 Day , Ages 15-20 years)	35.88%	33.31%	45.25%	+9.37	<0.001

Measure name	MY 2021 Rates %	MY 2022 Rtes %	MY 2023 Rtes %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Report Only Measures to DHCS					
Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception (60 Days, Ages 21-44 years)	35.18%	33.51%	41.19%	+6.01	<0.001
Depression Remission or Response for Adolescents and Adults—Depression Remission	New measure fo MY 2022	7.50%	8.94%	+1.44	<0.001
Depression Remission or Response for Adolescents and Adults—Depression Response	New measure fo MY 2022	13.40%	15.72%	+2.32	<0.001

Measure name	MY 2021 Rates %	MY 2022 Rtes %	MY 2023 Rtes %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Report Only Measures to DHCS					
Depression Remission or Response for Adolescents and Adults—Follow–Up PHQ–9	New measure fo MY 2022	40.44%	44.99%	+4.55	<0.001
Depression Screening and Follow–Up for Adolescents and Adults—Depression Screening***	New measure fo MY 2022	3.74%	8.78%	+5.04	<0.001
Depression Screening and Follow–Up for Adolescents and Adults—Follow–Up on Positive Screen***	New measure fo MY 2022	72.40%	71.70%	-0.70	0.007

Measure name	MY 2021 Rtes %	MY 2022 Rtes %	MY 2023 Rtes %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Report Only Measures to DHCS					
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.89%	78.62%	81.63%	+1.74	<0.001
Follow-Up After Emergenc Department Visit for Substance Abuse—7-Day Follow-Up	4.86%+	18.36%	18.96%	+14.10	<0.001
Follow-Up After Emergenc Department Visit for Mental Illness—7-Day Follow-Up	23.25%	33.57%	25.33%	+2.08	<0.001

Measure name	MY 2021 Rtes %	MY 2022 Rtes %	MY 2023 Rtes %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Report Only Measures to DHCS					
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	49.35%	52.39%	48.99%	-0.36	0.721
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication—Initiation Phase	42.14%	47.13%	46.80%	+4.66	<0.001
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	43.98%	39.39%	39.78%	-4.20	<0.001

Measure name	MY 2021 Rates %	MY 2022 Rtes %	MY 2023 Rtes %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Report Only Measures to DHCS					
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing	62.61%	59.76%	60.04%	-2.57	<0.001
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing	45.33%	40.56%	40.89%	-4.44	<0.001
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate [NSTV CB]	New measure fo MY 2022	N/A	N/A	N/A	N/A

Measure name	MY 2021 Rates %	MY 2022 Rtes %	MY 2023 Rtes %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Report Only Measures to DHCS					
Pharmacotherapy for Opioid Use Disorder	New measure fo MY 2022	21.60%	21.34%	-0.26	0.514
Plan All-Cause Readmissions—Observe Readmission Rate—To	9.19%	9.05%	9.23%	+0.04	0.628
Postpartum Depressio Screening and Follow Up Depression Screening**	New measure fo MY 2022	7.44%	13.11%	+5.67	<0.001
Postpartum Depressio Screening and Follow Up Follow–Up on Positive Screen	New measure fo MY 2022	71.48%	71.13%	-0.35	0.807
Prenatal Depression Screening and Follow Up Depression Screening**	New measure fo MY 2022	10.39%	17.16%	+6.77	<0.001

Measure name	MY 2021 Rates %	MY 2022 Rtes %	MY 2023 Rtes %	Change in rate from MY 2021 to MY 2023** *Dark blue = Statistically significant performance increase at p<0.01* *Orange= Statistically significant performance decline at p<0.01*	
				+/-	p-value
Report Only Measures to DHCS					
Prenatal Depression Screening and Follow Up—Follow–Up on Positive Screen	New measure fo MY 2022	51.12%	53.75%	+2.63	0.075
Prenatal Immunization Status—Combination (Influenza and Tdap)	New measure fo MY 2022	26.73%	27.05%	+0.32	0.080

Note: In 2023, the following measures met MY 2025 targets: Child and adolescent well-care visits; developmental screening in the first three years of life; immunizations for adolescents—Combination 2; controlling high blood pressure; chlamydia screening in women; prenatal and postpartum care—postpartum care; prenatal and postpartum care—timeliness of prenatal care; breast cancer screening; and cervical cancer screening.

*MY 2025 targets are based on the California State Minimum Performance Level (MPL) or High-Performance Level (HPL). The MPL and HPL are determined using the 50th and 90th percentile methodologies defined by NCQA. The breast cancer screening measure is based on the MPL/HPL from 2022, whereas the developmental screening and topical fluoride measures are based on the Centers for Medicare & Medicaid Services (CMS) Federal Fiscal Year averages in 2022; no HPL

is available for developmental screening and topical fluoride. Asthma Medication Ratio was reported only in MY 2021 and 2022 and changed to MPL in MY 2023.
** Changes between rates were calculated between MY 2021 and MY 2022 if the data from MY 2023 were not available. Similarly, if no baseline data were available in MY 2021, the differences were calculated between MY 2022 and MY 2023. Chi-squared tests and T-tests were used for significance testing.
*** Measure is part of the 2025 Bold Goals. Bold Goals targets vary by initiative aims and stratification of outcomes (see Table 4 and Table 5).
[+] FUA-30 Day and FUA-7 Day rates for MY 2021 were defined as "Follow up after ED visit for alcohol and other drug abuse or dependence." This terminology changed to "substance use" in MY 2022 and MY 2023.

Several MCAS measures overlapped with measures listed in the Behavioral Health Accountability Set (BHAS). The BHAS measures are selected by DHCS for annual reporting by County Behavioral Health Plans (BHPs), which include County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) plans. This intentional overlap is designed to drive coordination across Medi-Cal managed care and county behavioral health systems on a key clinical priority identified in the CQS to advance member-centered behavioral health. It reflects DHCS's use of multiple levers across delivery systems to promote a seamless and accountable continuum of care. Table 3 shows a list of the measures required by BHPs as of 2025. Their corresponding rates are also shown using statewide data from the CMS Core Set. The CMS Core Set is made up of standardized health quality measures provided to CMS by states, including behavioral health measures that align with BHAS. CMS Core Set data was presented in Table 3, since it was the only data source that was validated and publicly available for those behavioral health measures during MY 2021, MY 2022, and MY 2023 (apart from the MCAS rates listed in Table 2).

In general, about half of the behavioral health measures showed a decline in their rates between MY 2021 and MY 2022. The measure, "initiation of substance use disorder treatment" (IET) demonstrated the largest rate reduction from 35.7% to 19.8%, whereas "follow-up visits after emergency department visits for substance use disorder" (FUA) showed the largest improvement from 15.5% to 31.1%. Between MY 2022 and MY 2023, five out of eight behavioral health measures showed a statistically significant decline in their rates. The largest rate reduction, from 73.7% to 58.0%, occurred in the measure, "follow-up after hospitalization for mental illness" (FUH). During the same period, the largest improvement occurred in IET. The improvement in the IET initiation rate from 19.8% to 36.5% between MY 2022 and MY 2023, returned MY 2023 rates beyond the rate in MY 2021.

The 2021-2022 CMS Core Set data showed trends that differed from the same behavioral health measures included in the 2021-2023 MCAS (for instance, the FUM variable showed a statistically significant improvement by 3.4 percentage points between 2021 and 2023 in the MCAS data). The measure rates varied between these data sets due to multiple factors, including data reporting issues related to Behavioral Health (BH) Payment Reform for MY23 rates. In brief, the BH Payment Reform moved from a cost-based to a rate-based reimbursement approach to support improved quality reporting and future alternative payment models. The transition involved a change to Current Procedural Terminology (CPT) coding, in which providers now use more detailed and nationally standardized codes that better align with CMS

requirements for Medicaid programs. In turn, the BH Payment Reform significantly improves the accuracy and granularity of data starting with MY 23.

Table 3. Measures from the 2025 Behavioral Health Accountability Set (BHAS) with rates from the CMS Adult and Child Core Set, MY 2021-2023

BHAS Measure	County Behavioral Health Plan with reporting requirement	Measure included in MY 2022 MCAS	MY 2021 statewide rates	MY 2022 statewide rates	MY 2023 statewide rates	Difference between MY 2021 & MY 2022*	Difference between MY 2022 & MY 2023*
Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD, 30 days)	County Mental Health Plan (MHP)	Yes	57.9%	55.9%	50.8%	-2.1%*	-5.1%*
Follow-Up After Hospitalization for Mental Illness (FUH-AD, 30 days)	MHP	No	74.6%	73.7%	58.0%	-0.9%*	-15.7%*

BHAS Measure	County Behavioral Health Plan with reporting requirement	Measure included in MY 2022 MCAS	MY 2021 statewide rates	MY 2022 statewide rates	MY 2023 statewide rates	Difference between MY 2021 & MY 2022*	Difference between MY 2022 & MY 2023*
Antidepressant Medication Management (AMM-AD, continuation/ 6 months, 18-64 yrs)	MHP	Yes	47.2%	50.4%	56.4%	+3.2%*	+6.0%*
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH, Ages 1-17)	MHP	No	70.7%	62.6%	61.7%	-8.1%*	-0.9%

BHAS Measure	County Behavioral Health Plan with reporting requirement	Measure included in MY 2022 MCAS	MY 2021 statewide rates	MY 2022 statewide rates	MY 2023 statewide rates	Difference between MY 2021 & MY 2022*	Difference between MY 2022 & MY 2023*
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	MHP	No	62.7%	64.1%	63.2%	+1.5%*	-0.9%*
Follow-Up After Emergency Department Visit for Substance Use Disorder (FUA-AD, 30 days)[a]	Drug Medi-Cal Organized Delivery System (DMC-ODS)	Yes	15.5%	31.1%	27.7%	+15.6%*	-3.4%*
Pharmacotherapy of Opioid Use Disorder (POD)[b]	DMC-ODS	Yes	N/A	N/A	N/A	N/A	N/A

BHAS Measure	County Behavioral Health Plan with reporting requirement	Measure included in MY 2022 MCAS	MY 2021 statewide rates	MY 2022 statewide rates	MY 2023 statewide rates	Difference between MY 2021 & MY 2022*	Difference between MY 2022 & MY 2023*
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	DMC-ODS	No	60.5%	62.3%	60.5%	+1.7%*	-1.8%*
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)[a]	DMC-ODS	No	Initiation Total: 35.7% Engagement Total: 9.4%	Initiation Total: 19.8% Engagement Total: 6.4%	Initiation Total: 36.5% Engagement Total: 7.5%	Initiation Total: -15.9%* Engagement Total: -2.9%*	Initiation Total: +16.7%* Engagement Total: +1.1%*

*Statistically significant p-value ($p<0.05$); T- and Z-tests were used for significance testing.

[a] Measure included in 2025 Bold Goals.

[b] Measure not available in CMS Core Sets; MCAS only.

HEALTH EQUITY FRAMEWORK AND ROADMAP

The Health Equity Framework was a main component of the 2022 CQS. It was developed by DHCS as a framework for addressing health disparities while enhancing existing efforts to improve health equity. The three domains of the Health Equity Framework focused on improving data collection and stratification, workforce diversity and cultural responsiveness, and eliminating healthcare disparities. DHCS activities within each domain have so far included revising the Medi-Cal application to improve collection of demographic information such as race and ethnicity, and sexual orientation and gender identity (SOGI); recruiting a Chief Health Equity Officer at DHCS; prioritizing stronger health equity requirements in the MCP contract; launch by the Quality and Population Health Management of the Health Equity Collaborative; addition of Community Health Engagement and Outreach efforts, such as public comment periods to county policy manuals and community webinars for Enhanced Care Management and Community Supports; planned and updated reporting of health equity in Health Equity Reports (previously named as Health Disparities Data Report); integrating Healthy Places Index into Managed Care Plan enforcement policies; and implementing a Health Equity Measure Set in 2022 for Medi-Cal Managed Care Plans. DHCS has continued to use the roadmap to identify and expand key initiatives for addressing gaps in health equity. The following summarizes key achievements advancing the health equity framework goals at DHCS since 2022:

- Health Equity Roadmap Initiative and 2023-24 Medi-Cal Member Feedback Tour
- Data Collection and Reporting on Race and Ethnicity and SOGI
- 2025 CalAIM Bold Goals

Health Equity Roadmap Initiative and 2023-24 Medi-Cal Member Feedback Tour

Background

HEALTH EQUITY ROADMAP ENGAGEMENT SUMMARY

The California Department of Health Care Services (DHCS) created the Health Equity Roadmap Initiative to better understand and address Medi-Cal members' health needs based on listening to the real-life experiences of members across California, particularly those experiencing racial and ethnic health disparities.

The first phase of the Health Equity Roadmap Initiative included the Medi-Cal Member Feedback Tour, a statewide listening tour conducted from September 2023 to March 2024 to gain a deeper understanding of Medi-Cal member experiences, with a focus on actionable insights and ideas for the future to achieve equity in health care access, use, quality, and outcomes among historically marginalized communities. DHCS collaborated with community-based organizations and local leaders to invite people to share their thoughts and experiences, with a focus on ensuring that everyone's voice, especially those who often face more challenges, like Black, Indigenous, people of color, people with disabilities, LGBTQ+ members, immigrants, and those living in rural areas, was heard and valued. Community-based organization partners hosted a total of 11 feedback sessions (virtual and in-person), and 247 Medi-Cal members attended and shared their feedback.

At each session, members were presented with a series of structured questions, each aligning with one or more of the five domains of member experiences. Table 4 illustrates the key findings in correspondence with each topic. Examples of common themes included reports of long wait times for specialty care visits, desire to improve agency and access to comprehensive care, and desire to feel respected and understood by healthcare providers.

Table 4. DHCS Listening Tour Qualitative Measures and Findings Summary

Member Experience Topic	Findings
What is important to Medi-Cal members about their healthcare	Members want to feel respected, which involves being heard and experiencing a sense of agency over their healthcare. Members value access to high-quality care that supports their health and wellness. Affordability and ease of access are important to members.
Aspects of Medi-Cal that are not working for members	Members reported being treated negatively based on their identities and life circumstances. Members reported that bureaucracy negatively impacts their access to coverage, care, and quality. Members experience long wait times throughout the Medi-Cal and healthcare systems.
Key differences across Medi-Cal members	Some members described gaining access to affordable and convenient healthcare through Medi-Cal, while others described barriers keeping them from accessing efficient and affordable care.

Member Experience Topic	Findings
	Some members described feeling respected and valued by providers while others described negative experiences and low-quality care through Medi-Cal.
What Medi-Cal members would change about their healthcare	Members named a wide range of benefits and services that they wish were covered and/or more affordable through Medi-Cal, such as challenges accessing dental care benefits and services and home care.
What Medi-Cal members hope to see in the future	Members expressed their hopes and dreams for themselves and their communities in the future, including having better accessibility to services, improved sense of agency in healthcare decision-making, comprehensive care services, and patient-centered approaches to healthcare.

By focusing on member experiences, this initiative gathered firsthand accounts of Medi-Cal members that highlighted major difficulties with accessing quality care as well as documenting successful encounters within the healthcare system. Future efforts can build on improving these gaps, such as enhancing coverage flexibility, affordability, provider relationships, and securing access to cultural and linguistically appropriate care, which were among the top priorities expressed by members.

For the next phase of the Health Equity Roadmap Initiative, DHCS will work closely with experts, advocates, providers, members, and interest holders in a co-design process to ensure all relevant voices and experiences are included in the conversation. The final product will be the Health Equity Roadmap report, which will lay out specific, actionable items to help DCHS identify opportunities to eliminate health inequities and disparities.

Data Collection and Reporting

Background

As a subcomponent of the Health Equity Framework, DHCS prioritizes understanding the sociodemographic characteristics of Medi-Cal members for addressing gaps in health equity. A wide range of DHCS publications and public tools, such as the Bold Goals Dashboard and EQRO disparities report, stratify member outcomes by

characteristics such as race and ethnicity, age, or primary spoken language to identify trends in disparities. However, several challenges in data collection and data reporting hinder the accuracy or availability of data on certain subpopulations.

The following section describes changes to the collection of SOGI and race and ethnicity data from Medi-Cal enrollees since the publication of the 2022 CQS, and reviews improvements to address challenges with data collection and reporting.

Data collection and response rates for SOGI measures

Medi-Cal data on sociodemographic factors, such as SOGI, are often impacted by low response rates. According to the 2023 DHCS SOGI Data Collection report, fewer than four percent of eligible applicants completed the Medi-Cal application's optional SOGI questions. Due to these low response rates and data collection challenges, it is not currently possible to accurately report SOGI status within the Medi-Cal population.

Data collection and reporting for race and ethnicity measures

About 13% of Medi-Cal members in January 2024 hadn't provided race and ethnicity information on the Medi-Cal application and another 52% of the members had only identified as Hispanic or Latino and hadn't identified as a "race" category, separately. The Medi-Cal application formerly reported separate responses for "race" and "ethnicity," but newer data reporting standards have been in development since the release of the previous CQS in 2022.

Revisions to the Medi-Cal application workflow

The collection of Medi-Cal member information is governed by state and federal regulations. Under the current CMS approach, race and ethnicity and SOGI questions are optional, except for a required sex question with options for "male" or "female." Since 2017, options for "transgender: female to male" and "transgender: male to female" have been included in the online form. There are multitude of reasons why someone may choose not to report information regarding their SOGI, including increased concern about discrimination or privacy concerns. One structural reason may be due to the survey design and organization of the supplemental questions appearing at the end of the application. Information on race and ethnicity and SOGI is often omitted by members, possibly due to survey fatigue and reducing the visibility of vulnerable Medi-Cal subpopulations.

Changes in race and ethnicity reporting and collection

As of January 2025, DHCS began to implement new reporting standards for race and ethnicity to align with the federal reporting standards from the Office of Management and Budget (OMB). We began implementing OMB standards: (1) using a single, combined question for race and ethnicity; and (3) collecting information beyond the minimum required race and ethnicity categories to allow further data disaggregation. In December 2024, DHCS updated its public Medi-Cal member dashboards, such as the Long-Term Services and Supports Dashboard to more accurately reflect the race and ethnicity that Medi-Cal members identify with, including member identifications of two or more races. Additionally, the new DHCS standard integrated Hispanic ethnicity with other field selections so that it is co-equal to race, rather than shown as a separate category for Hispanic vs. non-Hispanic.

Two efforts at DHCS are underway to improve data collection: (1) Medi-Cal Eligibility Division will be updating DHCS's data collection standards to align with OMD SPD 15 and California Health and Human Services Agency's data collection standards by March 2029; and (2) DHCS Reporting Standards have been updated and DHCS is working on implementing them in 2025.

The OMB SPD 15 mandates the collection of disaggregate race and ethnicity data to enhance the accuracy of federal statistics. Data disaggregation is essential for advancing health equity among often masked inequities within aggregated groups. Previously, race and ethnicity collection was based on the OMB 1997 standards which didn't include a multiracial/multiethnic category and separated questions for race from questions for ethnicity. For example, members were reported in one of several racial categories, which include African American or Black, Indigenous people, Asian, Native Hawaiian or Pacific Islander, and White, while a separate ethnicity dimension indicated whether a member identified as "Hispanic" or "non-Hispanic. DHCS is working to introduce a combined question format for race and ethnicity, allowing individuals to select multiple identities that best represent them. A new category for Middle Eastern and North African individuals will be added, acknowledging the unique identities and lived experiences of these populations. DHCS collects Hispanic and Latino subcategories and Asian and Pacific Islander subcategories, with the latter required per California Statute. The top six most populous subgroups within each race and ethnicity category will be presented as checkbox options with the next three most populous groups listed as examples preceding the write-in option, in accordance to the California Data Standard. These updates aim to provide a more accurate and nuanced understanding of the state's demographic landscape, supporting health equity of all Medi-Cal members.

Summary

The recent updates to the Medi-Cal application workflow and the statewide standard for data collection and data reporting have been a significant accomplishment within DHCS. The implementation of reporting standards and upcoming modifications, coordination within the DHCS data warehouse, discussions with internal and external stakeholders, and managing the distribution of data across managed care plans and county departments, is anticipated to drive substantial enhancements in measure accuracy and performance. Inclusion of optional questions on SOGI in the electronic application supports efforts to enhance health equity and quality of care. With respect to the data reporting system, the work DHCS has begun to implement the new OMB standards for race and ethnicity will provide more fined-grained data reporting on racial and ethnic subcategories. Together these updates in data collection and reporting aim to better identify opportunities for advancing health equity and lifting the lived experiences of communities that have been historically marginalized within the Medi-Cal member population.

CalAIM Bold Goals: 50x2025

Introduction

As part of CA DHCS's mission to improve health care quality and equity in the state of California, the updated CQS for 2025 will continue to focus on measuring progress of key health outcomes described in the CalAIM Bold Goals: 50X2025. The Bold Goals are a statewide initiative that began in 2022. By 2025, the five Bold Goals are to (1) reduce racial and ethnic disparities in well-child visits and immunizations by 50% with respect to statewide performance, (2) close maternity care[69] disparities for Black and Native American persons by half with respect to statewide performance, (3) improve maternal and adolescent depression screening by 50%, (4) improve follow-up for mental health and substance use disorder (SUD) by 50%, and (5) ensure all health plans exceed the 50th percentile for all children's preventive care measures. They encompass health equity measures that fall under the DHCS clinical focus areas: children's preventive care, behavioral health integration, and birth equity. Seven of the 18 indicators have explicit targets that were stratified by race and ethnicity, with a focus on improving rates among

[69] *The Bold Goals initiative uses the term 'maternity care' to describe these disparities. However, for consistency and alignment with the broader CQS vision, this report refers to the focus area as 'birth equity,' acknowledging that disparities impact all birthing people.*

historically marginalized populations whose outcomes are much lower than the state average.

This section will summarize the current updates related to the 2025 Bold Goal measures since MY 2021. Findings will include changes between the baseline year in MY 2021 and the most recent available data from MY 2023 (or in MY 2022 for measures that were introduced during that year). The findings from this report will describe DHCS's midway progress towards achieving the Bold Goals for 2025.

Background on Bold Goals and Measures

Table 5 provides a description of the 2025 Bold Goals and corresponding measures, illustrating statewide rates from MY 2021 to MY 2023, along with target rates for comparison. Several measures, including those in maternity care and behavioral health, had target rates set at 50% above baseline, while measures stratified by race and ethnicity aimed to close the gap between baseline and statewide averages by 50%. DHCS is working to update race and ethnicity stratified data in evaluations of future measurement years beginning MY 2024 to the OMB standards for race and ethnicity. The target rates for children's preventive care (shown in Table 6) were based on California's State Minimum Performance Level (MPL) and High Performance Level (HPL), calculated using NCQA's 50th and 90th percentile methodologies. The goal for the latter set of measures was for all health plans to exceed the MPL, requiring a 100% success rate across all health plans, measured by MCP reporting units (geographical divisions like county or city), rather than statewide Medi-Cal rates.

A total of 21 measures were examined across five Bold Goals. The following seven measures were stratified by race and ethnicity, focusing on outcomes for Black/African American and Indigenous members: (1) well-child visits in the first 15 months with six or more well-child visits, (2) well-child visits for age 15 months to 30 months with two or more well-child visits, (3) child and adolescent well-care visits, (4) childhood immunization status, (5) immunizations for adolescents, (6) postpartum care, and (7) timeliness of prenatal care. Baseline data for Bold Goals measures is from MY 2021 apart from the following eight measures introduced in MY 2022: postpartum depression screening, prenatal depression screening, screening for depression for adolescents and adults, follow-up for positive depression screening for adolescents and adults, lead screening in children, and topical fluoride for children.

It is worth noting that some measures used a hybrid technique in MY 2022 and switched to the administrative method in MY 2023, leading to bigger denominators than in prior

years. As a result, compared to MY 2021 and MY 2022, some measures, including childhood immunization status, had much larger sample sizes in MY 2023. Due to the differences in the data collection methodologies between those periods, the rates for those measures are not comparable with the MY 2023 data.

Bold Goals Progress from MY 2021-2023

Overall, Bold Goals 1, 2, and 3 are on track to be achieved by MY 2025, with more than half of the underlying outcomes of each goal already achieved or showed improvements over time. Two of the five outcomes measured for Bold Goal 4 to improve follow-up for mental health and substance use disorder by 50% showed improvement over time, two outcomes did not demonstrate any change, and one outcome decreased over time. Bold Goal 5, while demonstrating slight increase over time, indicates a key area for improvement by MY 2025.

By MY 2023, 26 of the 63 outcomes had already achieved their 2025 targets, including three stratified measures (well-child visits among children of ages 0 to 30 months; well-care visits for Asian and Hispanic/Latino children and adolescents; immunization for Asian, Black/African American, Native Hawaiian or Other Pacific Islander, Some Other Race, and Hispanic/Latino adolescents), depression screenings (postpartum and prenatal screenings), depression screenings for adolescents and adults, and initiation of SUD treatment. Notably, well-child visits for Native Hawaiian or other Pacific Islander in the first 15 months of life demonstrated the greatest improvement, rising from 26% in MY 2021 to 50% in MY 2023 and exceeding the 2025 target by 17 percentage points. In addition, initiation of SUD treatment demonstrated an improvement of 16 percentage points, rising from 20% in MY 2021 to 36% in MY 2023.

Ten measures that missed their targets showed improvement over time. Eleven measures, however, declined in their respective rates. These indicators represented domains from the children's health and behavioral health domains, with the childhood immunization measure among members identifying with two or more races showing the greatest decrease in rate from 39% in MY 2021 to 24% in MY 2023. Three measures did not demonstrate any change in rates over time. They represented domains in well-care visits for Indigenous children and adolescents; immunization for Indigenous adolescents and adolescents who identify as two or more races; engagement of SUD treatment; and follow up for positive depression screening for adolescents and adults.

The last set of Bold Goal measures focused on the children's preventive care measures by MCP reporting unit (Table 6). These findings showed that no single measure reached a 100% success rate of meeting the MPL across all reporting units. However, some

measures showed slight improvement between MY 2021 and MY 2023. The Children's Preventive Care Comprehensive measure sums all numerators and denominators, looking at the overall passing rate of reporting units across all measures for Bold Goal 5 (Table 6). From 2021 to 2023, the comprehensive quality of children's preventive care improved, with 33% of unique county-MCP combinations meeting the Bold Goal 5 in 2023. Measures such as chlamydia screenings in women had more than 50% of MCPs surpass the MPL. Topical fluoride had the lowest proportion of reporting units meet the MPL (18%). This measure also showed the largest improvement, increasing by about 15 percentage points between MY 2022 and MY 2023.

Table 5. Statewide progress towards 2025 Bold Goals

Bold Goal measures	MY 2021 rate	MY 2022 rate	MY 2023 rate	MY 2025 target *Dark blue= 2025 target was achieved*	Rate change from MY 2021 to MY 2023*
Bold Goal 1: Close racial/ethnic disparities in well-child visits and immunizations by 50% with respect to statewide performance.					
First 15 months with six or more well-child visits: American Indian (AI) or Alaska Native (AN)	36%	37%	37%	38%	+1
First 15 months with six or more well-child visits: Asian	50%	58%	59%	50%	+9
First 15 months with six or more well-child visits: Black or African American	27%	35%	39%	34%	+12
First 15 months with six or more well-child visits: Native Hawaiian or Other Pacific Islander	26%	36%	50%	33%	+24
First 15 months with six or more well-child visits: White	39%	48%	51%	40%	+12
First 15 months with six or more well-child visits: Some Other Race	43%	51%	52%	43%	+9
First 15 months with six or more well-child visits: Two or More Race	36%	46%	46%	38%	+10

Bold Goal measures	MY 2021 rate	MY 2022 rate	MY 2023 rate	MY 2025 target *Dark blue= 2025 target was achieved*	Rate change from MY 2021 to MY 2023*
Bold Goal 1: Close racial/ethnic disparities in well-child visits and immunizations by 50% with respect to statewide performance.					
First 15 months with six or more well-child visits: No Race Selection and Hispanic or Latino Ethnicity	42%	51%	56%	42%	+14
Age 15-30 months with two or more well-child visits: AI/AN	48%	54%	58%	54%	+10
Age 15-30 months with two or more well-child visits: Asian	69%	74%	75%	69%	+6
Age 15-30 months with two or more well-child visits: Black or African American	42%	49%	51%	51%	+9
Age 15-30 months with two or more well-child visits: Native Hawaiian or Other Pacific Islander	46%	46%	50%	53%	+4
Age 15-30 months with two or more well-child visits: White	58%	61%	63%	59%	+5
Age 15-30 months with two or more well-child visits: Some Other Race	60%	64%	65%	60%	+5

Bold Goal measures	MY 2021 rate	MY 2022 rate	MY 2023 rate	MY 2025 target *Dark blue= 2025 target was achieved*	Rate change from MY 2021 to MY 2023*
Bold Goal 1: Close racial/ethnic disparities in well-child visits and immunizations by 50% with respect to statewide performance.					
Age 15-30 months with two or more well-child visits: Two or More Races	53%	58%	58%	57%	+4
Age 15-30 months with two or more well-child visits: No Race Selection and Hispanic or Latino Ethnicity	64%	68%	70%	64%	+6
Child and adolescent well-care visits: AI/AN	40%	40%	42%	44%	+2
Child and adolescent well-care visits: Asian	51%	51%	53%	51%	+2
Child and adolescent well-care visits: Black or African American	40%	40%	41%	44%	+1
Child and adolescent well-care visits: Native Hawaiian or Other Pacific Islander	39%	38%	39%	43%	0
Child and adolescent well-care visits: White	42%	41%	43%	45%	+1

Bold Goal measures	MY 2021 rate	MY 2022 rate	MY 2023 rate	MY 2025 target *Dark blue= 2025 target was achieved*	Rate change from MY 2021 to MY 2023*
Bold Goal 1: Close racial/ethnic disparities in well-child visits and immunizations by 50% with respect to statewide performance.					
Child and adolescent well-care visits: Some Other Race	46%	47%	49%	47%	+2
Child and adolescent well-care visits: Two or More Races	41%	41%	42%	44%	+1
Child and adolescent well-care visits: No Race Selection and Hispanic or Latino Ethnicity	50%	50%	53%	50%	+3
Childhood immunization status: AI/AN	26%	N/A	24%	33%	-2
Childhood immunization status: Asian	60%	58%	50%	60%	-10
Childhood immunization status: Black or African American	26%	21%	17%	33%	-9
Childhood immunization status: Native Hawaiian or Other Pacific Islander	31%	N/A	27%	35%	-4

Bold Goal measures	MY 2021 rate	MY 2022 rate	MY 2023 rate	MY 2025 target *Dark blue= 2025 target was achieved*	Rate change from MY 2021 to MY 2023*
Bold Goal 1: Close racial/ethnic disparities in well-child visits and immunizations by 50% with respect to statewide performance.					
Childhood immunization status: White	33%	31%	23%	36%	-10
Childhood immunization status: Some Other Race	42%	39%	33%	42%	-9
Childhood immunization status: Two or More Races	39%	31%	24%	39%	-15
Childhood immunization status: No Race Selection and Hispanic or Latino Ethnicity	43%	41%	32%	43%	-9
Immunizations for adolescents: AI/AN	27%	26%	27%	32%	0
Immunizations for adolescents: Asian	46%	46%	51%	46%	+5
Immunizations for adolescents: Black or African American	27%	34%	34%	32%	+7
Immunizations for adolescents: Native Hawaiian or Other Pacific Islander	36%	30%	38%	37%	+2

Bold Goal measures	MY 2021 rate	MY 2022 rate	MY 2023 rate	MY 2025 target *Dark blue= 2025 target was achieved*	Rate change from MY 2021 to MY 2023*
Bold Goal 1: Close racial/ethnic disparities in well-child visits and immunizations by 50% with respect to statewide performance.					
Immunizations for adolescents: White	29%	32%	31%	33%	+2
Immunizations for adolescents: Some Other Race	36%	40%	38%	37%	+2
Immunizations for adolescents: Two or More Races	27%	28%	27%	32%	0
Immunizations for adolescents: No Race Selection and Hispanic or Latino Ethnicity	42%	46%	45%	42%	+3
Bold Goal 2: Close maternity care disparities for Black and Native American persons by half with respect to statewide performance.					
Postpartum care: AI/AN	64%	71%	66%	72%	+2
Postpartum care: Black or African American	72%	72%	73%	76%	+1
Timeliness of prenatal care: AI/AN	70%	86%	76%	79%	+6
Timeliness of prenatal care: Black or African American	85%	83%	81%	86%	-4

Bold Goal measures	MY 2021 rate	MY 2022 rate	MY 2023 rate	MY 2025 target *Dark blue= 2025 target was achieved*	Rate change from MY 2021 to MY 2023*
Bold Goal 3: Improve maternal and adolescent depression screening by 50%.					
Follow up for positive depression screening for adolescents	New measure for MY 2022	88%	84%	94%	-4
Screening for depression for adolescents	New measure for MY 2022	4%	9%	7%	+5
Postpartum depression screening**	New measure for MY 2022	7%	13%	11%	+6
Prenatal depression screening**	New measure for MY 2022	10%	17%	15%	+7
Bold Goal 4: Improve follow-up for mental health and substance use disorder (SUD) by 50%.					
Engagement of SUD treatment	7%	6%	7%	14%	0
Follow up for positive depression screening for adolescents and adults**	New measure for MY 2022	72%	72%	86%	0
Follow up after ED visit for substance abuse - 30 days	32%	32%	29%	48%	-3
Initiation of SUD treatment	20%	20%	36%	36%	+16
Screening for depression for adolescents and adults**	New measure for MY 2022	4%	9%	6%	+5

* Changes between rates were calculated between MY 2021 and MY 2022 if the data from MY 2023 were not available. Similarly, if no baseline data were available in MY 2021, the differences were calculated between MY 2022 and MY 2023.
** Baseline data were derived from the Medi-Cal managed care (MCMC) unweighted averages in MY 2022.

Table 6. Progress for Children's Preventive Care Measures (Bold Goal 5) by MCP reporting unit*

Bold Goal measures	MY 2021 rate (% Reporting units that met MPL)	MY 2022 rate (% Reporting units that met MPL)	MY 2023 rate (% Reporting units that met MPL)	MY 2025 Target across reporting units
Bold Goal 5: Ensure all health plans exceed the 50th percentile (Minimum Performance Level or MPL) for all children's preventive care measures				
Children's preventive care comprehensive (CPCC)**	31.46%	29.06%	33.33%	100%
First 15 months with six or more well-child visits	19.23%	18.27%	36.89%	100%
Age 15-30 months with two or more well-child visits	23.08%	43.27%	35.92%	100%
Child and adolescent well-care visits	16.35%	15.38%	29.13%	100%
Child immunization status	39.42%	36.54%	25.24%	100%
Chlamydia screening in women	50.00%	51.92%	54.37%	100%
Developmental screening in the first 3 years of life	31.73%	32.69%	38.33%	100%
Immunizations for adolescents	40.38%	44.23%	41.75%	100%
Lead screening in children***	New measure for MY 2022	15.38%	19.42%	100%
Topical fluoride for children***	New measure for MY 2022	3.85%	18.45%	100%

* Reporting units are based on unique county-plan combinations. Newer plan reporting structures in MY 2023 combined some plans into a regional-level reporting units.
** CPCC measure sums all numerators and denominators, looking at the overall passing rate of reporting units across all measures.
*** Baseline data were derived from the Medi-Cal managed care (MCMC) unweighted averages in MY 2022.

VALUE-BASED PAYMENT

Value-based payments (VBPs) are related to DHCS priorities of linking payments and reimbursements to measures of value (including but not limited to quality measures). These priorities were outlined in the 2022 CQS in the VBP Roadmap, a five-year plan to strengthen value-based purchasing and improve health care quality and health equity outcomes in the state. The VBP Branch, which was created by DHCS in 2023, continues to play a foundational role in overseeing and aligning new developments in performance-related payment systems. Although several payment programs that are linked to value have been ongoing, DHCS planned to incorporate new health equity measures and clinical quality measures as part of improving Medi-Cal Managed Care Plan performance and working towards reducing health inequities.

Since 2022, DHCS has made several changes to key programs that drive quality. These changes include (1) developed and strengthening provider-facing programs, and (2) strengthening programs that push MCPs to improve quality. In both these areas, DHCS has sought to include and/or strengthen efforts to address health equity. A few notable VBP initiatives are highlighted in Table 7.

For providers, DHCS has strengthened and further developed the Quality Incentive Pool (QIP) program. Changes to QIP include strengthening the auditing of provider-produced quality rates, increasing expectations of performance as the effects of the COVID-19 pandemic decreased, stratifying multiple measures by race and ethnicity, and tying payment to reducing health disparities for a small number of measures.

For Skilled Nursing Facility (SNF) providers, the Workforce and Quality Incentive Program (WQIP) was developed and implemented. This program pays SNFs for performance on a wide variety of measures including staffing, quality, and health equity measures.

Additionally, the Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) was developed to push FQHCs to provide higher value care to members and decrease the incentive to drive volume over value. This program sets a capitated payment per-member-per-month (PMPM) for FQHCs which allows flexibilities in how FQHCs deliver more patient-centered care. For example, visits that are traditionally not billable by an FQHC can be provided through the FQHC APM and paid for using capitated payment revenue. Quality and utilization measures are used to assess the impact of the program, and poor performance can result in removal from the program.

For MCPs, the Quality Withhold and Incentive (QWI) program withholds a portion of capitated payments. MCPs then earn back funds based on performance on a set of quality measures. Any unearned funds roll over into an incentive portion of the program which is tied to reducing disparities in the Child and Adolescent Well Care (WCV) visit measure.

Table 7. Value-Based Payment Initiatives at DHCS

VBP Initiative	Key features added since 2022	Alignment with 2022 CQS
Quality Incentive Pool (QIP) Program	Pay-for-performance. Incorporated more rigorous reporting requirements and priority measures, with emphasis on health equity measures. Stratification of race and ethnicity on several priority measures including payment tied to disparity reduction.	Stronger performance requirements in 2022 and 2023, including health equity component.
Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP)	New program since 2023. This program focuses on incentivizing quality, health equity, and staffing measures for Skilled Nursing Facilities.	Program aligned with MCAS measures were relevant to long-term care.
COVID-19 Vaccine Incentive Program	New program since late 2021-2022. Performance-based incentive payments were used to improve vaccination rates during the COVID-19 pandemic.	Program mentioned as part of phase one of the DHCS Value-Based Roadmap in the 2022 CQS.
Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM)	New program starting in 2022. Focuses on meeting minimum quality measure expectations to remain in the program; shift away from prospective payment systems (PPS) towards a	Incentives aimed at meeting minimum quality measures that align with those included in the 2022 CQS.

	capitated model that promotes value over visit volume.	

VBP Initiative	Key features added since 2022	Alignment with 2022 CQS
Loan repayment program (LRP)	LRP enrolled its fifth cohort in 2023-2024. This program continues to reduce the educational debt burden among physicians and dentists, aiming to improve timely access to healthcare, limit geographic shortages of services, and enhance quality of care for diverse populations.	Addresses 2022 CQS requirements of improving workforce diversity and cultural responsiveness among physicians and dentists.
Quality Withhold and Incentive Program	New program since 2024. This program consists of a quality performance-based quality withhold component and an incentive program. The primary program is a withhold, with any unearned funds rolling over into incentive programs that focus on promoting health equity.	Mandatory pay-for-performance and health-equity strategy in alignment with the 2022 CQS. Program aligned with MCAS measures.

Quality Incentive Pool (QIP) program

Purpose

The Quality Incentive Pool (QIP) program was designed to allocate funds to public hospitals based on their performance across quality measures, including measures covering outpatient care, inpatient care, and birthing services. A health equity component was introduced to the QIP program in 2021, which linked reimbursement payments to reductions in healthcare inequities and improving the quality of members' experiences. This section will describe program updates since the 2022 CQS publication. Its ongoing activities are linked to the CQS primary objectives described within the 2021-22 portion of the Value-Based Roadmap. There was a QIP data report on the program's fifth year (PY 5). This summary highlights the program's developments towards reducing health inequities in PY 6, which ran from January 1st, 2023, to

December 31st, 2023. The most recent QIP data report, focused on calendar year 2023, was published in June 2025.

Participants

Participants in the QIP program included Designated Public Hospitals (DPHs) and District and Municipal Public Hospitals (DMPHs). In total, 17 DPHs and 32 DMPHs participated in the program during PY 6.

Measures of Success

The QIP updated its reporting requirements and performance targets between 2021 (PY 4) and 2022 (PY 5) in response to the COVID-19 pandemic. In 2023 (PY 6), QIP mostly returned to stringent pre-pandemic performance requirements and developed a focused set of priority measures. In summary, the program incorporated more rigorous reporting requirements, namely, a pay-for-performance rather than pay-for-reporting approach on a core set of nine priority measures with more stringent performance thresholds. Health equity was emphasized, with eleven measures requiring stratification by race and ethnicity for reporting.

In June 2025, DHCS published the findings from PY 6 in the 2023 QIP evaluation report. The data reported by the DPHs showed improvements in all but one (childhood immunization) of nine priority measures compared to PY 5. The data reported by the DMPHs showed improvements in all but two (childhood immunization and child and adolescent well care visits) of nine priority measures compared to PY 5. Overall, the priority measures demonstrated better achievement rates following the modifications to the QIP program's reporting requirements in 2022. The performance rates of all health equity measures improved from 2022 to 2023.

Summary

In summary, the activities conducted within the QIP program during PY 6 demonstrated progress towards narrowing quality gaps and health inequities. Even with setbacks during the COVID-19 pandemic and the following recovery period, the program was able to offer important insights on healthcare quality on priority measures, such as the need for focus on improving childhood immunization rates. The program also offered insights to identify ways to refine the reporting requirements and incorporate lessons learned from the annual evaluations. This iterative approach of the QIP program is crucial to its future success, driving continued quality improvement for public hospitals in the state.

COVID-19 Vaccine Incentive Program

Purpose

The COVID-19 Vaccine Incentive Program (VIP) was a managed care plan (MCP) incentive payment program that was implemented from September 1, 2021, through February 28, 2022. It was integrated into phase one of the DHCS Value-Based Roadmap, a multipronged framework outlined in the 2022 CQS. This program was designed to improve COVID-19 vaccination rates among individuals enrolled in Medi-Cal MCPs with the support of performance-based incentive payments. Participating MCPs were eligible for incentive payments by engaging in activities aimed at increasing vaccination rates among their Medi-Cal members, particularly among individuals with less equitable access to the vaccine and increased susceptibility to COVID-19 infection. All 25 plans chose to engage in the incentive program, which was voluntary but highly encouraged for MCPs. Eligible MCP members included those who had not been fully vaccinated against COVID-19 at the time of the incentive program.

Participants

Medi-Cal Managed Care Plans

Measures of Success

MCPs earned full or partial incentive payments by narrowing gaps in COVID-19 vaccination rates toward targeted measures. Incentive payments were tied to ten outcomes measures for sub-populations that faced significant healthcare barriers or had the lowest COVID-19 vaccination rates during the initial vaccine distribution period. DHCS tracked vaccination outcomes and collected data on total payments made to MCPs. DHCS conducted an evaluation, comparing baseline COVID-19 immunization rates from August 2021 to follow-up rates in March 2022, stratified by MCP, age, and race and ethnicity. The final report and program evaluation were published in February 2024.

Key findings showed that even though MCPs did not reach the performance targets across all measures, they made notable movement towards their targets. The one measure that met the target rate was the percent of primary care MCPs who provided the COVID-19 vaccine in their offices. The evaluation results also showed a partial reduction in racial disparities for vaccination rates among African American/Black and Indigenous Medi-Cal members. From qualitative reports, MCP leaders expressed that

incentive payments were effective in narrowing focus on addressing the priority measures. The activities that were most effective in engaging members and improving vaccination rates were data-driven, removed access barriers, and tailored outreach to populations of interest.

Summary

Overall, the implementation and evaluation of COVID-19 VIP contributed to a better understanding of COVID-19 vaccination disparities among Medi-Cal members. Consistent with the 2022 CQS objectives, this intervention encouraged health plans to address systemic gaps and inequities through quality improvement incentives, particularly among individuals who were disproportionately vulnerable to the COVID-19 virus. The evaluation findings and stakeholders input highlight some of the DHCS activities that were effective in increasing vaccination rates for COVID-19. Future programming can build on these findings by aligning comparable interventions with value-based payment models, while evaluating and reducing obstacles to health care access.

Quality Withhold and Incentive Program

Purpose

The Quality Withhold and Incentive Program began on January 1, 2024. The program entails a quality withhold component and an incentive program. The first part of the program withholds a portion of MCP capitated payments (per-member-per-month), which can be earned back depending on performance in specific quality and member experience measures listed in the Medi-Cal Managed Care Accountability Set (MCAS). Performance is determined by either achievement or improvement in target measures over a specific timeframe. The withhold in CY24 was 0.5% and is 1.0% in CY25. For both years, any unearned funds from the withhold are invested into an incentive portion of the program that focus on promoting health equity. The Quality Withhold and Incentive Program was implemented after the publication of the 2022 CQS. This program aligns with other VBP initiatives cited in the CQS and the 2023 phase of the Value-Based Roadmap that are together rooted in advancing quality and health equity.

Participants

Participants for this program were Medi-Cal MCPs.

Measures of Success

For the withhold, each health plan's performance is measured on a set of quality and member experience measures. Points are allocated for the better achievement or improvement. Achievement points are awarded between the 25th and the 66.67th NCQA Medicaid benchmarks, while improvement is measured as gap closure toward the NCQA Medicaid 90th percentiles. Each measure is scored from 0 to 10 points and then points are summed across all measures. For calendar year 2024, if a plan earns 80 points, then they earn back the full withhold. Results for calendar year 2024 are not yet available.

With any funds not earned in the withhold, each MCP within a county or region is incentivized to work with the two race and ethnicity subgroups that have historically had the lowest rates for the child and adolescent well care visit (WCV) measure. The incentive is designed to drive improvement in this measure, specifically gap closure toward the NCQA Medicaid 66.67th percentile. This incentive emphasizes only improvement rather than achievement. The key quality measures are derived from MCAS data and align with the DHCS Comprehensive Quality Strategy (CQS) and Bold Goals. The Quality Withhold and Incentive Program will be evaluated annually and is eligible for renewal, depending on program outcomes.

Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM)

Background and Purpose

The Federally Qualified Health Center (FQHC) alternative payment methodology (APM) pilot is a program that began on July 1, 2024. The Prospective Payment System (PPS), or the per-visit rate, has historically been used to compensate FQHCs for their services. This model incentivizes volume of patients overvalue of services provided. The purpose of the APM is to instead provide FQHCs with capitated payment per member each month. Participation in the APM would allow reimbursement systems to move away from the traditional PPS systems and the incentive for volume, focusing on value. Under this capitated model, FQHCs must fulfill minimum performance requirements to remain in the APM, which are a combination of maintaining and improving performance on quality measures as well as ensuring access to members. The APM includes all services within the providers' PPS rates. Some types of services can include primary care, non-specialty mental health services, and specialty care in PPS (cardiology, ophthalmology,

dermatology). Two pilot FQHCs have participated in the program so far. As described in the current APM plan, selection of the 2026 APM cohort will begin mid-2025.

Participants

Participants for this program are Federally Qualified Health Centers (FQHCs).

Measures of Success

The APM component of the program focuses on improving the following outcomes:

1. Healthcare quality and access.
2. Healthcare delivery transformation for clinics via prospective, predictable payments, and flexible use of resources.
3. Provider satisfaction in their practices and increased retention in FQHCs

FQHCs are required to meet performance targets for at least two APM measures from six domains, which are 12 metrics in total. One measure in each domain is required, and a second measure from each domain is optional (the FQHC must choose an optional measure from a list of optional measures in the domain). A seventh domain called "Patient Experience of Access and Care" has two metrics that are reporting only and do not impact participation in the program. FQHCs must meet targets that are established by DHCS to remain in the program. To determine whether FQHCs met the gap closure targets, an end-of-year performance rate is compared to the final target benchmark of that same program year.

Summary

The APM requires participating FQHCs to meet the required thresholds for specific measures summarized under the CQS clinical focus areas. The development of this program has been a major update since the 2022 CQS. After completing the APM requirements, FQHCs can potentially continue their participation with the APM in the next program cycle. This extension would promote continuous improvement in focused areas of healthcare quality. Applications for the next cohort of FQHCs are underway as of 2025 with a program starting date by early 2026.

Loan repayment program (LRP)

Purpose

The Loan Repayment Program (LRP) administers funding for physician and dentists who maintain a minimum caseload comprising of a minimum of 30 percent Medi-Cal

members and within 10 percent of the Medi-Cal patient caseload proposed in their application. Through the LRP, eligible physicians and dentists can apply for up to $300,000 in loan repayment under a five-year service obligation. Dentists may also pursue a Practice Support Grant up to $300,000 in exchange for ten years of service. The purpose of LRP is to ensure timely access to healthcare, limit geographic shortages of services, and enhance the quality of care for underserved patients, while easing financial burdens and educational debt among providers. In accordance with the Health Equity Framework from the 2022 CQS, this program shares the objective of addressing workforce diversity and cultural responsiveness among healthcare and dentalcare providers, particularly within underserved California communities.

Participants

Participants in the LRP are physicians and dentists with qualifying educational debt.

Scoring Criteria

LRP uses a scoring matrix for applicants during the selection process. Scoring is based on the following criteria among both eligible physicians and dentists:

1. **Language**: Providers can provide any languages spoken at their clinical placement in addition to English.
2. **Health professional shortage areas (HPSA)**: Providers can provide services in severe health professional shortage areas.
3. **Personal statements:** Providers describe their long-term commitment and how it will enhance services related to the cultural and linguistic needs of Medi-Cal communities.

The scope of impact from this program is notable, although no formal metrics or evaluations are currently available. So far, 872 physicians and dentists across the first three cohorts (2018-19, 2019-20, 2020-21) have participated in the program. Most providers associated with LRP have extended their services for Medi-Cal patients residing across underserved areas in California, as part of the LRP's eligibility criteria. For instance, applicants are required to be Medi-Cal providers or have applied to DHCS to become a Medi-Cal provider. Once accepted into the program, providers must include at least 30 percent Medi-Cal members in their patient caseloads and be willing to relocate their practices to priority regions within a California county.

The program entered its fifth application cycle in FY 2023-2024 with a new cohort of 297 participants. 263 physicians represented a total of 40 medical specialty services, and 34 dentists worked across seven dental specialty areas. The demographics of Cohort 5

included 55% female physicians and 44% male physicians, while 41% of dentists were female and 59% were male. Within the entire fifth cohort, the largest percentage of participants (34%) identified as Asian American or Pacific Islander, followed by 31% White, 15% Latino, 11% not reported, 5% Black, and 4% multiracial. About 75% of the cohort spoke a language other than English, with Spanish, Vietnamese, and Farsi as the three most widely spoken. Among Cohort 5 awardees, 72% have committed between 50% and 90% of their patient caseloads to Medi-Cal members, which is above the program's minimum requirement. Overall, the LRP reduced the educational debt of its fifth cohort by $72,576,099 out of a total debt burden of $238,714,115.

Summary

The scope of impact of the LRP is invaluable to members and providers alike. The LRP has supported both providers and members of the Medi-Cal community by striving to increase diversity within the healthcare workforce, a goal that closely relates to the aims illustrated in the 2022 CQS. In addition to alleviating educational debt, this program also addresses the demand for healthcare and dentalcare in areas with provider shortages. Providing financial support for the healthcare workforce is essential to maintaining a skilled and diverse staff that effectively serves all members of the Medi-Cal community, particularly individuals in geographical areas experiencing severe provider shortages.

POPULATION HEALTH MANAGEMENT FRAMEWORK

Overview

Background

In January 2023, DHCS launched the Population Health Management (PHM) program as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative to improve member engagement and outreach to those with low access or utilization of Medi-Cal services. PHM's contributions in the past two years have established new pathways to address social determinants of health, while placing a greater emphasis on whole-person care. The PHM Framework served as a central component of the 2022 CQS, providing guidance to address health disparities and strengthen the quality of Medi-Cal members' experiences. This framework entailed four multipronged strategies, which included information gathering, understanding risk, risk stratification, and care management services. Together, these approaches helped reach key milestones at DHCS over the past several years. The resulting accomplishments within the PHM Division, including the formation of the PHM Division itself, have aligned with the goals and clinical areas of focus illustrated in the 2022 CQS. These efforts support population health, while developing new structures to assess PHM's contributions to healthcare access and outcomes in the future.

PHM elements and key outcomes

Medi-Cal Managed Care plans were required to meet NCQA accreditation standards for PHM by developing systems of care that proactively addressed member needs in several domains, ranging from preventative levels of care to the provision of comprehensive treatment. Most of these requirements were organized into Figure 23 of the 2022 CQS. Figure 23 summarized each of the four aspects of the PHM Framework as the following:

- **Information gathering**: Involves determining patient health status and needs via preventive screenings, gathering data from providers, health plans, and DHCS via claims, clinical data, social services, and social risk information.
- **Understanding risk**: Predicting health and social risk for the purpose of outreach and assessments for care management. MCPs are required to implement a risk stratification and segmentation process that meets NCQA requirements and considers potential biases in risk stratification and segmentation processes.

- **Risk stratification, segmentation, and tiering**: In complement to Plan RSS processes, assigns members to risk tiers after determining status with the risk assessment. The organized tiers would support health plans and providers by predicting member's health care needs and allowing earlier intervention to meet these needs.
- **Care management services**: Members are assigned to specific care management services based on their health care needs assessment and risk tier. Members who require basic PHM services and care coordination can access them through this program. Members with complex needs may be eligible for the Enhanced Care Management (ECM) program, which provides complex case management services. Other benefits include wellness and preventative services, as well as Transitional Care Services (TCS) upon discharge from a hospital or skilled nursing facility.

Each interconnected component of the PHM framework has played a valuable role in guiding PHM activities. First, new information-gathering strategies, such as the DHCS Lobby Tours, led to significant improvements within the Medi-Cal program, with activities focused on enhancing engagement with members and stakeholders. The Lobby Tours entailed DHCS representatives identifying population health needs via public outreach and meetings with Medi-Cal providers, workers, and stakeholders. These conversations fostered stronger connections and communication among individuals with unique perspectives on the Medi-Cal system. Stakeholder participation was not initially part of the information-gathering strategy, but it was later integrated to strengthen PHM efforts in this area. By obtaining a greater scope of knowledge for both the strengths and suggestions for improvement within the Medi-Cal program, Lobby Tours also aligned closely with the PHM strategy for understanding risk.

Understanding risk involves the use of algorithms to predict and follow-up with the healthcare needs of Medi-Cal members. In late July 2025, PHM will initiate the Risk Stratification, Segmentation, and Tiering (RSST) algorithm, the first standardized risk stratification tool in California. With this tool, Medi-Cal members are assigned to risk tiers, which is the likelihood of an adverse health event or outcome occurring to an individual. Previously, MCPs used their own RSST models, each with different definitions of high risk, leading to variability in identification and interventions. The RSST tool from DHCS has a standardized definition of risk, allowing for targeted efforts to be measured across the state. Currently, in the first version of the algorithm, the predictive data comes from Medi-Cal claims and encounters, with later iterations planning to incorporate vital statistics and other non-Medi-Cal data methodologies to develop more nuanced algorithms. This tool was also designed to mitigate the risks of bias in the

algorithm. For instance, elements of structural racism could be inadvertently embedded in the algorithm unless explicitly addressed and removed. The new algorithm was developed to actively counteract these biases, enhancing its reliability, safety, and usability.

The PHM principles of understanding risk and risk stratification were also instrumental in the development of Medi-Cal Connect, a new DHCS program formerly known as the PHM Service. Medi-Cal Connect is a platform for streamlining health and social data to improve members' experiences, enhance population health monitoring, and provide better insights to address member health outcomes and healthcare disparities. Medi-Cal Connect will also enable users to identify and close gaps in access to care. As of November 2025, the program has been released to all DHCS users as well as Medi-Cal Managed Care Plans, and county Behavioral Health Plans. Medi-Cal Connect is designed as a technology platform to integrate data, support population health functions, and facilitate data access and sharing.

The fourth aspect of the PHM framework, care management services, was integrated into various community-based programs that have grown and evolved since the prior CQS. A few examples include the growth and expansion of the Community Supports and Enhanced Care Management (CS-ECM) programs, which support MCP members in addressing various social drivers of health. Since the launch of ECM-CS in 2022 through September 2024, 279.8k unique members received ECM services and 296.8k received Community Supports services. Beginning in 2023, there has been consistent quarter-over-quarter growth in members receiving ECM services. ECM-CS also aimed to strengthen community-based organizations for targeted populations. DHCS launched 14 ECM Populations of Focus over the three-year period (2022-2024), including individuals transition from incarceration, birth equity, children and youth involved in child welfare, children and youth experiencing homelessness, adults living in the community and at risk for long-term care institutionalization, adults experiencing homelessness, and more. In 2025, DHCS streamlined ECM authorizations, allowing specific provider types to bill for services prior to planning authorization. In addition, a statewide standardized referral template was introduced, thus decreasing ECM provider administrative burden. Although MCPs are not required to offer Community Supports services, every MCP in California has opted to include at least eight out of 14 preapproved Community Supports as of June 2024.

Since January 2023, MCPs have also been required to enhance Transitional Care Services (TCS) to ensure continuous long-term services and support (LTSS) for Medi-Cal members, with full implementation for all members by January 1, 2024. Care transitions

refer to members moving between care settings, such as hospitals, skilled nursing facilities, or home- and community-based environments. TCS ensures they receive the necessary services and support throughout this process. Following the policy launch, a summit was held for MCPs to discuss implementation. MCP accountability and policy effectiveness are monitored through quality reporting and Key Performance Indicators (KPIs), with ongoing improvements to enhance member-centered care.

Furthermore, PHM was used to support broader goals emphasized in the CQS, such as the CalAIM 2025 Bold Goals. As part of the PHM Program requirements, MCPs submitted the PHM Strategy Deliverable Template on October 31, 2024, to track progress toward the 2025 Bold Goals and to demonstrate meaningful participation across various local health jurisdictions (LHJs), community health assessments (CHAs), and community health improvement plans (CHIPs) for that year. This survey was distributed to 23 MCPs, covering 58 counties and service areas. The PHM Strategy Deliverable Template supported Population Health performance and monitoring efforts, while encouraging MCPs to leverage their community partnerships for effective collaboration and advancing toward their shared goals.

Lastly, most programs that emerged from PHM aligned with the CQS clinical areas of focus outlined in the 2022 CQS. In the birth equity domain, the ECM program offers services specific to the health care needs of the birthing population, while PHM initiatives like Birthing Pathway and the introduction of Doula services as a Medi-Cal benefit further support this sub-population. In the domain of children's preventive care, Performance Improvement Projects (PIPs) were developed under state plans to enhance healthcare quality and promote better health outcomes, with a strong focus on the child preventive health measures. Last, the Behavioral Health Integration domain is exemplified by Medi-Cal Connect, which facilitates the integration of both behavioral and physical health services. Medi-Cal Connect aims to accomplish this goal by helping members navigate Medi-Cal resources and by leveraging member data to improve health outcomes and health equity across the state.

Summary

PHM is a foundational element of the CalAIM initiative, dedicated to fostering a whole-system and person-centered approach for Medi-Cal members. The most recent activities and milestones within PHM mark significant advancements for DHCS. In accordance with the 2022 CQS, these initiatives were guided by the PHM Framework, which comprises four key components: (1) information gathering, (2) understanding risk, (3) stratification, segmentation, and tiering, and (4) care management services. These interconnected efforts resulted in the enhancement of critical services for members and

the development of new initiatives, such as Medi-Cal Connect, and the creation of novel key performance indicators (KPIs), which are described in the next section. In addition, the four components have the greatest impact on population health when working in concert to address the upstream and downstream drivers of health. The accomplishments and feedback gained from these PHM initiatives demonstrate their significant impact in identifying and addressing health inequities across California communities.

PHM Key Performance Indicators (KPIs)

Background

In 2023, the PHM Division initiated the development of new Key Performance Indicators (KPIs) as part of the broader PHM Monitoring effort. KPIs are defined measures that monitor Population Health outcomes, such as preventive care, emergency service utilization, and complex care management, across MCPs, while addressing gaps in health-related care. The PHM division launched a workstream that was centered around creating and implementing new KPIs for improving healthcare delivery and performance. The KPIs were launched with all MCPs and are currently under revision, with plans to implement universal reporting of the new KPIs, along with key existing quality measures, soon.

Overview of KPI of activities

New KPIs were developed by the PHM division to address gaps in collecting data that were essential for healthcare delivery and policy but had no prior standardization or collection of defined measures within specific healthcare domains. The new measures captured underutilization, disengagement, and administrative gaps in ways that were not available in the CMS Core Set or MCAS measures. As a result, five KPIs, also referred to as Population Health KPIs, were created, representing the domains of primary care engagement, complex care management, and transitional care services:

- KPI 1. The number and percentage of members who had more emergency department (ED) visits than primary care visits within a 12-month period.
- KPI 2. The number and percentage of members who had at least one primary care visit within a 12-month period.
- KPI 3. The percentage of members with no ambulatory or preventive visit within a 12-month period.
- KPI 4. The number and percentage of members eligible for Complex Care Management (CCM) who are successfully enrolled in the CCM program.
- KPI 5. 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.

PHM monitoring of these KPIs also required data stratifications by race, ethnicity, age, and language, aligning with NCQA requirements for reporting of race and ethnicity. Approximately two quarters of data were collected in late 2023 from all MCPs. Starting in 2024, reporting on KPIs was temporarily paused as DHCS engaged in efforts to

improve technical specifications. A small pilot group of MCPs were involved in providing technical feedback on KPIs, along with formal consultation by NCQA supporting the refinement of the new KPIs. These KPIs were mapped to internal DHCS monitoring dashboards in 2023.

Progress and implications

In terms of evaluating quantitative success, the creation of a new subset of KPIs will begin to address gaps in the measurement of healthcare delivery performance in areas that had no prior measures or standardization. Additionally, the KPIs from PHM will create better generalizability across Medicaid encounters that are relevant to those KPI domains, while showing finer detail on specific types of information, such as reporting level and population stratifications, compared to other existing quality measures.

Overall, the launch of PHM program and their foundational role in the PHM KPI initiative was a key qualitative measure of success for DHCS. In the 5/2023 PHM Policy Guide Update, DHCS explicitly mentioned PHM KPIs as a priority task required for the implementation of the PHM program. Additionally, the inclusion of key partners such as NCQA and MCPs as part of the discourse for developing this pilot program was valuable for strengthening partnerships between DHCS and external stakeholders. Sharing the technical specifications with this stakeholder workgroup also helped overcome data challenges and ensured alignment with DHCS priorities. Furthermore, as part of advancing PHM monitoring, the KPIs played a key role in promoting equity across novel monitoring domains, helping to assess their impact on outcomes and track progress in closing health disparities over time.

Summary

The new set of KPIs are in the final stages of feedback and testing with the pilot group of MCPs, with the goal of integrating and reporting them across all MCP partners. PHM will update its current monitoring methodology to incorporate year-to-year performance for future data collection. This approach for data trending is currently under development with the analytics teams at DHCS. In the long term, this information will be integrated into PHM dashboards and Medi-Cal Connect, providing critical information and enhancements to DHCSs monitoring workflow. With plans to extend these KPIs to a wider audience, PHM continues to refine the KPI methodology by addressing gaps in care and calculating the specifications for impactful performance measures.

CONCLUSION

This report provides an update on the DHCS activities outlined in the 2022 CQS through reporting year 2023 (i.e. measurement year 2024), highlighting key developments and initiatives that align with the CQS strategies.

The 2025 Bold Goals and MCAS measures have been instrumental in tracking progress across key clinical focus areas in the CQS, including children's preventive care, behavioral health integration, and birth equity. Statewide rates for clinical and race-stratified measures have generally improved from the baseline year in MY 2021 to MY 2023, with many measures nearing or exceeding their Bold Goals targets for 2025. Nonetheless, barriers to care within these clinical domains are still prevalent. Through continued statewide efforts, further progress in enhancing healthcare access, quality, performance, and health equity remain a top priority.

Guided by frameworks central to the 2022 CQS, such as the Health Equity Framework, Value-Based Payment Roadmap, and Population Health Management Framework, DHCS implemented a range of impactful initiatives. The DHCS Feedback Tour created a greater understanding of the needs to achieve equitable healthcare access for marginalized populations, while value-based payment programs advanced pay-for-performance models to enhance health equity. Refinements in demographic data collection, informed by stakeholder feedback, were implemented to increase the visibility for racial and ethnic and SOGI minorities in Medi-Cal data. The introduction of a Population Health Management program also fostered better integration of services across community-based programs and improved predictive algorithms to address structural racism.

In conclusion, DHCS has made meaningful progress in addressing healthcare disparities and improving key healthcare outcomes in accordance with the 2022 CQS. Measures from key initiatives have also been developed to permit increasingly rigorous evaluation of the CQS in the future. As it advances toward its 2025 goals, insights from these initiatives will guide statewide strategies to eliminate healthcare disparities and promote continuous quality improvement. These findings, reflecting both achievements and areas for growth at the midpoint of the 2022-24 CQS cycle, provide a foundation for shaping future DHCS initiatives and objectives.

SUPPLEMENTARY TABLE S1

Consolidated list of all MCAS measures and crosswalk results

Measure name	Measure acronym	Data crosswalk (The measure is listed in both CQS Appendix D and MY 2023 MCAS)	Notes
Behavioral Health Domain			
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	FUM_30	X	
Follow-Up After Emergency Department Visit for Substance Abuse—30-Day Follow-Up	FUA_30	X	2025 Bold Goals measure
Children's Health Domain			
Child and Adolescent Well-Care Visits—Total	WCV	X	2025 Bold Goals Measure
Childhood Immunization Status—Combination 10	CIS_10	X	2025 Bold Goals measure
Developmental Screening in the First Three Years of Life—Total	DEV	X	2025 Bold Goals measure
Immunizations for Adolescents—Combination 2	IMA_2	X	2025 Bold Goals measure
Lead Screening in Children	LSC	X	2025 Bold Goals measure
Topical Fluoride for Children—Dental or Oral Health Services	TFL_CH	X	2025 Bold Goals measure

Measure name	Measure acronym	Data crosswalk (The measure is listed in both CQS Appendix D and MY 2023 MCAS)	Notes
Children's Health Domain			
Topical Fluoride for Children—Dental Services	TFL_DS	X	
Topical Fluoride for Children—Oral Health Services	TFL_OH	X	
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	W30_6+	X	2025 Bold Goals Measure
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	W30_2+	X	2025 Bold Goals Measure
Chronic Disease Management Domain			
Asthma Medication Ratio	AMR	X	
Controlling High Blood Pressure	CBP	X	
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes—HbA1c Poor Control (>9.0 Percent)	HBD	X	
Reproductive Health Domain			
Chlamydia Screening in Women—Total	CHL	X	2025 Bold Goals Measure

Measure name	Measure acronym	Data crosswalk (The measure is listed in both CQS Appendix D and MY 2023 MCAS)	Notes
Reproductive Health Domain			
Prenatal and Postpartum Care—Postpartum Care	PPC_PST	X	2025 Bold Goals Measure
Prenatal and Postpartum Care—Timeliness of Prenatal Care	PPC_PRE	X	2025 Bold Goals Measure
Cancer Prevention Domain			
Breast Cancer Screening	BCS_E	X	
Cervical Cancer Screening	CCS	X	
Measures are Report Only			
Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months—Total	AMB_ED	X	
Adults' Access to Preventive/Ambulatory Health Services—Total	AAP	X	
Antidepressant Medication Management—Effective Acute Phase Treatment	AMM_ACUTE	X	
Antidepressant Medication Management—Effective Continuation Phase Treatment	AMM_CONT	X	

Measure name	Measure acronym	Data crosswalk (The measure is listed in both CQS Appendix D and MY 2023 MCAS)	Notes
Measures are Report Only			
Colorectal Cancer Screening	COL_E	X	
Contraceptive Care—All Women—Most or Moderately Effective Contraception	CCW_MMEC	X	
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days	CCP_MMEC60	X	
Depression Remission or Response for Adolescents and Adults—Depression Remission—Total	DRR_E_RM	X	
Depression Remission or Response for Adolescents and Adults—Depression Response—Total	DRR_E_RS	X	
Depression Remission or Response for Adolescents and Adults—Follow–Up PHQ–9—Total	DRR_E_PHQ	X	
Depression Screening and Follow–Up for Adolescents and Adults—Depression Screening—Total	DSF_E_DS	X	2025 Bold Goals Measure

Measure name	Measure acronym	Data crosswalk (The measure is listed in both CQS Appendix D and MY 2023 MCAS)	Notes
Measures are Report Only			
Depression Screening and Follow–Up for Adolescents and Adults—Follow–Up on Positive Screen—Total	DSF_E_FU	X	2025 Bold Goals Measure
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	X	
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up	FUM_7		Not listed in 2022 CQS; available in MY 2023 MCAS.
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up	FUA_7		Not listed in 2022 CQS; available in MY 2023 MCAS.
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	ADD_C&M	X	
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication—Initiation Phase	ADD_INIT	X	

Measure name	Measure acronym	Data crosswalk (The measure is listed in both CQS Appendix D and MY 2023 MCAS)	Notes
Measures are Report Only			
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	APM_AB	X	
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	APM_B	X	
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	APM_C	X	
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate [NSTV CB]	NTSV_CB	X	Not available in MY 2021-23 MCAS rate sheets.
Pharmacotherapy for Opioid Use Disorder	POD	X	
Plan All-Cause Readmissions—Observed Readmission Rate—Total	PCR	X	
Postpartum Depression Screening and Follow Up—Depression Screening	PDS_E_DS	X	2025 Bold Goals Measure

Measure name	Measure acronym	Data crosswalk (The measure is listed in both CQS Appendix D and MY 2023 MCAS)	Notes
Measures are Report Only			
Postpartum Depression Screening and Follow Up—Follow–Up on Positive Screen	PDS_E_FU	X	
Prenatal Depression Screening and Follow Up—Depression Screening	PND_E_DS	X	2025 Bold Goals Measure
Prenatal Depression Screening and Follow Up—Follow–Up on Positive Screen	PND_E_FU	X	
Prenatal Immunization Status—Combination (Influenza and Tdap)	PRS_E	X	
Long-Term Care (LTC) Measures are Report Only			
Number of Out-patient ED Visits per 1,000 Long Stay Resident Days [HFS]	HFS		This measure only appears in the MY 2023 MCAS report. It is not available on the MCAS dataset and is not listed in the 2022 CQS Appendix D.
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization [SNF HAI]	SNF_HAI		This measure only appears in the MY 2023 MCAS report. It is not available in the MCAS dataset and is not listed in the 2022 CQS Appendix D.

Measure name	Measure acronym	Data crosswalk (The measure is listed in both CQS Appendix D and MY 2023 MCAS)	Notes
Long-Term Care (LTC) Measures are Report Only			
Potentially Preventable 30-day Post-Discharge Readmission [PPR]	PPR		This measure only appears in the MY 2023 MCAS report. It is not available in the MCAS dataset and is not listed in the 2022 CQS Appendix D.