DEPARTMENT OF HEALTH CARE SERVICES

MEMBER CONTACT AND DEMOGRAPHIC INFORMATION (MCDI) INITIATIVE DRAFT STRATEGY

VISION, GOALS, AND PATHS TO IMPROVING MCDI

2023

DHCS

MEMBER CONTACT AND DEMOGRAPHIC INFORMATION (MCDI) INITIATIVE DRAFT STRATEGY

Contents

I. INTRODUCTION

Medi-Cal members' contact and demographic information (MCDI) are critical components of Medi-Cal's efforts to enroll members, achieve health equity, and advance population health.

Timely access to accurate and complete MCDI is essential to understand members' needs, ensure enrollment in health coverage, provide services to support members' health, and illuminate health disparities.

MCDI is crucial to health plans, providers, and community-based organizations to locate members, tailor outreach to optimize engagement, and provide linguistically and culturally appropriate care. If a provider or plan can't reach a member, they simply cannot provide essential preventive and life-saving services. Equally, erroneous address information or incorrect changes can have significant impact on members' Medi-Cal eligibility and threaten their healthcare coverage.

> *"The vision of CalAIM and the promise of population health hinges upon everyone who serves Medi-Cal members having real-time access to accurate member contact and demographic information. It seems basic, but the transformation of Medi-Cal often starts and ends with an accurate phone number or address.*
>
> *Foundational to this effort is providing Medi-Cal members with easy-to-use tools to update their contact and demographic information so that service providers can meaningfully engage them, identify their needs, and link them to the resources that improve their health."*
>
> *Palav Babaria, Chief Quality and Medical Officer and Deputy Director*

In order to be fully engaged participants in their care, members need easy-to-use and secure methods to access, update, and correct their contact and demographic information. It is also critical for members to trust that their information is used in accordance with their preferences and supports their ability to receive services.

Currently, stakeholders face a number of significant obstacles in their efforts to collect and use MCDI.[1] Members often lack a clear understanding of why their information is being collected and how it will be used. As a result, many choose to provide a limited amount of MCDI. Many members have difficulty correcting and updating their information for a variety of reasons. In addition, some members have inconsistent access to a phone, have multiple addresses, or may be experiencing homelessness.

[1] For the purpose of the Strategy document, stakeholders are individuals and entities with a need to provide, collect, or use contact and demographic information, including members, authorized representatives, health plans, providers, community-based organizations, and federal, state and local governments.

Organizations that use contact and demographic information to engage members also face a number of technical, operational, and data governance challenges. Stakeholders collect MCDI at multiple times, for differing purposes, in different formats, and in varying degrees of accuracy. In some instances, the complexity of the data collection, siloed systems, and lack of automation overwhelm the ability to update, reconcile, and use MCDI in a timely fashion.

To better understand challenges and potential solutions, the Department of Health Care Services (DHCS) launched the MCDI initiative in early 2020. After a hiatus due to the COVID-19 pandemic, in fall 2022 the MCDI initiative re-engaged state government, managed care plans (MCPs), providers, counties, and other stakeholders to chart a vision and strategy for the future of MCDI. DHCS convened monthly workgroup meetings of these stakeholder groups, as well as in-depth interviews with DHCS staff and other stakeholders to discuss current challenges related to MCDI and identify opportunities for improvement. Insights gathered through this process directly inform the current state descriptions and improvement opportunities laid out in the sections that follow.

DHCS learned a great deal during the MCDI initiative hiatus related to the COVID-19 Public Health Emergency (PHE). The PHE and subsequent "unwinding" of its continuous coverage requirements have exacerbated and highlighted the challenges associated with collecting and sharing timely and accurate MCDI. During the PHE, DHCS and county eligibility offices had minimal or no contact with many members for more than three years, as members were not required to renew their eligibility and thus may not have reported a new address or other changes to their contact information. Despite concerted planning and outreach efforts by DHCS, a significant number of Medi-Cal members could lose coverage if they are unable to receive renewal-related communications due to outdated data. Strategies leveraged and best practices identified during the unwinding period will inform the State's longer-term efforts to improve the collection, quality, and use of MCDI.

Purpose of the MCDI Initiative and Draft Strategy Document

The MCDI initiative builds on and complements the California Health and Human Services Agency's (CalHHS') broader efforts to address health equity and support DHCS' California Advancing and Innovating Medi-Cal (known as CalAIM) initiative and Population Health Management (PHM) Program.

This MCDI Draft Strategy provides a vision, goals, and measures of success to improve the collection, accessibility, quality, and use of MCDI. The MCDI Draft Strategy serves as a path to inform the development of more detailed work plans, and it frames MCDI through two critical drivers.

The first driver is MCDI in support of ongoing **Medi-Cal outreach, enrollment, and redetermination**. MCDI is a critical input to determine an individual's eligibility for Medi-Cal and ensure ongoing coverage.

The second driver is MCDI in support of **population health management**. In order to conduct effective and efficient population health management, DHCS, MCPs, providers, counties, and other stakeholders require accurate and timely MCDI to identify health disparities and connect members to services.

For each driver, the MCDI Draft Strategy provides an overview of the current state of MCDI as well as challenges faced by stakeholders and opportunities for improvement. These opportunities are organized into business needs and potential functional requirements.[2] The appendix includes a list of possible measures to gauge the initiative's progress, as well as descriptions of key terms, data elements, State programs, and data systems.

The MCDI Draft Strategy provides a foundation for continued engagement with all stakeholders to better understand their priorities and to guide the future development of detailed workplans that will improve the collection, accessibility, and use of MCDI.

Based on feedback on the MCDI Draft Strategy, DHCS will publish a final version in Summer 2023 that will inform and guide work moving forward.

Vision and Goals

In support of Medi-Cal members, state agencies, MCPs, providers, and counties have a wide range of needs for and uses of MCDI. The unifying vision for the MCDI initiative is:

> ***Members and authorized users (e.g., state and county governments, MCPs, providers) can submit, access, manage, and update member contact and demographic information in a trusted, timely, and efficient manner to enable Medi-Cal members to retain healthcare coverage and receive services to lead longer, healthier, and happier lives.***

In support of this vision, stakeholders identified the following goals for the collection, accessibility, and use of MCDI.

[2] While the MCDI Draft Strategy identifies business needs (i.e., the problems to be solved) and potential functional requirements (i.e., the specific actions to be taken), it does not include technical requirements (i.e., technical specifications and operational details). DHCS expects that subsequent workplans will include technical requirements, implementation options, and detailed timelines.

1. **Collecting and Updating MCDI**
    a. Provide easy-to-use, methods for members to self-report and update MCDI
    b. Accommodate multiple channels to collect and update MCDI
    c. Streamline and automate processes to collect and update MCDI with appropriate safeguards to ensure members' continued access to services
    d. Improve the quality of MCDI in terms of its accuracy, completeness, consistency, and timeliness
    e. Create standard processes to identify, differentiate, and accurately classify various types of contact information (e.g., permanent address, current residence)

2. **Accessing MCDI**
    a. Enable authorized users to access MCDI from a wide range of interfaces
    b. Improve the ability of authorized users to access the most current and accurate MCDI
    c. Streamline and automate processes needed to access MCDI

3. **Using MCDI**
    a. Improve the ability to identify the highest-quality and most relevant MCDI and reconcile any data discrepancies
    b. Inform authorized uses of the data
    c. Inform efforts that support health equity and population health improvement

Foundational to these goals is an imperative to build and maintain members' trust, particularly given the sensitivity regarding the use and retransmission of certain types of MCDI. Achieving trust among all stakeholders requires:

- Collecting MCDI using culturally, linguistically, situationally aware, and trauma-informed methods;
- Ensuring that collected MCDI is securely managed;
- Empowering members to access, validate, and update their information;
- Providing easy-to-use methods for members to control who accesses which parts of their MCDI;
- Educating members on how changes to MCDI may impact their Medi-Cal eligibility and access to services;
- Using MCDI for purposes designated by members as applicable; and
- Using MCDI in compliance with all applicable federal, state, and local laws, regulations, and rules, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA).

II. DRIVER #1: MCDI IN SUPPORT OF MEDI-CAL OUTREACH, ENROLLMENT, AND REDETERMINATION

Driver Overview

The MCDI initiative will support the ability of Medi-Cal members and other authorized parties to provide and update their contact information. Driver #1 is focused on the need for accurate contact information for Medi-Cal eligibility, enrollment, and redeterminations.

Member addresses are a critical input to determining an individual's eligibility for Medi-Cal and to reaching members to ensure sustained coverage and access to Medi-Cal services.[3] Yet ensuring accurate, complete, and timely MCDI is a significant challenge with 15.8 million individuals enrolled in Medi-Cal via a variety of enrollment channels, as well as multiple government systems collecting and storing MCDI. The magnitude of erroneous contact information is immense. For example, when in Q1 2022 DHCS sent a PHE mailer to all members, 12% of the mailers – *over one million pieces of mail* – were returned to DHCS due to incorrect addresses.

On January 24, 2023, the FCC issued guidance allowing states to make Medicaid enrollment calls and send text messages to members. This will help to ensure people can efficiently receive the information they need to avoid losing health care coverage as result of the COVID-19 Medicaid Continuous Coverage unwinding. The guidance underscores the importance of accurate mobile phone numbers for texting related to eligibility and enrollment.

Further underscoring the importance of accurate MCDI, it is estimated that during the PHE continuous coverage unwinding period, two to three million Californians may lose Medi-Cal. The vast majority will be eligible for other types of coverage, but many Californians who remain Medi-Cal eligible are at risk of getting disenrolled from the program for procedural reasons such as returning a renewal form without the enrollee's current address.[4] As noted above, strategies to engage members to provide updated MCDI gleaned from the continuous coverage unwinding will inform future approaches to improving MCDI quality broadly.

While the MCDI Strategy will not solve the immediate unwinding challenge, it presents opportunities for DHCS and its partners to address challenges with collecting and managing MCDI. These include:

- **Multiple Pathways**: There are multiple touchpoints where member contact information can be updated and where counties might receive updated contact

[3] While DHCS offers other services in addition to Medi-Cal, Driver #1 is focused only on the Medi-Cal program.
[4] Medi-Cal and the End of the Federal Continuous Coverage Requirement

information. Reconciling these various sources of MCDI is a time consuming and burdensome process for County Eligibility Workers (CEWs).

- **Manual Processing of Allowable Sources of Contact Information**: Data from federally allowable sources of MCDI is not automated to the fullest extent possible, impacting the quality of MCDI and exacerbating the burden on staff at both the state and local levels.

- **Processing Delays**: Updated information sent by MCPs to the counties is not being processed in a timely manner due to high volume and manual processes. The MCDI Strategy illustrates how these delays result in accurate contact information stored by MCPs being overwritten with outdated data from the State.

Below is a description of the current state of MCDI eligibility related data flows and opportunities for improvement.

Definitions

Data Elements

Below is a list of MCDI data elements required to support effective member contact efforts. Identifying additional data elements for the future state, such as nickname or geocode information (for someone who may not have a physical address but whose location can still be known) could further support improved Medi-Cal outreach and enrollment efforts.

Many, but not all, of the data elements are collected or stored across various State, county, and MCPs' information technology (IT) systems. As part of the envisioned future state, these and additional data elements will need to be readily accessible and usable to support efficient Medi-Cal eligibility, enrollment, and redetermination.

- Name (First, Middle, Last)
- Primary Address
- Mailing Address
- Email Address
- Phone Number, Mobile
- Phone Number, Home
- Phone Number, Work

CalHHS' Core MCDI IT Systems

Three data systems in California – California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), California Statewide Automated Welfare System (CalSAWS), and Medi-Cal Eligibility Data System (MEDS) – are central to the collection, storage, and accuracy of MCDI.[5,6]

Table 1 provides the system names, a brief overview of their roles, and the applicable oversight agency. Additional details on these and other systems can be found in Appendix 3.

Table 1: Overview of CalHHS' Core IT Systems

System Name	Brief Overview of System	Oversight Agency
California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)	CalHEERS is an automated system that serves as the consolidated system support for eligibility, enrollment, and retention for Covered California, Medi-Cal, and Healthy Families. CalHEERS supports consumer application, eligibility rules, and health plan selection for insurance affordability programs, including Medi-Cal, Covered California, and the Children's Health Insurance Program. CalHEERS also includes a self-service portal, CoveredCA.org, for Medi-Cal and Covered California exchange coverage that is integrated into CalHEERS. Eligibility results are provided in real time when information is entered or updated in the portal.	DHCS and Covered California
California Statewide Automated Welfare System (CalSAWS)	CalSAWS is a system that includes the following functions: (1) a case management tool for the monitoring of the case; (2) a budget calculator for Medi-Cal and other social services programs; and (3) a public-facing consumer portal, BenefitsCal, to access eligibility information, complete required reports, and update case information.[7]	DHCS, California Department of Social Services and Local Counties

[5] Counties are in the process of migrating from three separate county-level consortia welfare systems (e.g., CalWIN) to one statewide CalSAWS system.
[6] Other eligibility and enrollment data systems that collect MCDI include the County Children's Health Insurance Program's eligibility system (MAXe2), the In-Home Supportive Services program's Case Management Information and Payrolling System, and the Social Security Administration data systems.
[7] Eligibility determinations are not made in the BenefitsCal portal.

Medi-Cal Eligibility Data System (MEDS)	MEDS is a statewide data hub that supports eligibility, enrollment, and reporting functions for Medi-Cal and other state and federal benefit programs. Serving as California's system of record for Medi-Cal and other programs, MEDS maintains eligibility history for Medi-Cal and other health and human services programs.	DHCS

Public Benefit Programs and Related Eligibility Systems

CalHEERS, CalSAWS, and MEDS are also the core systems used to collect and exchange data for Medi-Cal eligibility, enrollment, and redetermination. CalHEERS and CalSAWS determine eligibility for the identified State programs listed in Table 2. MEDS stores final eligibility data for all programs listed in Table 2.

Table 2: Benefit programs that leverage California's core eligibility and storage data systems.

Program*	CalHEERS	CalSAWS	MEDS
California Children's Services			X
CalFresh		X	X
CalWORKs		X	X
Children's Health Insurance Program	X		
Covered California	X		X
General Assistance		X	X
In-Home Supportive Services			X
Medi-Cal	X	X	X

*For program definitions, see Appendix 2.

The Current State

While the three core CalHHS systems outlined above are linked and regularly share certain MCDI data related to eligibility and enrollment in Medi-Cal, the systems' sources of truth often differ, leading to potentially incongruent data between varied users. Manual reconciliation and adjudication processes are burdensome, often resulting in an overwhelming backlog of unadjudicated MCDI changes and, in some instances, outdated contact information overwriting newer data. Outdated member contact information can also be costly. For example, one analysis estimated that returned mail processes can cost organizations $3-$25 per piece of returned mail.[8] Understanding the data sources, pathways, and hierarchies is foundational to developing a strategy for improvement.

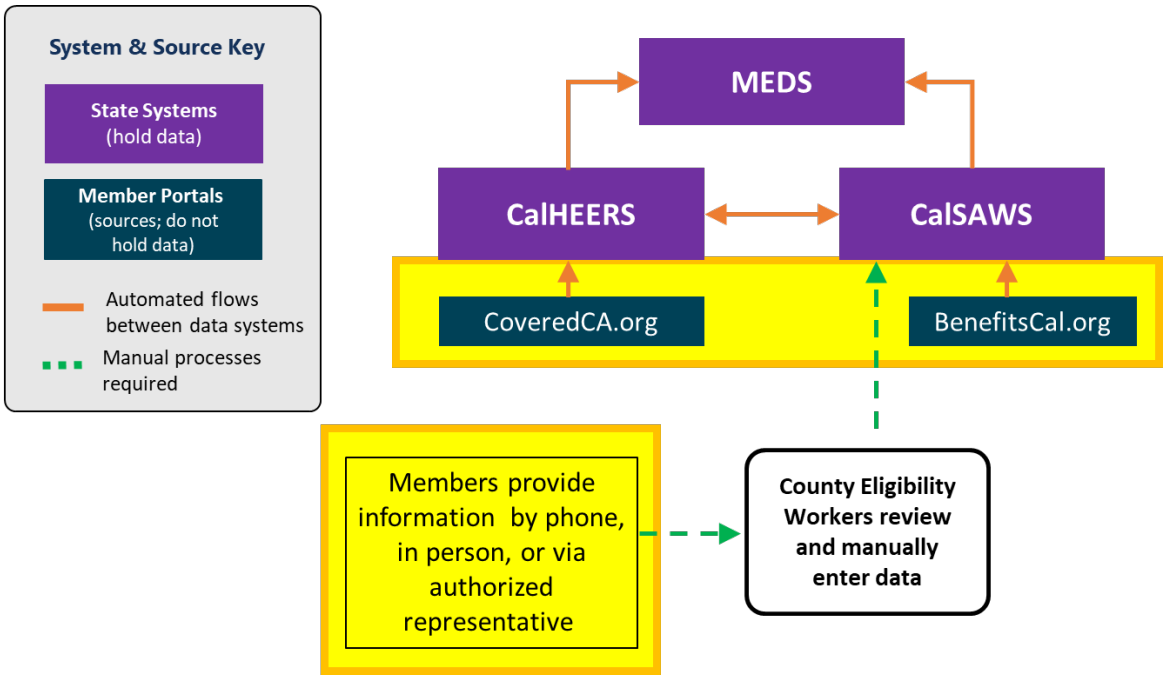
[8] Stemming the Tide: Control the Quantity and Cost of Returned Mail

Medi-Cal eligibility-related MCDI is transmitted to State and county systems through two pathways: (1) directly from members and (2) indirectly from the member (via an authorized representative) or from other sources. In all cases, member contact information is ultimately transferred to and stored in MEDS.

MCDI Enrollment Data Pathways: Directly Provided by Member

Figure 1 depicts the current flow of member data between systems and highlights the methods members use to provide MCDI for Medi-Cal enrollment and ongoing communication related to changes in circumstance and coverage renewals.

Figure 1: Current state of the systems and flows of MCDI directly from Medi-Cal members to support Medi-Cal enrollment



As depicted above, members have multiple methods to provide MCDI for eligibility, enrollment, and redetermination purposes:

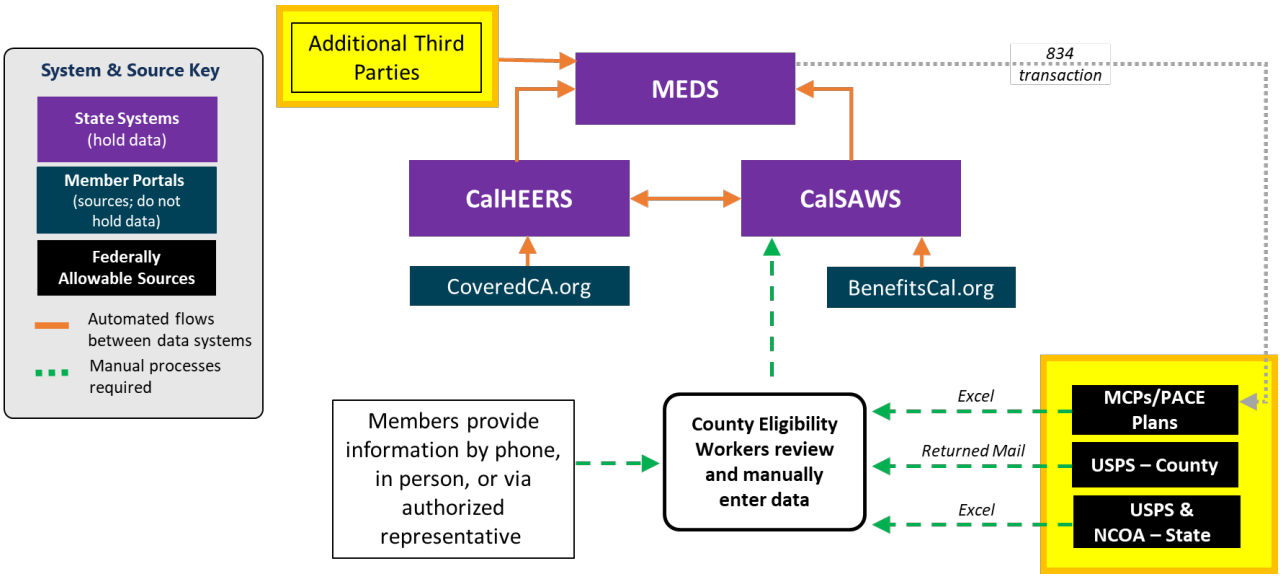
- **Using consumer-facing online portals** (CoveredCA and BenefitsCal) during initial application and renewal, or mid-year to report new changes. Changes are then electronically transferred directly to MEDS or CalSAWS for manual CEW adjudication.
- **Calling** CEWs who enter data manually into CalSAWS.
- **Visiting** county offices in person. CEWs enter data manually into CalSAWS.
- **Mailing or faxing** local county offices. CEWs enter data manually into CalSAWS.

When provided through these channels by a Medi-Cal member, changes to contact information are effectuated without additional validation.

MCDI Data Pathways: Indirect From Members or Other Sources

The highlighted portion of Figure 2 depicts the current flow of MCDI from "external" data sources to support Medi-Cal enrollment.

Figure 2: Current flow of MCDI from "external" data sources to support Medi-Cal enrollment



Sources of contact data, highlighted in yellow in Figure 2, include data from MCPs and Program of All-Inclusive Care for the Elderly (PACE) plans, the United States Postal Service (USPS), and the National Change of Address (NCOA) database.[9] Additional third-party sources of MCDI data are also flagged and described below. In the absence of a waiver of federal requirements, MCDI received through these pathways must be validated with the member before changes to contact information can be implemented in CalSAWS.[10] These allowable third parties currently exchange and use data in the following ways:

- **MCPs and PACE Plans**: MCPs store MCDI data for their Medi-Cal members. PACE plans hold data for members who receive services in community settings instead of in nursing homes or other care facilities. Both programs send and receive MCDI.

[9] Data is also manually entered into MEDS by authorized parties for programs such as In-Home Support Services (IHSS) and California Children's Services (CCS).
[10] Under 1902(e) waiver authority, DHCS received approval to leverage the NCOA database and data from plans to update contact information without validating the change with the member for the purposes of the continuous coverage unwinding. Once these waiver flexibilities sunset in May 2024, CEWs will need to resume additional attempts to confirm reported MCDI received from sources other than the Medi-Cal member.

MCPs and PACE plans regularly send Excel documents to the Counties and State that contain thousands of potential address changes. Currently, these changes must be manually adjudicated and entered into CalSAWS by CEWs. This lift is substantial, as each member change needs to be adjudicated by a CEW. And there is variability between counties in terms of frequency and volume. For example, one county in California receives a daily Excel file with approximately 5,000 member changes that need adjudication. Not all counties receive daily Excel files, but all MCPs must share a member change file with counties at least bi-monthly.

Address information in MEDS is transmitted to MCPs and PACE plans via an 834 transaction, a federally mandated file transmission standard to provide MCP member enrollment information. In some instances, the MEDS 834 file overwrites the plans' existing MCDI, which can result in outdated contact information from MEDS replacing more accurate contact information in the plans' systems. Some plans report that it can take up to four months before contact information included in the MEDS 834 file matches the updated contact information they have previously reported to the county. Such delays in having accurate information can result in significant disruption in member outreach and service delivery.

- **USPS and NCOA**: Currently, a state-contracted vendor receives returned mail from USPS resulting from State mailers, checks it against NCOA, and then sends Excel files to the counties that contain thousands of potential address changes to be manually adjudicated and entered into CalSAWS by CEWs. Counties also receive returned mail from USPS that contains in-state forwarding address information that must be manually processed and entered into CalSAWS one piece at a time.

DHCS quantifies if returned mail is received for some, but not all mailers. DHCS identified a return mail rate of 12% for the first member mailer sent out by DHCS for the COVID-19 PHE. This represents almost one million pieces of returned mail. For Outreach Mailer #2 that will be sent to each Medi-Cal member, DHCS will be tracking how many are returned.

Additional Third Parties: In addition to CalSAWS and CalHEERS, the Social Security Administration (SSA), Medicare intermediaries, and other smaller eligibility systems also provide MCDI data to DHCS via MEDS, creating an additional need for constant data adjudication. Reconciliation processes designed to protect data integrity in MEDS contribute to an immense volume of work at the county level; enormous Excel files (larger than those sent to the counties by MCPs) are transmitted quarterly to CEWs making manual adjudication on this scale impossible. See details in Appendix 3, "Additional MCDI Related Systems".

Opportunities for Improvement

DHCS, county agencies, MCPs, and other authorized parties must have accurate and timely contact information, particularly phone numbers and addresses, to locate members, communicate effectively and tailor outreach for enrollment activities. Achieving this vision will require addressing the processes depicted in Figure 2, including the data overwrites, manual adjudication of data, and consequent delays in updating information.

The business needs that could improve Medi-Cal outreach, enrollment, and re-determination include:

- **Leverage Third Party Data Sources**: To validate members' contact information, DHCS should utilize additional third-party databases and leverage existing databases wherever possible.

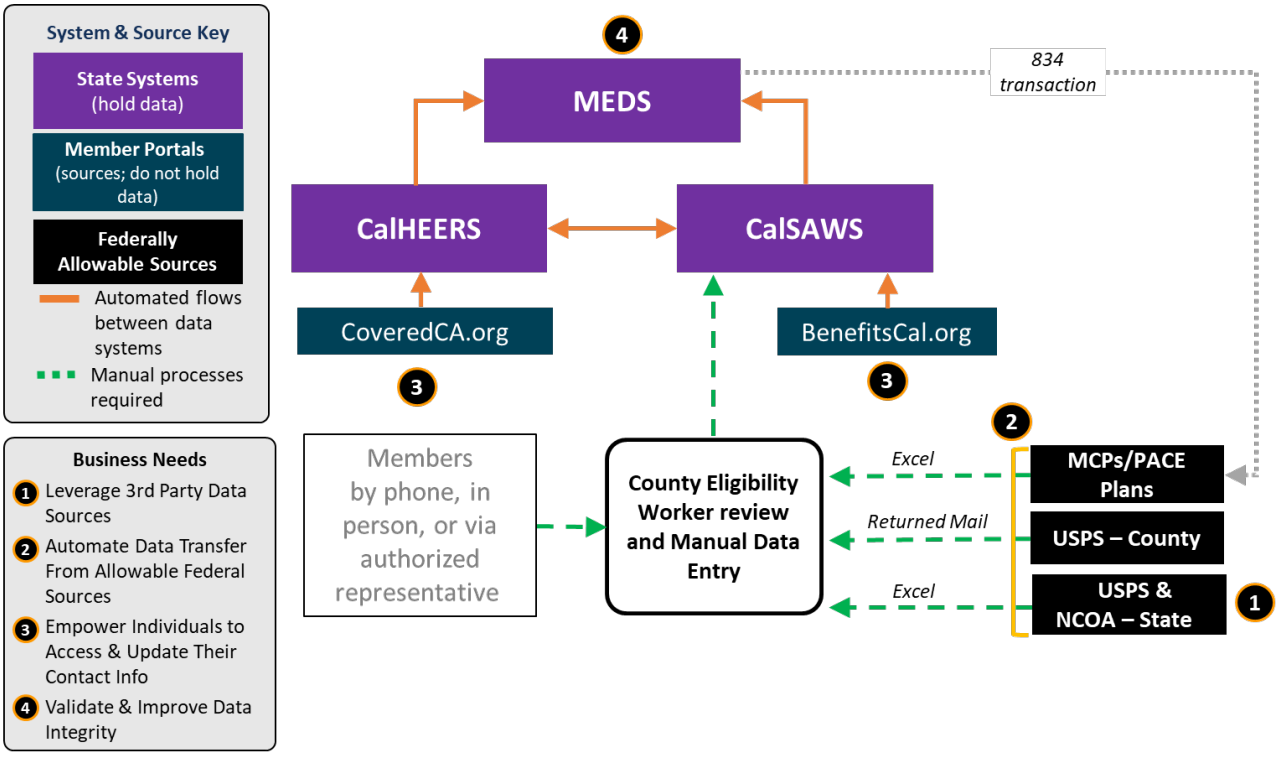
- **Automate Data Transfer From Allowable Federal Sources**: Stakeholders should develop automated electronic processes to transmit and validate MCDI and eliminate the need for manual data entry wherever possible.

- **Empower Individuals to Access and Update Their Contact Information**: Members should be aware of and able to access easy-to-use channels to update and manage their contact information including the ability to access assistance in multiple modalities.

- **Validate and Improve Data Integrity**: MCDI should be assessed to identify and reconcile conflicts prior to overwriting existing information in other systems.

Figure 3 enumerates the business needs to improve the data flow in support of Medi-Cal enrollment.

***Figure 3*:** Current MCDI data flows and opportunities for improvement



Each of the business needs above corresponds with potential functional requirements, policy considerations, and operational guidance as described below. Given the significant impact that a change of address can have on member's Medi-Cal eligibility and coverage, ensuring appropriate data governance processes and safeguards for each of the business needs below will be critical. For example, a member address that is changed within the same town or county could result in coverage loss if the member cannot be contacted or if mail is returned without a forwarding address. In addition, a change of address that crosses county or state lines can have significant impact on both eligibility and access to care.

1. **Leverage Third Party Data Sources**. To reduce the previously referenced workforce and cost burdens of incorrect MCDI, DHCS should proactively identify additional third-party databases and leverage existing databases wherever possible (e.g., NCOA and phone number verification tools) to validate member data. Leveraging these existing databases would build on the returned mail and NCOA initiatives implemented by DHCS as part of its continuous coverage unwinding plan.

1.1. Potential Functional Requirements
1. To the extent possible, implement automated accuracy checks from allowable third parties (e.g., NCOA) before transferring to CalSAWS for any additional validation by CEWs.[11] 2. Expand the use of third-party tools or processes (e.g., phone number validation by call center representatives) and integrate into automated processes.
1.2. Policy Considerations
▪ Interpretation of state statute may provide an opportunity for additional data validation approaches. ▪ Current continuous coverage unwinding waiver flexibilities will sunset in May 2024 at which time CEWs will need to resume additional attempts to confirm reported MCDI received from sources other than the Medi-Cal member. The waiver provided exemptions, such as not needing to contact a member when change of address is reported via NCOA or returned mail.
1.3. Applicable Statutes Or Operational Guidance
▪ California Code, Welfare and Institutions Code (WIC) § 14005.36 ▪ California Code, Welfare and Institutions Code – (WIC) § 14100.2 ▪ California Welfare and Institutions Code § 14015.5 (2019) :: 2019 California Code :: US Codes and Statutes :: US Law :: Justia ▪ 42 Code of Federal Regulations § 431.300 ▪ SHO# 22-001 ▪ SHO# 22-002 ▪ SHO# 22-004 ▪ Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations

[11] For the purposes of this document, **accuracy checks** are tasks that can be performed by vendors and other authorized entities. **Validation** is an activity, which per federal guidance, must be performed by local county CEWs in the member's county of residence.

2. **Automate Data Transfer From Allowable Federal Sources**. Currently, much of the data from allowable federal sources is transmitted in hard copy using manual processes. Automating processes, while also safeguarding members' coverage, could be instrumental in reducing processing delays and workflow burdens.

2.1. Potential Functional Requirements
1. Replace hard copy transcription and manual data reentry with automated electronic processes that reliably transmit and validate MCDI. 2. Provide the ability for a CEW or member to update MCDI without disrupting Medi-Cal coverage or enrollment in other programs (e.g., CalFresh, CalWORKs).
2.2. Policy Considerations
▪ Data elements, reporting periods, and other CalFresh and CalWORKs program requirements differ from those of Medi-Cal (i.e., data misalignment). ▪ DHCS does not have jurisdiction or authority over California Department of Social Services (CDSS) CalFresh and CalWORKs programs. ▪ DHCS and CDSS are currently exploring regulatory options to better align policy between programs. The U.S. Department of Agriculture, which oversees the Supplemental Nutrition Assistance Program (SNAP), known as CalFresh, has recently provided guidance to allow the use of the Medi-Cal address for CalFresh with some conditions, which is a potential pathway for policy alignment.
2.3. Applicable Statutes Or Operational Guidance
▪ California Welfare and Institutions Code § 14015.7 ▪ Code of Federal Regulations § 431.10 Single State Agency ▪ 22 CCR § 50004 ▪ California Welfare and Institutions Code § 10823 (e)(1)

3. **Empower Individuals to Access and Update Their Contact Information**. The best source of accurate MCDI is members themselves, yet many members are unaware of the urgency to alert DHCS and/or counties when changes occur, or they face other barriers to updating their contact information. In the future state, members should be aware of and able to access easy-to-use processes and systems to update and manage their contact information. This will involve using new and existing communication channels and ensuring they are as user-friendly as possible.

3.1. Potential Functional Requirements

1. Conduct activities to increase member awareness of the importance of updating MCDI and provide the most user-friendly channels through which to do so.

2. Design new and/or leverage existing online channels for optimal performance on smart phones and mobile devices.

3. Optimize all channels for low-literacy individuals, non-English speakers, and varying degrees of technical access and sophistication.

3.2. Policy Considerations

- DHCS should consider policies to maximize use of all the above channels. For example, policies could ensure members without phones are provided free mobile phones and data plans via the California Lifeline Program, and unhoused individuals made aware they can apply for a free P.O. box.

- January 2023 FCC guidance on robocalls and automated texting will help DHCS and partners reach members and build awareness.

- State departments are not subject to the requirements of the Telephone Consumer Protection Act (TCPA), providing significant flexibility in text and phone outreach.

- Counties, MCPs, and other state contractors can leverage the signed Medi-Cal application as express consent to send text message and make auto-dialed calls, in compliance with applicable federal and state requirements.

3.3. Applicable Statutes Or Operational Guidance

- FCC Declaratory Ruling

4. **Validate and Improve Data Integrity**. As stated previously, processing volume and overwrites are significant problems for DHCS and its MCP partners. In the future state, DHCS can use technology to automate adjudication and resolve the current overwriting of current data with old, inaccurate data.

4.1. Potential Functional Requirements
1. Create business rules and processes to automatically reconcile data, where possible, and otherwise provide improved discrepancy alerts to CEWs to adjudicate. This may involve identifying additional core data elements, such as MCDI update history, in DHCS' systems. 2. Provide members themselves with real-time discrepancy alerts and resolution tools to allow them to confirm or correct information.
4.2. Policy Considerations
▪ Policy considerations here are similar to those in business need #1 above with regard to interpretation of statute and which entities have authority at which point in the data flow process to adjudicate and validate MCDI. ▪ Safeguards will need to be put in place to ensure that automated adjudication which could affect a member's Medi-Cal enrollment (e.g., change of address outside of current county of residence) is appropriately reviewed and vetted.
4.3. Applicable Statutes Or Operational Guidance
▪ None applicable.

III. DRIVER #2: MCDI IN SUPPORT OF POPULATION HEALTH MANAGEMENT

Driver Overview

The DHCS Population Health Management (PHM) Program aims to ensure all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, leading to improved outcomes and health equity.[12]

Specifically, the PHM Program intends to:

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

In support of their population health management efforts, DHCS, MCPs, providers, counties, and other stakeholders require accurate, complete, and timely contact and demographic information to: (1) communicate with members and connect them to additional Medi-Cal services and programs such as Women, Infants, and Children (WIC); (2) understand health disparities at a population level, identify high-risk individuals, and engage them to address their needs.

Across these broad population health management aims, stakeholders face a number of challenges in their ability to leverage MCDI, including:

- **Reluctance to Share MCDI**: Some members are reluctant to provide certain types of demographic information (e.g., race, ethnicity, sexual orientation, gender identity, housing status) due to long-standing concerns about privacy and discrimination or, in some cases, the lack of clear understanding of the consent process, what information is optional to provide, and how their information may be used.[13]

- **Variability in Data Collection and Storage**: Data collection tools, requirements, and systems for MCDI vary across programs, and the differing approaches make it

[12] DHCS CalAIM: Population Health Management (PHM) Policy Guide Updated: December 2022
[13] Unlocking Race and Ethnicity Data to Promote Health Equity in California: Proposals for State Action

difficult to use data from different sources.[14,15] For example, members are given the option to respond to questions regarding sexual orientation and gender identity (SOGI) when applying for benefits through the Medi-Cal online application, but SOGI questions are not currently asked in the paper version of the Medi-Cal application.[16] In addition, MEDS only has the ability to collect male/female/non-binary gender selections at this time. However, for data validation with federal and State entities, the sex at birth is required and used for these validations.

- **Data Standardization Issues**: Standardization for a number of critical contact and demographic data elements (e.g., contact preference, race, ethnicity, sexual orientation, gender identity) remains in a nascent state. Even for data elements that have well-established national standards, interpretations vary and implementation is inconsistent.

- **Data Management and Governance Considerations**: As discussed in Driver #1, Medi-Cal members provide contact and demographic information to a wide range of state agencies, health plans, and providers. In some instances, members answer a contact or demographic question differently depending on the circumstances and their understanding of its intended uses. For example, a member may provide one phone number to their trusted primary care provider and a different number to a business office. The resulting variability of MCDI data elements across systems and over time makes it challenging to create a single "source" of truth and requires entities that collect MCDI to develop approaches for defining data management rules to reconcile, interpret, and use MCDI.

- **Persistence of Manual Processes**: As noted previously, MCDI is frequently manually collected and updated, which delays the provision of accurate MCDI to authorized users.

In the next section, the MCDI Strategy highlights two population health management aims:

- **Aim 1**: Increase stakeholders' ability to communicate with members and connect them to services.

- **Aim 2**: Understand health disparities at a population level, identify high-risk individuals, and engage them to address their needs.

Each aim includes a description of: (1) the current state of MCDI and examples of some of the challenges stakeholders face; (2) key data elements; and (3) the opportunities to improve the collection, accessibility, and use of MCDI.

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[14] Multiple DHCS systems (e.g., CalHEERS, CalSAWS, MEDS) receive SOGI data.
[15] For example, DHCS collects race and ethnicity data in separate fields in the Medi-Cal application, but these fields are combined into one field and marked as optional within the DHCS Data Warehouse.
[16] DHCS' behavioral health data systems do not collect SOGI data. However, non-Medi-Cal programs (e.g., FPACT, EWC, CCS, GHPP) collect gender identity information.

Aim 1: The Current State

The scenario below highlights some of the challenges in collecting, accessing, and using MCDI to communicate with members and connect them to services.

> *Rachel receives Enhanced Care Management (ECM) benefits through her MCP.[17] While meeting with her ECM provider to help support her housing needs, ECM staff learn Rachel is pregnant and obtain her latest contact information and communication preferences, which they enter into their system. These systems are not linked to DHCS systems, and Rachel's most current contact information is unavailable outside of the ECM provider's system. The ECM staff make sure Rachel is following up with her primary care provider, but they learn she is not sure if she is enrolled in WIC for provision of additional support to her (and eventually her newborn). ECM staff do not have access to the WIC enrollment system, and WIC enrollment data is not in the DHCS system of record database, MEDS. ECM staff provide Rachel a referral on paper to the WIC office closest to her current residence.*
>
> *Two weeks later, Rachel's ECM provider calls several times to make sure she enrolled in WIC, but Rachel doesn't answer her phone. The following week, however, Rachel attends her in-person ECM follow-up appointment and tells her ECM provider that she doesn't usually check her voicemail and moved to a new apartment last week. She has not yet updated her MCDI and does not know about the member self-service channels through which to do so. Once again, ECM staff update her MCDI in their system only, noting her preference to be contacted via text message. ECM staff also learn Rachel completed her virtual WIC enrollment before she moved but has not followed up or provided the WIC office with her new address. ECM staff provide a new referral to help Rachel transfer to a WIC office closer to her new residence. Since ECM staff do not have access to the WIC system, they provide another referral on paper. ECM staff text Rachel (her preferred communication modality) two weeks later and confirm she went to her first in-person nutritional counseling session at the WIC office nearest to her new residence.*

Data Elements

Below is a list of data elements for the scenario described above. In the future, additional data elements may be identified to support stakeholders' ability to reach patients and connect them with services.

- Member identifiers (e.g., date of birth, Social Security number, Medi-Cal client index number) for purposes of linking members to other data sources
- Name, current (first, last, middle)
- Legal guardian name/contact info/relationship to member

[17] ECM, as described in the CalAIM Enhanced Care Management (ECM) Policy Guide, is a whole person care management benefit, which includes coordinating the medical and social needs beyond the Member's mental health or SUD conditions.

- Pronouns
- Race/ethnicity
- Current address
- Previous address(es)
- Phone number
- Phone number type (home, work, mobile)
- Email address
- Preferred contact method (i.e., best way to contact)
- Data sharing preferences/authorizations on file

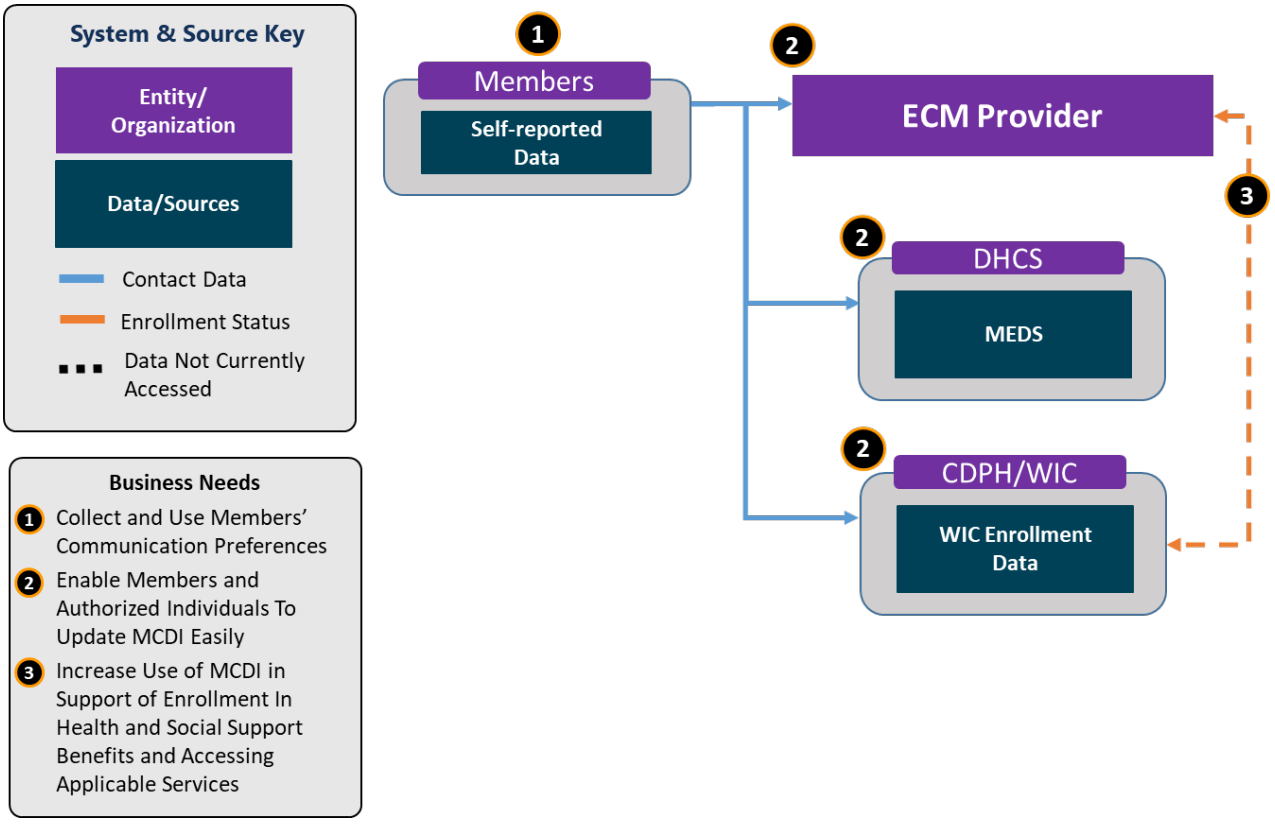
Some, but not all, of these data elements are currently collected or stored across various State, county and external stakeholders' IT systems.

Aim 1: Opportunities for Improvement

A critical first step in providing services to members is ensuring the ability to contact them to provide appointment reminders, updates on available services, etc. MCPs and providers require accurate contact information (e.g., telephone numbers, email addresses, home/business address) and information on communication preferences, which may include multiple addresses or contact methods.

Enumerated in Figure 4 are the business needs to improve the flow of MCDI in support of this aim.

Figure *4*: Current MCDI data flows and opportunities for improvement



The potential functional requirements, policy considerations, and operational guidance for each of the above business need are described below.

1. **Collect and Use Members' Preferred Methods of Communication**. With updated contact information and details regarding members' communication preferences, MCPs and providers can optimize their member outreach and engagement efforts. Improved communication, which includes communicating to members via their preferred methods, can enhance the member experience and augment member engagement.

1.1. Potential Functional Requirements
1. Entities that collect MCDI (e.g., state agencies, MCPs, providers) offer capabilities to collect, store, and share more detailed information about members' communication preferences.
1.2. Policy Considerations
▪ Efforts must ensure alignment with applicable national data standard efforts (e.g., United States Core Data for Interoperability) and/or California data standards.
1.3. Applicable Statutes Or Operational Guidance
▪ Currently, Medi-Cal's Single Streamlined Application includes questions regarding home and mailing address but doesn't include fields for applicants to choose preferred locations to be contacted or their preferred pronouns.

2. **Enable Members and Authorized Individuals to Update MCDI Easily**. As noted in the business needs of Driver #1 above, improving the ability for members and authorized users to update, modify, or correct their contact and demographic information will improve the accuracy and usability of the MCDI.

2.1. Potential Functional Requirements
1. Program administrators, providers, and other entities serving members provide information, including links to online portals, via multiple channels through which members and authorized users can provide and update MCDI. 2. Program administrators, providers, and other entities serving members design new and/or reconfigure existing consumer-facing portals for optimal performance on smart phones and mobile devices. 3. Optimize all channels for low-literacy individuals, non-English speakers, and varying degrees of technical access and sophistication. 4. Develop automated discrepancy alerts for members to resolve conflicting MCDI within state agencies' systems and via third party allowable sources, such as the NCOA database.
2.2. Policy Considerations
▪ Appropriate member data sharing consent(s) will need to be examined as consent requirement may vary across programs and agencies.
3.3. Applicable Statutes Or Operational Guidance
▪ None applicable.

3. **Increase Use of MCDI in Support of Enrollment in Benefits and Accessing Applicable Services**. Member enrollment in health and social support benefits would be significantly increased if authorized users can easily access and utilize MCDI. Gathering information in a modality that is accessible to a member and sharing data in a member-centered way between physical health, behavioral health, and social services systems will reduce member assessment and screening fatigue.

3.1. Potential Functional Requirements
1. Authorized users have streamlined access to complete, current MCDI. 2. Entities have data management approaches to reconcile data from multiple sources. 3. Entities automate required validation processes to the greatest extent possible. 4. Authorized users have appropriate permissions to view and use Medi-Cal members' information regarding their engagement with and/or enrollment in other social supports (e.g., WIC).
3.2. Policy Considerations
▪ Data sharing consents will need to be examined including what data can be shared versus viewed, by whom, and for what purposes. ▪ Providers are not currently federally approved third-party sources of MCDI in California. The State would need technical assistance from the Centers for Medicare & Medicaid Services (CMS) to understand options and the best path forward to getting approval to include providers as third-party sources. ▪ The current role of CEWs in validating MCDI would need to be considered in introducing a new source of MCDI that would ultimately be transmitted to MEDS.
3.3. Applicable Statutes Or Operational Guidance
▪ Assembly Bill (AB) 133, which includes provisions for the creation of Data Exchange Framework (DxF).

Aim 2: The Current State

A second aim of the population health management driver is to understand health disparities at a population level, identify high-risk individuals, and engage them to address their needs.

Below is a scenario that illustrates applicable workflows and data in support of this aim:

> *Consistent with the Bold Goals identified in DHCS' Comprehensive Quality Strategy, a MCP seeks information to help identify and close health disparities in child and adolescent well-child visits in the LGBTQ+ community. The MCP needs to use these stratified data to identify existing gaps in well-child visits among LGBTQ+ youth based on demographic and geographic considerations. This MCP also aims to tailor its provider network development to ensure adequate resources are available to the community and develop engagement strategies in a culturally and linguistically appropriate manner, including use of preferred pronouns. The MCP collects SOGI-related information on its members but struggles with the incompleteness of the self-reported data. The MCP also collects SOGI-related data from external sources, but this data is in inconsistent formats.*

Data Elements

Below is a list of data elements that support the population health management scenario described above. In the future, additional data elements may be identified to support stakeholders' ability to identify disparities and high-risk individuals.

- Member identifiers (e.g., date of birth, Social Security number, Medi-Cal client index number) for purposes of linking members to other data sources
- Name, preferred (first, last, middle)
- Name, current (first, last, middle)
- Name, suffix
- Name, previous/birth name (first, last, middle)
- Primary language
- SOGI-related information
- Pronouns
- Current address
- Previous address
- Incarceration status

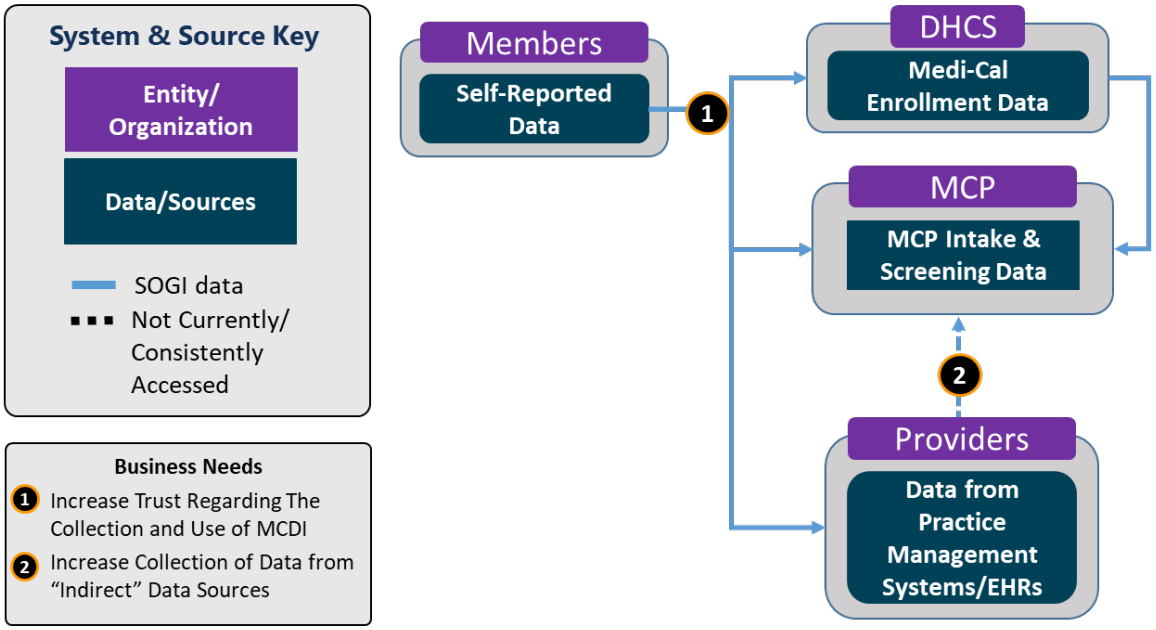
These data elements are currently collected or stored across various State, county and external stakeholders' IT systems, and flow between systems in a variety of automated and manual processes.

Aim 2: Opportunities for Improvement

The collection of MCDI, particularly discrete demographic information, is critical to identifying disparities in utilization of services, member experience, quality of care, and health outcomes. Inaccurate use of demographic information has been shown to cause negative health outcomes and social stressors.[18]

Enumerated in Figure 5 are the business needs to improve the flow of MCDI to understand health disparities, identify high risk individuals and address their needs.

Figure 5: Current MCDI data flows and opportunities for improvement



The potential functional requirements, policy considerations, and operational guidance for each of the above business needs are described below.

1. **Increase Trust Regarding the Collection and Use of MCDI**. Individuals are the source of truth regarding their MCDI, and many choose not to share it with state and county agencies, health plans, or providers.[19] Reluctance to self-identify may stem from long-standing concerns about privacy and lived experiences of discrimination.[20] Individuals may also have concerns with responding to MCDI questions because of lack of understanding regarding why the information is being collected, how it may be used, fears of being denied access to programs, and categories not aligning with how they self-identify.[21]

[18] All County Welfare Director Letter (ACWDL) 21-25
[19] Unlocking Race and Ethnicity Data to Promote Health Equity in California: Proposals for State Action
[20] Unlocking Race and Ethnicity Data to Promote Health Equity in California: Proposals for State Action
[21] Medicaid Race and Ethnicity Data Collection and Reporting: Recommendations for Improvement

Recognizing the importance of building and maintaining trust, many stakeholders are taking steps to improve their communication regarding the use of MCDI. Some counties, for example, are training staff on how to collect the information using culturally, linguistically, and trauma-informed methods.[22] To increase completeness of members' self-reported data, stakeholders should ensure that members are made aware of the importance of reporting accurate and complete MCDI and opportunities to control its release and use.

1.1. Potential Functional Requirements
1. Entities that collect MCDI publish information on both the benefits of providing accurate and complete MCDI and how member MCDI will be used. This information must be accessible and easy to understand in multiple languages. 2. Entities that collect MCDI publish education and training resources to help members understand and select the applicable MCDI options. 3. Entities that collect MCDI ensure members have granular control of their information, including who may access and use their information, and for what purposes.
1.2. Policy Considerations
▪ Alignment with CalHHS' cross-agency health equity efforts. ▪ Alignment with national efforts to improve the collection, exchange and use of MCDI.
1.3. Applicable Statutes Or Operational Guidance
▪ Section 1557 of the Affordable Care Act requires Medicaid programs to serve individuals equitably, and therefore prohibits Medi-Cal from denying or limiting health services that are ordinarily or exclusively available to cisgender individuals based on their gender identity or recorded gender. ▪ State law AB 1726 (Bonta, 2016) requires disaggregation of AAPI ethnic groups.

2. **Increase Collection of Data From "Indirect" Data Sources.** A number of studies point to the value of collecting MCDI from "indirect" data sources, such as clinical data from providers' electronic health record systems and health information exchanges (HIEs), or other external administrative data resources.[23,24] Data from

[22] DMH Information Notice 10-02 established countywide standards and criteria regarding cultural and linguistic competence. In accordance with the guidance, each county must develop and submit a cultural competence plan consistent with specific standards and criteria (per California Code of Regulations, Title 9, Section 1810.410).
[23] Unlocking Race and Ethnicity Data to Promote Health Equity in California: Proposals for State Action.
[24] Improving Medicaid Data To Advance Racial And Ethnic Health Equity In The United States.

additional sources can be used to pre-populate forms, which can reduce data entry for members. Expanding access to and use of MCDI from new data sources will require a combination of technical, operational, and regulatory changes.

2.1. Potential Functional Requirements

1. Entities that collect MCDI have the technical, operational, and legal capabilities to access data from "indirect" sources.

2. Entities that collect and share MCDI adhere to applicable national and/or California data standards to promote the usability of MCDI once it is shared.

3. Entities have the capability to distinguish and adjudicate differences in MCDI received from different data sources.

2.2. Policy Considerations

- Compliance with Executive Order N-16-22, which directs state agencies and departments to take additional actions to embed equity analysis and considerations in their mission, policies and practices.

- Expanding the collection and use of MCDI is a central tenet of CalHHS' strategy to improve health equity and includes: (1) promoting quality measures that include health equity benchmarks, and (2) advancing new contract requirements for Medi-Cal plans that focus on health equity.

- Alignment with national data standard efforts (e.g., United States Core Data for Interoperability, Health Level 7 Gender Harmony Logical Model, Fast Healthcare Interoperability Resources).

2.3. Applicable Statutes Or Operational Guidance

- AB 959 (Chiu, 2015) mandates that agencies collect voluntary self-identification information pertaining to sexual orientation and gender identity."
- SB 179 (2017) or California's Gender Recognition Bill allow for noting non-binary gender identity.
- DHCS has submitted an updated version of the Single Streamlined Application for CMS review that includes gender category options beyond male and female as well as pronoun options. If CMS approves the requested changes, DHCS will update Medi-Cal applications and systems to include the SOGI categories and response options.
- DHCS' All County Welfare Director Letter (ACWDL) 21-25 directs counties that use CalSAWS to collect optional SOGI data on the "Individual Demographics Detail" page.

IV. NEXT STEPS

The MCDI Initiative Draft Strategy identifies potential pathways to achieve a future state of MCDI where all stakeholders can submit, access, manage, and update MCDI in a trusted, timely, and efficient manner. The business needs and potential functional requirements laid out above provide a foundation for subsequent engagement with all stakeholders, including members, to better understand their priorities for MCDI.

Next steps include developing milestones, timelines, and detailed workplans. Ideally, this Strategy will enhance DHCS' ability to solve persistent challenges with MCDI and ensure the success of Medi-Cal's transformation.

V. APPENDICES

Appendix 1. Key Terminology

1. **Business needs** are the intended purposes or goals of an activity.

2. **Care management** is a team-based, person-centered approach to supporting an individual.

3. **Contact information** includes information on an individual's name; address (including current and previous addresses); phone numbers; email addresses; and preferred method(s) of contact.

4. **Data quality** includes the following dimensions:
   - Accuracy: The data reflects the real-world objects and/or events it is intended to model. Accuracy is often measured by how the values agree with an information source that is known to be correct.
   - Completeness: The data makes all required records and values available.
   - Consistency: Data values drawn from multiple locations do not conflict with each other, either across a record or message, or along all values of a single attribute. Note that consistent data is not necessarily accurate or complete.
   - Timeliness: Data is updated as frequently as necessary, including in real time, to ensure that it meets user requirements for accuracy, accessibility and availability.

5. **Demographic information** refers to particular characteristics of an individual or population can include data on date of birth, race, ethnicity, gender identity and expression, sexual orientation, preferred languages, disability, marital status, etc.

6. **Functional requirements** are linked to business needs and provide more detailed descriptions of the activities, and they include details on the processes and timing of the steps required to achieve the activity.

7. **Population health** refers to the health outcomes of a group of individuals. These outcomes depend on aggregation and analysis of data to support risk stratification, identification of gaps in care, assessment processes, and holistic care/case management interventions.

8. **Population health management (PHM)** means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identification of gaps in care, standardized assessment processes, and holistic care/case management interventions.

9. **Self-identified data** is data provided by individuals, and excludes data collected by entities that has not been validated by the individual or the individual's authorized representative.

Appendix 2. Data Elements

Below is a list of example data elements that constitute MCDI. The list is provided for informational purposes and not intended be exhaustive.

Data Element Name
Name, preferred (i.e., first, last, middle)
Name, current (i.e., first, last, middle)
Name, suffix
Name, previous (i.e., first, last, middle)
Name, birth name (i.e., first, last, middle)
Pronouns
Social Security number
Date of birth
Sex
Sexual orientation
Gender identity
Race
Ethnicity
Tribal affiliation
Disability
Marital status
Language, spoken
Language, written
Language, alternative format (i.e., Braille)
Current address
Previous address
Phone number
Phone number type (i.e., home, work, mobile)
Email address
Preferred contact method (i.e., best way to contact)
Related person's name
Related person's relationship
Guardian name (i.e., first, last, middle)
Guardian relationship
Medi-Cal Client Identification Number (CIN)
Medi-Cal Health Insurance Claim (HIC) number
Managed Care Plan information
Medicare plan information
Primary Care Physician information

Data Element Name
Citizenship status
Veteran status/branch
Incarceration status
Housing status
Years in current city/region
School status
School of attendance/alumni
Religious affiliation
Church of attendance
Income type
Trade/employment history
Poverty indicator
Minor emancipation status
Refugee and asylum-seeking status
Last updated field
Source of information
Rurality information
Data sharing preferences/authorizations on file

Appendix 3. Description of Programs, Initiatives, and Projects

California Advancing and Innovating Medicaid (CalAIM) Initiative

The MCDI effort is a key component of CalAIM – DHCS' plan to transform the Medi-Cal delivery system to improve the quality of life and health outcomes of Medi-Cal members. Accurate contact and demographic information is critical for ongoing Medi-Cal eligibility, enrollment, care management, and care coordination, and it is central to operationalizing the various transformational programs that make up CalAIM.

CalSAWS Migration

CalSAWS is a new enrollment portal being implemented incrementally across California counties. Replacing the two existing SAWS systems that will sunset in 2023, CalSAWS will be used by staff at county social service agencies to administer Medi-Cal and other social services. The CalSAWS migration is an enormous lift and priority for counties, impacting their ability to tackle additional projects.

Data Exchange Framework (DxF) and Digital Identity

The California Health and Human Services Agency (CalHHS) has established a statewide Data Exchange Framework (DxF) to develop a single data sharing agreement and common set of policies and procedures that will govern and require the exchange of health information among health care entities and government agencies in California. Part of the DxF is development of a strategy for unique, secure digital identities capable of supporting master patient indices to be implemented by both private and public organizations in California. Contact data attributes defined in the strategy will overlap and be valuable to the future state of MCDI.

Single Streamlined Application

California's Single Streamlined Application allows individuals to apply for Medi-Cal and other healthcare coverage programs, as well as CalFresh and CalWORKS. The application collects member contact information, including home and mailing addresses for applicants and their household members. California has recently been working to modify its single streamlined application to include an opt-in for consent for communications via text messages and other means for outreach related to eligibility, enrollment and other program administration activities. These modifications – which are currently undergoing review by CMS – will provide additional flexibility for County Eligibility Workers to conduct outreach to members for case management and other needs.

Public Health Emergency (PHE) Unwinding

At the start of the COVID-19 pandemic, Congress enacted the Families First Coronavirus Response Act (FFCRA), which provided enhanced federal funding to states under the condition that Medicaid programs keep people continuously enrolled in Medicaid coverage through the end of the month in which the COVID-19 PHE ends. These continuous coverage requirements have contributed to a significant uptick in Medi-Cal enrollment – as of May 2023, Medi-Cal was providing health coverage to nearly 15.8 million members.

While the Biden Administration officially ended the COVID-19 public health emergency on May 11, 2023, the continuous coverage requirement (which was de-linked from the larger PHE initiative) ended on March 31, 2023. Starting on April 1, 2023, California was required to resume standard renewal processes and conduct full redeterminations for all members who would have otherwise been subject to redetermination. This has the potential to result in significant coverage disruptions, in many instances because DHCS and county partners will have had minimal or no contact with members for an extended period due to the pause on renewal processes, and many members will not have updated their address or contact information since their last completed renewal (in most cases prior to the PHE).

To minimize member burden and promote continuity of coverage, DHCS launched a Continuous Coverage Unwinding Communication and Outreach Campaign that includes targeted public information, education, and outreach efforts to raise awareness among Medi-Cal members about the return of Medi-Cal redeterminations. These activities began when the continuous coverage requirement ended, and support to reach and retain eligible members will continue. DHCS Continuous Coverage Unwinding resources include:

- The Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan (Updated January 13, 2023)
- The Medi-Cal Continuous Coverage Requirement Phase 2 Toolkit

Population Health Management (PHM) Program

CalAIM's PHM Program seeks to establish a cohesive, statewide approach to all populations that brings together and expands on many existing population health strategies. Under PHM, Medi-Cal Managed Care Plans and their networks and partners will be responsive to individual member needs within the communities they serve while also working within a common framework and set of expectations. The PHM Program intends to:

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

Appendix 4. Data System and Service Descriptions

California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)

CalHEERS is overseen by DHCS and Covered California. CalHEERS is an automated system that serves as the consolidated system support for eligibility, enrollment, and retention for Covered California, Modified Adjusted Gross Income (MAGI) Medi-Cal, and CHIP (Medi-Cal Access Program, Medi-Cal Access Infant Program (MCAIP), and County Children's Health Initiative Program (CCHIP). CalHEERS supports consumer application, eligibility rules, and health plan selection for insurance affordability programs. CalHEERS includes a self-service portal, CoveredCA.org, for Medi-Cal and Covered California exchange coverage that is integrated into CalHEERS. Eligibility results are provided in real time when information is entered or updated in the portal.

California Statewide Automated Welfare System (CalSAWS)

CalSAWS is overseen by DHCS, California Department of Social Services (CDSS) and local counties. The implementation of CalSAWS will merge California's most recent three county-level consortia welfare systems and will support six core programs: California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, Medi-Cal, Foster Care, Refugee Assistance, and County Medical Services. CalSAWS includes the following functions: (1) a case management tool for the monitoring of the case; (2) a budget calculator for Medi-Cal and other social services programs; and (3) a public-facing consumer portal, BenefitsCal, to access eligibility information, complete required reports, and update case information.

Health Exchange and Medi-Cal Interface (HEMI)

HEMI is a component of the CalHEERS. Through HEMI, DHCS updated the MEDS legacy interfaces to be interoperable, real-time web service interfaces and integrated those interfaces with various health eligibility and enrollment systems such as CalHEERS, CalSAWS, CalWIN, and various state agencies to enable real-time eligibility determination and enrollment for MAGI Medi-Cal, Advance Payment of Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR).

MIS/DSS (Management Information System/Decision Support System)

The MIS/DSS is a subsystem of the California Medicaid Enterprise System (MES) and serves as the DHCS Medi-Cal Data Warehouse. As a current and comprehensive database of eligibility, provider, and claims information for the Medi-Cal program, the MIS/DSS contains Medi-Cal fee-for-service claim and managed care encounter records from October 1, 2004, including associated eligibility and provider data. MIS/DSS integrates data from the Medi-Cal Fiscal Intermediaries (medical and dental), County Organized Health Systems, CDSS, and Department of Developmental Services. MIS/DSS includes a relational database that provides a one-stop-shop to retrieve data for reporting, analysis, and decision support. The system is refreshed on a monthly basis with the most recent available data.

Medi-Cal Eligibility Data System (MEDS)

MEDS is overseen by DHCS. MEDS is a statewide data hub serving a variety of eligibility, enrollment, and reporting functions for Medi-Cal and other state and federal benefits. MEDS maintains current and historical eligibility data for Medi-Cal and other health and human services programs. MEDS has data exchanges and interfaces with the SAWS, the federal Social Security Administration, Medicare intermediaries, CalHEERS, Employment Development Department through the California Department of Social Services, the Franchise Tax Board and the Internal Revenue Service.

A reconciliation process compares SAWS data to MEDS data and updates MEDS when appropriate to sync to the SAWS record. The reconciliation process produces MEDS alerts that inform the Counties when reconciliation results in an inconsistency between MEDS and the SAWS or when an attempted MEDS change was processed with successful, failed, or partially successful outcomes. The reconciliation also generates various reports to the County for review and action. Other systems, including the County Children's Health Insurance Program's eligibility system, the In-Home Support Services program's Case Management Information and Payrolling System, and the Post-Adjudicated Claims and Encounters System, also provide MCDI to DHCS via MEDS.

Population Health Management (PHM) Service

The PHM Service is a statewide data-driven service that will support whole-person care by integrating and aggregating data from a wide range of state and non-state systems. When launched, the PHM Service will provide MCPs, providers, counties, members, and other authorized users with access to comprehensive data on members' health history, needs, and risks, including historical administrative, medical, behavioral, dental, and social service data and other program information from disparate sources. The PHM Service will use this data to support risk stratification, segmentation and tiering, assessment and screening processes, and analytics and reporting functions. The PHM Service will also improve data accuracy and timeliness by providing members with the ability to update their information and improve DHCS' ability to understand population health trends and the efficacy of various PHM interventions as well as strengthen oversight.

Statewide Verification Hub (SVH) Project

The SVH Project is an agency-wide IT solution that will improve California families' access to services by streamlining the eligibility verification process for many means-tested public benefit programs. Initial efforts are focused on CalFresh, CalWORKs and Medi-Cal (for the non-modified adjusted gross income members). The SVH will verify an applicant's eligibility information against a variety of data sources to confirm accuracy. The executive sponsor for the SVH Project is the CalHHS Office of the Agency Information Officer with formal project sponsorship by the CDSS and DHCS.

Appendix 5. Measures of Success

Below are potential measures to assess the MCDI Initiative's progress in meeting its goals that are framed within the MCDI two drivers.

Driver #1: Medi-Cal Outreach, Enrollment, and Redetermination

MCDI Goals	Potential Measures Of Success
1. Collecting and Updating MCDI	1. Volume of returned mail to DHCS 2. Volume of returned mail to counties 3. Volume of members who provide updated contact information 4. Usability of channels through which members provide and update their information 5. Reduction in the time to clear data processing 6. Reduction in stakeholders' costs and time to collect contact information 7. Quality of contact data from data sources (e.g., data accuracy, completeness, consistency with data standards) 8. Number or percentage of members who do not have a working phone number
2. Accessing MCDI	1. Number of accessible/linked data sources and systems 2. Creation of publicly accessible tools to collect and update contact information 3. Number of authorized users with the ability to access and update their contact information 4. Reduction in stakeholders' costs and time to access contact information 5. MCPs' validation of improvements in outdated data overwrites from MEDS
3. Using MCDI	1. Reduction in stakeholders' costs and time to use contact information 2. Number of members who lose Medi-Cal coverage
4. Building Trust	1. Member feedback regarding their trust in the receipt and use of their MCDI for Medi-Cal enrollment 2. Volume of member complaints regarding use of their contact information for Medi-Cal enrollment 3. Volume of successful text outreach 4. Volume of members using online portals to update contact information 5. Incidence/Volume of MCDI changes in a particular time period made by the same member

Driver #2: Population Health Management

MCDI Goals	Potential Measures Of Success
1. Collecting and Updating MCDI	1. Usability of channels through which members provide and update their information 2. Degree of automation 3. Reduction in stakeholders' costs and time to collect MCDI information 4. Quality of MCDI from data sources (e.g., data accuracy, completeness, consistency with data standards)
2. Accessing MCDI	1. Number of accessible/linked data sources and systems 2. Creation of publicly-accessible tools to collect and update contact information 3. Number of authorized users with the ability to access and update their MCDI 4. Reduction in stakeholders' costs and time to access contact information
3. Using MCDI	1. Percentage of individual records available to authorized users with MCDI 2. Reduction in stakeholders' costs and time to access MCDI 3. Percentage of phone numbers that are not functional or out of date 4. Increased enrollment in WIC, CalFresh and other non-Medi-Cal programs
4. Building Trust	1. Percentage of an organization's staff trained in the appropriate collection of MCDI 2. Number of organizational staff who have completed cultural competency training 3. Number of member and family complaints related to cultural competency 4. Member feedback regarding their trust in the receipt, storage, and sharing of MCDI