POLICY INTO ACTION

Context

Medi-Cal Connect is an innovative population health management solution that aggregates data from multiple sources to provide a complete, integrated view of Medi-Cal members' health, needs, and risks. It is designed to support the policy goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiative by enhancing data access and coordination across the Medi-Cal program. Exploring Medi-Cal Connect is crucial to understanding its capabilities and maximizing its data.

This guide demonstrates how Managed Care Plans (MCPs) can leverage Medi-Cal Connect to effectively implement population health policies established by the Department of Health Care Services (DHCS) and ensure high-quality delivery of required benefits. It serves as a resource to support exploration and utilization of Medi-Cal Connect, without introducing new policies or requirements. The goal is to help MCPs streamline their workflows and foster a stronger, ongoing partnership between DHCS and its managed care partners.

Each section of this guide highlights a specific policy, explains its relevance to Medi-Cal Connect functionality, and outlines possible corresponding actions—at the population health level and for individual members.

Because Medi-Cal Connect is new, best practices and workflows are still developing. This guide is meant as a starting point for learning and exploration, not a complete catalog of every policy or use case. We will continue to update this document as new feedback and practices emerge.

We seek your feedback to understand how we can adapt both Medi-Cal Connect and this document to better meet members' and MCP needs. Please share your feedback with us through the Medi-Cal Connect Help Desk: Medi-CalConnectHelpDesk@gainwelltechnologies.com

Table of Contents

1.0 Introduction

This paper is organized by benefit or program, with some specific suggestions that may help various Plan employees to get started with Medi-Cal Connect. The Quick Reference Table gives a summary of actions to take within Medi-Cal Connect and how to apply these ideas to outreach. The Plan employee most likely to take the actions are noted.

Each policy area has a narrative that discusses a simple way to use the service. In the Reference Materials, we have included sample screen shots to support use. In addition, we have developed more sophisticated approaches to using Medi-Cal Connect, to give a sense of the possibilities. Guidance is structured into two distinct formats to accommodate varying levels of detail and audience needs:

- **Option One: Simple Narrative**. This is a straightforward, cohesive explanation embedded directly within the main body of the paper.
- **Option Two: High-Level, Non-Technical Use Cases**. Located in the Reference Materials, these use cases focus on real-world applications without requiring technical expertise.

DHCS engaged MCPs during the development of this paper, gathering input that highlighted several key areas of focus. These themes are addressed in the sections that follow.

1.1 Medi-Cal Connect Data Sources and Caveats

Claims data is the backbone of Medi-Cal Connect. Other data inputs are listed in the table below. Over time, more data sources will be added. The majority of data in Medi-Cal Connect starts with 2021 with the exception of Enhanced Care Management (ECM) and Community Supports data. ECM and Community Supports data start with data from the Quarterly Implementation Monitoring Report (QIMR) in January of 2022 and then in April of 2024, data in the JSON format is used.

The Longitudinal Member Record (LMR) presents the most recent 24 months of data. There is a claims lag of approximately 3 to 6 months. The LMR is not a real time health record and should not be considered as such. It does, however, bring together multiple data sources to provide a more complete view of each member. Even with the claims lag, Medi-Cal Connect can be used extensively for population health management and care coordination purposes, as described in this document. DHCS encourages MCPs to validate the data with their own data systems.

Medi-Cal Connect contains rich data. DHCS will be incorporating additional data sources in future releases and expects to include more programs and services flags, supplemental aid codes, and inputs from our state partners.

Table 1. Medi-Cal Connect Data Sources

Data Sources	Description	Plan Data Feed	Risk API	LMR API	Portal
All-Payer Claims Database Common Data Layout (APCD-CDL)	Comprehensive claims data, including medical, behavioral, dental, and pharmacy claims and member demographic information	X	X	X	X
Supplemental Eligibility (SUME)	Enriches core eligibility data by adding detailed member demographic and contact information		X	X	X
Enhanced Care Management / Community Supports QIMR and JSON	Comprehensive Enhanced Care Management and Community Supports data, including encounters and providers or organizations involved in care			X	X
274 File	Contains provider attribution data for medical, dental and behavioral health			X	X
Primary Care Provider Assignment (PCPA)	Contains PCP assignment and contact information by member			X	X
Women, Infants, and Children (WIC)	Contains a flag indicating potential eligibility for the WIC federal assistance program			X	X
Risk Tiering	Contains Risk tiering data from the APCD-CDL and SUME files		X	X	X
Quality Measures	Contains Risk Tiering data from the APCD-CDL and SUME files			X	X
Programs and Service Flags	Contains program and Service eligibility and enrollment flag data derived from APCD-CDL, SUME, ECM/Community Supports QIMR & JSON			X	X

Medi-Cal Connect takes continuous enrollment into account. Continuous enrollment for quality measures calculations is defined using NCQA specifications when we have the full year of data. Generally, continuous enrollment requires a member to be enrolled in Medi-Cal for at least 11 months in any given year to be considered in a calculation. If a member is included in a calculation, the member is then attributed to the appropriate MCP by assessing which MCP they were enrolled in on the last month of the measurement year or last month they were in enrolled in Medi-Cal. Regarding enrollment in programs (like ECM and Community Supports), we have not grouped these members by length of enrollment. DHCS is interested in pursuing this enhancement in future iterations of Medi-Cal Connect.

There is great interest in the most accurate and up to date member contact information and DHCS understands the need for current information for outreach. Member contact information in Medi-Cal Connect will be the same as what is shared with plans. Medi-Cal Connect does not have a feature for updating member contact information and members must update their contact information with the county Medi-Cal offices However, some features (such as Care Team in the LMR and Pharmacy Claims) may provide clues about how and where to contact members. A Care Team member may have more current contact information; a pharmacy at which the member picks up their medications may also have better information. These sources can be leveraged by Plan Care Managers and others trying to contact members. For Release 3 of Medi-Cal Connect, MCPs that directly contract with DHCS (referred to as Prime Plans) have been given access, given that member attribution is clear for Prime MCPs. We understand that there is very strong interest in allowing delegated entities to have direct access to Medi-Cal Connect. At this point in development, we do not have a way to allow access for delegates. DHCS is looking for a solution that may help alleviate this issue. Prime Plans may share the data downstream with their delegated entities in accordance with regulation.

Behavioral health plans (BHPs) will have access to Medi-Cal Connect with Release 4 in November 2025, just as MCPs will have with Release 3.1. BHPs will be able to access dashboards and the LMR as well as the Learning Management System (LMS). While member risk levels determined by DHCS' new Risk Segmentation, Stratification, and Tiering (RSST) algorithm will be available in each member's LMR, BHPs are not subject to the RSST PHM Policy to which MCPs are subject. State Partners and Agencies are also included in Release 4.

2.0 Summary Table: Policy → Tool → Action

Policy	Tool			Action
Policy	**Plan Role**	**Medi-Cal Connect Functionality**	**How to Use Functionality**	**Other Actions**
Doula	PHM Analyst	Quality Measure Dashboard	Compare outcomes/ quality measures by Doula utilization	Understand how Doula utilization affects quality outcomes.
	Care manager	LMR - Member Info	Access demographics and plan details	Outreach to member
		LMR - Diagnosis summary	View chronic conditions and provider history	Connect member to needed care and services
		LMR - Programs and Services	Check eligibility for reproductive health services	
		LMR - Care team	Identify PCP and care manager	
		LMR - Risk Profile and Measures	Review risk tier and quality measures	
		LMR - Claims History	Access prenatal and postpartum claims	
Community Health Workers	PHM Analyst	Quality Measure Dashboard	Compare outcomes/quality measures by CHW utilization	Stratify by race and ethnicity
	Care manager	LMR - Risk Profile and Measures	Identify high-risk members	Inform CHW assignment
		LMR - Programs and Services	Check CHW eligibility	Refer for CHW intervention

Policy	Tool			Action
Policy	**Plan Role**	**Medi-Cal Connect Functionality**	**How to Use Functionality**	**Other Actions**
Community Supports	PHM Analyst	Quality Measure Dashboard	Compare outcomes/ quality measures by Community Supports utilization	Benchmark against state averages
	Care manager	LMR - Programs and Services	Identify eligible but non-utilizing members	Share with Community Supports providers
Complex Care Management	Care manager	LMR - Claims History	Review prior utilization	Better understand member context.
		LMR - Care team	Identify care manager and PCP	Link to primary care and support teams
		LMR - Risk Profile and Measures	Check for ECM eligibility	Connect member to needed care and services
Dyadic Services	PHM Analyst	Quality Measure Dashboard	Compare outcomes/ quality measures by dyadic service utilization	Stratify by race, ethnicity, and language
	Care manager	LMR - Claims History	Identify families needing outreach	Better understand member context.
		LMR - Risk Profile and Measures	Use risk tier to prioritize outreach	N/A

Policy	Tool			Action
Policy	**Plan Role**	**Medi-Cal Connect Functionality**	**How to Use Functionality**	**Other Actions**
Enhanced Care Management	PHM Analyst	Quality Measure Dashboard	Compare outcomes/ quality measures by ECM service utilization	Stratify by demographic details
	Care manager	LMR - Programs and Services	Check ECM eligibility flags	Outreach to eligible members
		LMR - Care team	Coordinate across providers	Link to primary care and support teams
RSST	PHM Analyst	Dashboard - RSST Outputs	Transition MCP to use of standardized risk tiers	Flag population segments being underserved by own risk tiers
	Care manager	LMR - Risk Profile and Measures	Identify high-risk members	Integrate tiers into workflows
Transitional Care Services	Care manager	LMR - Claims History	Support discharge planning	Coordinate follow-up services
		LMR - Care team	Identify providers involved in care	Coordinate follow-up services
		LMR - Risk Profile and Measures	Flag high-risk discharges	Engage ECM CM if needed Assign TCS care manager

Note: All DHCS Benefits and Services for which Medi-Cal Connect tracks utilization in the Quality Measures dashboard reflect the same demographic stratification capabilities,

including age, sex, ethnicity, race, and language. This includes Doula, Community Health Workers, Community Supports, Dyadic Services, and ECM as listed above.

3.0 Community Health Workers

The Community Health Worker (CHW) benefit launched July 1, 2022. As trusted members of the community, CHWs can address a variety of health and health-related issues including supporting members' engagement with their PCP, identifying services addressing SDOH needs, and promoting wellness and prevention. MCPs are encouraged to use CHWs through the CHW benefit or partner with the member's PCP to facilitate member outreach and engagement.

The links to the related policy documents are below:

- PHM Policy Guide
- APL: CHW Services
- CHW Provider Manual

3.1 Medi-Cal Connect Supporting Functionality

1. The Quality Measures Dashboard includes the ability to filter Quality Measures (QM) by CHW utilization. A user can view differences in health outcomes for utilizing versus non-utilizing members. This data can also be stratified by age, sex, ethnicity, race, and language demographic data.

2. The LMR in the Portal provides MCPs and care managers individual member information, including their RSST risk tier and potential program eligibility. The LMR includes:

- Member Information for Plans and Care Managers: Member demographics and contact information as well as plan detail and health plan enrollment history.
- Diagnoses Summary: Provides a list of the member's chronic conditions, list of active and historical conditions, along with providers associated with each specific diagnosis.
- Programs and Services: Ability to review the Programs and Services (ie ECM, Community Supports, WIC etc.) a member might be eligible for or enrolled in. The flags help MCPs with care coordination and prioritize members for CHW outreach.

- Care Team: Ability to view member's PCP, ECM or CCM care manager (if enrolled) and most frequently seen provider including those in specialty care and behavioral health.
- Risk Profile and Measures: Ability to view risk tier within the Adverse Event, Underutilization and Social risk domains. These risk tiers flow from the RSST algorithm. (See companion document: RSST Transparency Document July 2025.)
- Quality Measures: Member-level quality measures indicate which measures have been met or remain outstanding for the individual. These measures are based on NCQA HEDIS measures.
- Claims History: Plans can access member information with all historical claim data (those from every MCP a member has been enrolled with, including BHPs) and medication information inclusive of institutional, pharmacy, outpatient, dental, and behavioral health claims.

3.2 How Medi-Cal Connect may be used for Increasing Awareness and Access to as well as Monitoring and Oversight of the CHW benefit

Population Health Management:

- Compare utilization to member demographics and health conditions that can be addressed by CHWs, to address equity gaps and identify populations that would benefit from CHW services
- Analyze members in high-risk tiers that have not engaged in services and leverage CHW interaction link them to primary and specialty care.
- Benchmark performance against state averages to inform quality improvement plans

Care Management:

- Identify members eligible for CHW services but not yet engaged; inform outreach strategies

4.0 Community Supports

Community Supports services launched in January 2022 and were informed by the Whole Person Care and Health Homes Program pilots. Community Supports are supportive services designed to enhance the overall health and wellbeing of Medi-Cal

MCP members. By addressing members' health-related social needs, these services help members live healthier lives and prevent the need for more intensive and costly care.

The links to the related policy documents are below:

- ECM Policy Guide
- Community Supports Policy Guide (Volume 1 and 2)
- APL 21-017 – Community Supports Requirements
- MCP Contract – Community Supports Provisions (Exhibit A, Attachment III, Section 4.5)

4.1 Medi-Cal Connect Supporting Functionality

The Quality Measures Dashboard includes the ability to filter Quality Measures by Community Supports utilization. A user can view differences in health outcomes for utilizing versus non-utilizing members and stratify by age, sex, ethnicity, race, and language.

The Longitudinal Member Record in the Portal provides MCPs and care managers a view of member-specific information, including RSST risk tier and potential program eligibility, to assist with member identification for Community Supports services. The Programs and Services section of the LMR shows the programs (i.e. ECM, Community Supports, WIC, etc.) a member might be potentially eligible for or enrolled in. The flags are designed to help care coordinators prioritize members for Community Supports outreach.

4.2 How Medi-Cal Connect may be used for Monitoring and Implementation of Community Supports

Population Health Management

- Compare utilization of Community Supports to member demographics including race, ethnicity, age, language, and location to identify equity gaps and populations that would benefit from engagement in Community Supports services.
- Analyze member data for common demographics, care needs, and geographies to understand how member engagement efforts and Community Supports delivery can be targeted.
- Develop geographically tailored outreach strategies.

- MCPs can view Quality Measures by Community Supports Utilization, including race and ethnicity demographic data to better understand the intersection of Community Supports utilization and health outcomes. Outcomes for those who use Community Supports services can be compared to the outcomes of members who do not use the services.
- Benchmark performance against statewide averages to inform quality improvement plans related to Community Supports service utilization and related health outcomes as reflected in Quality Measures.
- Differences in health outcomes for members utilizing/not utilizing Community Supports services can be used to inform and influence strategies to increase service uptake.
- MCPs may use the data to inform efforts to increase member and provider awareness which, in turn, could increase awareness and utilization.
- Better understand geographic distribution of the social drivers of health that Community Supports services seek to alleviate. Leverage data to justify provider expansion or changes to Community Supports elections.

Care Management

- Identify members eligible for Community Supports services but not yet engaged; inform outreach strategies. Share this information with Community Supports providers.

5.0 Complex Care Management

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

Note: CCM functionality is coming to Medi-Cal Connect in November 2025.

5.1 Medi-Cal Connect Supporting Functionality

The Longitudinal Member Record in the Portal will give MCPs access to member-specific information (including risk tier and possible program eligibility) to assist with CCM member identification and outreach. Specifically, Care Team and Claims History will be a

rich source of information. 5.2 How Medi-Cal Connect may be used for Monitoring and Implementation of CCM

Care Management

- MCPs may more effectively implement CCM if their care managers have access to the LMR. The LMR contains rich data on member medical and behavioral health history. This historical record can be especially vital when a member is new to the MCP.
- Useful data points include: list of prior claims information; assigned PCP; other care team members; and any specific areas of high-risk that may warrant further (optional) assessment based on DHCS's RSST policy.
- Care managers may also see that a member receiving CCM is eligible for ECM and offer that service, as appropriate.

6.0 Doula Services

Improving maternal health is one of DHCS' Bold Goals. DHCS introduced doula services as a covered benefit on January 1, 2023. Doula services, available through fee-for-service providers and MCPs, provide personal support to birthing individuals throughout pregnancy and for one year postpartum. This support encompasses emotional and physical assistance during pregnancy, labor, birth, and the postpartum period, as well as support before and after miscarriage or abortion.

Doula services can be provided in-person or through telehealth modalities (i.e., audio-visual synchronous communications) in various settings, including member homes, provider offices, hospitals, and alternative birth centers.

The links to the related policy documents are below:

- PHM Policy Guide
- ECM Policy Guide
- CQS
- APL23-24

6.1 Medi-Cal Connect Supporting Functionality

1. The Quality Measures Dashboard includes the ability to filter Quality Measures by Doula Services Utilization and relate these to specific measures for Reproductive Health as a pre-defined subset in the CMS Core Set including age, sex, ethnicity, race, and

language demographic data.

2. The Longitudinal Member Record in the Portal will show member-specific information including access to Reproductive Health Claims History including Prenatal and Postpartum Care.

6.2 How Medi-Cal Connect may be used for Increasing Awareness and Access to as well as Oversight and Monitoring of Doula Services

Population Health Management

- To understand the relationship between doula utilization and health outcomes, MCPs can analyze Quality Measures, including specific reproductive health measures from the CMS Core Set, stratified by doula service utilization and demographic factors such as race and ethnicity.
- Compare doula utilization to member demographics and care needs that can be addressed by doulas including race, ethnicity, and language to identify and plan strategies to address equity gaps.
- Benchmark performance against statewide averages to inform quality improvement plans related to doula benefit utilization and related reproductive health outcomes.
- Differences in health outcomes for members utilizing/not utilizing doula services can be used to inform and influence strategies to increase benefit uptake.
- MCPs may use the data to inform efforts to increase member and provider awareness which, in turn, could increase awareness and utilization.

Care Management

- Identify members eligible for doula services but not yet engaged; inform outreach strategies and Care Team engagement.

7.0 Dyadic Services

DHCS added dyadic services as a benefit effective January 1, 2023. Dyadic services are available to Medi-Cal members through MCPs and FFS.

Dyadic services are a family and caregiver focused model of care intended to address developmental and behavioral health conditions of children (Members under age 21)

and includes services provided to parent(s)/caregiver(s) (known as a "dyad"). Dyadic services help improve access to preventive care for children and immunization completion. They also address coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health. Dyadic services include the following:

- Behavioral health (DBH) visits
- Access to community supports services
- Psychoeducational services
- Family training and counseling for child development

The link to the related policy document is below:

- APL 22-029

7.1 Medi-Cal Connect Supporting Functionality

The Quality Measures Dashboard includes the ability to filter Quality Measures by Dyadic Services Utilization. It enables users to see the differences in health outcomes for members who use and those who do not use dyadic services, including age, sex, ethnicity, race, and language demographic data.

7.2 How Medi-Cal Connect may be used for Increasing Awareness and Access to as well as Oversight and Monitoring of Dyadic Services

Population Health Management

- MCPs can view Quality Measures for members utilizing versus not utilizing Dyadic Services, including race and ethnicity demographic data to better understand the intersection of dyadic utilization and health outcomes.
- Compare dyadic utilization to member demographics including race, ethnicity, and language to identify and plan strategies to address equity gaps.
- Benchmark performance against statewide averages to inform quality improvement plans related to dyadic benefit utilization and related developmental and behavioral health outcomes.

- Differences in health outcomes for members utilizing/not utilizing dyadic services can be used to inform and influence strategies to increase benefit uptake.
- MCPs may use the data to inform efforts to increase member and provider awareness which, in turn, could increase awareness and utilization.

Care Management

- Use Risk Tiers and/or Claim History to identify members eligible for dyadic services but not yet engaged; inform outreach strategies and Care Team engagement.

8.0 Enhanced Care Management

Enhanced Care Management (ECM) is a statewide benefit that launched January 1, 2022. With Community Supports, ECM is a foundational part of CalAIM, the transformation of Medi-Cal. ECM focuses on:

- Breaking down the traditional walls of health care, extending beyond hospitals and health care settings into communities;
- Introducing a better way to coordinate care; and
- Providing high-need members with in-person care management where they live.

The links to the related policy documents are below:

- PHM Policy Guide
- ECM Policy Guide

8.1 Medi-Cal Connect Supporting Functionality

1. The Quality Measures Dashboard includes the ability to filter Quality Measures by ECM utilization. MCPs will thus be able to compare differences in health quality measures between members who are receiving and not receiving ECM including age, sex, ethnicity, race, and language demographic data.

Because ECM eligibility criteria identify members with higher needs, members eligible for and receiving ECM may have differences in service utilization and quality measure outcomes that are not "caused" by ECM. For instance, a member's housing insecurity may allow a member to be eligible for ECM and also lead to poorer management of chronic disease.

Medi-Cal Connect can provide valuable insight on the degree of utilization and outcome gaps that may exist between people who are receiving ECM as compared to those who are not. Outcomes can also be stratified by race, ethnicity, and other demographic factors. This analysis can be used to identify which sub-groups of members—differentiated by demographics as well as by common care needs and geographies—could be supported via more targeted outreach and/or adjustments to ECM delivery.

2. The LMR in the Portal will give MCPs access to member-specific data and novel views of these data in the LMR. Each member's LMR will include flags to indicate whether that member may be eligible for ECM and could warrant further assessment. When data are available, members' ECM lead care manager and contact information will be displayed to facilitate care management.

8.2 How Medi-Cal Connect may be used for Monitoring and Implementation of ECM

Population Health Management

- MCPs can assess the health status of their ECM participants in comparison to non-ECM-receiving members.
- If MCPs lack a ready way to examine demographic characteristics of ECM-receiving members compared to general membership, Medi-Cal Connect provides a way to use more granular race/ethnicity/language data to understand differences in ECM utilization and address those disparities.
- Member flags for potential eligibility for ECM will also allow MCPs to compare demographic characteristics of members potentially eligible for ECM and members actually receiving ECM. This comparison may help account for differences in ECM eligibility across demographic subgroups.

Care Management

- MCP care management teams can use Medi-Cal Connect to identify other people involved in a member's care. This will support coordination of care across delivery systems and settings.
- LMR data enriches the understanding of the member's context including Diagnoses and Claims History across Institutions, Pharmacy, and Behavioral Health for plans and other care team members supporting their care.

9.0 Risk Stratification, Segmentation, and Tiering

The Risk Stratification, Segmentation, and Tiering (RSST) Algorithm is a predictive analytics system developed by the California Department of Health Care Services (DHCS) as part of its Population Health Management (PHM) strategy. RSST provides a monthly, data-driven method for identifying Medi-Cal members who may be at increased risk of poor outcomes or underutilization of essential services, and who may benefit from additional outreach or care coordination. Each month, the system assigns each eligible member to a risk tier—low, rising, or high—based on predicted likelihood of future outcomes, allowing for more proactive and equitable deployment of resources across the state.

RSST was designed to create a standardized and transparent method of risk tiering that can be applied uniformly across MCPs statewide. The creation of this tool supports DHCS's broader objective to improve consistency, transparency, and equity in how risk is assessed across the Medi-Cal population. Traditional risk models often identify only those who are already high-cost or high-utilizing. RSST was designed to also flag individuals who have clinical indicators suggesting unmet need. These may include, for example, a lack of primary care follow-up after an emergency department visit or a behavioral health diagnosis without a recent prescription refill. This "Underutilization" Domain helps highlight members facing systemic barriers to care who may otherwise go unflagged.

At launch in July of 2025, the use of the DHCS RSST risk tiers will be strongly encouraged but not required. However, after a one year "Initial Implementation Period," DHCS will require MCP plans to use the Medi-Cal Connect RSST outputs to assess high-risk members and provide them with identified supports.

The links to the related policy documents are below:

- PHM Policy Guide
- Comprehensive Quality Strategy

9.1 Medi-Cal Connect Supporting Functionality

RSST algorithms for Adult and Pediatric populations will run monthly and assign a risk tier to every Medi-Cal member. Each MCP will receive risk tier data only for their enrolled members, delivered via SFTP or API. These risk tiers will also appear in DHCS-facing dashboard and across Care Management screens within the Medi-Cal Connect Portal. The birthing population will be added in Q1 2026.

9.2 How Medi-Cal Connect may be used for Monitoring and Implementation of RSST

- RSST risk tier output may be used by MCPs during an "initial implementation" period (began 7/18/2025 with R3 launch and will end no earlier than July 2026) to identify additional members as being high-risk and to provide DHCS feedback on how DHCS's RSST approach compares to previously used MCP approaches for risk segmentation and stratification.
- DHCS strongly suggests that MCPs ingest the RSST data and begin piloting its use. An initial step would be to compare the overlap in MCP–determined high risk members versus DHCS's RSST-determined high risk members. Plans can also assess RSST-determined high risk members to see how many members may have already been assessed and linked to care.
- The Medi-Cal Connect Portal with the LMR can be used to view the members risk profile. This risk profile will display the overall risk tier, along with the domains and subdomains that an individual might be identified as high risk. MCPs can use this portal view to see if a member was flagged for high-risk due to physical health or behavioral health, and track how long the member has been flagged as high-risk. Policy requirements are not fully set but, in the initial implementation period (July 2025 through June 2026) plans must develop internal processes and infrastructure to digest and integrate RSST risk tiers into their care management systems and workflows.
- *Subject to final policy determination: MCPs must assess all high-risk members identified as potentially needing services to understand their needs and preferences and to engage them in appropriate care and supports.*

10.0 Transitional Care Services

Beginning January 1, 2023, MCPs were required to provide strengthened Transitional Care Services (TCS) for **high-risk members**, including assigning a TCS care manager or single point of contact to assist with the members' transition. As of January 1, 2024, MCPs were required to provide TCS for all members, with different minimum requirements for high-risk members and lower-risk members.

The purpose of TCS is to ensure that members who are transferring from one setting or level of care to another, including but not limited to, discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities to home, community-

based, or long-term care settings, are supported through their transition and until they have been successfully connected to all needed services and supports. For full details, please see PHM Policy Guide July 2025, with details on TCS services starting on page 42.

MCPs are accountable for ensuring all TCS are provided to all transitioning members including:

- Receiving timely information on member admissions, discharges, and transfers;
- Implementing prior authorization without delay;
- Ensuring every member has a primary or ambulatory provider identified who can provide timely follow-up care.

For high-risk members, MCPs must also assign a TCS care manager or single point of contact., For lower-risk members, MCPs must ensure access to a dedicated TCS team or TCS phone number is available to support them as needed.

The link to the related policy document is below:

- Transitional Care Services

10.1 Medi-Cal Connect Supporting Functionality

The LMR in the Portal supports MCPs in delivering effective TCS by providing a centralized view of member information. Through the LMR, Care Managers can identify RSST-flagged high-risk members and ensure they receive TCS, including all required care coordination and follow-up services. The LMR can also assist in identifying members who should receive TCS for high-risk members by virtue of fitting into the following categories:

- Those with LTSS needs
- Those receiving CCM or ECM
- Children with Special Health Care Needs
- All pregnant individuals, including those admitted during the 12-month postpartum period
- Seniors and persons with disabilities
- SMH/SUD population
- Members transitioning to or from SNFs
- Members identified as “high-risk” by a discharging facility
- Members assessed as high-risk by RSST (as noted above)

The LMR can be helpful for members deemed high risk who are receiving TCS. The TCS care manager can:

- View historical plan enrollment, demographics, and claims data, including medical professional, medical institutional, behavioral health, pharmacy and dental claims.
- Determine which providers are engaged with the member, facilitating coordination and handoffs between care setting and who a member has historically engaged with
- Access a detailed diagnosis and visit history from prior admissions

Although claims data in the LMR has a 3-to-6-month lag, it complements real-time admission, discharge and transfer data by offering a longitudinal perspective on members' care trajectories and provider relationships. Care teams are encouraged to use both data sources together to enable comprehensive, person-centered TCS-particularly for members with complex care needs or gaps in care history. The LMR is intended to enhance—but not replace—MCP's existing obligations under federal and state TCS policies and should be integrated into care management workflows as a tool to improve coordination, accuracy and equity in transitions of care.

10.2 How Medi-Cal Connect may be used for Monitoring and Implementation of TCS

Care Management

MCPs should track admissions, discharges, and transfers (ADT). They authorize inpatient stays and SNF stays. MCP Care Managers can use Medi-Cal Connect data (especially the LMR) to better understand a member's health history, conditions, risk profile, program/service eligibility, and obtain information regarding their extended care team. Medi-Cal Connect is a complement to existing MCP data systems and can enrich demographic and clinical information.

11.0 Medi-Cal Connect Reference Materials

These screenshots are intended to give a quick visual introduction to key Medi-Cal Connect functionalities that are highlighted in this document. They are based on synthetic data. Screenshots are shown in grayscale for accessibility. The actual dashboards that users see when logged into the tool are in color.

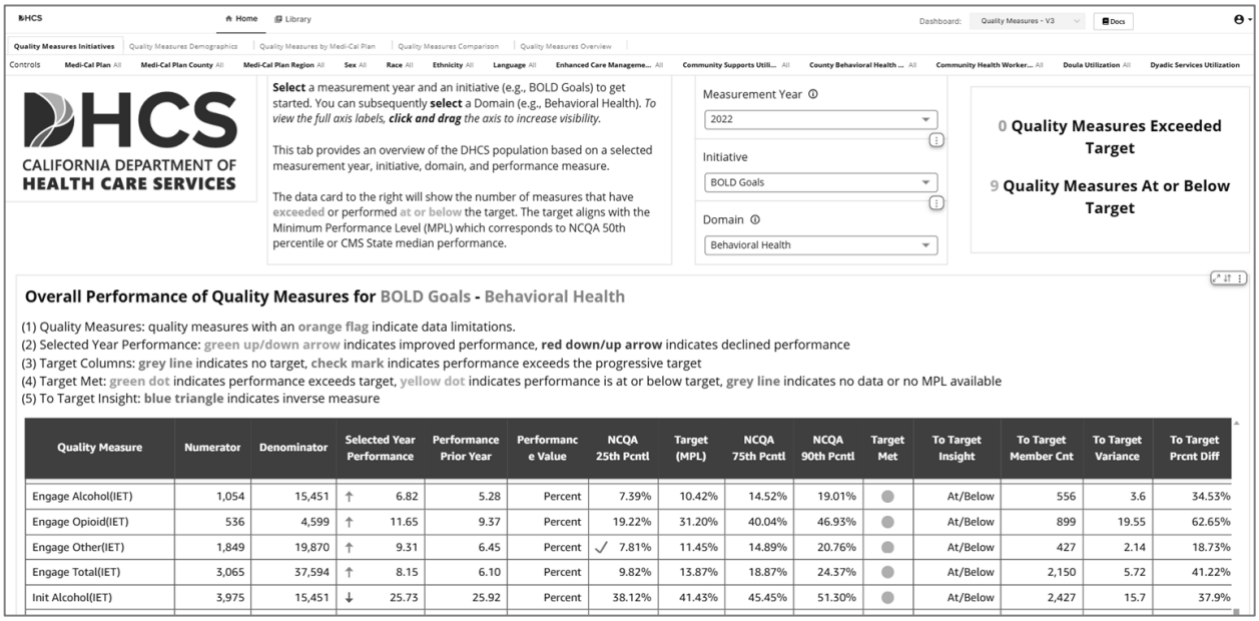
11.1 Medi-Cal Connect Screenshots

Quality Measures Dashboard

The Quality Measures Dashboard includes individual MCP data for 140 Quality Measures benchmarked against state averages. It enables plans to see their members' population health trends, view quality measure plan performance, and compare to state benchmarks. Data can be stratified by region, county, age, race, language, and select program utilization.

Quality Measure Dashboard Overview

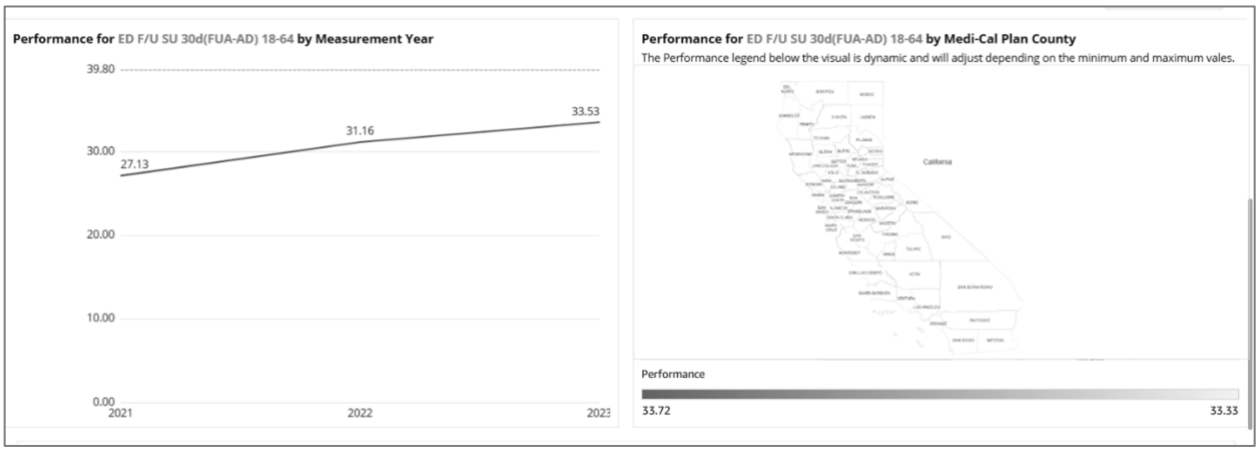
Quality Measure Performance against Target/MPL



Quality Measure	Numerator	Denominator	Selected Year Performance	Performance Prior Year	Performance Value	NCQA 25th Pcntl	Target (MPL)	NCQA 75th Pcntl	NCQA 90th Pcntl	Target Met	To Target Insight	To Target Member Cnt	To Target Variance	To Target Prcnt Diff
Engage Alcohol(IET)	1,054	15,451	↑ 6.82	5.28	Percent	7.39%	10.42%	14.52%	19.01%	●	At/Below	556	3.6	34.53%
Engage Opioid(IET)	536	4,599	↑ 11.65	9.37	Percent	19.22%	31.20%	40.04%	46.93%	●	At/Below	899	19.55	62.65%
Engage Other(IET)	1,849	19,870	↑ 9.31	6.45	Percent	✓ 7.81%	11.45%	14.89%	20.76%	●	At/Below	427	2.14	18.73%
Engage Total(IET)	3,065	37,594	↑ 8.15	6.10	Percent	9.82%	13.87%	18.87%	24.37%	●	At/Below	2,150	5.72	41.22%
Init Alcohol(IET)	3,975	15,451	↓ 25.73	25.92	Percent	38.12%	41.43%	45.45%	51.30%	●	At/Below	2,427	15.7	37.9%

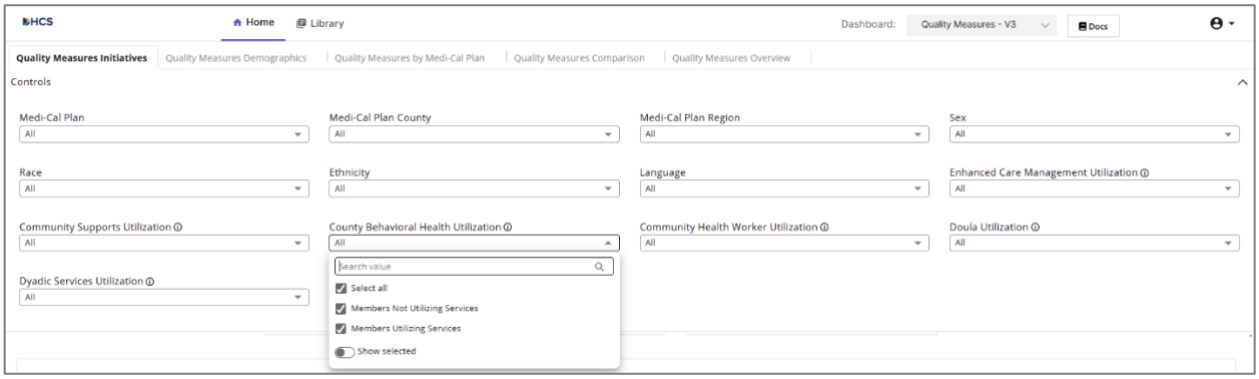
Quality Measure Dashboard: Trend and Geographic View

Quality Measure Performance Trend by Year and County



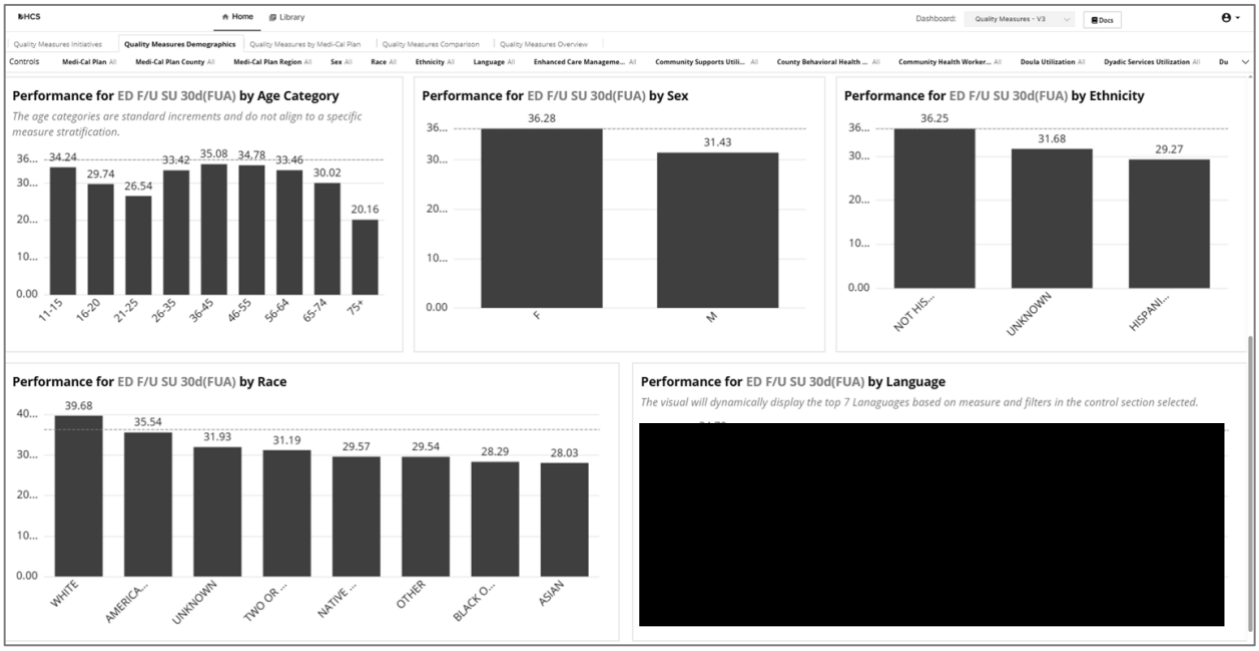
Quality Measure Dashboard: Available Stratifications

Each filter can be used to further refine the data. Select one or several to narrow in on specific populations or identify utilizers of services and differences in Quality Measures across program utilizers and non-utilizers.



Quality Measure Dashboard: Demographics Tab

View Quality Measure Performance by Age, Sex, Ethnicity, Race, and Language



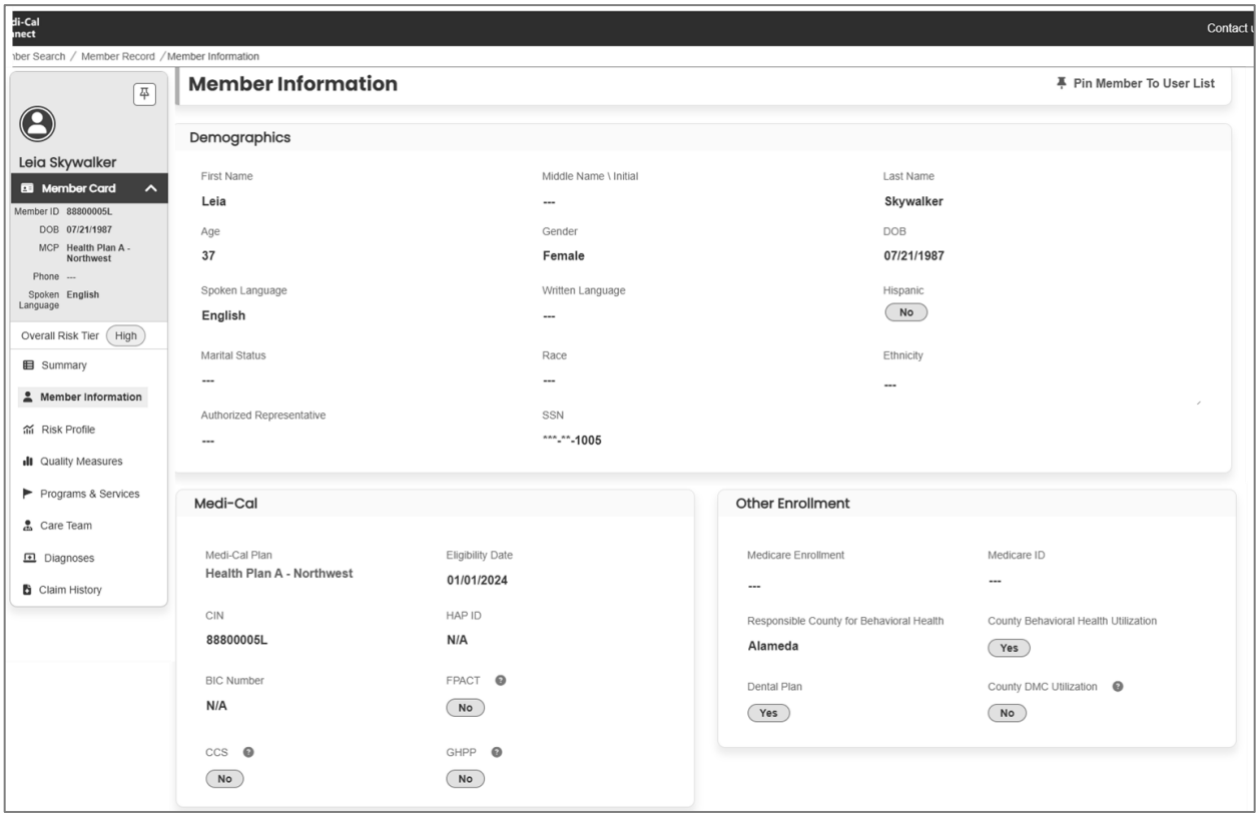
Longitudinal Member Record

The Medi-Cal Connect Care Management Portal Includes a Longitudinal Member Record (LMR) enabling access to data for members currently associated with the plan. It includes the following member-specific information, all of which can help provide a holistic view of member care history for care coordination across delivery systems:

Note: The information in the slides highlighting the Longitudinal Member Record is fictional and is not intended to bear resemblance to real members, providers or entities.

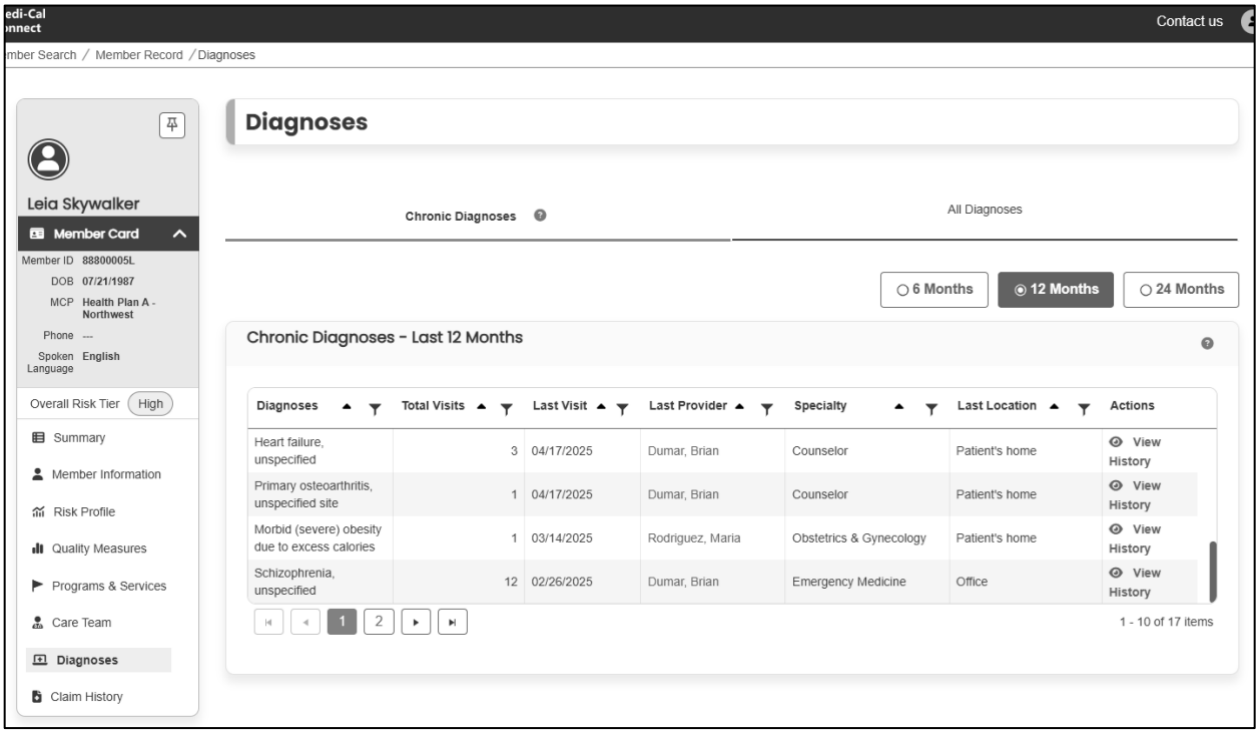
Member Information for Plans and Care Managers

Member demographics and contact information as well as plan detail.



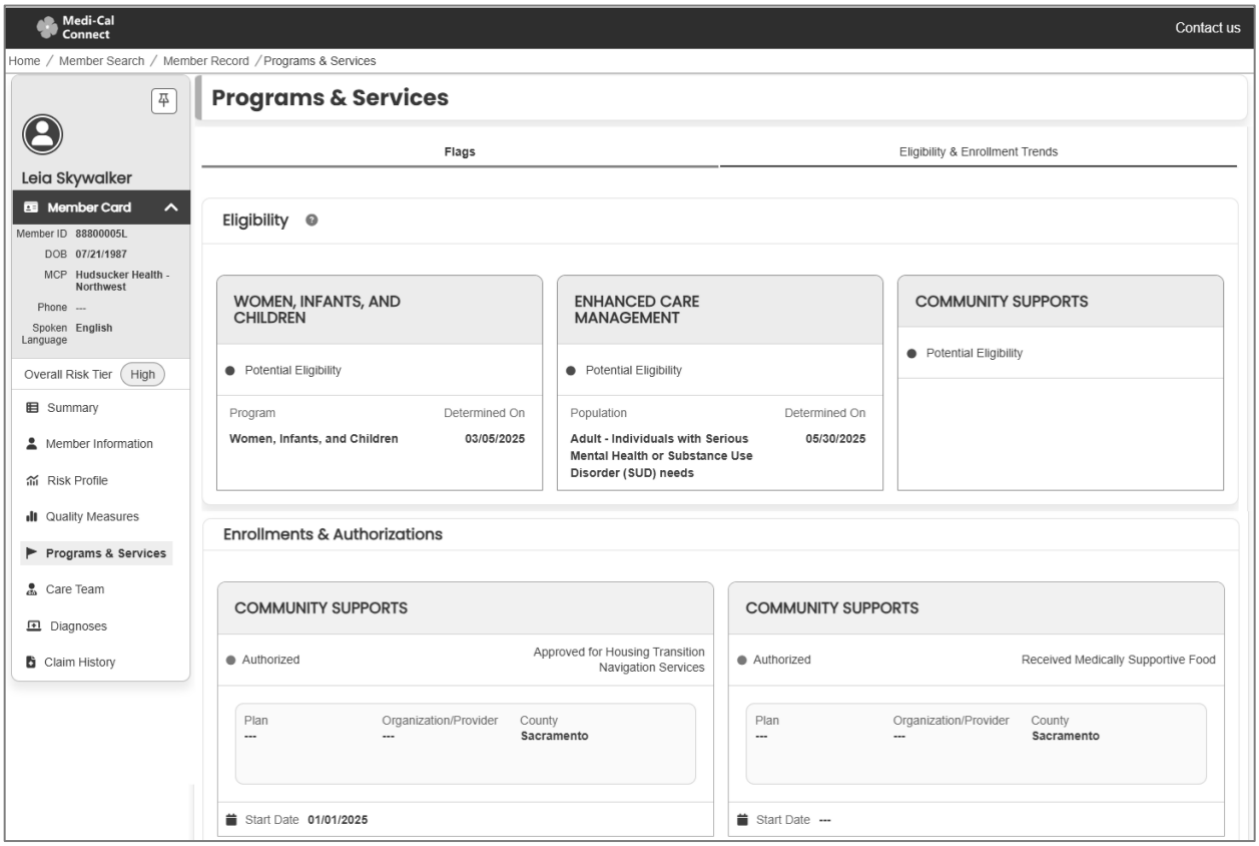
Diagnoses Summary

Current member's chronic conditions, the providers who treated a member for that specific diagnosis, and a historical view.



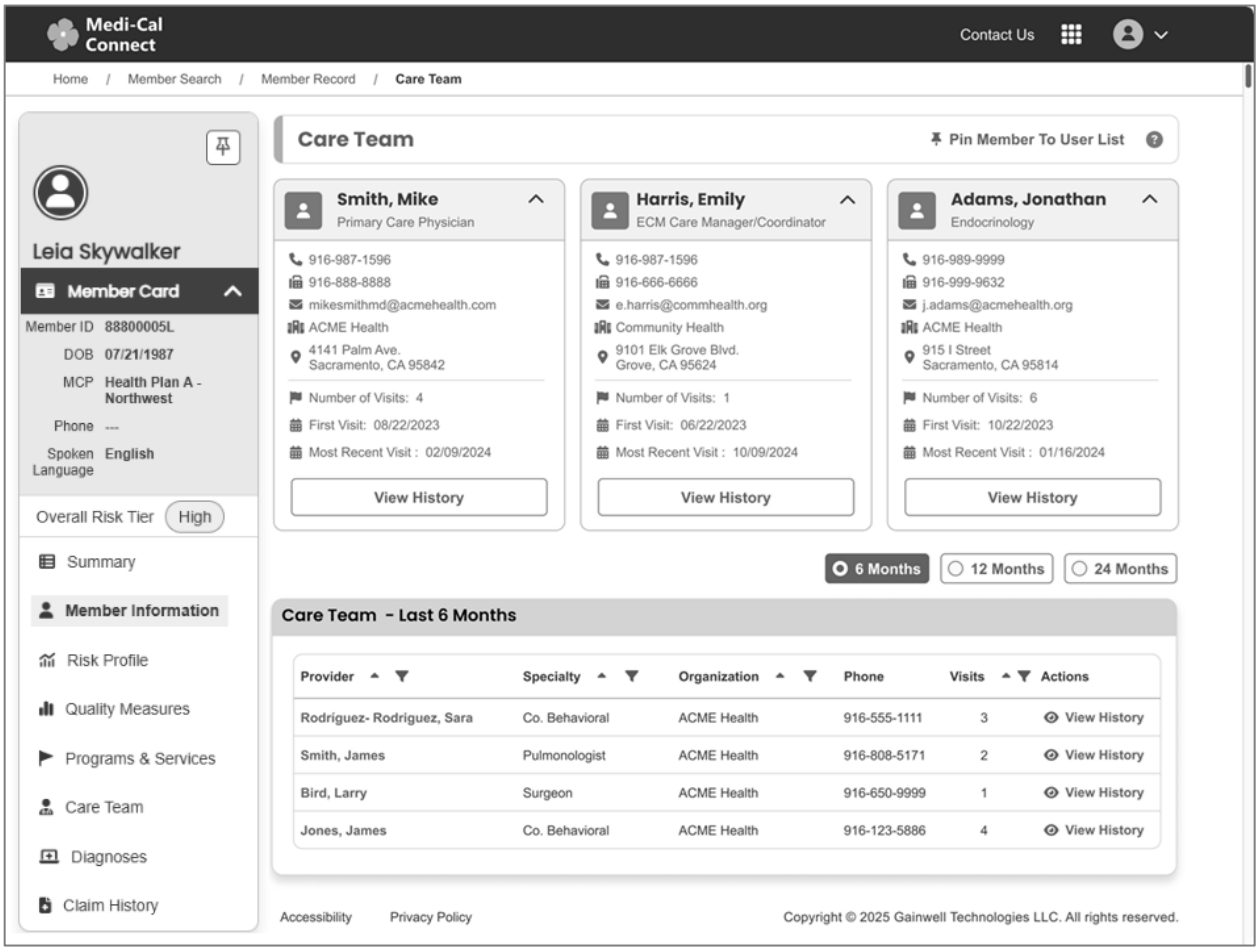
Programs and Services

Ability to review the Programs and Services based on member flag logic of enrolled or possibly eligible for various programs.



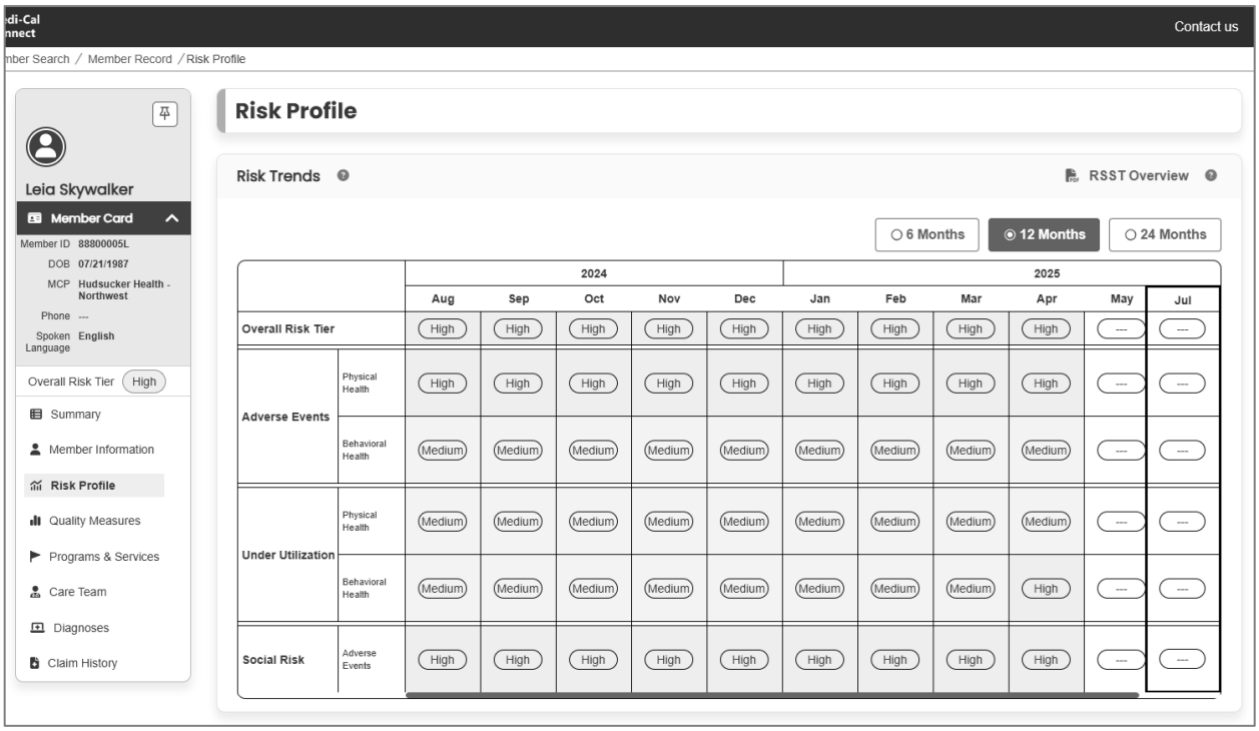
Care Team

Ability to view member's PCP, ECM or CCM care manager, and most frequently seen provider including those in specialty care and behavioral health.



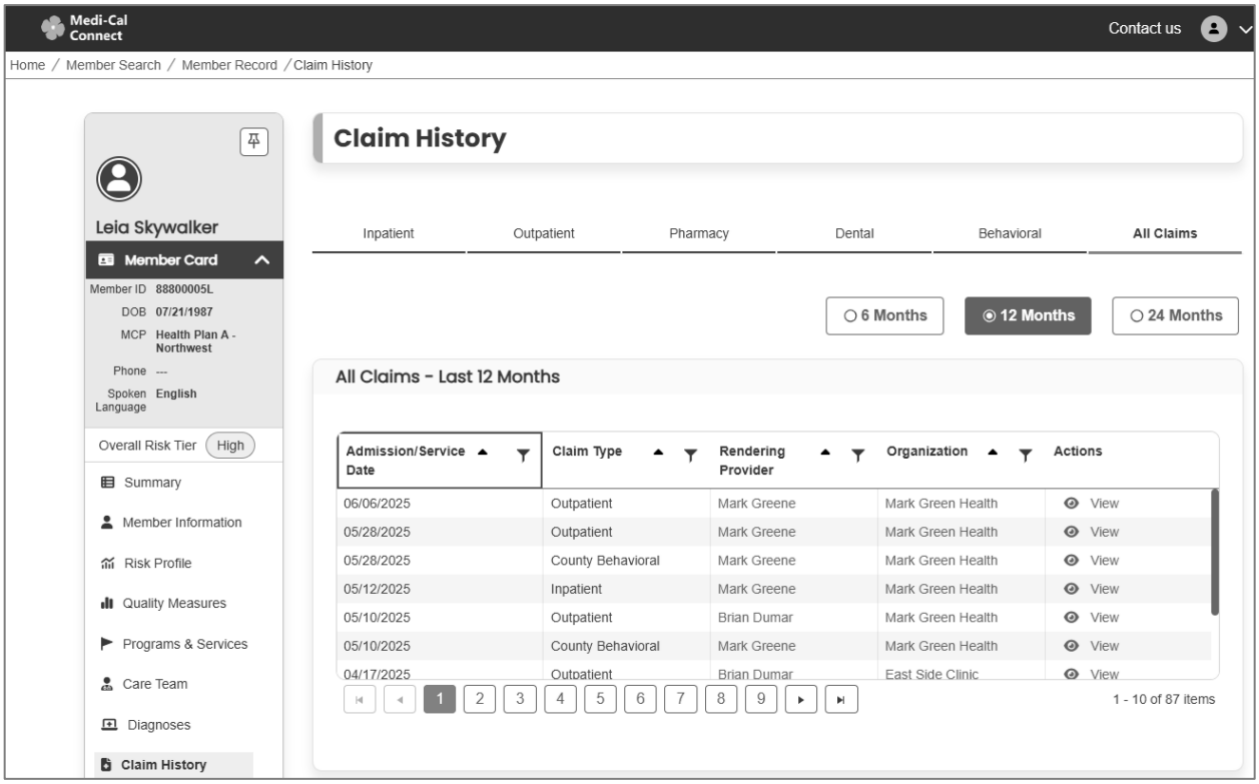
Risk Profile and Measures

Ability to view risk tier within the Adverse Event, Underutilization and Social risk domains. These risk tiers flow from the Risk Stratification, Segmentation and Tiering Algorithm (see companion document – the RSST Transparency Document). In addition, the measures overview will display quality measures that a member has either "met" or "not met."



Claims History

Plans can access member information with all historical claim data and medication information inclusive of institutional, pharmacy, outpatient, dental, and behavioral health claims.



12.0 Medi-Cal Connect: Option 2 Tables by Benefit Area

These examples are designed for executive, policy, and operational audiences, illustrating how Medi-Cal Connect supports decision-making, improves processes, or enhances member outcomes.

Doula Services

Category	Details
Objective/Goal	Improve utilization of the Doula Benefit
Leverage Dashboard or LMR	Filter by doula-related measure; overlay demographics to spot equity/access gaps.
Plan Targeted Member Outreach	Identify groups with low uptake; coordinate mailer + reminder call' campaigns.
Track Trends Over Time	Quarterly snapshots vs. benchmarks to show month-to-month uptake.

Community Health Workers (CHW)

Category	Details
Objective/Goal	Identify and expand the reach of CHWs to high-need populations.
Leverage Dashboard or LMR	View outcomes with/without CHW engagement; filter by race/ethnicity/language on dashboard.
Plan Targeted Member Outreach	Generate a list of rising-risk members from the RSST data feed. Using the LMR, focus on the rising-risk members with low contact; collaborate with CHWs to engage in care.
Track Trends Over Time	Monitor engagement/outcome changes by population.

Community Supports

Category	Details
Objective/Goal	Expand the use of Community Supports for Members
Leverage Dashboard or LMR	Compare outcomes of utilizers vs. non-utilizers; stratify by demographics.
Plan Targeted Member Outreach	Identify low-uptake regions; share eligibility insights with Community Supports providers.

Track Trends Over Time	Compare quarterly Community Supports uptake/outcomes to inform engagement and elections.

Complex Care Management (CCM) Functionality coming in November 2025

Category	Details
Objective/Goal	Support care coordination for Members with complex needs.
Leverage Dashboard or LMR	Use LMR to review risk profile and care history.
Plan Targeted Member Outreach	Assign care managers to rising-risk; evaluate for ECM eligibility.
Track Trends Over Time	Assess CCM outcomes via care management data.

Dyadic Services

Category	Details
Objective/Goal	Expand the use of the Dyadic Care Benefit
Leverage Dashboard or LMR	Use dashboard to identify demographic gaps and compare outcomes.
Plan Targeted Member Outreach	Identify eligible families with risk/claims; partner with clinics/providers.
Track Trends Over Time	Track child health and caregiver engagement improvements.

Enhanced Care Management (ECM)

Category	Details
Objective/Goal	Expand the use of the ECM benefit
Leverage Dashboard or LMR	Compare outcomes between ECM participants and non-participants.
Plan Targeted Member Outreach	Use LMR flags to find ECM-eligible; coordinate referrals internally/externally.
Track Trends Over Time	Monitor ECM outcomes and engagement by subgroup.

Risk Stratification, Segmentation and Tiering (RSST)

Category	Details
Objective/Goal	Understand how RSST tiers interact with MCP – generated tiers

Leverage Dashboard or LMR	Use RSST risk tier outputs; compare to internal stratification.
Plan Targeted Member Outreach	Focus outreach on high-risk tier; prioritize referrals.
Track Trends Over Time	Evaluate outcomes by tier to improve workflows.

Transitional Care Services (TCS)

Category	Details
Objective/Goal	Improve understanding of Members experiencing Transitions of Care
Leverage Dashboard or LMR	Use LMR to find high-risk discharges; review care team and prior services.
Plan Targeted Member Outreach	Assign care managers for discharge coordination; include ECM staff.
Track Trends Over Time	Monitor readmission/follow-up for transitioned members.

13.0 Programs and Services in Medi-Cal Connect

The purpose of this table is to give a summary of where within Medi-Cal Connect information about programs can be found. We are actively working to add more flags and data categories.

Flag Category (High Level)	Category Type	Flag Name	QM Dashboard	LMR API	Portal
Community Supports	Community Supports - Utilization	Other Community Supports Utilization		X	
		Post-Hospitalization Housing and Recuperative Care		X	
		Housing Trio Utilization		X	
	Community Supports - Utilization	Total Community Supports Utilization	X	X	X
	Community Supports - Potential Eligibility	Asthma Preventive Services		X	X
		Day Habilitation Programs		X	X

Flag Category (High Level)	Category Type	Flag Name	QM Dashboard	LMR API	Portal
Community Supports (continued)	Community Supports - Authorized	Housing Transition/Navigation Services		X	X
		Housing Deposits		X	X
		Housing Tenancy and Sustaining Services		X	X
		Short-Term Post-Hospitalization Housing		X	X
		Recuperative Care		X	X
		Respite Services		X	X
		Day Habilitation Programs		X	X
		Approved for NF Transition to ALF		X	X
		Nursing Facility Transition to a Home		X	X
		Personal Care and Homemaker Services		X	X
		Environmental Accessibility Adaptations		X	X
		Medically-Supportive Food Meals/Medically Tailored Meals		X	X
		Sobering Centers		X	X
		Asthma Remediation		X	X
		Other Services - Transitional Rent		X	X
Enhanced Care Management	ECM - Utilization	ECM Utilization	X	X	X
	ECM - Potential Eligibility	Adults At Risk for Avoidable Hospital or ED Utilization		X	X

Flag Category (High Level)	Category Type	Flag Name	QM Dashboard	LMR API	Portal
Enhanced Care Management (continued)		Adults with Serious Mental Health and/or SUD Needs		X	X
		Birth Equity Population of Focus - Adults		X	X
		Birth Equity Population of Focus - Child		X	X
		Children and Youth At Risk for Avoidable Hospital or ED Utilization		X	X
		Children and Youth Enrolled in CCS or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		X	X
		Children and Youth with Serious Mental Health and/or SUD needs		X	X
		Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness		X	X
		Individuals and Families Experiencing Homelessness		X	X
	ECM - Enrollment	Adult – Individuals Experiencing Homelessness-Families		X	X

Flag Category (High Level)	Category Type	Flag Name	QM Dashboard	LMR API	Portal
Enhanced Care Management (continued)		Adult – High Utilizer		X	X
		Adult – Avoidable Hospital or ED Utilization		X	X
		Adult – Individuals with Serious Mental Health or Substance Use Disorder (SUD) needs		X	X
		Adult – Transitioning from Incarceration		X	X
		Adult – LTC At-Risk for Institutionalization		X	X
		Adult – NF Transitioning to Community		X	X
		Adult – Birth Equity Population of Focus		X	X
		Child – Individuals Experiencing Homelessness		X	X
		Child – SED or CHR for Psychosis		X	X
		Child – Family Experiencing Homelessness		X	X
		Child – Avoidable Hospital or ED Utilization		X	X
		Child – SMI or SUD		X	X
		Child – CCS/CCS WCM with Additional Needs		X	X
		Child – Child Welfare		X	X

Flag Category (High Level)	Category Type	Flag Name	QM Dashboard	LMR API	Portal
Enhanced Care Management (continued)		Child – Transitioning from Incarceration		X	X
		Child – Birth Equity		X	X
Other Programs	Other - Dual Eligible Membership	Dual Enrollment Status	X	X	X
	Utilization	Enhanced Community Health Worker utilization	X	X	X
		Community Health Worker utilization	X	X	X
		Doula service utilization	X	X	X
		Dyadic service utilization	X	X	X
		Members Utilizing Behavioral Health (BH) Delivery Systems	X	X	X
	Eligibility	WIC – Eligible not enrolled**		X	X

14.0 Quality Measures in Medi-Cal Connect

The purpose of this table is to list quality measures available in Medi-Cal Connect. Measures are included in the Quality Measure Dashboard and the LMR.

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI)	PQI01	Diabetes Short-Term Complications Admission Rate: Ages 18 to 64 (PQI01-AD)
	PQI01	Diabetes Short-Term Complications Admission Rate: Ages 65 and Older (PQI01-AD)
	PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate: Ages 18 to 64 (PQI05-AD)
	PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate: Ages 65 and Older (PQI05-AD)
	PQI08	Heart Failure Admission Rate: Ages 18 to 64 (PQI08-AD)
	PQI08	Heart Failure Admission Rate: Ages 65 and Older (PQI08-AD)
	PQI15	Asthma in Younger Adults Admission Rate: Ages 18 to 39 (PQI15-AD)
Center for Medicare and Medicaid Services (CMS) Core Set	CCP	Contraceptive Care - Postpartum Women LARC - within 3 days of delivery: Ages 15 to 20 (CCP-CH)
	CCP	Contraceptive Care - Postpartum Women Long-acting Reversible Method of Contraception (LARC) - within 3 days of delivery: Ages 21 to 44 (CCP-AD)
	CCP	Contraceptive Care - Postpartum Women LARC - within 90 days of delivery: Ages 15 to 20 (CCP-CH)
	CCP	Contraceptive Care - Postpartum Women Long-acting Reversible Method of Contraception (LARC) - within 90 days of delivery: Ages 21 to 44 (CCP-AD)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Center for Medicare and Medicaid Services (CMS) Core Set (continued)	CCP	Contraceptive Care - Postpartum Women Most or moderately effective contraception - within 3 days of delivery: Ages 15 to 20 (CCP-CH)
	CCP	Contraceptive Care - Postpartum Women Most or moderately effective contraception - within 3 days of delivery: Ages 21 to 44 (CCP-AD)
	CCP	Contraceptive Care - Postpartum Women Most or moderately effective contraception - within 90 days of delivery: Ages 15 to 20 (CCP-CH)
	CCP	Contraceptive Care - Postpartum Women Most or moderately effective contraception - within 90 days of delivery: Ages 21 to 44 (CCP-AD)
	CCP	Contraceptive Care-Postpartum Women: Most or Moderately Effective Contraception 90 days (CCP-MMEC)
	CCW	Contraceptive Care - All Women LARC: Ages 15 to 20 (CCW-CH)
	CCW	Contraceptive Care - All Women: Ages 21 to 44 (CCW-AD)
	CCW	Contraceptive Care - All Women MME: Ages 15 to 20 (CCW-CH)
	CCW	Contraceptive Care - All Women: Ages 21 to 44 (CCW-AD)
	CCW	Contraceptive Care-All Women: Most or Moderately Effective Contraception (CCW-MMEC)
	CDF	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
	CDF	Screening for Depression and Follow-Up Plan: Ages 18 to 64 (CDF-AD)
	CDF	Screening for Depression and Follow-Up Plan: Ages 65 and Older (CDF-AD)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Center for Medicare and Medicaid Services (CMS) Core Set (continued)	DEV	Developmental Screening in the First Three Years of Life: Ages 1 (DEV-CH)
	DEV	Developmental Screening in the First Three Years of Life: Ages 2 (DEV-CH)
	DEV	Developmental Screening in the First Three Years of Life: Ages 3 (DEV-CH)
	DEV	Developmental Screening in the First Three Years of Life: Ages 0 to 3 (DEV-CH)
	HVL	HIV Viral Load Suppression: Ages 18 to 64 (HVL-AD)
	HVL	HIV Viral Load Suppression: Ages 65 and Older (HVL-AD)
	OEV	Oral Evaluation, Dental Services Under 21 (OEV-CH)
	OEV	Oral Evaluation, Dental Services Under 3 (OEV-CH)
	OEV	Oral Evaluation, Dental Services: Ages 15 to 20 (OEV-CH)
	OEV	Oral Evaluation, Dental Services: Ages 3 to 5 (OEV-CH)
	OEV	Oral Evaluation, Dental Services: Ages 6 to 14 (OEV-CH)
	OUD	Use of Pharmacotherapy for Opioid Use Disorder Total (Rate 1): Ages 18 and Older (OUD-AD)
	OUD	Use of Pharmacotherapy for Opioid Use Disorder Total (Rate 1): Ages 18 and Older (OUD-AD)b,b,,,
	OUD	Use of Pharmacotherapy for Opioid Use Disorder Buprenorphine (Rate 2): Ages 18 and Older (OUD-AD)
	OUD	Use of Pharmacotherapy for Opioid Use Disorder Oral naltrexone (Rate 3): Ages 18 and Older (OUD-AD)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Center for Medicare and Medicaid Services (CMS) Core Set (continued)	OUD	Use of Pharmacotherapy for Opioid Use Disorder Long-acting, injectable naltrexone (Rate 4): Ages 18 and Older (OUD-AD)
	OUD	Use of Pharmacotherapy for Opioid Use Disorder Methadone (Rate 5): Ages 18 and Older (OUD-AD)
	SFM	Sealant Receipt on Permanent First Molars: At Least 1 Sealance (Rate 1): Ages 10 (SFM-CH)
	SFM	Sealant Receipt on Permanent First Molars: All 4 Molars (Rate 2): Ages 10 (SFM-CH)
	TFL	Topical Fluoride for Children, Dental or Oral Under 21 (TFL-CH)
	TFL	Topical Fluoride for Children, Dental or Oral: Ages 1 to 2 (TFL-CH)
	TFL	Topical Fluoride for Children, Dental or Oral: Ages 15 to 20 (TFL-CH)
	TFL	Topical Fluoride for Children, Dental or Oral: Ages 3 to 5 (TFL-CH)
	TFL	Topical Fluoride for Children, Dental or Oral: Ages 6 to 14 (TFL-CH)
	TFL	Topical Fluoride for Children, Dental Under 21 (TFL-CH)
	TFL	Topical Fluoride for Children, Dental: Ages 1 to 2 (TFL-CH)
	TFL	Topical Fluoride for Children, Dental : Ages 15 to 20 (TFL-CH)
	TFL	Topical Fluoride for Children, Dental : Ages 3 to 5 (TFL-CH)
	TFL	Topical Fluoride for Children, Dental : Ages 6 to 14 (TFL-CH)
	TFL	Topical Fluoride for Children, Oral Under 21 (TFL-CH)
	TFL	Topical Fluoride for Children, Oral: Ages 1 to 2 (TFL-CH)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Center for Medicare and Medicaid Services (CMS) Core Set (continued)	TFL	Topical Fluoride for, Oral: Ages 15 to 20 (TFL-CH)
	TFL	Topical Fluoride for Children, Oral: Ages 3 to 5 (TFL-CH)
	TFL	Topical Fluoride for Children, Oral: Ages 6 to 14 (TFL-CH)
Healthcare Effectiveness Data and Information Set (HEDIS)	AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)
	AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 18 to 64 (AAB-AD)
	AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 65 and Older (AAB-AD)
	AAP	Adults' Access to Preventive/Ambulatory Health Services (AAP)
	ADD	Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication Initiation: Ages 6 to 12 (ADD-CH)
	ADD	Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication Continuation and Maintenance: Ages 6 to 12 (ADD-CH)
	AIS	Adult Immunization Status Influenza: Ages 66 and Older (AIS-AD)
	AIS	Adult Immunization Status Influenza: Ages 19 to 65 (AIS-AD)
	AIS	Adult Immunization Status Pneumococcal: Ages 66 and Older (AIS-AD)
	AIS	Adult Immunization Status Tetanus and Diphtheria or Tetanus, Diphtheria and Acellular Pertussis: Ages 66 and Older (AIS-AD)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	AIS	Adult Immunization Status Tetanus and Diphtheria or Tetanus, Diphtheria and Acellular Pertussis: Ages 19 to 65 (AIS-AD)
	AIS	Adult Immunization Status Zoster: Ages 66 and Older (AIS-AD)
	AIS	Adult Immunization Status Zoster: Ages 50 to 65 (AIS-AD)
	AMM	Antidepressant Medication Management Effective Acute Phase Treatment: Ages 18 and Older (AMM)
	AMM	Antidepressant Medication Management Effective Acute Phase Treatment: Ages 18 to 64 (AMM-AD)
	AMM	Antidepressant Medication Management Effective Acute Phase Treatment: Ages 65 and Older (AMM-AD)
	AMM	Antidepressant Medication Management Effective Continuation Phase Treatment: Ages 18 and Older (AMM)
	AMM	Antidepressant Medication Management Effective Continuation Phase Treatment: Ages 18 to 64 (AMM-AD)
	AMM	Antidepressant Medication Management Effective Continuation Phase Treatment: Ages 65 and Older (AMM-AD)
	AMR	Asthma Medication Ratio: Ages 12 to 18 (AMR-CH)
	AMR	Asthma Medication Ratio: Ages 19 to 50 (AMR-AD)
	AMR	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)
	AMR	Asthma Medication Ratio: Ages 5 to 11 (AMR-CH)
	AMR	Asthma Medication Ratio: Ages 51-64 (AMR-AD)
	AMR	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	AMR	Asthma Medication Ratio (AMR)
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose Testing: Ages 1 to 11 (APM-CH)
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose Testing: Ages 1 to 17 (APM-CH)
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose Testing: Ages 12 to 17 (APM-CH)
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics Cholesterol Testing: Ages 1 to 11 (APM-CH)
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics Cholesterol Testing: Ages 1 to 17 (APM-CH)
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics Cholesterol Testing: Ages 12-17 (APM-CH)
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose and Cholesterol Testing: Ages 1 to 11 (APM-CH)
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose and Cholesterol Testing: Ages 1 to 17 (APM-CH)
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose and Cholesterol Testing: Ages 12 to 17 (APM-CH)
	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 11 (APP-CH)
	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17 (APP-CH)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 12 to 17 (APP-CH)
	BCS	Breast Cancer Screening: Ages 50 to 64 (BCS-AD)
	BCS	Breast Cancer Screening (BCS)
	BCS	Breast Cancer Screening: Ages 65 to 74 (BCS-AD)
	CBP	Controlling High Blood Pressure: Ages 18 to 64 (CBP-AD)
	CBP	Controlling High Blood Pressure (CBP)
	CBP	Controlling High Blood Pressure: Ages 65-85 (CBP-AD)
	CCS	Cervical Cancer Screening: Ages 21 to 64 (CCS-AD)
	CHL	Chlamydia Screening in Women: Ages 16 to 20 (CHL-CH)
	CHL	Chlamydia Screening in Women: Ages 16 to 24 (CHL)
	CHL	Chlamydia Screening in Women: Ages 21 to 24 (CHL-AD)
	CIS	Childhood Immunization Status-Combination 10 (CIS-CH)
	CIS	Childhood Immunization Status Combination 3 (CIS-CH)
	CIS	Childhood Immunization Status Combination 7 (CIS-CH)
	CIS	Childhood Immunization Status DTaP (CIS-CH)
	CIS	Childhood Immunization Status Hepatitis A (CIS-CH)
	CIS	Childhood Immunization Status Hepatitis B (CIS-CH)
	CIS	Childhood Immunization Status HiB (CIS-CH)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	CIS	Childhood Immunization Status Influenza (CIS-CH)
	CIS	Childhood Immunization Status MMR (CIS-CH)
	CIS	Childhood Immunization Status IPV (CIS-CH)
	CIS	Childhood Immunization Status Pneomococcal Conjugate (CIS-CH)
	CIS	Childhood Immunization Status Rotavir (CIS-CH)
	CIS	Childhood Immunization Status VZV (CIS-CH)
	COL	Colorectal Cancer Screening: Ages 45-75 (COL-E)
	COL	Colorectal Cancer Screening: Ages 46 to 50 (COL-AD)
	COL	Colorectal Cancer Screening: Ages 51 to 65 (COL-AD)
	COL	Colorectal Cancer Screening: Ages 66 to 75 (COL-AD)
	DRR	Depression Remission or Response for Adolescents and Adults: Follow-Up PHQ-9 (DRRA)
	DRR	Depression Remission or Response for Adolescents and Adults: Depression Remission (DRRB)
	DRR	Depression Remission or Response for Adolescents and Adults: Depression Response (DRRC)
	FUA	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)
	FUA	Follow-Up After ED Visit for Substance Use-30 days (FUA)
	FUA	30-day Follow-Up After Emergency Department Visit for Substance Use: Ages 18 to 64 (FUA-AD)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	FUA	30-day Follow-Up After Emergency Department Visit for Substance Use: Ages 65 and Older (FUA-AD)
	FUA	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)
	FUA	Follow-Up After ED Visit for Substance Use-7 days: Ages 13 and Older (FUA)
	FUA	7-day Follow-Up After Emergency Department Visit for Substance Use: Ages 18 to 64 (FUA-AD)
	FUA	7-day Follow-Up After Emergency Department Visit for Substance Use: Ages 65 and Older (FUA-AD)
	FUH	30-day Follow-Up After Hospitalization for Mental Illness: Ages 18 to 64 (FUH-AD)
	FUH	30-day Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)
	FUH	30-day Follow-Up After Hospitalization for Mental Illness: Ages 65 and Older (FUH-AD)
	FUH	7-day Follow-Up After Hospitalization for Mental Illness: Ages 18 to 64 (FUH-AD)
	FUH	7-day Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)
	FUH	7-day Follow-Up After Hospitalization for Mental Illness: Ages 65 and Older (FUH-AD)
	FUM	30-day Follow-Up After Emergency Department Visit for Mental Illness: Ages 18 to 64 (FUM-AD)
	FUM	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH) 30 day
	FUM	30-day Follow-Up After Emergency Department Visit for Mental Illness: Ages 65 and Older (FUM-AD)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	FUM	Follow-Up After ED Visit for Mental Illness-30 days (FUM)
	FUM	7-day Follow-Up After Emergency Department Visit for Mental Illness: Ages 18 to 64 (FUM-AD)
	FUM	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH) 7 day
	FUM	Follow-Up After ED Visit for Mental Illness-7 days: Ages 6 and Older (FUM)
	FUM	7-day Follow-Up After Emergency Department Visit for Mental Illness: Ages 65 and Older (FUM-AD)
	GSD	Glycemic Status Assessment for Patients with Diabetes Glycemic Status <8.0%: Ages 18 to 64 (GSD-AD)
	GSD	Glycemic Status Assessment for Patients with Diabetes<8%: Ages 18 to 75 (GSD)
	GSD	Glycemic Status Assessment for Patients with Diabetes Glycemic Status <8.0%: Ages 65 to 75 (GSD-AD)
	GSD	Glycemic Status Assessment for Patients with DiabetesGlycemic Status >9.0%: Ages 18 to 64 (GSD-AD)
	GSD	Glycemic Status Assessment for Patients with Diabetes >9%: Ages 18 to 75 (GSD)
	GSD	Glycemic Status Assessment for Patients with Diabetes Glycemic Status >9.0%: Ages 65 to 75 (GSD-AD)
	IET	Initiation of Alcohol Use Disorder Treatment: Ages 13 and Older (IET)
	IET	Initiation of Alcohol Use Disorder Treatment: Ages 18 to 64 (IET-AD)
	IET	Initiation of Alcohol Use Disorder Treatment: Ages 65 and Older (IET-AD)
	IET	Initiation of Opioid Use Disorder Treatment: Ages 13 and Older (IET)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	IET	Initiation of Opioid Use Disorder Treatment: Ages 18 to 64 (IET-AD)
	IET	Initiation of Opioid Use Disorder Treatment: Ages 65 and Older (IET-AD)
	IET	Initiation of Other Substance Use Disorder Treatment: Ages 13 and Older (IET)
	IET	Initiation of Other Substance Use Disorder Treatment: Ages 18 to 64 (IET-AD)
	IET	Initiation of Other Substance Use Disorder Treatment: Ages 65 and Older (IET-AD)
	IET	Initiation of Substance Use Disorder Treatment Total: Ages 13 and Older (IET)
	IET	Initiation of Substance Use Disorder Treatment Total: Ages 18 to 64 (IET-AD)
	IET	Initiation of Substance Use Disorder Treatment Total: Ages 65 and Older (IET-AD)
	IET	Engagement of Alcohol Use Disorder Treatment: Ages 13 and Older (IET)
	IET	Engagement of Alcohol Use Disorder Treatment: Ages 18 to 64 (IET-AD)
	IET	Engagement of Alcohol Use Disorder Treatment: Ages 65 and Older (IET-AD)
	IET	Engagement of Opioid Use Disorder Treatment: Ages 13 and Older (IET)
	IET	Engagement of Opioid Use Disorder Treatment: Ages 18 to 64 (IET-AD)
	IET	Engagement of Opioid Use Disorder Treatment: Ages 65 and Older (IET-AD)
	IET	Engagement of Other Substance Use Disorder Treatment: Ages 13 and Older (IET)
	IET	Engagement of Other Substance Use Disorder Treatment: Ages 18 to 64 (IET-AD)
	IET	Engagement of Other Substance Use Disorder Treatment: Ages 65 and Older (IET-AD)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	IET	Engagement of Substance Use Disorder Treatment Total: Ages 13 and Older (IET)
	IET	Engagement of Substance Use Disorder Treatment Total: Ages 18 to 64 (IET-AD)
	IET	Engagement of Substance Use Disorder Treatment Total: Ages 65 and Older (IET-AD)
	IMA	Immunizations for Adolescents Combination 1 (Meningococcal, Tdap) (IMA-CH)
	IMA	Immunizations for Adolescents Combination 2 (Meningococcal, Tdap, HPV) (IMA-CH)
	IMA	Immunizations for Adolescents HPV (IMA-CH)
	IMA	Immunizations for Adolescents Meningococcal Serogroups A, C, W, Y (IMA-CH)
	IMA	Immunizations for Adolescents tetanus, diphtheria toxoids and acellular pertussis (Tdap) (IMA-CH)
	LSC	Lead Screening in Children (LSC-CH)
	PCR	Plan All-Cause Readmissions (PCR-AD)
	POD	Pharmacotherapy for Opioid Use Disorder (POD)
	PPC2	Prenatal and Postpartum Care: Under 21 (PPC2-CH)
	PPC2	Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment state date or within 42 days of enrollment: Ages 21 and Older (PPC2-AD)
	PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)
	PPC2	Prenatal and Postpartum Care: Under: Ages 21 (PPC2-CH)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	PPC2	Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery: Ages 21 and Older (PPC2-AD)
	PPC	Prenatal and Postpartum Care: Postpartum Care (PPC)
	PRS	Prenatal Immunization Status Combination: Under 21 (PRS-CH)
	PRS	Prenatal Immunization Status: Combination: Ages 21 and Older (PRS)
	PRS	Prenatal Immunization Status: Combination (PRS)
	PRS	Prenatal Immunization Status Influenza: Under 21 (PRS-CH)
	PRS	Prenatal Immunization Status: Influenza: Ages 21 and Older (PRS)
	PRS	Prenatal Immunization Status: Influenza (PRS)
	PRS	Prenatal Immunization Status Tdap: Under 21 (PRS-CH)
	PRS	Prenatal Immunization Status: tetanus, diphtheria toxoid and acellular pertusis (Tdap)
	PRS	Prenatal Immunization Status: Tdap (PRS)
	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia: Ages 18 and Older (SAA-AD)
	SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications: Ages 18 to 64 (SSD-AD)
	W30	Well-Child Visits in the First 30 Months of Life 0 to 15m (W30-CH)
	W30	Well-Child Visits in the First 30 Months of Life 15 to 30m (W30-CH)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Body mass index (BMI) Percentile documentation: Ages 3 to 11 (WCC-CH)
	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Body mass index (BMI) Percentile documentation: Ages 12 to 17 (WCC-CH)
	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Body mass index (BMI) Percentile documentation: Ages 3 to 17 (WCC-CH)
	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Counseling for Nutrition: Ages 12 to 17 (WCC-CH)
	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Counseling for Nutrition: Ages 3 to 11 (WCC-CH)
	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Counseling for Nutrition: Ages 3 to 17 (WCC-CH)
	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Counseling for Physical Activity: Ages 12 to 17 (WCC-CH)
	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Counseling for Physical Activity: Ages 3 to 11 (WCC-CH)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
Healthcare Effectiveness Data and Information Set (HEDIS) (continued)	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Counseling for Physical Activity: Ages 3 to 17 (WCC-CH)
	WCV	Child and Adolescent Well-Care Visits: Ages 12 to 17 (WCV-CH)
	WCV	Child and Adolescent Well-Care Visits: Ages 18 to 21 (WCV-CH)
	WCV	Child and Adolescent Well-Care Visits: Ages 3 to 11 (WCV-CH)
	WCV	Child and Adolescent Well-Care Visits: Ages 3 to 11 (WCV-CH)
National Center for Quality Assurance (NCQA)	HPCMI	Diabetes Care for People with Serious Mental Illness Glycemic Status > 9.0%: Ages 18 to 64 (HPCMI-AD)
	HPCMI	Diabetes Care for People with Serious Mental Illness Glycemic Status > 9.0%: Ages 65-75 (HPCMI-AD)
Pharmacy Quality Alliance (PQA)	COB	Concurrent Use of Opioids and Benzodiazepines: Ages 18 to 64 (COB-AD)

Quality Measure Category	Quality Measure Abbreviation	Quality Measure Description
	COB	Concurrent Use of Opioids and Benzodiazepines: Ages 65 and Older (COB-AD)
	OHD	Use of Opioids at High Dosage in Persons Without Cancer: Ages 18 to 64 (OHD-AD)
	OHD	Use of Opioids at High Dosage in Persons Without Cancer: Ages 65 and Older (OHD-AD)

15.0 Additional DHCS Policies & Programs that Medi-Cal Connect can Support

In the future, DHCS will release recommendations for how Medi-Cal Connect functionality can support these additional Policies, Programs, and Services:

- Behavioral Health Monitoring
- Blood Lead Screening Improvement
- Children's Health
- Dental Services
- Maternal Health Programs
- Native Americans and Tribal Communities Health Equity
- PHM Program Monitoring

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