Data Elements Recommended to Share between Managed Care Plans (MCPs) and Continuums of Care (CoCs) to Improve Coordinated Care

The following tables outline possible data elements to share, when available, to facilitate bidirectional data sharing between MCPs and CoCs to support coordinated care, program eligibility determination and renewal, and alignment of housing and health services.

Data shared from MCP to CoC

Data Element	Use Case / Rationale
Medi-Cal ID	Confirms the member has a history in Medi-Cal
Record match	Confirms client is enrolled in a specific MCP (where multiple MCPs exist) and is actively enrolled
MCP Enrollment Status and Effective Dates	Confirms whether a member is currently enrolled, pending, or disenrolled from an MCP and provides clarity on coverage start/end dates to support eligibility verification
ECM and/or Community Supports authorized/enrolled	Provides information to CoC and on-the-ground workers about the types of services a member is receiving (e.g., ECM, CS Transitional Rent, other non-housing related supports)
ECM and/or Community Supports Provider/s Name, Case manager (and/or Health Plan Case Manager), and Contact Information	Improves care coordination activities, i.e., CoC providers can follow-up for information they know about a member
ECM and/or Community Supports Enrollment/Effective Date/s	Improves care coordination activities, i.e., homeless services providers know how long a member has been eligible for or receiving services
ECM and/or Community Supports Termination Date/s (if applicable)	Improves care coordination activities, i.e., homeless services providers know when a member's additional services may expire
Housing Status	Improves care coordination activities, i.e., CoCs get updated information from the MCPs when their members' housing status changes
Primary Care Provider Name and Contact Information	Improves care coordination activities, i.e., CoC is able to support whole-person care coordination and

	communication with medical providers
Participating Provider Group (PPG) Name and Contact Information	Improves care coordination activities, i.e., provides insight into the member's provider network, if applicable
Medi-Cal Renewal Deadline	CoC can support members in renewing and retaining their health care coverage

Data shared from CoC to MCP

Data Element	Use Case / Rationale
Record match	Confirms member is touching the homeless system of care, i.e., identifying a member meets eligibility criteria for services because they are homeless or at risk of homelessness or chronically homeless. The MCP can learn that a member is no longer working with the homeless system of care or may have moved out of the county
HMIS ID	Unique ID used for searching and matching members in HMIS for MCPs with access to system
HMIS Program Name/Start Date/Contact Info	Improves care coordination activities, i.e., identifies the specific homeless services program a member is enrolled in with context re: length of engagement and information to contact the program directly
Active HMIS Program Enrollments	Improves care coordination activities, i.e., MCPs know what support a member is receiving, what agencies they are working with and who to contact to locate or get in touch with a member.
Case Manager/ Housing Navigator name and contact information	Improves care coordination activities, i.e., MCPs know who to contact to help locate or get in touch with a member
Housing Support Plan (HSP)	Improves care coordination activities, i.e., as an important requirement for Transitional Rent, MCPs can learn if an HSP already has been developed for a member or use CoC data to populate an HSP without having to start from scratch, as well as enable an MCP to get information needed to authorize or approve of Transitional Rent
Self-Reported Mental Illness or Substance Use	Improves care coordination activities, i.e., MCPs can learn if a member may be eligible for the Transitional Rent Behavioral Health Population of Focus, for Community Supports, and/or exemptions for HR 1

Self-Reported history of chronic health condition	Improves care coordination activities, i.e., MCPs can learn if a member may be eligible for Community Supports and/or exemptions for HR 1
Self-Reported developmental disability	Improves care coordination activities, i.e., MCPs can learn if a member may be eligible for Community Supports and/or exemptions for HR 1
Self-Reported physical disability	Improves care coordination activities, i.e., MCPs can learn if a member may be eligible for Community Supports and/or exemptions for HR 1
Disability Verification (which might include enrollment in a program that requires disability verification to be eligible)	MCP can use this information to assess whether individuals meet an exemption from the new Medicaid work requirements or need support meeting exemption criteria
Member is working with Behavioral Health (if available), which may include member participation in specific programs requiring involvement with Behavioral Health to be eligible	Improves care coordination activities, i.e., MCPs can quickly identify whether a member already is a client of the local Behavioral Health dept
Coordinated Entry Status	Improves care coordination activities, i.e., helps MCP know the member has been assessed for vulnerability and may even be able to share where the member is placed on the prioritization for housing and vulnerability
Housing requests and/or assessment scores	Improves care coordination activities, i.e., helps MCP know if the member is awaiting a voucher or what type of housing they have been assessed for (interim v. permanent, RRH v. PSH), or what their assessment score is to determine possible eligibility for MCP programs.
Housing Status	Improves care coordination activities, i.e., MCPs get updated information from the CoCs when their members' housing status changes.
Income Sources/Amounts (including dates of last update/history), and/or Employment Status and History, if available	MCP can use this information to assess whether individuals meet new HR 1 Medicaid work requirements or need support meeting criteria
Referrals and/or enrollment in employment or education	MCP can use this information to assess whether individuals meet new HR 1 Medicaid work requirements or need

programs	support meeting the requirements