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DEPARTMENT OF HEALTH CARE SERVICES

CalAIM: Population Health Management (PHM) Frequently Asked Questions

Updated: June 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Introduction

California Advancing and Innovating Medi-Cal (known as CalAIM) aims to improve the quality of life and health outcomes of all Medi-Cal members by implementing broad delivery system, program, and payment reform across the Medi-Cal program. On January 1, 2023, the Department of Health Care Services (DHCS) launched the Population Health Management (PHM) Program, which is a cornerstone of CalAIM. The PHM Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity.

PHM is a journey rather than a destination. DHCS recognizes that California Medi-Cal Managed Care Plans (MCPs), providers, counties, community-based organizations, and others, are working together to implement the PHM Program, and the Department is offering a range of technical assistance and support, including implementation materials posted on the DHCS PHM webpage, PHM Advisory Group meetings, and other technical assistance forums for discussion. This FAQ provides up-to-date information about the PHM Program implementation and PHM Service and will be updated regularly.

For questions and additional information, please email PHMSection@dhcs.ca.gov.

PHM Program General

1. **What NCQA requirements are Medi-Cal MCPs required to meet by 1/1/2023 under the PHM Program?**

   MCPs are required to comply with all National Committee for Quality Assurance (NCQA) PHM standards by 1/1/2023 and obtain NCQA Health Plan Accreditation and Health Equity Accreditation by 1/1/2026. DHCS does not require any providers to be certified by NCQA under the PHM Program. For any questions related to how NCQA will oversee MCPs who contract with providers to fulfill PHM requirements, DHCS encourages MCPs to reach out to NCQA directly.

PHM Program – Gathering Member Information

2. *(Updated June 2023)* **What are the requirements for the Initial Health Appointment under the PHM Program?**

   The former Initial Health Assessment is now known as the "Initial Health Appointment" . Effective January 1, 2023, for members who are newly enrolled adults, the Initial Health Appointment must be completed within 120 days. For newly enrolled members less than 18 months of age, the Initial Health Appointment, must be completed within 120 calendar days of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP)/ Bright Futures for ages 2 and younger, whichever is sooner. DHCS also issued a revised Initial Health Appointment APL 22-030 simplifying previous requirements.[1]

   MCPs should continue to hold network providers accountable for providing all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF). DHCS no longer requires all of these elements to be completed during the Initial Health Appointment, so long as members receive all required screenings in a timely manner consistent with USPSTF guidelines. MCPs may find it convenient for providers to complete USPSTF preventive screening during the Initial Health Appointment, but these elements are not required.

   DHCS will use existing Medi-Cal Managed Care Accountability Set (MCAS) quality measures focused on preventive services, such as Child and Adolescent Well-Care Visits, Depression Screening and Follow-Up for Adolescents and Adults, Breast Cancer Screening, and Adults' Access to Preventive/Ambulatory Health Services as proxies for monitoring the Initial Health Appointment.

[1] Detailed Initial Health Appointment requirements are outlined in 22 C.C.R. § 53851(b)(1) and the Medi-Cal Managed Care Contract.

3. *(Updated June 2023)* **Can the Initial Health Appointment be completed in multiple visits? Can some of the visits be done via telehealth?**

   Yes, the Initial Health Appointment can be completed over the course of multiple visits. Telehealth visits can be used as an option for completing one or more components of the Initial Health Appointment, but not all of the IHA. For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be done over multiple appointments based on AAP /Bright Futures periodicity schedule, as referenced in APL 23-005.

4. **Does the Initial Health Appointment need to be periodically rescheduled or re-administered to enrolled Members?**

   No, the Initial Health Appointment does not need to be periodically rescheduled or re-administered to Members. MCPs should continue to hold network providers accountable for providing all preventive screenings for adults and children as recommended by the USPSTF. DHCS will measure primary care visits and childhood screenings to ensure Member needs are being met.

5. **What are some reasons why the Initial Health Appointment would not be completed in the required 120-day timeframe for newly enrolled adults?**

   An Initial Health Appointment is not necessary if the member's PCP determines that the member's medical record contains complete information that was updated within the previous 12 months. This information must be assessed by the PCP during the first 120 days of member enrollment. The conclusion of the PCP's assessment must be documented in the member's medical record. Other reasons a member may not complete an Initial Health Appointment are the following: Member disenrolled before 120 days; Member refuses Initial Health Appointment completion; and reasonable attempts by the MCP or delegated provider to contact the member were unsuccessful. All Initial Health Appointment attempts should be documented in the member's medical record.

6. *(New June 2023)* **Can MCPs use the Health Risk Assessment (HRA) to fulfill the Health Information Form (HIF)/Member Evaluation Tool (MET) requirement?**

   No, MCPs cannot use the HRA to fulfill the HIF/MET requirement, given the differences in their purposes and content. The HIF/MET is a brief federal initial screening requirement that is used to identify general member needs within 90 days of enrollment. The HRA is a more in-depth assessment that includes required LTSS referral questions,[2] which should be completed within 30 days after a member is identified through Risk Stratification and Segmentation (RSS), referral or other means. MCPs should be responsible for administering both the HIF/MET in addition to the HRA.

[2] PHM Policy Guide, Appendix 3: Standardized Long-Term Services and Supports (LTSS) Referral Questions

PHM Program – Understanding Risk

7. Can MCPs use their own RSS. methodology once the PHM Service's RSS functionality is available and vetted?

Yes, MCPs are allowed to use their own RSS methodologies to supplement the PHM Service's statewide risk tiers. However, MCPs will be required to use the PHM Service's risk tiers, at a minimum, to assess any members identified as high risk through the PHM Service. The assessment process must include identifying any needs and connecting members to appropriate services. Further details of the required use of the PHM Service risk tiers will be published prior to statewide launch .

8. Since DHCS plans to launch the PHM Service statewide, what assessment and Risk Stratification and Segmentation (RSS) processes will MCPs need to have in place, before transitioning to the PHM Service's new RSS model?

- **RSS:**

Prior to the PHM Service RSS and Risk Tiering (RSST) functionalities going live, MCPs must utilize an RSS approach that meets requirements outlined in the PHM Policy Guide Section II D. 1) RSS and Risk Tiers; MCPs' RSS approach must comply with NCQA PHM Standards and avoid and reduce biases to prevent the exacerbation of health disparities. MCPs do not need to use standardized risk tiers, but must use their RSS approach to identify members who should be connected to available interventions and services.

- **Assessment:**

Assessments are required to be conducted for certain populations as outlined in PHM Policy Guide Section II D. 2) Assessment to Understand Member Needs, both before and after the PHM Service's launch , including:

- Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver).[3]
- Those entering Complex Care Management (CCM per NCQA).
- Those entering Enhanced Care Management (ECM).
- Children with Special Health Care Needs (CSHCN).[4]

[3] 42 C.F.R. § 438.208; CA W.I.C. § 14182(c)(12). A Standard Terms and Conditions of Federal 1115 Demonstration Waiver titled "A Bridge to Reform."

[4] Aligned with federal regulations, DHCS CQS states, "Each MCP is required to implement and maintain a program for [CSHCN], who are defined by the state as having, or being at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond that generally required by children. Each MCP's CSHCN program is required to include standardized procedures for identifying CSHCN at enrollment and on a periodic basis after enrollment. Members identified as

- Pregnant individuals.[5]
- Seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements,[6] namely:
  - Members who have been authorized to receive:
    - IHSS greater than, or equal to, 195 hours per month;
    - Community-Based Adult Services (CBAS), and/or
    - Multipurpose Senior Services Program (MSSP) Services.
  - Members who:
    - Have been on oxygen within the past 90 days;
    - Are residing in an acute hospital setting;
    - Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
    - Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
    - Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
    - Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
    - Have cancer and are currently being treated;
    - Are pregnant;
    - Have been prescribed antipsychotic medication within the past 90 days;
    - Have been prescribed 15 or more prescriptions in the past 90 days;
    - Have a self-report of a deteriorating condition; and
    - Have other conditions as determined by the MCP, based on local resources.
- Prior to the statewide RSS and risk tiers becoming available through the PHM Service, MCPs are required to assess members who are identified through their own RSS approaches (e.g., upon enrollment, annually after enrollment, based on significant change in health status or level of care, or upon receipt of new information that the MCP determines as potentially changing a member's level of risk and need).
- Once the statewide RSS and risk tiers are available through the PHM Service, MCPs will be required at a minimum to assess members who are identified as high-risk through the PHM Service.

CSHCN must receive comprehensive assessment of health and related needs. The MCP must implement methods for monitoring and improving the quality and appropriateness of care for CSHCN."

[5] Medi-Cal Managed Care Boilerplate Contract, Exhibit A, Attachment 10, Scope of Services, 7. Pregnant Women.

[6] APLs 17-012 and 17-013.

To reduce current duplicative and burdensome processes, DHCS encourages MCPs to contract with providers to conduct assessment and integrate it with care and care management to the greatest extent possible. Assessments results are also expected to be shared between MCPs and providers responsible for following up with the member. MCPs must follow up on any positive assessment result or contract with the Primary Care Provider (PCP) to conduct follow up. Lastly, DHCS also streamlined requirements related to Seniors and Persons with Disabilities Health Risk Assessment (HRA) requirements, as outlined in Box A: Changes to Seniors and Persons with Disabilities Health Risk Assessment (HRA) requirements in the PHM Policy Guide.

9. When should members be re-stratified?

MCPs must re-stratify members in real-time upon a significant change in the health status or level of care (e.g., inpatient medical admission or emergency room visit, pregnancy, or diagnosis of depression), or upon the receipt of new information that the MCP determines as potentially changing a member's level of risk and need, including but not limited to information contained in assessments or referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), Transitional Care Services, and Community Supports. MCPs are also required to conduct annual re-stratification for all members

10. How often should MCP members be re-assessed?

Similar to the re-stratification requirements, MCPs should re-assess in real-time upon a significant change in the health status or level of care of the member, or upon the receipt of new information that the MCP determines as potentially changing a member's level of risk and need. At a minimum, MCPs are required to conduct re-assessment as follows:

- Enhanced Care Management (ECM) – there is no re-assessment requirement, however, most MCPs conduct re-assessment annually.
- Complex Care Management (CCM) – there is no re-assessment requirement.
- Children with Special Health Care Needs (CSHCN) – a re-assessment that is at least every 12 months is required based on federal regulations.
- Population with Long Term Services and Supports (LTSS) Needs – a re-assessment that is at least every 12 months is required based on federal regulations.
- Seniors and Persons with Disabilities – all members who meet the definition of "high risk" as defined in the PHM Policy Guide are required to be assessed, but there is no re-assessment requirement.

11. How does the retirement of APLs 17-012 and 17-013 change requirements related to Seniors and Persons with Disabilities Health Risk Assessment (HRA)?

APLs 17-012 and 17-013 contained care management requirements for SPDs and dual-eligible members. They were developed by DHCS in conjunction with stakeholders as a result of previous initiatives and federal requirements. Given the passage of time, DHCS believes there is an opportunity to update the requirements within APLs 17-013 and 17-012 and eliminate redundancies while keeping specific member protections in place. As such, APLs 17-012 and 17-013 were retired following the November 2022 release of APL 22-024 Population Health Management Program Guide, and effective January 1, 2023, they were replaced with simplified requirements; however, the majority of the specific member protections contained in these APLs are kept in place through requirements outlined in PHM Policy Guide, D. Understanding Risk, Box A: Changes to Seniors and Persons with Disabilities Health Risk Assessment (HRA) Requirements. Starting in 2023:

- **Assessment for high risk SPDs:** Specific populations are required to receive an assessment, including SPDs who meet the definition of "high risk" as defined in the PHM Policy Guide, even if they do not have LTSS needs. MCPs may leverage their ECM and/or CCM assessment tools, or components of those tools, for Seniors and Persons with Disabilities considered at "high risk."
- **HRA tools:** MCPs are not be required to retain the use of their existing HRA tools that were previously approved by DHCS under the APLs 17-012 and 17-013, although they may choose to do so. If MCPs decide to retain existing HRA tools, they are encouraged to adapt them to allow delegation to providers.
- **Standardized LTSS Referral Questions:** Even though the HRA tools are no longer be required beginning on January 1, 2023, MCPs or their delegates must continue to assess members who may need LTSS, using the existing standardized LTSS referral questions (see PHM Policy Guide Appendix 3).
- **Timeline for Assessment:** DHCS simplified the expected timeline for assessment of those with LTSS needs to align with NCQA's requirements for care management assessments, which include beginning to assess within 30 days of identifying the member through RSS, referral, or other means, and completing assessment within 60 days of that identification.
- **Care plans:** MCPs must comply with federal regulations that stipulate specific care plan requirements for members with LTSS needs.

Basic Population Health Management

12. *(Updated June 2023)* **When will Closed Loop Referrals be required?**

MCPs will be required to meet Closed loop referral requirements in January 2025, based on guidance to be released by DHCS in 2024.

Care Management

13. What care management services and supports should be provided to members within each risk tier (e.g., low-, medium-rising-, and high-risk)?

Care management services and supports can be provided to members in each risk tier at the MCP's discretion. However, MCPs are required to provide Basic Population Health Management (BPHM) to all members, including those medium-rising and high-risk members. For more information related to care management services and supports under the PHM Program, please refer to the PHM Policy Guide, Section E. 2) Care Management Programs.

Transitional Care Services (TCS)

14. What are TCS and who should receive TCS under the PHM Program?

MCPs are accountable for providing strengthened TCS to members transferring from one setting or level of care, to another, for the duration of the transition under the PHM Program. This includes knowing when members are admitted, discharged, and transferred, processing prior authorizations in a timely manner, and assigning or notifying a single point of contact (or care manager) to ensure TCS are complete. For members enrolled in CCM or ECM, MCPs must ensure that the member's assigned ECM Lead Care Manager or CCM care manager is the care manager who must provide all TCS. For members not enrolled in ECM or CCM, this single point of contact (or care manager) does not need to be employed by the plan and can be contracted (e.g., to the PCP team or an Accountable Care Organization or to the hospital staff).

The assigned single point of contact (care manager) must coordinate with the discharging facility to ensure: 1) a discharge risk assessment is complete, 2) a discharge planning document is created and shared with the member, providers, and other appropriate parties, and 3) all needed post-discharge services such as referral to at-home services or medication reconciliation are provided and follow-ups are scheduled.

TCS will end once the member has been connected to all the needed services or has been assessed for eligibility for further care management support (e.g., ECM or CCM).

15. What is the implementation timeline for TCS?

In 2023, MCPs must ensure that all TCS are complete (including having a single point of contact/care manager) for **all high-risk members**. For TCS, high risk members are defined as any population listed under Section D. Understanding Risk, 2) Assessment to Understand Member Needs Section, which include the following populations:

- Any "high risk" members as identified through the MCPs' RSS mechanisms[7] or through the PHM Service once the statewide RSS and risk tiers are available;
- Any other populations who require assessments, including but not limited to:[8]
    - Those who are in ECM or CCM (TCS must be provided by the ECM or CCM Care Manager); and
    - Those who received LTSS.

In 2023, MCPs must also implement timely prior authorizations and know when members are admitted, discharged or transferred for **all members**.

By January 1, 2024, MCPs are required to ensure all TCS are complete for **all members**. Additional technical assistance will be provided by DHCS to support the ramp up. For more information, please refer to the updated PHM Policy Guide.

16. If the MCP contracts with hospitals, Accountable Care Organizations (ACOs), PCPs, or other entities to provide transitional care services (TCS), will these entities be subject to delegation and subcontracting requirements under APL 17-004?

No. Requirements under APL 17-004 would not apply if the MCP contracts with network providers, including hospitals, ACOs, PCPs, or other entities to provide TCS requirements. MCPs can fulfill the TCS requirements and assign a single point of contact/care manager either by using its own staff or contracting with other network partners and will be required to submit data to DHCS for PHM program monitoring. Please refer to the updated PHM Policy Guide regarding guidance on the PHM Monitoring approach for MCPs.

[7] MCPs' RSS approach and stratification timeframes must meet requirements outlined in the D. Understanding Risk, 1) RSS and Risk Tiers Section.

[8] Members who are defined as high risk include populations that require assessment as outlined in Section D. Understanding Risk, 2) Assessment to Understand Member Needs Section, including: those with LTSS needs, those entering CCM, those entering ECM, CSHCN, pregnant individuals, seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements, those identified through the MCP' own RSS approaches prior to the PHM Service's statewide RSS and risk tiers available, and those who are identified as high-risk through the PHM Service, once the statewide RSS and risk tiers are available. Those who are in ECM, CCM, and individuals receiving LTSS are spelled out here for emphasis.

17. *(New June 2023)* **To ensure effective collaboration and timely support for members undergoing a transition, how will the facility where the member is admitted (referred to as "discharging facility") know the contact information for the assigned single point of contact/care manager?**

    The MCP must implement processes to ensure that the contact information (name and phone number) for the assigned single point of contact/care manager is shared with the discharging facility and that the contact information is incorporated into the discharge planning document shared with the member. A best practice is to have the discharging facility incorporate the name and contact information in the discharge instructions they give to the member.

18. **As part of TCS, will emergency room (ED) follow up be provided at the discretion of the plan?**

    In 2023, ED follow ups are provided at the discretion of the plan. However, MCPs are encouraged to provide ED follow up as part of TCS, especially for the highest risk members. Based on literature and existing research, ED follow ups are highly effective in reducing avoidable hospital admissions and improving outcomes.[9] In addition, quality measures regarding follow-up after ED visits for mental illness and substance abuse are also part of the Medi-Cal Managed Care Accountability Set (MCAS) for Managed Care Health Plans (MCPs) for Measurement Year 2022/Reporting Year 2023.

19. **What are the required responsibilities for the MCP if an admitted member indicates that they do not wish to receive TCS when the MCP's assigned care manager (or single points of contact) reaches out?**

    If a member indicates that they do not wish to receive TCS, the assigned care manager (single point of contact) must still act as a liaison coordinating care among the discharging facility, the PCP, and the MCP.

20. **Does DHCS have minimum requirements for the number of outreach calls that MCPs must conduct to support TCS for members?**

    DHCS does not have any expectation for the volume of calls MCPs are required to conduct to implement TCS and will be monitoring the efficacy of TCS, not attempted outreach.

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[9] Carmel AS, Steel P, Tanouye R, Novikov A, Clark S, Sinha S, Tung J. Rapid Primary Care Follow-up from the ED to Reduce Avoidable Hospital Admissions. West J Emerg Med. 2017 Aug;18(5):870-877. doi: 10.5811/westjem.2017.5.33593. Epub 2017 Jul 14. PMID: 28874939; PMCID: PMC5576623.
Lin MP, Burke RC, Orav EJ, Friend TH, Burke LG. Ambulatory Follow-up and Outcomes Among Medicare Beneficiaries After Emergency Department Discharge. *JAMA Netw Open.* 2020;3(10):e2019878. doi:10.1001/jamanetworkopen.2020.19878

DHCS encourages MCPs to be innovative in meeting member's needs and fulfilling TCS requirements. MCPs can contract with hospitals, ACOs, PCPs or other entities to ensure the completion of TCS and minimize the number of calls while still meeting member's needs. In addition, rather than phone calls, plans may consider messaging or automated platforms that allow two-way communication between care managers or with members for outreach.

21. What are the MCP's responsibilities for coordinating TCS for members who are dual-eligible for Medi-Cal and Medicare?

Generally, MCPs are responsible for coordinating with the primary payor and hospitals/facilities, including establishing necessary relationships, data sharing arrangements, and other mechanisms to know when members are expected to be and are admitted, discharged, or transferred.

For members who are dual-eligible for MMPs or any other D-SNP, the Medi-Cal MCP is not responsible for assigning a TCS care manager (single point of contact) or any TCS manager responsibilities. The MMP/D-SNP is responsible for coordinating the delivery of all benefits covered by Medicare and Medi-Cal.

For those members dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA plans (except D-SNPs), MCPs remain responsible for ensuring all TCS requirements are complete.

22. What are the MCP's responsibilities for coordinating TCS for members who have the county Mental Health Plans (MHPs) or the Drug Medi-Cal Organized Delivery System (DMC-ODS) as their primary payor?

Similar to above, MCPs are responsible for coordinating with the primary payor and hospitals/facilities, including establishing necessary relationships, data sharing arrangements, and other mechanisms to know when members are expected to be and are admitted, discharged, or transferred.

For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where the county MHP is the primary payor, and for members who are admitted for residential SUD treatment, including residential withdrawal management, where DMC-ODS is the primary payor, MHPs or DMC-ODS are primarily responsible for coordination of care with the member upon discharge. However, MCPs are also be required to assign a care manager or contract with a hospital, ACO, or provider to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services such as CCM, ECM, or Community Supports.

23. How can the MCP's assigned care manager (single point of contact) avoid creating duplicative discharge planning document if the hospital/discharge planning facility has already created one, to meet TCS requirements?

DHCS recognizes that hospitals/discharging facilities already provide discharge documentation to members at discharge. The TCS requirements for the discharge planning document are complimentary to what hospitals/discharging facilities provide. Specifically, the MCP's assigned care mangers must collaborate with the hospital/discharging facility staff on the discharge planning document and ensure that it is complete and accurately coordinated, shared with appropriate parties, and that the member does not receive two different discharge documents from the discharging facility and the care manager. If the hospital discharge planning document fulfills all requirements, including the name and contact information of the care manager responsible for TCS, that would fulfill the MCPs' responsibility as well. A key part of the requirement is for the discharge planning document to include the name and contact information of the care manager responsible for TCS so that the member knows who to reach out to if there are any issues.

The PHM Policy Guide Section E. c.Transitional Care Services (TCS), vi. Discharge Risk Assessment and Discharge Planning provides more information about how MCPs can fulfill their contractual requirements through coordination with the hospital/discharging facility to avoid member confusion and duplication of discharge documents.

24. How will MCPs know or be notified when their members are admitted, discharged, or transferred when they are the secondary payor? Will ADT feeds be available?

MCPs are required to set up systems to be notified of their members' admission, discharges or transfers. They should work with their local health information exchanges and/or contracted hospitals to establish requirements for ADT notifications to be sent to all parties that need to be alerted to an admission, discharge, or transfer of a member. When that is not possible, they should work on establishing data use agreements or other mechanisms for data sharing with other payors or institutions (hospitals, psychiatric facilities, etc.).

25. Will there be a standard DHCS form for discharge planning?

No, DHCS is not planning to issue a standard discharge planning form at this time.

26. Does the Discharge Risk Assessment require DHCS approval?

No, DHCS does not require discharge risk assessment to be approved at this time.

PHM Program – Monitoring

27. *(New June 2023)* How will DHCS monitor MCPs' PHM program implementation, effectiveness, and outcomes?

DHCS will review the holistic performance of each MCP's PHM Program implementation through monitoring performance across multiple PHM categories. These categories are organized by the following monitoring domains: PHM program

areas/themes, populations, and cross-cutting priorities. Core aspects of the PHM program areas include basic population health, RSST, CCM, ECM, and TCS. Specific populations for which DHCS will be monitoring the implementation of the PHM Program in 2023 include Children and Youth, Birthing Populations, and Individuals with Behavioral Health Needs, which align with the clinical focus areas in DHCS's CQS. DHCS anticipates monitoring the implementation of the PHM Program for seniors and dual-eligible members as a population of focus in the future. In 2023, DHCS will also be monitoring equity across all monitoring domains and categories.

Within each category, DHCS identified existing quality measures from Medi-Cal Managed Care Accountability Set (MCAS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) and high priority key performance indicators (KPIs). The Department will review the overall picture revealed by MCP performance across all of the measures within a category to understand if core aspects of a MCP's PHM program are working as intended. The intent is also to look over time using early measure performance as a baseline and looking for improvements, as well as identifying outliers. By reviewing each monitoring category, DHCS will be able to spot priority issue areas that require direct DHCS follow-up with MCPs and identify areas in the PHM Program requirements that need additional DHCS guidance or clarifications. For more information, please refer to the PHM Policy Guide, III. Monitoring Approach for Implementation of the PHM Program

28. *(New June 2023)* **What will MCPs be required to submit for PHM monitoring?**

MCPs will be required to report **five new KPIs** at the plan level on a quarterly basis beginning on August 15, 2023. For detailed KPI reporting and stratification requirements, please refer to thePHM Policy Guide, Appendix 5: PHM Monitoring KPI Technical Specifications:

- Percentage of members who had more ED visits than primary care visits within a 12-month period;
- Percentage of members who had a primary care visit within a 12-month period;
- Percentage of members with no ambulatory or preventive visit within a 12-month period;
- Percentage of members eligible for CCM who are successfully enrolled in the CCM program; and
- Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge.

MCPs will not need to report on other data points that they already report on; DHCS will leverage existing datafrom the ECM Quarterly Implementation Monitoring Reporting (QIMR), the CalAIM Incentive Payment Program (IPP), and MCAS and

CAHPS quality measures reported through the annual quality and performance improvement process as well as through its Core Set reporting processes for all other monitoring activities.

Please refer to the PHM Policy Guide, III. Monitoring Approach for Implementation of the PHM Program for detailed lists of Quality Measures and KPIs.

29. *(New June 2023)* **Given DHCS will leverage existing MCP reported data, including IPP, for PHM monitoring purporses, what is considered an ADT notification for the two IPP measures below that are also part of the PHM monitoring measure list? For example, is Care Everywhere considered, or other daily reports?**

    - **Percentage of contracted acute care facilities from which MCPs receive ADT notifications**
    - **Percentage of contracted skilled nursing facilities (SNFs) from which MCPs receive ADT notifications**

    An ADT notification is a specific type of message that has prescribed use and formatting. ADTs may be sent from facilities to providers directly. They may also be sent through health information exchanges (HIEs)/health information organizations (HIOs). Care Everywhere is an example of an HIE that is hosted by Epic (EHR vendor) to support data exchange. ADTs could be transmitted through Care Everywhere, but the use of Care Everywhere does not mean an ADT has been sent. Examples of HIOs in CA include Los Angeles Network for Enhanced Services (LANES), San Diego Health Connect, Santa Cruz HIO, and Manifest Medex.

30. *(New June 2023)* **Similar to above, for the "Percentage of contracted acute care facilities from which MCPs receive ADT notifications" IPP/PHM monitoring measure, what facility types should be included as an "acute care facility" (ED, Inpatient, etc)?**

    Acute care facilities include inpatient and ED facilities.

31. *(New June 2023)* **What is the timeline for PHM monitoring submissions?**

    MCPs will be required to report stratified KPIs to DHCS at the plan level on a quarterly basis, beginning on August 15, 2023. Existing reporting timelines associated with MCAS and CAHPS measures, ECM QMIR and IPP measures will not change.

PHM Service

32. What kind of functionalities will the PHM Service be able to support?

The PHM Service will support nine core business practices: (1) intake, screening and assessment, (2) care coordination and planning, (3) population health management, (4) beneficiary and stakeholder engagement, (5) enterprise relationship management, (6) advanced data and analytics, (7) quality, performance management and reporting, (8) regulation and compliance, and (9) business support services. DHCS is currently working with stakeholders to identify the specific PHM Service functionalities that will be made available both at launch and over time.

33. Will the PHM Service include information on all Medi-Cal beneficiaries or just those in managed care?

The PHM Service will include information on all Medi-Cal members (i.e., those in fee-for-service Medi-Cal or managed care).

34. Once the PHM Service is live, what data will be expected to be in the PHM Service's comprehensive data portal?

Data in the PHM Service will be made available in phases over time. At time of statewide launch, DHCS anticipates that the PHM Service will primarily leverage existing DHCS data, such as historical claims and administrative data.

DHCS is working with a broad range of stakeholders across the State to identify other priority data that the PHM Service will provide access to over time. DHCS anticipates sharing more information about this data roadmap with stakeholders in the near future.

35. Will the PHM Service interface with provider electronic health records (EHRs)?

At the time of statewide launch, DHCS does not expect that the PHM Service will connect directly to provider EHRs or health information exchange (HIE) networks. DHCS will assess opportunities for the PHM Service to connect to provider EHRs and HIE networks as part of the long-term PHM Service strategy. What makes the PHM Service different is the goal to collect and aggregate data from across a broad set of programs and services across the State. This will enable users to have access to data from medical, behavioral, social, and other programs in a platform which HIEs do not support.

36. How does the PHM Service differ from a HIE network? Will information in the PHM Service be made available through a HIE network?

HIE networks typically focus on the collection and transmission of clinical data from providers' EHR systems. While the PHM Service will not initially connect to HIE networks to access, link, and/or exchange clinical data from providers' EHR

systems, DHCS will assess opportunities for the PHM Service to connect to EHRs and HIE networks as part of the long-term PHM Service strategy.

37. How will users access the PHM Service? Will interested users be able to register for an account?

The PHM Service will be accessed through different modalities including, but not limited to, web-accessible user portals and application programming interfaces (API) in accordance with national and state interoperability standards. DHCS will work with stakeholders across the State to inform PHM Service deployment and access through a structured engagement process.

38. How will the PHM Service's RSST algorithm(s) be developed? Will stakeholders be engaged?

DHCS has established a RSST Work Group of national experts who will lead the design and development recommendations and considerations for the RSST algorithm(s) in consultation with the Scientific Advisory Council (SciAC), PHM Advisory Group, and DHCS.

DHCS has established the Scientific Advisory Council (SciAC) to act in an advisory role to DHCS in guiding the development and deployment of the PHM Service-specific RSST algorithms.

39. Will the PHM Service replace the need for MCPs to have a separate methodology to identify ECM-eligible populations through their data?

No, MCPs will still need to maintain a separate capability to identify individuals eligible for ECM based on Populations of Focus definitions. Identification of ECM-eligible populations requires access to a diverse set of timely information, not all of which is expected to be available through the PHM Service at the time of its launch.