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Population Health Management Policy Guide

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I. Introduction

A. Purpose of the Population Health Management (PHM) Program Guide

The California Advancing and Innovating Medi-Cal (CalAIM) PHM Program Guide is one of three key California Department of Health Care Services (DHCS) guidance documents that set forth comprehensive requirements applicable for all Medi-Cal Managed Care health plans (MCPs) for the implementation of PHM, beginning on January 1, 2023.

The other two guidance documents – the PHM All Plan Letter (APL)[1] and the Amended 2023 MCP Contract provide baseline DHCS' requirements for MCPs to implement the PHM Program. The PHM Program Guide, PHM APL, and Amended 2023 MCP Contract build upon the vision and foundational expectations outlined in the Final PHM Strategy and Roadmap, which was released in July 2022.

The PHM Program Guide outlines the expectations that DHCS has for how MCPs will operate the PHM Program. Certain requirements will be phased in between January 1, 2023, and the effective date of the new MCP contract on January 1, 2024. The PHM Program Guide will continue to evolve to clarify and provide details on the implementation of the PHM Program and will be regularly updated. Please refer to Section II-G for a detailed implementation timeline.

Based on this PHM Program Guide and MCP contract requirements, MCPs will be required to submit to DHCS a PHM Program Guide Readiness Deliverable on October 21, 2022, describing specific components of their PHM programs and attesting to their implementation readiness prior to program launch.

B. What Is the PHM Program?

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. Specifically, the PHM Program intends to:

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

[1] DHCS will release an APL prior to the end of 2022 that explains that the role of this Program Guide is to provide details of MCPs' existing contractual requirements for the PHM Program.

- Reduce health disparities; and
- Identify and mitigates Social Drivers of Health (SDOH).

The launch of the PHM Program is part of a broader arc of change to improve health outcomes that is further articulated in DHCS' Comprehensive Quality Strategy (CQS), which emphasizes the long-lasting impact of coupling quality and health equity efforts with prevention.[2]

Under the PHM Program, MCPs and their networks and partners will be responsive to individual member needs within the communities they serve while working within a common framework and set of expectations.

While the PHM Program is a statewide endeavor that interacts with other delivery systems and carved-out services, and requires meaningful engagement and partnerships with members and other stakeholders, the requirements outlined in the PHM Program Guide apply specifically to MCPs.

C. What Is the PHM Service?

In tandem with the PHM Program rollout, DHCS is building a statewide **PHM Service**, which is a technology service designed to support PHM Program functions. The PHM Service will provide MCPs, providers, counties, members, and other authorized users with access to comprehensive data on members' health history, needs, and risks, including historical administrative, medical, behavioral, dental, and social service data and other program information from disparate sources. The PHM Service will use these data to support risk stratification, segmentation and tiering, assessment and screening processes, and analytics and reporting functions.[3] The PHM Service will also improve data accuracy and timeliness by providing members with the ability to update their information and improve DHCS' ability to understand population health trends and the efficacy of various PHM interventions, and strengthen oversight.

The PHM Service will be deployed statewide in July 2023, with additional PHM Service capabilities incrementally phased in thereafter. DHCS intends to test-launch the PHM Service with a subset of partners from January 2023 to June 2023 to optimize functionality before the statewide launch.

Given the period of time between the launch of the PHM Program (January 2023) and the launch of the PHM Service (July 2023), DHCS is clarifying expectations for PHM Program implementation within two distinct time periods: before and after the PHM Service is available. Prior to the launch of the PHM Service and prior to any requirements to use the PHM Service, DHCS will not require MCPs to develop new

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[2] The PHM Program is a part of CalAIM, which is a long-term commitment to transform and strengthen Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory: https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-Infographic.pdf.

[3] The PHM Service is part of a broader, statewide effort to accelerate and expand access to health and social service information among health care entities, government agencies, and social services organizations under California's Data Exchange Framework (DxF). The PHM Service is not being designed to provide real-time clinical decision support capabilities.

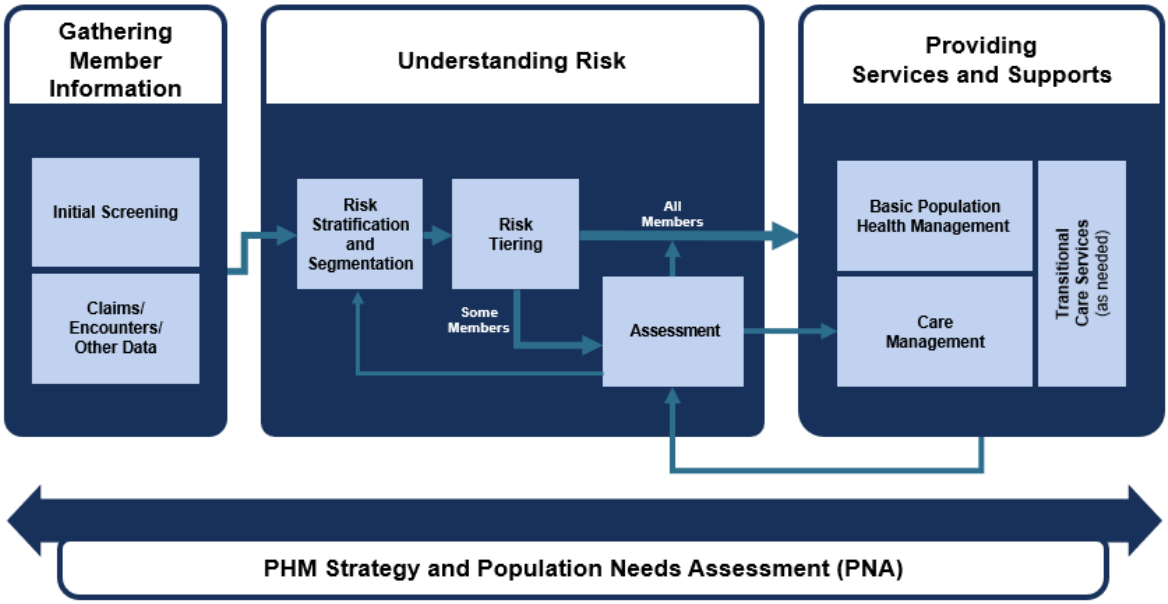
capabilities and infrastructure that would subsequently be replaced by the PHM Service. Additional guidance on how MCPs will be expected to use the PHM Service is forthcoming.

D. PHM Program Requirements

On January 1, 2023, all MCPs will be required to meet PHM standards and have either full National Committee for Quality Assurance[4] (NCQA) Health Plan Accreditation or otherwise demonstrate to DHCS that they meet the PHM standards for NCQA Health Plan Accreditation.[5] By January 1, 2026, all MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation.

II. PHM Program

A. PHM Framework



DHCS uses the PHM Framework above consistently to promote common terminology and communication about PHM. MCPs are encouraged to use the PHM Framework within their organizations and are required to meet requirements in each of the four domains of this framework: PHM Strategy and Population Needs Assessment, Gathering Member Information, Understanding Risk, and Providing Services and Supports.

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[4] NCQA is a nonprofit organization committed to evaluating and publicly reporting on the quality of MCPs.

[5] PHM standards are one component of NCQA Health Plan Accreditation, which also includes standards on Quality Management and Improvement, Network Management, Utilization Management, Credentialing and Recredentialing, Member' Rights and Responsibilities, Member Connections, and Medicaid Benefits and Services.

B. PHM Strategy and Population Needs Assessment (PNA)

DHCS is updating the requirements to the existing PNA and designing a new PHM Strategy to:

- Increase the level of meaningful community engagement and local alignment in meeting member needs
- Decrease the administrative burden and duplication.

Modified guidance on these updated requirements is expected to be published at the beginning of 2023 (Q1). Please refer to Section II-G. Implementation Timeline for more details.

1) PHM Strategy

The PHM Strategy as formulated by the MCPs will serve as an actionable plan that details each component of an MCP's PHM approach, prioritizes strong ties to the community, and incorporates cross-sector strategies to improve health in all neighborhoods and communities, especially those with poor health outcomes. This new comprehensive PHM Strategy will replace the PNA Action Plan that MCPs submitted previously. As referenced in the PHM Strategy and PNA section of the Amended 2023 MCP Contract, updated requirements for the PHM Strategy align with the CQS' Clinical Focus Areas and Bold Goals and have more emphasis on community engagement. The updated requirements and a corresponding template for the PHM Strategy will be released in Q1 2023.

PHM Strategy Submission Timeline:

- In October 2023, MCPs will submit their first annual comprehensive PHM Strategy under a new template, which builds on their PHM Readiness Deliverable submission in October 2022.[6]
- MCPs will submit the PHM Strategy annually thereafter.

2) Updated PNA

MCPs are already required to submit an annual PNA[7] describing the needs of their populations, focusing on their cultural, linguistic, and health education needs, as well as health disparities. As referenced in the PHM Strategy and PNA section of the Amended 2023 MCP Contract, DHCS intends to implement a modified PNA process that will require MCPs to provide a more robust description of the population needs of their members and the communities they live in, less frequent data collection, and more meaningful and systematic community engagement that will augment the data currently available to provide a fuller picture of the needs of members as well as the needs and strengths of the communities in which they live. Specifically, MCPs will be required to submit a PNA every three years, which will be developed by working alongside the community to gather and evaluate population-level data related to the health and social

[6] New MCPs entering in 2024 will complete the PHM Program Readiness Deliverable due in Q2 2023 and submit their PHM Strategy for the first time in Q3 2024, which will build on the Readiness Deliverable submission.

[7] Current PNA requirements are delineated in APL 19-011. DHCS is maintaining current PNA requirements in 2022.

needs of their members, including cultural, linguistic, and health education needs; health disparities and inequities; and the root causes of barriers related to coverage, access, quality, health outcomes, and SDOH. MCPs will be required to develop the PNA in partnership and alignment with Local Health Jurisdictions' Community Health Improvement Plans (CHIPs), and hospitals' Community Health Needs Assessments (CHNAs) and processes.

Modified PNA Submission Timeline:

- Previously, MCPs were responsible for an annual PNA submission following guidance outlined in APL 19-011. These requirements were maintained for the July 2022 submission.
- After the July 2022 PNA submission, MCPs will be required to submit a PNA every three years under modified guidance (to be released in Q1 2023). The next full PNA submission will be due in 2025.[8]

Corresponding APL Updates:

APL 19-011 will be superseded in Q1 2023 to outline the new PNA/PHM Strategy requirements.

Existing APL	Upcoming Updates and Timing
APL 19-011 "Health Education and Cultural and Linguistic Population Needs Assessment"	• APL 19-01, which delineates current PNA requirements, will be replaced in Q1 2023 with a new APL that will delineate requirements for the new PHM Strategy and modified PNA. The new APL will also be accompanied by an update to the PHM Program Guide, which will provide more operational details for MCPs on how to implement both the PNA and PHM Strategy.

C. Gathering Member Information

An effective PHM approach begins with gathering accurate and robust information to understand each member's health and social needs, as well as their health goals and preferences, to ensure that they receive the right services at the right time and right place.

1) Leveraging Existing Health and Social Data

Building upon current requirements related to MCPs' use of various data sources for internal management and reporting purposes,[9] MCPs will be required to leverage a broad set of data sources to support PHM Program information gathering, inform Risk Stratification and Segmentation (RSS), provide a broader understanding of the health

[8] New MCPs entering in 2024 will be required to include a PNA in their Readiness Deliverable submissions.

[9] Under current requirements related to Management Information System (MIS) capabilities, MCPs must utilize various data elements both for internal management use and to meet the data quality and timeliness requirements of DHCS' Encounter Data submission.

needs and preferences of the member, and support more meaningful member engagement.

Data to be used as part of information gathering and to inform RSS include:

- Screenings and assessments;
- Managed care and fee-for-service (FFS) medical and dental claims and encounters;
- Social services reports (e.g., CalFresh; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); California Work Opportunity and Responsibility to Kids (CalWORKs); In-Home Services and Supports (IHSS));
- Electronic health records;
- Referrals and authorizations;
- MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment (MTOUD, also known as Mediations for Opioid Use Disorder), and other substance use disorders (SUD), and other non-specialty mental health services information;[10]
- County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) claims system;[11]
- Pharmacy claims and encounters;
- Disengaged member reports (e.g., assigned members who have not utilized any services);
- Laboratory test results;
- Admissions, discharge, and transfer (ADT) data;
- Race, ethnicity, and language information;
- Sexual orientation and gender identity (SOGI) information;
- Disability status;
- Justice-involved data;
- Housing reports (e.g., through the Homeless Data Integration System (HDIS), Homelessness Management Information System (HMIS), and/or Z-code claims or encounter data); and
- For members under 21, information on developmental and adverse childhood experiences (ACEs) screenings.

DHCS understands that MCPs may have limited access to some of the required RSS data listed above and that some of these data may not be available until the PHM Service is fully operationalized. As such, during this period prior to Service launch,

[10] In certain circumstances, the sharing of 42 C.F.R. Part 2 data may require a member's signed consent in accordance with state and federal law; please refer to the 2022 DHCS Data Sharing Authorization Guidance for more information.

[11] In certain circumstances, the sharing of 42 C.F.R. Part 2 data may require a member's signed consent in accordance with state and federal law; please refer to the 2022 DHCS Data Sharing Authorization Guidance for more information.

MCPs will be expected to make a good-faith effort to use and integrate the above data to the greatest extent possible from currently available data sources.

Once the PHM Service is available and supports access to and use of required data sources, MCPs will be required to use the PHM Service and the available data accessible through the Service – in accordance with federal and state privacy rules and regulations – to conduct RSS, screening and assessment, basic PHM, and member engagement and health education activities. DHCS anticipates only having historical data (e.g., through claims/encounters) at the time of PHM Service launch and expects MCPs to source more real-time data (e.g., ADT feeds) from local data sources even after the PHM Service is available.

Lastly, MCPs must expand their MIS capabilities to integrate these additional data sources in accordance with the MIS Capability section of the Amended 2023 MCP Contract and all NCQA PHM standards. MCPs must adhere to data-sharing requirements as defined by the California Health & Human Services Agency Data Exchange Framework.

2) Streamlining the Initial Screening Process

DHCS is issuing the guidance below to streamline several initial screening processes while ensuring compliance with federal and NCQA requirements. Change is needed with respect to screening and assessment as existing mechanisms do not always cultivate member trust and are often burdensome to members and other stakeholders.

Effective on January 1, 2023, DHCS is implementing the following changes to the Health Information Form (HIF)/Member Evaluation Tool (MET) and the Individual Health Education Behavior Assessment (IHEBA)/Staying Healthy Assessment (SHA).

Modifications to the HIF/MET, Initial Health Appointment (IHA), and the IHEBA/SHA

- The **HIF/MET** will still be required to be completed within 90 days of enrollment for new members. However, DHCS is clarifying that:
    - MCPs may delegate the HIF/MET to providers. If delegated, the provider is responsible for following up on positive screening results. If the HIF/MET is not delegated to providers, the MCP must either directly follow up on positive screening results or delegate follow-up to the provider (and share relevant information with the provider to do so).
    - IHAs[12] results that are completed and shared back with the MCP within 90 days of enrollment would fulfill the HIF/MET requirement and, thus, the federal initial screening requirement.
- **The IHEBA/SHAs are eliminated.** However, DHCS is preserving the following requirements:

[12] Starting in 2023, the Initial Health Assessment will be known as the "Initial Health Appointment." Current requirements for the Initial Health Assessment are contained in APL 13-017, APL 18-004, APL 20-004, PL 08-003, PL 13-001 (Rev), and PL 14-004.

- The **IHA** must be completed within 120 days[13] of enrollment for new members and must continue to include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.[14]
- For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered in accordance with the American Academy of Pediatrics (AAP) /Bright Futures periodicity schedule, as referenced in APL 19-010.[15]
- 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) but will no longer require all of these elements to be completed during the initial appointment, so long as members receive all required screenings in a timely manner consistent with USPSTF guidelines.
- DHCS will measure primary care visits as a proxy for the IHA, leveraging Managed Care Accountability Sets (MCAS) measures specific to infant and child/adolescent well-child visits and adult preventive visits. For children, DHCS will measure both primary care visits and childhood screenings, including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and SUD.

Corresponding APL Updates

APLs	Upcoming Updates and Timing
PL 08-003 "Initial Comprehensive Assessment"	• PL 08-003 will be retired entirely by 12/31/22.
APL 13-017 "Staying Healthy Assessment/Individual Education Behavioral Assessment for Enrollees from Low-Income Health Program"	• APL 13-017 will be retired entirely by 12/31/22 since the IHEBA/SHA standardized questions are being completely eliminated.

[13] For members less than 18 months of age: within 120 calendar days of enrollment or within periodicity timelines established by the AAP Bright Futures for age 2 and younger, whichever is sooner. For adults age 21 and over: within 120 days of enrollment. Specific time frames are included in the 2022 Medi-Cal Managed Care Contracts.
[14] These required IHA elements are specified in 22 C.C.R. § 53851(b)(1).
[15] For more information about the AAP/Bright Futures initiative and to view the most recent periodicity schedule and guidelines, go to https://brightfutures.aap.org/Pages/default.aspx. Additional information on the periodicity schedule is available at https://www.aap.org/en-us/professional-resources/practicetransformation/managing-patients/Pages/Periodicity-Schedule.aspx.

APLs	Upcoming Updates and Timing
PL 13-001 revised "Requirements for the Staying Healthy Assessment/ Individual Education Behavioral Assessment for Enrollees from Low-Income Health Program"	• PL 13-001 will be retired entirely by 12/31/22.
PL 14-004 "Site Reviews: Facility Site Review and Medical Record Review"	• PL 14-004 will be modified to remove references to IHEBA/SHA, by 12/31/22.
APL 16-014 "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries") **APL 17-016 "Alcohol Misuse: Screening and Behavioral Health Counseling Interventions in Primary Care"**	• These APLs will be modified to decouple requirements from outdated IHEBA/SHA requirements by 12/31/22.
APL 18-004 "Immunization Requirements" APL 20-004 "Emergency Guidance for Medi-Cal Managed Care Plans in Response to COVID-19"	• No changes to APL 18-004 and APL 20-004.

In addition to the above, DHCS is considering other ways to streamline the initial screening process by leveraging the PHM Service, when available, which will help reduce member screening fatigue as well as better connect members to services and supports and improve data sharing between plans and providers via California's Data Exchange Framework. Through design work on the PHM Service, DHCS is exploring how the PHM Service can host screening and assessment functionalities that pre-populate relevant previously collected data to further mitigate duplication and burden on members.

D. Understanding Risk

1) RSS and Risk Tiers

Risk Stratification and Segmentation (RSS) means the process of differentiating all members into separate risk groups and/or meaningful subsets. RSS results in the categorization of all members according to their care and risk needs at all levels and intensities.

Risk tiering means the assigning of members to risk tiers that are standardized at the State level (i.e., high, medium-rising, or low risk), with the goal of determining the appropriate level of care management or other specific services for members at each risk tier.

In accordance with the Population RSS and Risk Tiering section of the Amended 2023 MCP Contract, DHCS is setting expectations toward greater standardization with regard to how MCPs use RSS algorithms, employ risk tiers, and connect members to services.

The PHM Service will include a single, statewide, open-source RSS methodology with standardized risk tier criteria that will place all Medi-Cal members into high-, medium-rising-, and low-risk tiers. Because the PHM Service will be in pilot mode until statewide scaling and launch in July 2023, DHCS requirements for RSS and risk tiering across all populations are set for two distinct time periods: prior to and after the RSS and risk tiering functionalities become available.

For the Period Prior to Availability of the PHM Service RSS and Risk Tiering Functionalities

a. RSS:

MCPs must meet the following requirements prior to the PHM Service's RSS functionalities becoming available:

- Utilize an RSS approach that:
    - Complies with NCQA PHM standards, including using utilization data integrated with other data sources such as findings from the PNA, clinical and behavioral data, or population and social needs data;
    - Incorporates a minimum list of data sources listed in the "Information Gathering" section to the greatest extent possible;
    - Avoids and reduces biases to prevent exacerbation of health disparities;
        - Many current RSS methodologies rely on utilization or cost data only, which may result in racial, condition, or age bias. Many RSS methodologies look only at past costs or utilization, which tends to result in prioritizing white patients over Black patients because white patients have higher medical expenses. Similarly, conditions that generate greater health care expenditures, such as those requiring dialysis, are prioritized over those that generate fewer expenditures. Lastly, older individuals with more chronic, complex conditions tend to be prioritized over younger individuals.[16]
        - To address these biases and improve outcomes for all of MCPs' members, MCPs are encouraged to use all relevant data, keep the information updated (e.g., through care managers), continuously evaluate key performance indicators and RSS outputs, use appropriate metrics to measure the accuracy and effectiveness of RSS model prediction of people who do or do not need help, and monitor whether RSS improves care for all populations.[17,18]
    - Stratifies members at least annually and during each of the following time frames:
        - Upon each member's enrollment.

[16] "Beyond Racial Bias: Rethinking Risk Stratification In Health Care," Health Affairs Blog, January 15, 2020. DOI: 10.1377/hblog20200109.382726.
[17] "Beyond Racial Bias: Rethinking Risk Stratification In Health Care," Health Affairs Blog, January 15, 2020. DOI: 10.1377/hblog20200109.382726.
[18] "Topic-Specific Implementation Guides." Comprehensive Primary Care. The Center for Medicare & Medicaid Innovation. June 2014. https://downloads.cms.gov/files/cmmi/cpci-combined-implementationguide.pdf.

    - Annually after each member's enrollment.
    - Upon a significant change in the health status or level of care of the member (e.g., inpatient medical admission or emergency room visit, pregnancy, or diagnosis of depression).
    - 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), TCS, and Community Supports.
- Continuously reassess the effectiveness of the RSS methodologies and tools.

b. Risk Tiering:

Prior to the PHM Service's RSS and risk tiering capabilities becoming available, MCPs are **not** required to use standardized risk tiers (i.e., high, medium-rising, or low) across their members but must use their RSS approach to identify members who should be connected to available interventions and services, including care management, and ensure all members are connected to appropriate Basic Population Health Management (BPHM).

After the PHM Service RSS and Risk Tiering Functionalities Are Available

a. RSS and Risk Tiers

DHCS recognizes that some plans have developed and significantly invested in their own RSS approaches. Once the PHM Service's RSS functionality is available and vetted, DHCS will require MCP plans to use the PHM Service RSS outputs and tiers to support statewide standardization and comparisons; MCPs may supplement these outputs with local data sources and methodologies.

Once the PHM Service RSS and risk tiering functionalities become available, the PHM Service will use the standardized criteria for all individuals served by Medi-Cal, taking information from all delivery systems into account. The PHM Service will place each individual into a risk tier (i.e., high, medium-rising, or low). MCPs will be required to use the PHM Service risk tiers to identify and assess member-level risks and needs and, as needed, connect members to services.

The risk tiers identified through the PHM Service will set a standard to identify members who require further assessment and connection to appropriate services. DHCS acknowledges that since the PHM Service will be using historical data, MCPs may have local data sources or real-time data that could supplement these outputs and may be used for the purpose of identifying additional members for further assessments and services. For example, while an MCP must assess the needs of any member who is identified as high-risk through the PHM Service, MCPs may use additional data sources to identify other members who require an assessment that the PHM Service may not have identified.

MCPs will not be able to manually "override" a risk tier given by the PHM Service on a member, as these risk tiers will be used to ensure equity and accountability across the state; however, MCPs will be expected to work with network providers to exercise judgment and shared decision-making with the member about the services a member

needs, including through use of real-time information that may be available and through the assessment/reassessment process described below. The PHM Service risk tiers are designed to be a starting point for assessment but not a requirement for or barrier to services.

DHCS will issue additional guidance on MCPs' use of risk tiers and required reporting prior to the statewide launch of the PHM Service.

2) Assessment to Understand Member Needs

After the RSS and risk tiering processes identify members that may need available interventions and services, additional efforts are required to better understand the members' needs and preferences and meaningfully engage them in the most appropriate services and supports. In the context of the PHM Framework, the term "assessment" describes this process, and it involves requesting information from members about their health and individual needs. Generally, MCPs are expected to delegate assessment to providers and integrate it with care and care management processes to the greatest extent possible, rather than siloed at the plan level. Either an MCP or a delegated provider, such as a Primary Care Provider (PCP), will conduct an additional assessment of members by asking them questions in a culturally and linguistically appropriate manner that builds trust with the member and seeks to define the nature of the risk factor(s) and/or problem(s) a member is experiencing; determine a member's overall needs and preferences, health goals, and priorities; and aid in the development of specific treatment recommendations to meet the member's needs and preferences.

Importantly, this assessment process is separate and distinct from "screening" in that it is more comprehensive, and because it occurs after members have been identified by the RSS and risk tiering processes (which is informed by screening data).

Populations Required to Receive an Assessment

Assessments vary in length and scope, and some are mandated by federal and/or state law, by NCQA, or by DHCS' new PHM requirements. Populations required to receive an assessment include:

- Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver).[19]
- Those entering CCM (per NCQA).
- Those entering ECM.
- Children with Special Health Care Needs (CSHCN).[20]

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[19] 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."

[20] 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.[21]
- Seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements,[22] 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 will be 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."

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

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

Changes to Assessment Requirements

To reduce current duplicative and burdensome processes, MCPs are encouraged to delegate assessment to providers and integrate it with care and care management to the greatest extent possible. Whether the assessment is performed in person, telephonically, or by telehealth, it should be conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

Assessment results are also expected to be shared between MCPs and providers responsible for following up with the member, similar to the expectation to be put in place for HIF/MET screening (above). MCPs must also follow up on any positive assessment result or delegate to the PCP for follow-up.

Box A: Changes to Seniors and Persons with Disabilities Health Risk Assessment (HRA) Requirements

Effective January 1, 2023, assessment requirements for Seniors and Persons with Disabilities (which are called HRA requirements) are simplified, while specific member protections are kept in place. DHCS has consistently heard feedback that the existing HRA requirements often contribute to duplicative or otherwise burdensome processes for members, whereby the same information is taken in via one or more screening tools and by the HRA, as well as through the usual course of care at the provider level. Therefore:

Starting in 2023, MCPs will 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. However, following federal and state law, MCPs or their delegates must continue to assess members who may need LTSS, using the existing standardized LTSS referral questions (see Appendix 3). MCPs must also comply with federal regulations that stipulate specific care plan requirements for members with LTSS needs.

Additionally, for 2023, DHCS will retain the requirement that MCPs assess Seniors and Persons with Disabilities who meet the definition of “high risk” for Seniors and Persons with Disabilities as outlined above, even if they do not have LTSS needs. MCPs may alternatively leverage their ECM and/or CCM assessment tools, or components of those tools, for Seniors and Persons with Disabilities considered at “high risk.” If MCPs decide to retain existing HRA tools, they are encouraged to adapt them to allow delegation to providers.

DHCS will also simplify 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.

Corresponding APL Updates

APLs	Upcoming Updates and Timing
APL 17-013 "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities" **APL 17-012 "Care Coordination Requirements for Managed Long-term Services and Supports"**	• APL 17-013 and APL 17-012 will be retired entirely by 12/31/22. Specific requirements from these APLs that still apply to MCPs are outlined within this PHM Program Guide.

E. Providing PHM Program Services and Supports

1) Basic Population Health Management (BPHM)

BPHM is an approach to care that ensures needed programs and services are made available to each member, regardless of the member's risk tier, at the right time and in the right setting. In contrast to care management, which is focused on populations with significant or emerging needs, all MCP members receive BPHM, regardless of their level of need. BPHM replaces DHCS' previous "Basic Case Management" requirements.

BPHM includes access to primary care, care coordination,[23] navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the new CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children under EPSDT.

Although the key components of BPHM are not new, DHCS has not previously articulated them as a comprehensive package of services and supports that all MCP members can expect.

BPHM is ultimately the responsibility of the MCP. Some functions of BPHM will need to be retained by the MCP, such as authorizing specialty services in a timely manner and providing a full suite of wellness and prevention and chronic disease management programs. However, MCPs are encouraged to delegate certain components of BPHM to providers, as described below, while ensuring appropriate oversight of the delegate in meeting required responsibilities and functions. For example:

- For members who are successfully engaged in primary care, for example, MCPs should delegate responsibility to PCPs (including Federally Qualified Health Centers (FQHCs), counties, or other primary care) for select care coordination and health education functions, whenever feasible.
- For members who have been assigned a PCP but have not yet engaged with the

[23] 42 CFR § 438.208

PCP (e.g., assigned but not seen or lost to follow-up), MCPs may delegate outreach functions to the PCP. If the PCP makes contact with and engages the member, the MCP may also delegate responsibility to the PCP for BPHM care coordination and health education functions whenever feasible. If a member does not engage with a PCP, MCPs are fully responsible for the provision of BPHM.

- For members enrolled in ECM, and since ECM, by design, happens in the community by an ECM provider, the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of their care management.

Required BPHM Elements and Processes:

In accordance with the Basic Population Health Management section of the Amended 2023 MCP Contract, MCPs must comply with the following requirements:

a. Access, Utilization, and Engagement with Primary Care

To ensure all members have access to and are utilizing primary care, MCPs must:

- Ensure members have an ongoing source of primary care;
- Ensure members are engaged with their assigned PCPs (such as helping to make appointments, arranging transportation, and providing health education on the importance of primary care);
- Identify members who are not using primary care via utilization reports and enrollment data, which are stratified by race and ethnicity;
- Develop strategies to address different utilization patterns; and
- Ensure non-duplication of services.

All BPHM services should promote health equity and align with National Standards for Culturally and Linguistically Appropriate Services (CLAS), which is a U.S. Department of Health and Human Services (HHS)-developed framework of 15 standards focused on the delivery of services in a culturally and linguistically appropriate manner that is responsive to patient needs, beliefs, and preferences.

Starting in 2024, DHCS will expand reporting requirements to include reporting on primary care spending as a percentage of total spending stratified by age ranges and race/ethnicity.

b. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports

Even though some Medi-Cal services are typically carved-out of the MCP benefit package, MCPs must ensure that members have access to needed services that address all their health and health-related needs, including developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs.

MCPs are required to partner with primary care and other delivery systems to guarantee that members' needs are addressed. This includes ensuring that each member's assigned PCP plays a key role in coordination of care, ensuring each member has sufficient care coordination and continuity of care with out-of-network providers, and communicating with all relevant parties on the care coordination provided. MCPs must

also assist members in navigation, provider referrals, and coordination of health and services across MCPs, settings, and delivery systems.

MCPs should begin to establish relationships and processes to meet Closed Loop Referral requirements in January 2024. DHCS will begin pre-implementation monitoring prior to holding MCPs accountable for meeting these requirements in January 2024. Closed Loop Referrals are defined in the 2024 Re-Procurement as coordinating and referring the member to available community resources and following up to ensure services were rendered. MCPs must ensure Closed Loop Referrals, in compliance with all federal and state laws, to:

- ECM;
- Community Supports;
- Services provided by CHWs, peer counselors, and local community organizations;
- Dental providers;
- California Children's Services (CCS);
- Developmental Services (DD);
- CalFresh;
- WIC providers;
- County social service agencies and waiver agencies for IHSS and other home- and community-based services (HCBS); and
- The appropriate delivery system for specialty mental health services to ensure members receive timely mental health services (in the MCP provider network, county Mental Health Plan (MHP) network, or Medi-Cal FFS delivery system) without delay regardless of where they initially seek care, in accordance with DHCS' "No Wrong Door" policy;[24] and
- The appropriate delivery system for SUD services (in DMC or DMC-ODS).[25]

Beginning in January 2024, MCPs are also required to coordinate warm handoffs with local health departments and other public benefits programs including, but not limited to, CalWORKs, Early Start, and Supplemental Security Income (SSI).

MCPs are required to enter into Memorandums of Understanding (MOUs) with various programs and services, including county MHPs to facilitate care coordination and information exchange.[26] In 2024, the MOU requirements for MCPs will expand to include additional entities.[27,28]

c. Information Sharing and Referral Support Infrastructure

[24] APL 22-005
[25] 2024 Re-Procurement, Exhibit A, Attachment III, 5.5. This requirement will take effect in 2024.
[26] Amended 2023 MCP Contract.
[27] 2024 Re-Procurement, Exhibit A, Attachment III, 5.6.
[28] DHCS has launched the CalAIM Behavioral Health Quality Improvement Program (BH QIP). BHQIP has three domains, one of which focuses on data-sharing agreements among MCPs, county MHPs, and DMC-ODS plans. More information is available at https://www.dhcs.ca.gov/bhqip.

To support effective BPHM, MCPs are required to implement information-sharing processes and referral support infrastructure. MCPs must ensure appropriate sharing and exchange of member information and medical records by providers and MCPs in accordance with professional standards and state and federal privacy laws and regulations.

d. Integration of Community Health Workers (CHWs) in PHM

MCPs will be required to describe how they will integrate CHWs in their PHM Strategy and as part of their PHM Readiness Deliverable. As trusted members of the community, CHWs may be able to address a variety of health and health-related issues, including, but not limited to: supporting members' engagement with their PCP, identifying and connecting members to services that address SDOH needs, promoting wellness and prevention, helping members manage their chronic disease, and supporting efforts to improve maternal and child health. DHCS launched a new CHW benefit on July 1, 2022, which is a pathway for reimbursement for a specific set of CHW services. These reimbursable CHW services are defined by State Plan Amendment 22-0001 and Title 42 Code of Federal Regulations (C.F.R.) Section 440.130(c).[29,30] Even prior to the launch of this new benefit, MCPs may have already employed CHWs to implement a wide array of activities, including BPHM-related interventions, such as wellness and prevention. The new CHW benefit provides a new mechanism for providing and reimbursing for BPHM services provided by CHWs.

e. Wellness and Prevention Programs

MCPs are required to provide comprehensive wellness and prevention programs that, at minimum, meet NCQA requirements, including offering evidence-based self-management tools that provide information on at least the following areas:

- Healthy weight (BMI) maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying depressive symptoms

MCPs will be required to report annually, through their PHM Strategy, on how they are using community-specific information gained in the PNA to design and implement evidence-based wellness and prevention strategies to meet the unique needs of their populations, as well as to drive toward the Clinical Focus Areas and Bold Goals in the CQS. The expectation is that over time, these wellness programs result in improved outcomes, such as decreasing population prevalence of chronic diseases, rates of strokes and heart attacks, and other conditions amenable to upstream risk factor modification.

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[29] *See* 42 C.F.R. 440.130(c). The C.F.R. is searchable, available at: https://www.ecfr.gov/.
[30] CHW SPA information is available at https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx.

f. Programs Addressing Chronic Disease

MCPs are required to offer evidence-based disease management programs in line with NCQA requirements at a minimum. These programs must incorporate health education interventions, identify members for engagement, and seek to close care gaps for the cohorts of members participating in the interventions with a focus on improving equity and reducing health disparities. DHCS requires that these programs address the following conditions at a minimum:

- Diabetes
- Cardiovascular disease
- Asthma
- Depression

While all MCPs must offer programs that target the above conditions, MCPs' chronic disease programs should additionally be tailored to the specific needs of each plan's Medi-Cal populations and connected with the PNA and PHM Strategy, along with other community programs (e.g., local health jurisdiction chronic disease initiatives, focus areas for plan community reinvestment programs, data collection efforts by local public health and community organizations).

g. Programs to Address Maternal Health Outcomes

Improving maternal health is one of the DHCS CQS' Bold Goals, which specifically seeks to improve maternity outcomes and birth equity, including access to prenatal and postpartum care. DHCS is also introducing the doula benefit later this year to improve culturally competent birth care. PHM programs offered by MCPs have a key role to play in improving outcomes in this area by supporting quality improvement and health disparity reduction efforts with their network providers and addressing systemic discrimination in maternity care, particularly for Black, Native American, and Pacific Islander birthing persons.

MCPs must continue to meet all requirements for pregnant individuals, including covering the provision of all medically necessary services for pregnant women, implementing and administering a comprehensive risk assessment tool that is comparable to the American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 C.C.R. Section 51348 developing individualized care plans to include obstetrical, nutrition, psychosocial, and health education interventions, and providing appropriate follow-ups.[31,32,33] Future guidance will be issued for MCPs regarding best practices to address maternal health outcomes.

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[31] 2022 Medi-Cal Managed Care Contract and PL 12-001.

[32] Section 1902(e)(5) of the Social Security Act 6; 42 C.F.R. § 435.170. The Centers for Medicaid and CHIP Services, SHO #21-007.

[33] Effective April 1, 2022, DHCS extended the postpartum care coverage period for currently eligible and newly eligible pregnant individuals. The American Rescue Plan Act (ARPA) Postpartum Care Expansion (PCE) extends the coverage period from 60 days to 365 days (one year) for individuals eligible for pregnancy and postpartum care services in Medi-Cal and the

h. PHM for Children

All children under the age of 21 enrolled in Medicaid are entitled under federal and state law to the EPSDT benefit, which requires that children receive all screening, preventive, and medically necessary diagnostic and treatment services, regardless of whether the service is included in the Medicaid State Plan.

MCPs must meet requirements outlined in the Other Population Health Requirements for Children and the Services for Members under 21 sections of the Amended 2023 MCP Contract:

- Ensure all members under 21 receive an IHA within 120 calendar days of enrollment or within the AAP Bright Futures periodicity timeline for children age 18 months and younger, whichever is sooner.
- Provide preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule.
- Ensure that all medically necessary services, including those that are not necessarily covered for adults, are provided as long as they could be Medicaid-covered services.
- Coordinate health and social services for children between settings of care and across other MCPs and delivery systems. Specifically, MCPs must support children and their families in accessing medically necessary physical, behavioral, and dental health services, as well as social and educational services.
- Actively and systematically promote EPSDT screenings and preventive services to children and families.

MCPs must ensure EPSDT is provided to all children and youth as part of their PHM Program, including BPHM, CCM, and ECM. Starting in 2023, as part of MCPs' annual PHM Strategy submission, MCPs will be required to review the utilization of children's preventive health visits and developmental screenings and outline their strategies for improving access to those services, as well as articulate and track how BPHM may be deployed to ensure any follow-up and care coordination needs identified from screenings are delivered. For example, BPHM should ensure that all children with abnormal vision screenings receive glasses or that all children with an abnormal developmental screen receive additional required testing. As part of BPHM, MCPs continue to be required to meet all EPSDT requirements related to timely access to services.

In addition, to support children enrolled in Medi-Cal in accessing and receiving wellness and prevention programs, starting in 2024, MCPs will also be required to enter into MOUs with First 5 programs and providers, WIC providers, and every Local Education Agency (LEA) in each county within their service area for school-based services to strengthen provision of EPSDT within schools.

Medi-Cal Access Program (MCAP). ARPA PCE coverage includes the full breadth of medically necessary services during pregnancy and the extended postpartum period.

2) Care Management Programs

a. Complex Care Management (CCM)

CCM equates to "Complex Case Management," as defined by NCQA. MCPs are already required to provide CCM. MCPs will continue to be required to provide CCM in 2023, in line with the requirement that all MCPs must meet NCQA PHM standards on January 1, 2023.

CCM is a service for MCP members who need 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.

Following NCQA's requirements, MCPs must consider CCM to be an opt-out program – (i.e., members may choose not to participate in CCM if it is offered to them), and MCPs may delegate CCM to providers and other entities who are themselves NCQA-certified.

Required CCM Elements and Processes:

In accordance with the Care Management Programs section of the Amended 2023 MCP Contract and in line with NCQA CCM requirements, MCPs must comply with the following CCM requirements:

i. Eligibility

CCM is a service intended for higher- and medium-rising-risk members and is deliberately more flexible than ECM. MCPs are allowed to determine their own eligibility criteria (within NCQA guardrails[34]) based on the risk stratification process outlined above and local needs identified in the PNA.

ii. Core Service Components:

CCM must include:

1) Comprehensive Assessment and Care Plan

   As in ECM, CCM must include a comprehensive assessment of each member's condition, available benefits, and resources (including Community Supports), as well as development and implementation of a Care Management Plan (CMP) with goals, monitoring, and follow-up.

2) Services and Interventions

   CCM must include a variety of interventions for members who meet the differing needs of high and medium-/rising-risk populations, including:

   - Care coordination focused on longer-term chronic conditions
   - Interventions for episodic, temporary member needs
   - Disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education
   - Community Supports, if available and medically appropriate, and cost-effective

[34] NCQA 2021 Health Plan Accreditation PHM Standards. PHM 5: Complex Case Management.

CCM must also include BPHM as part of the care management provided to members. For children and youth under age 21, CCM must include EPSDT; all medically necessary services, including those that are not necessarily covered for adults, must be provided as long as they could be Medicaid-covered services.

iii. Care Manager Role

1) Assignment of a CCM Care Manager

   MCPs must assign a care manager for every member receiving CCM. Following NCQA's requirements, MCPs may delegate CCM to providers and other entities who are themselves NCQA-certified. PCPs may be assigned as care managers when they are able to fulfill all CCM requirements.

   If multiple providers perform separate aspects of care coordination for a member, the MCP must:

   - Identify a care manager
   - Communicate the identity of the care manager to all treating providers and the member
   - Maintain policies and procedures to:
     - Ensure compliance and non-duplication of medically necessary services.
     - Ensure delegation of responsibilities between the MCP and the member's providers meets all care management requirements.

   MCPs must provide the member's PCP with the identity of a member's assigned care manager (if the PCP is not assigned to this role) and a copy of the member's CMP.

2) Care Manager Responsibilities

   CCM care managers are required to ensure all BPHM requirements and NCQA CCM standards are met. This includes conducting assessments of member needs to identify and close any gaps in care and completing a CMP for all members receiving CCM. CCM care managers must also ensure communication and information sharing on a continuous basis and facilitate access to needed services for members, including Community Supports, and across physical and behavioral health delivery systems. MCPs should provide assistance with navigation and Closed Loop Referrals, such as to CHWs or community-based social services.

b. Enhanced Care Management (ECM)

ECM, which went live in January 2022, is a new statewide managed care benefit that addresses the clinical and nonclinical needs of Medi-Cal's highest-need members through intensive coordination of health and health-related services.[35] For detailed requirements and implementation timeline for ECM, please refer to the Finalized ECM and Community Supports MCP Contract Template and ECM Policy Guide.

[35] ECM requirements are contained in the ECM Policy Guide and website. This document does not alter or add to ECM program design or requirements.

ECM is community-based, interdisciplinary, high touch, person-centered, and provided primarily through in-person interactions. MCPs are required to contract with "ECM Providers," existing community providers such as FQHCs, Counties, County behavioral health providers, Local Health Jurisdictions, Community Based Organizations (CBOs), and others, who will assign a Lead Care Manager to each member. The Lead Care Manager meets members wherever they are – on the street, in a shelter, in their doctor's office, or at home. ECM eligibility is based on members meeting specific "Populations of Focus" criteria. These Populations of Focus are going live in phases throughout 2022 and 2023.

For children and youth under age 21, CCM must include EPSDT; all medically necessary services, including those that are not necessarily covered for adults, must be provided as long as they could be Medicaid-covered services.

Starting in the second quarter of 2022 and extending for at least three years, DHCS is instituting MCP quarterly reporting requirements to monitor the implementation of ECM. DHCS will monitor outcomes for the group served by ECM and evaluate whether and how the existing Populations of Focus definitions and policies may be improved over time to ensure that the ECM benefit continues to serve those with the highest needs.

ECM and CCM Overlap Policy and Delegation

An individual cannot be enrolled in ECM and CCM at the same time; rather, CCM is on a care management continuum with ECM. CCM can be used to support members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all members in CCM previously received ECM, and not all members who step down from ECM require CCM. DHCS encourages MCPs to work with providers to contract for a care management continuum of ECM and CCM programs, wherever possible, including as a way to maximize opportunities for members to step down from ECM to CCM or BPHM under the care of a single provider.

c. Transitional Care Services (TCS)

Care transitions are defined as a member 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 (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings.

Under PHM and in line with CalAIM, MCPs are accountable for providing strengthened TCS beginning in 2023 for all members across all settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports. This is accomplished by ensuring that a single point of contact, herein referred to as a care manager,[36] can assist members throughout their transition and ensure all required services are complete.

[36] A care manager can have a variety of experiences or credentials to support transitional care activities and does not need to be a licensed provider. However, care manager assignment should consider the level of need for each member.

The transitional care policies are consistent with the CQS and are being measured through quality reporting. At this time, this includes ensuring timely follow-up for members with emergency department (ED) visits for mental health issues or SUD. Moving forward, as future policy guidance is developed to ensure member-centered care during this critical time, additional quality and process measures and reporting will also be added to be synergistic with these transitional care policies.

Required TCS Elements and Processes:

MCPs are required to meet contract requirements outlined in the TCS section of the 2023 Contract and additional operational requirements outlined in this Program Guide, as follows:

i. Admission, Discharge, and Transfer (ADT)

MCPs are responsible for knowing, in a timely manner, when their members have planned admissions, and when they are admitted, discharged, or transferred, and therefore experiencing a transition, through the following mechanisms:

- MCPs are responsible for ingesting and utilizing ADT feeds when they exist. MCPs are expected to enter agreements with facilities to gain access to ADT feeds where their members are admitted.
- When ADT feeds are not available (for example, many SNFs do not create ADT data feeds), MCPs are expected to identify other mechanisms or establish other data-sharing agreements to know when members are expected to be and are admitted, discharged, or transferred. These can include but are not limited to requirements for notification by admitting facilities and institutions directly or leveraging existing prior authorization requests.
- The PHM Service will not have ADT feeds at launch, so MCPs are expected to establish infrastructure to utilize ADT feeds locally as described above.

ii. Prior Authorizations and Timely Discharges

As referenced in the TCS section of the Amended 2023 MCP Contract, MCPs must ensure timely prior authorizations and discharges, which includes, but is not limited to, ensuring that prior authorizations required for a member's discharge are processed in a timely manner.

iii. Care Manager Responsible for TCS

Once a member has been identified as being **admitted**, MCPs must identify the care manager, who is **the single point of contact** responsible for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge. 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 ("care manager") does not need to be employed by the plan and can be delegated (e.g., to the PCP team or an Accountable Care Organization or to the hospital staff) as long as the plan ensures that a single point of contact is assigned until needs are met and that all TCS can be completed.

Members must be offered the direct assistance of the care manager, but members may choose to have limited to no contact with the care manager. In these cases, at a minimum, the care manager must act as a liaison coordinating care among the discharging facility, the PCP, and the MCP.

iv. Communication of Assignment to the Care Manager

MCPs are required to communicate both with the responsible care manager (or delegated care manager) and with the facility where the patient is admitted (referred to as the "discharging facility") in a timely manner so that the care manager can participate in discharge planning and support access to available services.[37] For members receiving TCS, their assigned care managers (including ECM and CCM) must be notified within 24 hours of admission, transfer or discharge when an ADT feed is available or within 24 hours of the MCP being aware of any planned admissions, or of any admissions, discharges or transfers for instances where no ADT feed exists (such as for SNF admissions). However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

MCPs will notify the identified responsible care manager of the assignment and of the member's admission status, including the location of admission, and ensure that the discharging facility has the name and contact information, including phone number, of the identified care manager in the discharge planning document. The member must be given the care manager's contact information as part of the discharge planning document, as described below.

v. Care Manager Responsibilities

The care manager responsible for TCS is responsible for coordinating and verifying that members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. Hospital and nursing home staff who help with discharge plans should work with, but do not supplant the need for, a care manager unless the responsibility for TCS is fully delegated.

The care manager is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the care manager does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services and follow-ups, noted below.[38]

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[37] In the instance that the care manager is at the facility, the MCP's role is to communicate with the facility.

[38] The care manager must also ensure non-duplication of services provided by other team members (including facility or PCP-based care managers if care management is not fully delegated).

vi. Discharge Risk Assessment and Discharge Planning

Per the Amended 2023 contract requirements, a core responsibility of the care manager is to ensure that a discharge risk assessment is complete and that a discharge planning document is created and shared with appropriate parties. This discharge risk assessment and discharge planning document may be completed by the discharging facility (and, at a minimum, should be informed by discharging providers). However, the assigned care manager must ensure that it is complete and accurately coordinated, shared with appropriate parties as listed below, and that the member does not receive two different discharge documents from discharging facility and from the care manager. Details on the discharge risk assessment and discharge planning document are below:

A **discharge risk assessment** should be completed prior to discharge to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition, and/or SUD relapse. As part of this discharge risk assessment done prior to discharge, care managers must ensure that members are assessed to determine if they are newly eligible for ongoing care management services such as ECM or CCM.

Care managers must also ensure a **discharge planning document is created and shared** with the member, member's parents or authorized representatives, and the treating providers, including the PCP, the discharging facility, and the receiving facility or provider in order to facilitate communication and information sharing of the member's specific discharge plan.

The discharge planning document should use language that is culturally, linguistically, and literacy-level appropriate, and must include all items as noted in the Amended 2023 MCP Contract, such as preadmission status, predischarge support needs, discharge location, barriers to post-discharge plans, and information regarding available care and resources after discharge.

This discharge planning document should also include the care manager's name and contact information and a description of TCS.

vii. Necessary Post-Discharge Services and Follow-Ups

As outlined in the Transitional Care Services section of the contract, MCPs must ensure needed post-discharge services are provided, and follow-ups are scheduled, including but not limited to follow-up provider appointments, SUD and mental health treatment initiation, medication reconciliation, Closed Loop Referrals to social service organizations, and referrals to necessary at-home services.

viii. End of TCS

TCS will end once the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document. As noted above, if the MCP has delegated TCS, the MCP must ensure that the delegate follows and coordinates services for the member until all aforementioned activities are completed. For those who have ongoing unmet needs, eligibility for ECM or CCM should be reconsidered.

If the member is enrolled in ECM or CCM, and if the care manager responsible for TCS will not continue as their ECM or CCM Lead Care Manager, the member should be connected to their new care manager through a Closed Loop Referral.

ix. Guidance for Members Enrolled with Multiple Payors

Consistent with the policy that the MCP is responsible for coordinating whole-person care, even for services or benefits carved-out of Medi-Cal managed care, the MCP or its delegated care manager is responsible for ensuring transitional care coordination for its members as outlined above. This also applies in instances where the MCP is not the primary source of coverage for the triggering service (e.g., hospitalization for a Medicare FFS dual-eligible member, or an inpatient psychiatric admission covered by a County MHP).

For all members enrolled with multiple payors undergoing any transition, MCPs must know when their members are admitted, discharged, or transferred; MCPs must notify existing Medi-Cal care managers (ECM or CCM) of admissions, discharges, and transfers; and MCPs must conduct prior authorizations and coordinate, in a timely manner, for any Medi-Cal covered benefits where Medi-Cal is the primary payor.[39] However, there are specific modifications to the assignment of a care manager and care manager responsibilities as follows:

Requirements for Members Dual-Eligible for Medi-Cal and Medicare in Medicare Medi-Cal Plans or Dual-Eligible Special Needs Plans (D-SNPs):

For admissions, transfers and discharges involving dually eligible members enrolled in Medicare Medi-Cal Plans (MMPs), or members enrolled in any other D-SNP, the MMP/ D-SNP is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including services delivered via Medi-Cal Managed Care and Medi-Cal FFS. Thus, the Medi-Cal MCP is not responsible for assigning a transitional care manager or any transitional care manager responsibilities for dually eligible beneficiaries enrolled in MMPs or D-SNPs. However, if a member has an existing ECM or CCM care manager, the MCP is responsible for notifying that care manager of the admission, discharge or transfer

For admissions, transfers and discharges involving MCP members dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA plans (except D-SNPs), MCPs remain responsible for ensuring all transitional care requirements are complete, including assigning or delegating a care manager.

Requirements for When County MHPs or DMC-ODS Are the Primary Payors:

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

[39] Examples of services where MCP is the primary payor for individuals dually eligible for Medicare and Medi-Cal include but are not limited to CBAS, LTC services, transportation to medical appointments, hearing aids and routine eye exams (when not covered by a Medicare Advantage (MA) plan), Community Supports, and ECM.

discharge. However, MHPs and DMC-ODS have limited access/ability to coordinate across the MCP or physical health care needs, therefore:

- In addition to the core MCP responsibilities noted above, MCPs will also be required to assign or delegate a care manager 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.
- As outlined in the BPHM section above, MCPs are required to have MOUs with required entities, including County MHPs, to facilitate care coordination and ensure non-duplication of services. In 2024, the MOU requirements for MCPs will expand to include additional entities, including local alcohol and SUD treatment services.

Additional Requirements for Inpatient Medical Admission with Transfer to Inpatient Psychiatry or Residential Rehab:

For members who are admitted initially for a medical admission and transferred or discharged to a behavioral health facility, including a SUD psychiatric or a residential rehab facility (including intra-hospital transfers to a psychiatric-distinct unit of a hospital):

- MCPs are responsible for all TCS during the transfer/discharge to the behavioral health facility.
- TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination. In these instances, this likely will be after the member arrives at the behavioral health facility, medication reconciliation has occurred, and all information sharing between institutions is complete.
- After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, MCPs must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

F. PHM Implementation Monitoring

MCPs should already be using their own data and Key Performance Indicators (KPIs) to continuously assess the efficacy of specific programs, including ECM, CCM, and wellness and prevention approaches, to gain an internal understanding of the impact on quality and equity for the groups served by the interventions.

DHCS' measurement of the effectiveness of each MCP's PHM Program will ultimately be assessed through a variety of programs and mechanisms, including monitoring of health outcomes, health equity, preventive care access, connections to primary care, and member experience.

For the purpose of supplementing those broader efforts and gaining insight into short-term PHM advances, DHCS will conduct PHM implementation monitoring.

To prioritize oversight of PHM interventions for members with the highest needs and reduce unnecessary administrative burden, DHCS intends to utilize PHM Service risk

tiers to monitor penetration rates of PHM interventions by service risk tier once the functionality is available.

However, DHCS will begin to monitor penetration rates prior to statewide deployment of the PHM Service. By the end of 2022, DHCS will release guidance on 2023 implementation monitoring, which will be subsumed under broader MCP reporting requirements. This reporting will collect information that is not available from routine encounter submissions and will focus on select KPIs. The reporting will be significantly briefer than ECM and Community Supports Quarterly Implementation Reporting and will be aggregate rather than member-level. DHCS plans to prioritize KPIs reflecting:

- The number of members who are being assessed for care management;
- Penetration rates for CCM, wellness and prevention programs, maternal health, and chronic disease programs;
- Engagement rates in usual care with PCPs;
- Provision of EPSDT benefit;
- Deployment of CHW Services; and
- Deployment of transitional care management.

DHCS expects to modify the initial reporting structure once the PHM Service is fully implemented.

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

G. Implementation Timeline

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
2022			
Q1 & Q2	▪ **April: Draft PHM Strategy and Roadmap** published	▪ **June: 2022 PNA and Action Plan** due (no change to current APL 19-011 requirements)	▪ **January 1: ECM goes live in WPC or Health Homes Program (HHP) counties for the Individuals & Families Experiencing Homelessness, High Utilizer Adults, and Adults with Serious Mental Illness (SMI)/SUD Populations of Focus**
Q3	▪ **July: Final PHM Strategy and Roadmap** published ▪ **September:** This **Final 2023 Program**		▪ **July 1: ECM goes live in non-WPC or HHP counties for the Individuals & Families Experiencing Homelessness, High**

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
	Guide & 2023 PHM Program Readiness Deliverable Template published		**Utilizer Adults, and Adults with SMI/SUD Populations of Focus**
Q4	▪ **By end of 2022: 2023 Supplemental Reporting Guidance for PHM** published ▪ **By end of 2022**, amend APLs regarding IHEBA/SHA and Individual Health Assessment, which include but are not limited to, APL 08-003, APL 13-001, APL 13-017.	▪ **October 21: PHM Program Readiness Deliverable due for current plans**, to include: ▪ Attestation of NCQA PHM accreditation or equivalent ▪ Readiness to use diverse data sources to guide RSS ▪ Approach to screening and assessment within revised 2023 requirements ▪ Approach to assessing for care management within revised 2023 requirements ▪ Approach to BPHM, CCM and TCS	
2023			
Q1	▪ **January 1:** ▪ Elimination of IHEBA/SHA and Replacement of Individual Health Assessment with		▪ **January 1: PHM Program Goes Live statewide with the following requirements, to the**

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
	Individual Health Appointment ▪ Retirement of APLs 17-012 and 17-013 ▪ **Q1:** Release updated APL 19-011 regarding PNA/PHM Strategy requirements		**extent not already met:** ▪ NCQA PHM accreditation or show equivalent ▪ Good-faith effort to use DHCS-listed data sources to perform RSS ▪ Wellness/prevention as required by NCQA ▪ Initiatives to improve pregnancy outcomes ▪ CCM as defined by NCQA ▪ TCS requirements ▪ **January 1: PHM Service Pilot begins** ▪ **January 1: ECM goes live in all counties for LTC Populations of Focus**
Q2		▪ **PHM Program Readiness Deliverable due for new plans[40]** ▪ **PHM Quarterly Implementation Reporting starts**	
Q3		▪ **October: PHM Strategy due** for current plans under revised requirements, to	▪ **July 1: ECM goes live in all counties for Children and Youth Populations of Focus**

[40] PHM Program Readiness Deliverable for new plans (due May 2023) is the same as the PHM Program Readiness Deliverable for current plans (due October 2022). Specifically, the PHM Program Readiness Deliverable to include Attestation of NCQA PHM accreditation or equivalent; readiness to use diverse data sources to guide RSS; approach to screening and assessment within revised 2023 requirements; approach to assessing for care management within revised 2023 requirements; and approach to BPHM, CCM, and TCS.

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
		more comprehensively detail the PHM Program's PNA Approach and use of the PHM Service. Annual submission thereafter.	▪ **July: From statewide PHM Service Deployment:** ▪ Use PHM Service and tiers for RSS ▪ Leverage PHM Service for data sharing as functionality becomes available
2024			
Q1	▪ **January 1: New MCP Contract Goes Live**		
Q2			
Q3		▪ **October: PHM Strategy due** for the first time for new plans and annually thereafter	
2025			
Q1-Q4	▪ CQS Bold Goals must be met	▪ MCPs must submit first PNA under new three-year cycle requirements	
2026			
Q1-Q4		▪ MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation	

Appendix 1: Key Terminology

1. **Assessment** is a process or set of questions for defining the nature of a risk factor or problem, determining the overall needs or health goals and priorities, and developing specific treatment recommendations for addressing the risk factor or problem. Health assessments can vary in length and scope.
2. **Basic Population Health Management (BPHM)** is an approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
3. **Care manager** is an individual identified as a single point of contact responsible for the provision of care management services for a member.
4. **Care Management Plan (CMP)** is a written plan that is developed with input from the member and/or their family member(s), guardian, authorized representative, caregiver, and/or other authorized support person(s), as appropriate, to assess strengths, risks, needs, goals, and preferences, and make recommendations for service needs.
5. **Complex Care Management (CCM)** is an approach to care management that meets differing needs of high-and rising-risk members, including both longer-term chronic care coordination and interventions for episodic, temporary needs. Medi-Cal Managed care plans (MCPs) must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.
6. **Enhanced Care Management (ECM)** is a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of high-cost and/or high-need members who meet ECM Populations of Focus eligibility criteria through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
7. **Risk stratification and segmentation (RSS)** is the process of separating member populations into different risk groups and/or meaningful subsets using information collected through population assessments and other data sources. RSS results in the categorization of members with care needs at all levels and intensities.
8. **Risk tiering** is the assigning of members to standard risk tiers (i.e., high, medium-rising, or low), with the goal of determining appropriate care management programs or specific services.
9. **Population Health Management (PHM)** is a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
10. **The Population Health Management (PHM) Service** collects and links Medi-Cal beneficiary information from disparate sources and performs risk stratification and segmentation (RSS) and tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multiparty data access and use in accordance with state and federal law and policy.
11. **Population Health Management Strategy (PHM Strategy)** is a comprehensive plan of action for addressing member needs across the continuum of care, based on

Population Needs Assessment (PNA) results, data-driven risk stratification, predictive analysis, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions. Each MCP would be required to include, at a minimum, a description of how it will:

- Keep all members healthy by focusing on wellness and prevention services;
- Identify and manage care and services for members with high and rising risk;
- Ensure effective transition planning across delivery systems or settings, through care coordination and other means, to minimize patient risk and ensure appropriate clinical outcomes for the member; and
- Identify and mitigate member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance health equity.

12. **Screening** is a brief process or questionnaire for examining the possible presence of a particular risk factor or problem to determine whether a more in-depth assessment is needed in a specific area of concern.
13. **Social drivers of health (SDOH)** are the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning and quality-of-life outcomes and risk factors.
14. **Transitional care services** are services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).
15. **Wellness and prevention programs** are programs that aim to prevent disease, disability, and other conditions; prolong life; promote physical and mental health and efficiency; and improve overall quality of life and well-being.

Appendix 2: Upcoming Updates to All Plan Letters (APLs)

Topic Within PHM Framework	Existing APLs	Upcoming Updates and Timing
PNA and forthcoming PHM Strategy	**APL 19-011 "Health Education and Cultural and Linguistic Population Need Assessment"**	• APL 19-01, which delineates current PNA requirements, will be replaced in Q1 2023 with a new APL that will delineate requirements for the new PHM Strategy and modified PNA. The new APL will also be accompanied by an update to the PHM Program Guide, which will provide more operational details for MCPs on how to implement both the PNA and PHM Strategy.
HRA/Risk Stratification/Care Management Plans	**APL 17-013 "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities"** **APL 17-012 "Care Coordination Requirements for Managed Long-term Services and Supports"**	• APL 17-013 and APL 17-012 will be retired entirely by 12/31/22. Specific requirements from these APLs that still apply to MCPs are outlined within the August 2022 PHM Program Guide.
Initial Health Assessment and IHEBA/SHA	**PL 08-003 "Initial Comprehensive Assessment"**	• PL 08-003 will be retired entirely by 12/31/22.
	APL 13-017 "Staying Healthy Assessment/ Individual Education Behavioral Assessment for Enrollees from Low-	• APL 13-017 will be retired entirely by 12/31/22 since the IHEBA/SHA standardized questions are being completely eliminated.

Topic Within PHM Framework	Existing APLs	Upcoming Updates and Timing
	Income Health Program"	
	PL 13-001 revised "Requirements for the Staying Healthy Assessment/ Individual Education Behavioral Assessment for Enrollees from Low-Income Health Program"	• PL 13-001 will be retired entirely by 12/31/22.
	PL 14-004 "Site Reviews: Facility Site Review and Medical Record Review"	• PL 14-004 will be modified to remove references to IHEBA/SHA by 12/31/22.
	APL 16-014 "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries" **APL 17-016 "Alcohol Misuse: Screening and Behavioral Health Counseling Interventions in Primary Care"**	• These APLs will be modified to decouple requirements from outdated IHEBA/SHA requirements by 12/31/22.
	APL 18-004 "Immunization Requirements" **APL 20-004 "Emergency Guidance for Medi-Cal Managed Care Plans in**	• No changes to APL 18-004 and APL 20-004.

Topic Within PHM Framework	Existing APLs	Upcoming Updates and Timing
	Response to COVID-19”	

Appendix 3: Standardized Long-Term Services and Supports (LTSS) Referral Questions

These standardized LTSS referral questions from APL 17-013 will continue to be required for MCPs or their delegates to use to assess members who may need LTSS. The questions are organized in the following two tiers, and MCPs must take a holistic view of questions in both tiers and identify members in need of follow-up assessment:

- Tier 1 contains questions directly related to LTSS eligibility criteria and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
- Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.

The headings in italics are not part of the questions but provide the intent of the questions.

<u>Tier 1 LTSS Questions:</u>

Activities of Daily Living Functional Limitations/Instrumental Activities of Daily Living Limitations/Functional Supports (Functional Capacity Risk Factor)

Question 1: Do you need help with any of these actions? (Yes/No to each individual action)

a) Taking a bath or shower
b) Going up stairs
c) Eating
d) Getting dressed
e) Brushing teeth, brushing hair, shaving
f) Making meals or cooking
g) Getting out of a bed or a chair
h) Shopping and getting food
i) Using the toilet
j) Walking

k) Washing dishes or clothes
l) Writing checks or keeping track of money
m) Getting a ride to the doctor or to see your friends
n) Doing house- or yardwork
o) Going out to visit family or friends
p) Using the phone
q) Keeping track of appointments

If yes, are you getting all the help you need with these actions?

Housing Environment/Functional Supports (Social Determinants Risk Factor)

Question 2: Can you live safely and move easily around in your home? (Yes/No) If no, does the place where you live have: (Yes/No to each individual item)

a) Good lighting
b) Good heating
c) Good cooling
d) Rails for any stairs or ramps
e) Hot water
f) Indoor toilet
g) A door to the outside that locks
h) Stairs to get into your home or stairs inside your home
i) Elevator
j) Space to use a wheelchair
k) Clear ways to exit your home

Low Health Literacy (Social Determinants Risk Factor)

Question 3: “I would like to ask you about how you think you are managing your health conditions”

a) Do you need help taking your medicines? (Yes/No)
b) Do you need help filling out health forms? (Yes/No)
c) Do you need help answering questions during a doctor’s visit? (Yes/No)

Caregiver Stress (Social Determinants Risk Factor)

Question 4: Do you have family members or others willing and able to help you when you need it? (Yes/No)

Question 5: Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)

Abuse and Neglect (Social Determinants Risk Factor)

Question 6a: Are you afraid of anyone, or is anyone hurting you? (Yes/No)

Question 6b: Is anyone using your money without your okay? (Yes/No)

Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)

Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No)

Tier 2 LTSS Questions:

Fall Risk (Functional Capacity Risk Factor)

Question 8a: Have you fallen in the last month? (Yes/No)

Question 8b: Are you afraid of falling? (Yes/No)

Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)

Isolation (Social Determinants Risk Factor)

Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one)

- ☐ None – I never feel lonely
- ☐ Less than five days
- ☐ More than half the days (more than 15)
- ☐ Most days – I always feel lonely