



Population Health Management (PHM) Advisory Group Kickoff

March 18, 2022

2pm-3:30pm

Pause for Member Story

DHCS and Manatt Facilitators

DHCS

- **Palav Babaria**, Deputy Director, Quality and Population Health Management
- **Susan Philip**, Deputy Director, Health Care Delivery and Systems (HCDS)
- **Bambi Cisneros**, Assistant Deputy Director, Managed Care, HCDS
- **Dana Durham**, Division Chief, Managed Care Quality and Monitoring Division (MCQMD)
- **Aita Romain**, Population Health Management
- **Ivan Mendoza**, Population health Management

Manatt Health Facilitators

- **Sharon Woda**, Senior Managing Director
- **Natassia Rozario**, Senior Manager
- **Jonah Frohlich**, Senior Managing Director

Agenda

Context & Level Setting	10 min
Overview of the PHM Service	10 min
Overview of the PHM Program	10 min
Detailed Overview of PHM Program Requirements	40 min
Next Steps & Q&A	15 min

Context & Level Setting

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Population Health Management (PHM)

DHCS' Goals and Definition

PHM Goals

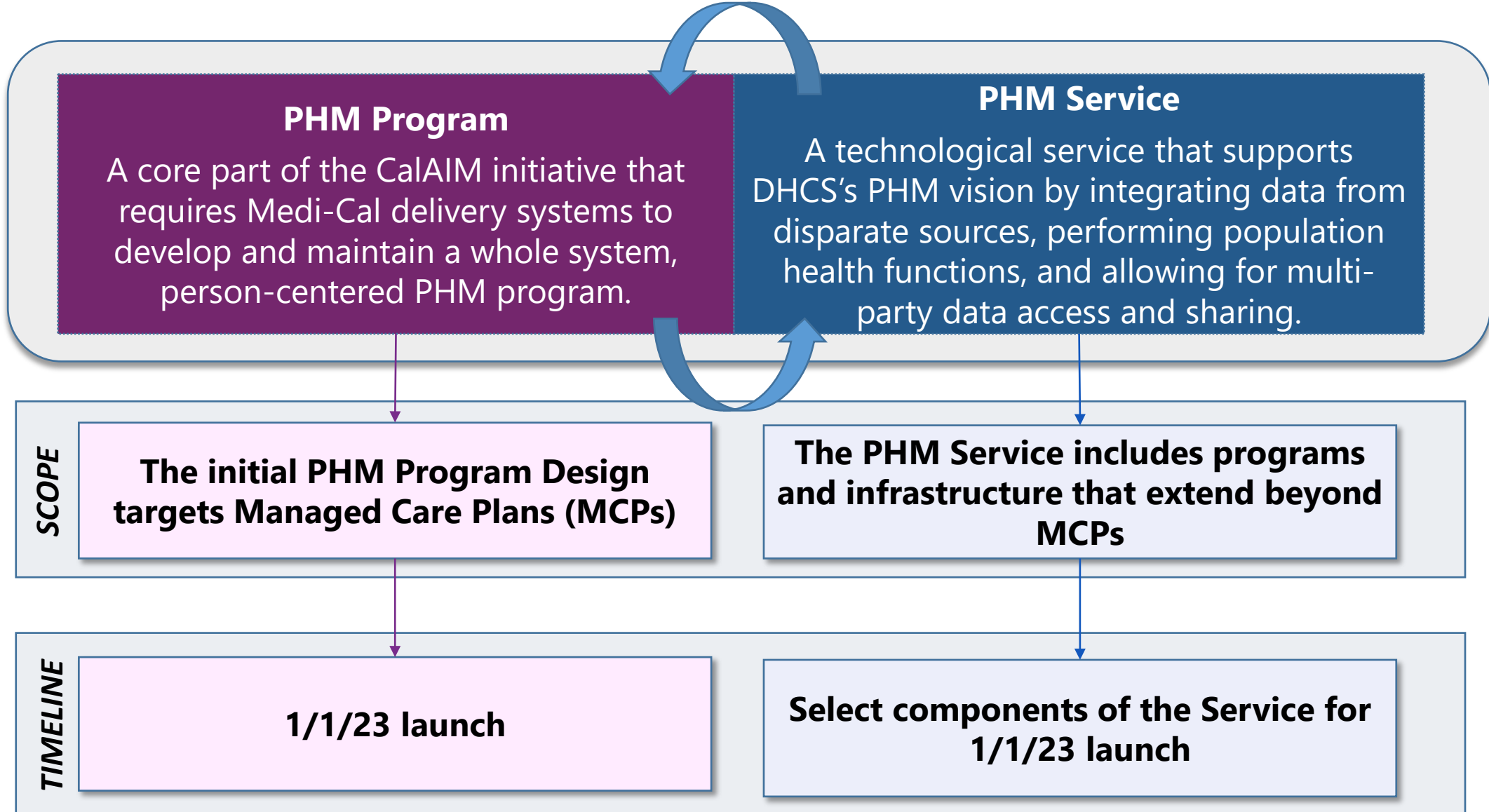
Establish a cohesive, statewide approach to population health management, which ensures that all Members have access to a comprehensive program that **leads to longer, healthier and happier lives, improved outcomes and a reduction in disparities.**

PHM Definition

A comprehensive **plan of action** for addressing Member needs and preferences across the **continuum of care** that:

- Is based on **data-driven risk stratification, predictive analytics, identifying gaps in care** and **standardized assessment** processes;
- Focuses on keeping Members healthy through **upstream approaches that link to public health, social services** and address **wellness and prevention services**;
- Provides **care management, care coordination** and **care transitions** across delivery systems and settings; and
- Identifies and mitigates **social drivers of health** to reduce disparities.

Introducing the PHM Program & PHM Service



PHM Advisory Group: Context & Purpose

Context

- The PHM Program and PHM Service must be designed to meet the needs of Members across the continuum of care.¹
- The PHM Program and Service will evolve over time and be dynamic to meet the goal of Medi-Cal members achieving longer, healthier, happier lives and reductions in disparities.
- Achieving these goals requires close collaboration and consultation with stakeholders actively implementing the program.

Purpose

- The PHM Advisory Group is comprised of cross-sector stakeholders that will provide feedback and make recommendations on the CalAIM PHM Program and the PHM Service.

Meeting Format & Expectations for Today

Meeting Format & Expectations

- Today's inaugural meeting consists of a presentation from DHCS orienting the PHM Advisory Group members and all interested stakeholders to the PHM Program and PHM Service.
- **The Department will not be soliciting public comment or feedback today.**
- **Future meetings** of the PHM Advisory Group will continue to be open to the public; however, **active participation will be limited to the PHM Advisory Group members.**
- At the next meeting, PHM Advisory Group members will be asked to provide feedback on the material and concepts presented as well as discuss other priority topics related to the 2023 launch.
- There will be ~15 minutes at the end of today's presentation for Q&A; both PHM Advisory Group members and all other attendees are welcome to **submit questions through the Q&A feature.**

CaAIM PHM Advisory Group Membership (1)

Stakeholder Type	Name	Organization
<i>Providers</i>	Dr. Kelvin Vu	Open Door Community Health Centers
	Dr. Laura Miller	Community Health Center Network
	Dr. Heyman Oo	Marin Community Clinics
	Dr. Sam Skootsky	UCLA Faculty Practice Group and Medical Group
	Bhumil Shah	Contra Costa County Health Services
	Tangerine Brigham	Alameda Health System
	Kathy Bristow	CommonSpirit Health
	Dr. Daniel Calac Al Rowlett	Indian Health Council Turning Point Community Programs
<i>MCPs</i>	Rebecca Boyd Anderson	Partnership HealthPlan
	Dr. Amy Scribner	Health Plan of San Mateo
	Dr. Takashi Wada	Inland Empire Health Plan
	Elaine Sadocchi-Smith	LA Care Health Plan
	Dr. Soham Shah	Kern Health Systems
	Dr. Dipa Patolia	Health Net/California Health and Wellness
	Dr. Tim Ho	Kaiser

CaAIM PHM Advisory Group Membership (2)

Stakeholder Type	Name	Organization
Counties	Peter Shih	San Mateo County Health
	Dr. Nina Park	Los Angeles County Department of Health Services
	Dr. Gail Newel	Santa Cruz County
	Susie Smith	San Francisco Human Services Agency
	Dr. Robert Oldham	Placer County
	Phebe Bell	Nevada County
	Dr. Gary Tsai	Los Angeles County
Advocates	Anna Leach-Proffer	Disability Rights California
	Katherine Haynes	California Health Care Foundation
Community Organizations	Dr. Amie Miller	CalMHSA
	Caroline Sanders	California Pan-Ethnic Health Network (CPEHN)
Governments Agencies	Kim Lewis	National Health Law Program
	Maria Lemus	Vision Y Compromiso
	Mike Odeh	Children Now
Foundations	Dana Moore	California Department of Public Health
	Dr. Sarita Mohanty	The SCAN Foundation

PHM Service Overview

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PHM Service Overview

Design

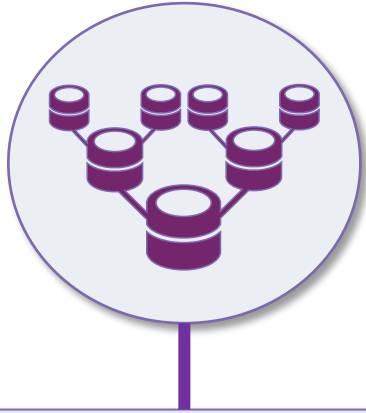
- The PHM Service will support DHCS's vision for population health management by integrating data from disparate sources, performing population health functions, and allowing for multi-party data access and exchange.
- DHCS is gathering information on population health needs and data-related priorities from Medi-Cal payers, providers, counties, and Members.

Deployment

- The PHM Service will be launched January 1, 2023, and it will be deployed in phases.
- The timing for the deployment of specific capabilities is being developed now based on feedback on stakeholders' priorities.

PHM Service: Overview of Capabilities

The PHM Service will aggregate, link, and provide access to a variety of data types and support key population health functions.



1. Integrate Data from DHCS and Other Sources

Integrate physical and behavioral health data, social services, dental, developmental, home and community-based services, IHSS, 1915c waiver, and other program and administration data from providers, MCPs, counties, CBOs, DHCS, and other government departments and agencies.



2. Enable Key PHM Functions and Services

Facilitate and support key population health functions such as individual screening and assessment; risk stratification, segmentation and tiering; and gap reporting.

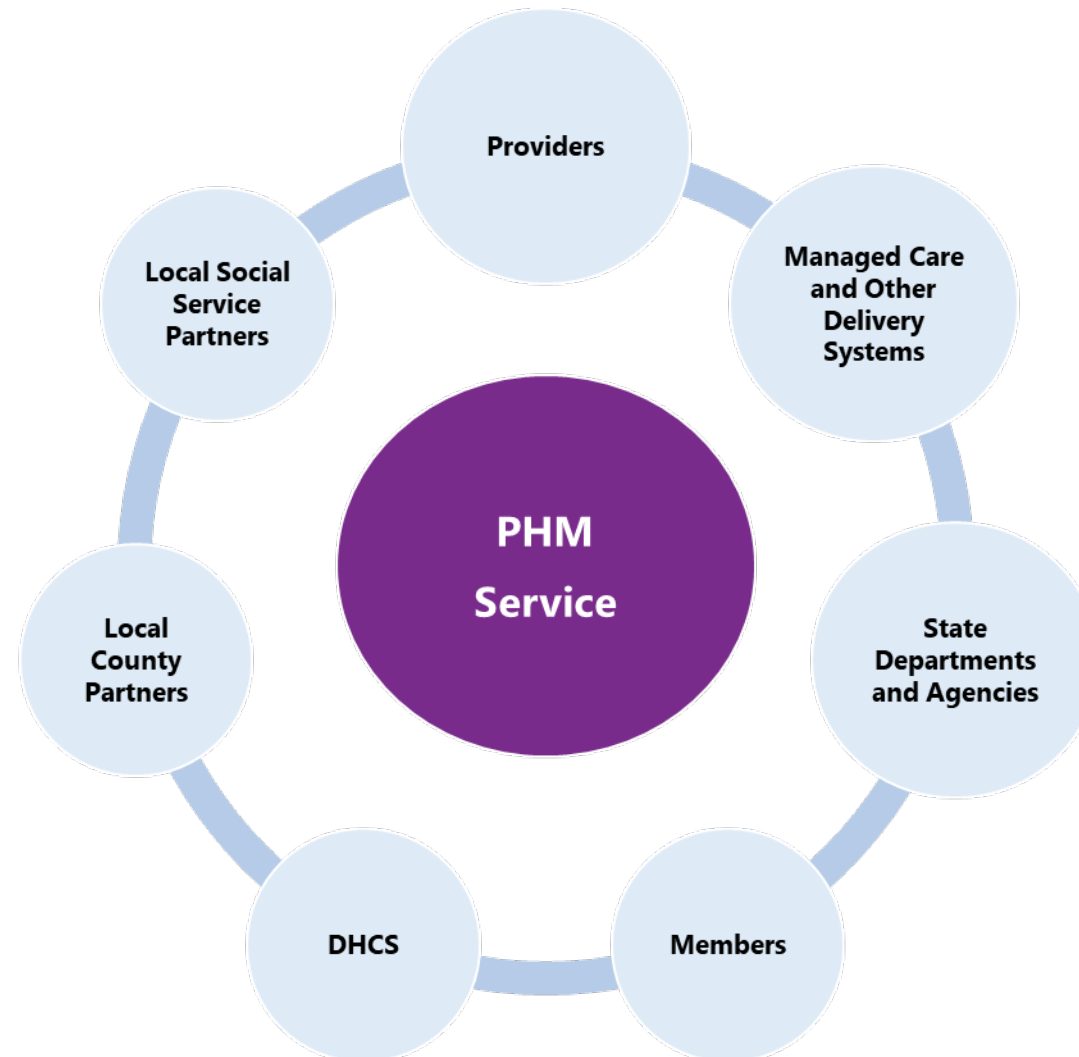


3. Provide Access to PHM Data

Provide users access to integrated data to support population health management use cases and streamline care delivery. Intended users include DHCS as well as MCPs, counties, providers, Members, human services programs, and other partners.

PHM Service: Supporting Multiple Stakeholder's Needs

The PHM Service will address the needs of a diverse set of stakeholders.



PHM Service: Anticipated Capabilities (1)

The PHM Service is still being designed.
Stakeholders have identified the following capabilities as high-priorities:

- 1. Data Aggregation and Sharing.** Identify, source, aggregate, and normalize a broad set of data elements to be shared with authorized users.
- 2. Risk Stratification/Segmentation & Tiering.** Create a standard risk stratification algorithm, methodology, and risk tiers that allow DHCS and MCPs to compare and stratify risk across populations and subpopulations.
- 3. Screening and Assessments.** Establish a capability, with roles and rules-based access, for Members to securely access and complete health-related screening and assessments. To reduce redundant data entry, the PHM Service would pre-populate data fields with information already collected on the beneficiary.

PHM Service: Anticipated Capabilities (2)

The PHM Service is still being designed.
Stakeholders have identified the following capabilities as high-priorities:

- 4. Program Enrollment and Engagement.** Provide capabilities for Members to better understand their eligibility for social service programs and community-based services.
- 5. Member Access and Updates.** Provide capabilities to allow Members to access information regarding their rights and benefits, and details regarding the use of their information, and to securely update their demographic information and share with designated entities (e.g., Medi-Cal MCPs).
- 6. Member Informing & Health Education.** Provide DHCS with the ability to contact and communicate with Members, including to share health education information.

PHM Program Overview



PHM Program Overview

DHCS is establishing a standardized, statewide approach to PHM through which MCPs are responsive to community needs and work within a common framework to improve outcomes and reduce disparities.

PHM Program Overview

- A cornerstone of CalAIM includes the expectation that starting in 2023, each MCPs will **have and maintain a whole system, person centered Population Health Management (PHM)** program.
- Several of the **key elements of PHM were already in place** in the Medi-Cal program prior to CalAIM through both Department of Health Care Services (DHCS) policies and MCPs' own programs.
- **These are a cohesive set of concepts and requirements that apply to all populations served by MCPs.**

Implementing the PHM Program: Timing Expectations

Timing Expectations

- Beginning in 2023, all MCPs will be required to meet National Committee for Quality Assurance (NCQA) PHM standards.¹
- MCPs will be expected to adhere to new PHM requirements, which are consistent with the 2024 re-procurement and aligned with existing MCP standards to form a glide path. Broadly, the new requirements seek to:
 - Streamline, simplify and standardize existing approaches to PHM;
 - Incorporate the role of the PHM Service in the PHM Program; and
 - Set expectations for Member engagement in PHM programs and services.
- To account for PHM Service functionality, DHCS will roll out new PHM requirements gradually between 2023 and 2024.

1. This can be achieved by having full NCQA health plan accreditation or by demonstrating to DHCS that they have equivalent capabilities for PHM.

Detailed Overview of PHM Program Requirements



Preview of the PHM Strategy & Roadmap Paper

DHCS POPULATION HEALTH MANAGEMENT APPROACH AND 2023- 2024 ROADMAP

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I. Introduction

DHCS' ten-year vision for the Medi-Cal program is for all Medi-Cal Members to enjoy longer, healthier and happier lives. To accomplish this, DHCS is moving towards a whole-system, person-centered approach in which health care services are only one element of supporting better care for Members. Partnerships between Medi-Cal Managed Care (MCMC) plans and Medi-Cal Members, health care providers, counties, communities, public health agencies, schools and community based organizations (CBOs) are essential to preventing illness, supporting health care needs, addressing health care disparities, and reducing the impact of poor health. Launched in 2021, California Advancing and Innovating Medi-Cal (known as CalAIM) is California's long term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory.

In mid-April, DHCS will release the **PHM Strategy & Roadmap document**, which describes and elaborates on the PHM Program.

Purpose of Paper

- ✓ Defines and describes the key PHM concepts and terminology that will be used by DHCS to support the implementation of the PHM Program in the coming years
- ✓ Sets out the “roadmap” for MCPs for 2023 and beyond
- ✓ Includes Member goals vignettes to delineate Member perspective on the “Why”
- ✓ Solicits stakeholder comments on specific issues

The remaining slides in this section elaborate on the key PHM Program components.

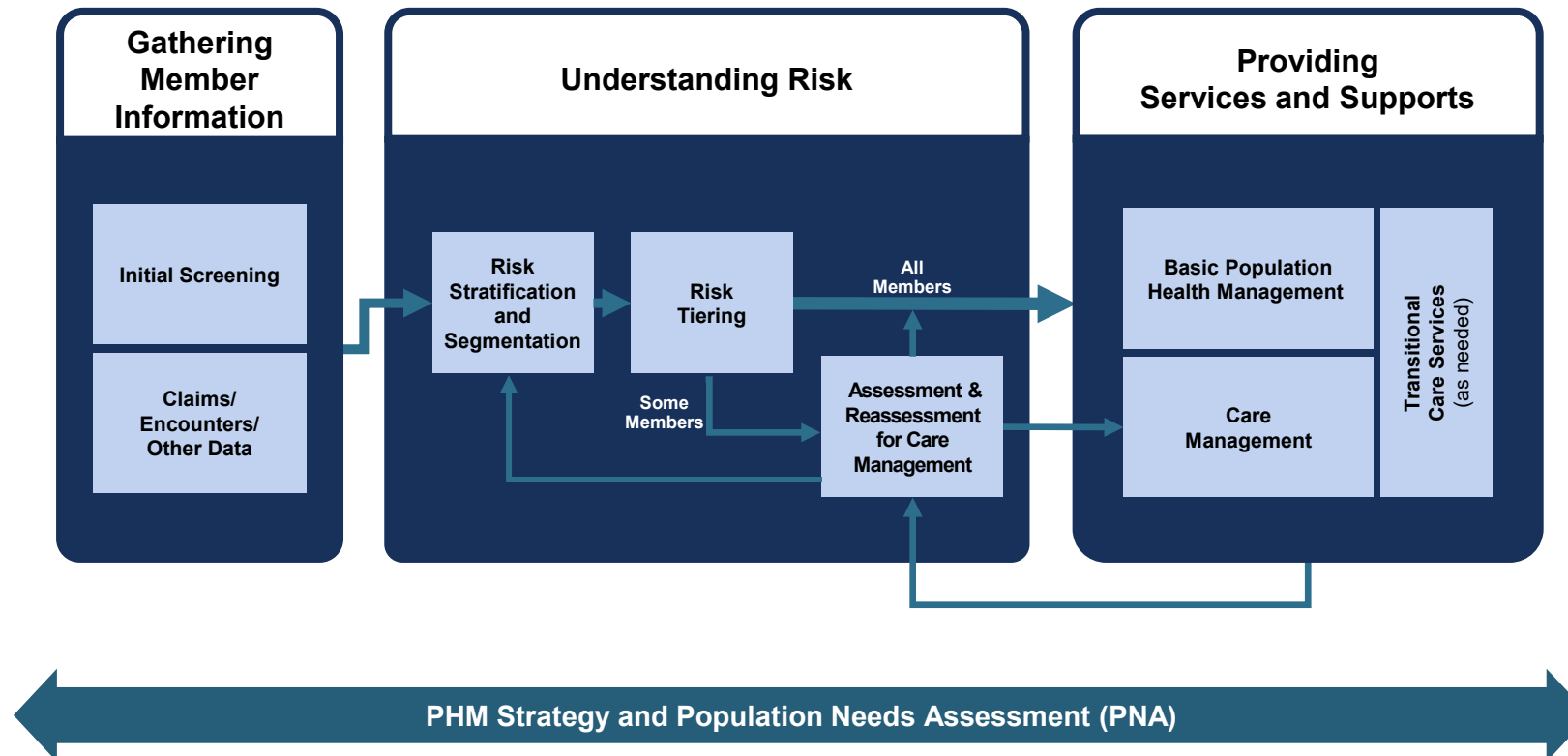
PHM Framework Overview

DHCS intends to use a PHM framework visual (*see next slide*) to consistently promote common terminology and understanding in the market about PHM.

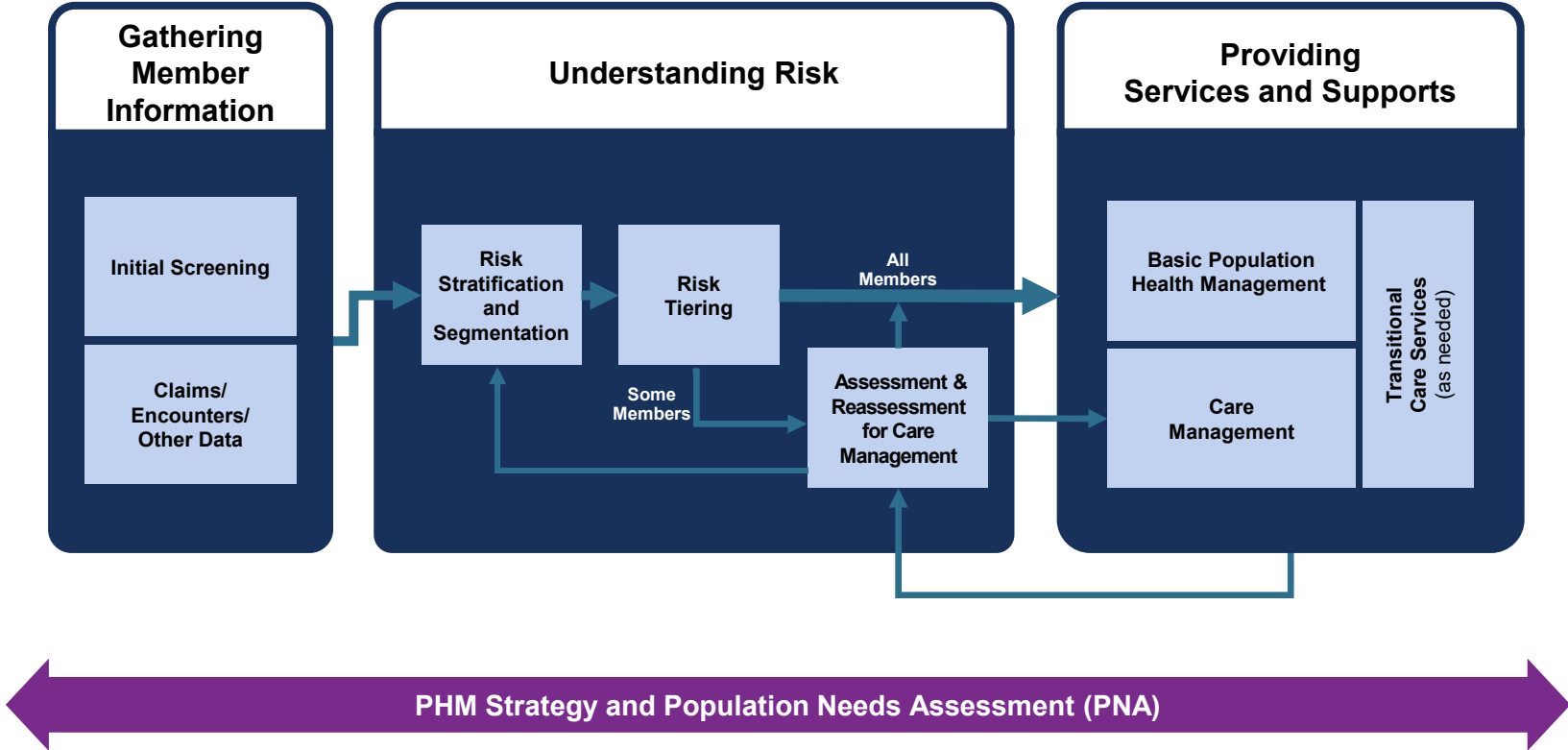
PHM Framework

- The PHM Framework is a visual diagram outlining the key **components and requirements** around **how MCPs will provide PHM to Members**.
- It consists of **four domains**, all of which will be detailed on the subsequent slides.
 1. Population Needs Assessment (PNA) and Population Health Management Strategy (PHMS)
 2. Gathering Information
 3. Understanding Risk
 4. Providing Services

PHM FRAMEWORK



#1 PNA & PHMMS



#1: PNA and PHMS

PNA &
PHMS

Gathering
Information

Understanding
Risk

Providing
Services and
Supports

Through the PNA and PHMS, MCPs will work alongside other community partners to identify disparities, analyze data, and develop an overarching strategy for PHM.

Population Needs Assessment (PNA):

- Currently an annual assessment and report to identify Members' health status/ behaviors, health education and cultural and linguistic needs, health disparities and gaps in services.
- Will evolve as a tool to:
 - More broadly engage community partners
 - Prioritize more diverse data points that address population-based needs
 - Serve as a foundational input to the PHMS

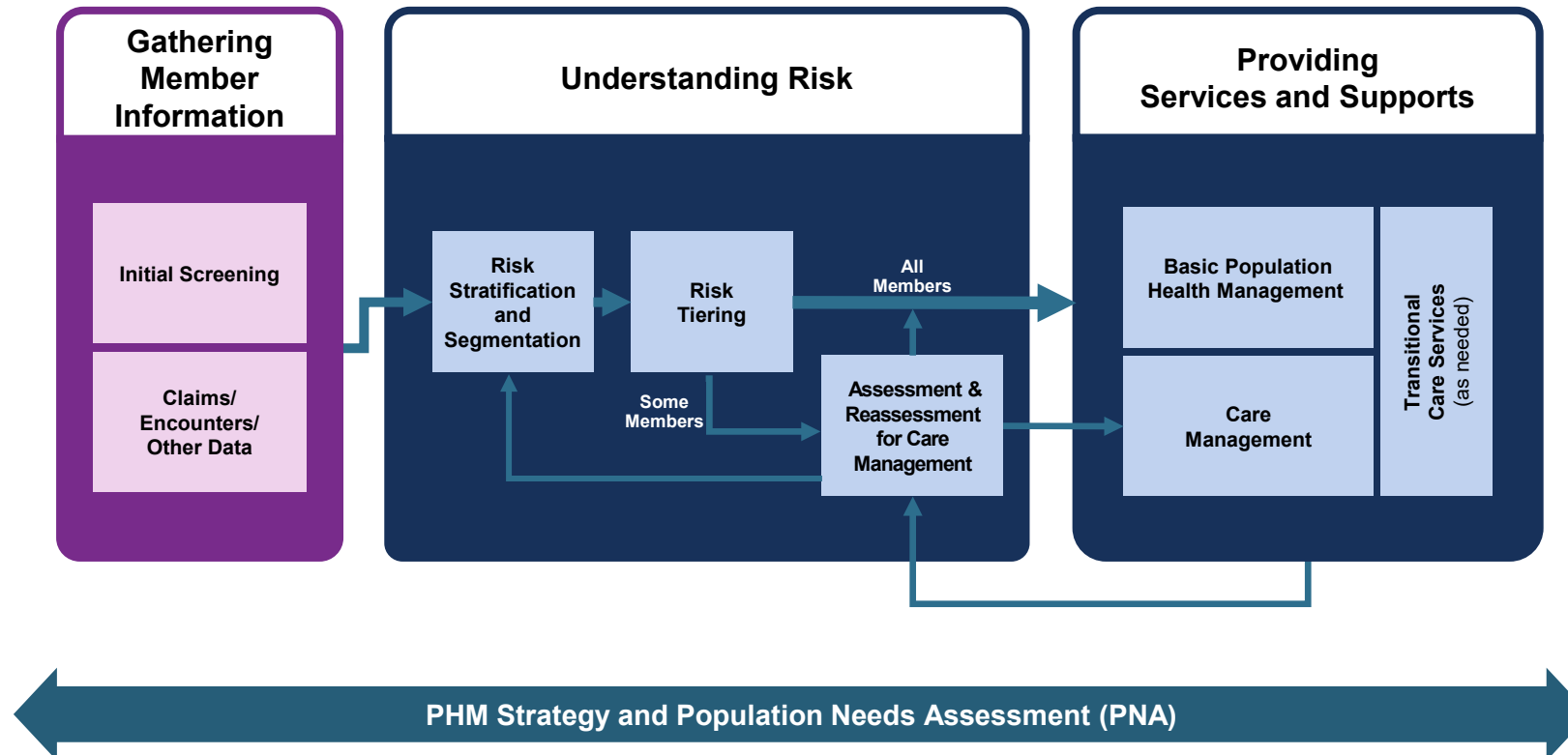
Population Health Management Strategy (PHMS):

- In mid-2023, MCPs will be required to submit an annual PHMS.
- The PHMS will detail all components of an MCP's PHM strategy and approach, including:
 - Strategies and initiatives that help address the Clinical Quality Strategy's Clinical Focus Areas and achieve the Bold Goals
 - Specific health disparities and conditions identified by each MCP's PNA.

To ensure comprehensive engagement with community organizations and maximize local planning efforts, the PNA report will evolve to be submitted on a three-year cycle.



#2: Gathering Information



#2: Gathering Information

PHM begins with gathering accurate and robust Member-level information to understand Members' health and social needs. The PHM Program will focus on two areas:

Leveraging Existing Member Data

- The introduction of the PHM Service, will allow MCPs and other stakeholders access to data from inside and outside the MCP's own claims and encounters.
- In the short term, DHCS is clarifying expectations about the data MCPs should use for understanding Member risk in 2023 (see next slide).

Streamlining Screening and Assessment

- To reduce duplication, DHCS will add new requirements for the sharing of information between MCPs and providers, which will:
 - Eliminate the existing Individual Health Education Behavior Assessment (IHEBA) / Staying Health Assessment (SHA) mechanisms while strengthening primary care.
 - Preserve protections to ensure that providers provide age-specific assessments and services during preventive health visits.

Leveraging Existing Member Data

As part of initial information gathering, MCPs are expected to access and use data to inform whole-person care approaches.

- Screening or assessment data;
- Claims and encounter data, including fee-for-service data;
- Available social needs data;
- Electronic health records;
- Referral data;
- Behavioral Health data (including SBIRT and other SUD data);
- Pharmacy data;
- Utilization data;
- Disengaged Member reports;
- Lab results data;
- Admissions, discharge and transfer (ADT) data;
- Race/ethnicity data; and
- Sexual orientation and gender identity (SOGI) data.
- For Members under 21, information on developmental and ACEs screenings.

Level-Setting Timing Expectations

- DHCS acknowledges that while the PHM Service is coming online, MCPs have imperfect access to some of the required data sources.
- **MCPs are expected to make a good faith effort to use these data sources to the greatest extent possible** prior to the PHM Service being available.

Screening & Assessment (1)

PNA &
PHMMS

Gathering
Information

Understanding
Risk

Providing
Services and
Supports

To promote effective primary care engagement and improve wellness and preventive care, DHCS is streamlining requirements, with broader changes planned when the PHM Service is available.

Health Information Form (HIF)/Member Evaluation Tool (MET)

- MCPs will be **required to share HIF/MET results with PCPs** and any other providers serving the Member
- DHCS is clarifying that the **HIF/MET** may be **delegated to the provider level**

Note: The introduction of the PHM Service allows for improved interoperability to enable dynamic screening mechanisms. As such, and in response to stakeholder feedback, the **state is no longer pursuing the “Individual Risk Assessment” (IRA)** that was posited in the CalAIM Proposal.

Screening & Assessment (2)

PNA &
PHMMS

Gathering
Information

Understanding
Risk

Providing
Services and
Supports

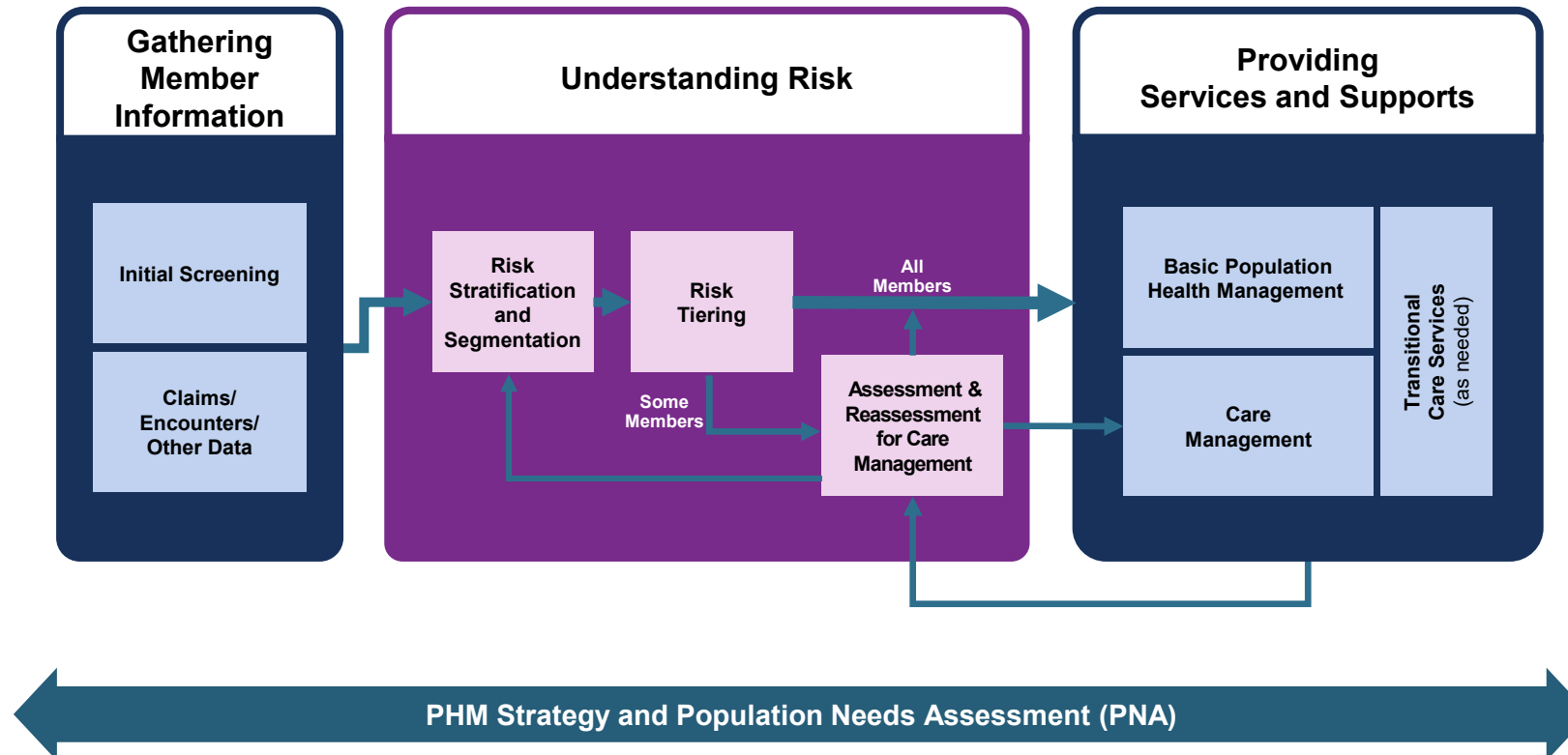
To promote effective primary care engagement and improve wellness and preventive care, DHCS is streamlining requirements, with broader changes planned when the PHM Service is available

Initial Health Assessment (IHA) Process

- DHCS will **simplify the Initial Health Assessment “IHA” process** by retiring the existing associated requirements for the Individual Health Education Behavior Assessment (IHEBA) and the Staying Health Assessment (SHA) while strengthening primary care.
 - For children, the elimination of the current IHEBA/SHAs will not affect requirements to cover EPSDT screenings.
 - DHCS will continue to require that MCPs hold network providers accountable for providing all preventive screenings for adults and children recommended by the United States Preventive Services Task Force (USPSTF)



#3 Understanding Risk



Defining Risk Stratification/Segmentation (RSS) & Tiering

RSS and tiering enables each MCP to proactively identify Members who may benefit from services or interventions. For the purposes of the PHM Program, the following definitions apply:

Risk Stratification/Segmentation

- A process of separating Member populations into different risk groups and/or meaningful subsets
- This is achieved by using information collected through member and population level assessments and other data sources to understand medical and social risk.
- RSS results in the categorization of Members with care needs at all levels and intensities.

Risk Tiering

- A process of assigning Members to standard Risk Tiers (i.e., high, medium-rising or low) that are standardized across MCPs.
- The goal is to determine the baseline needs of Members based on their risk tier, including care management programs or other specific services.

RSS In relation to the PHM Service

DHCS is moving towards greater standardization for how MCPs develop RSS algorithms, employ Risk Tiers, and connect Members to services, with the PHM Service as a critical component to this approach.

Prior to the PHM Service

MCPs must use an RSS approach that:

- Complies with NCQA standards
- Incorporates a minimum list of data sources as noted in the "Information Gathering" section
- Explains how they will avoid and reduce biases to prevent exacerbation of Health Disparities.

Once the PHM Service Becomes Available

- DHCS will require MCPs to use the PHM Service RSS methodologies to support statewide standardization and comparisons.

DHCS will conduct a robust stakeholder engagement process before issuing guidance on the required use of the PHM Service once the RSS functionalities are available.

Tiering In relation to the PHM Service

When the PHM Service is live, MCPs will be expected to use the Risk Tiers as a starting point for connecting Members with services.

Prior to the PHM Service

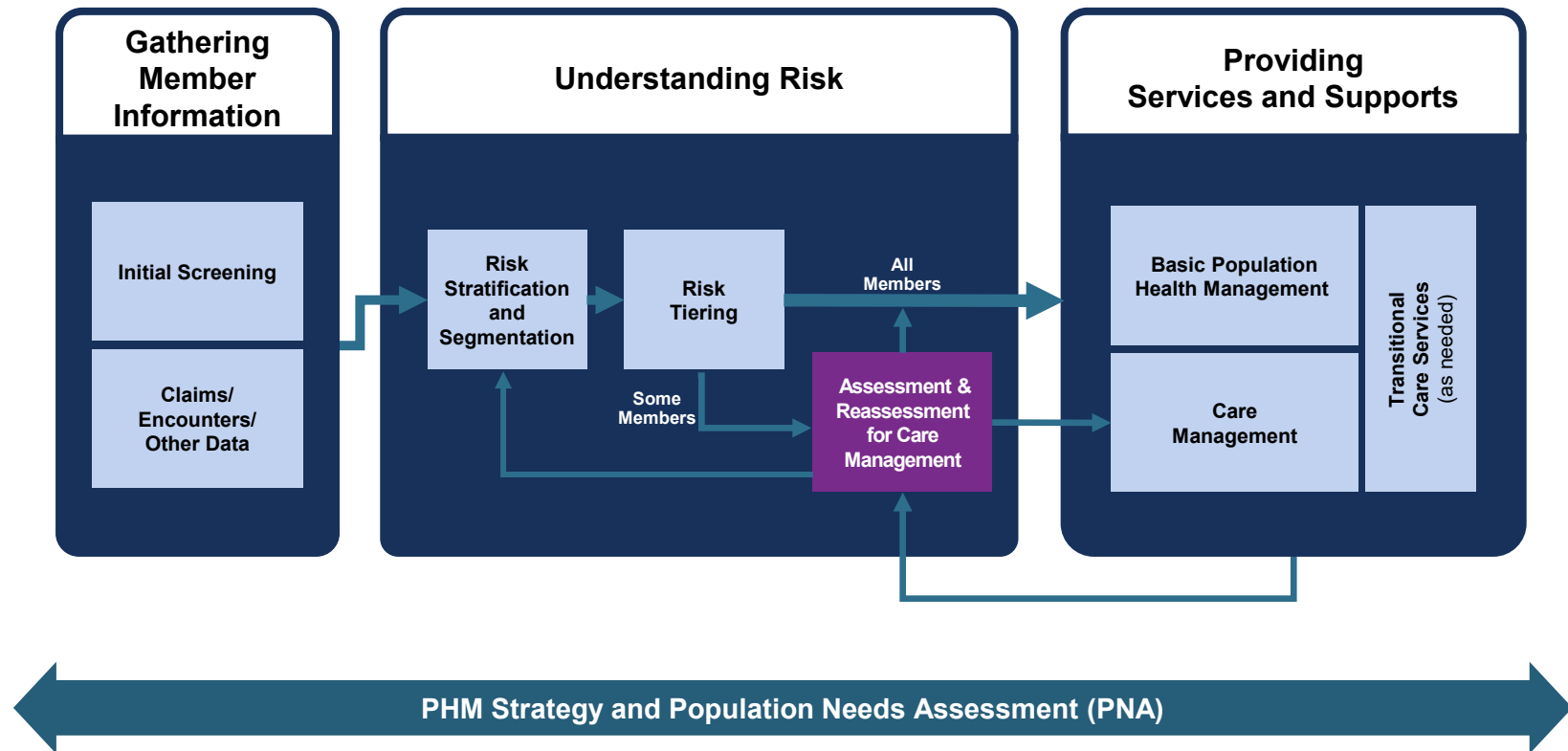
- MCPs **use their RSS approach** to identify Members who should be connected to **services**, incl. care management
- MCPs are not **required to establish standardized Risk Tiers** (i.e., High, Medium-Rising, or Low)

Once the PHM Service Becomes Available

- The PHM Service will assign Risk Tiers to Members using the standardized criteria across delivery systems.
- The PHM Service will place individuals into specific Risk Tiers (i.e., High, Medium-Rising, or Low)
- **MCPs will be required to use these Risk Tiers as a baseline**, which can be supplemented with local data, to connect Members to services
- DHCS will use Risk Tiers to **monitor Members access to all services**

The RSS methodology and Risk Tier criteria will be developed with public input and through the implementation of a new Scientific Advisory Committee.

Assessment & Reassessment for Care Management



Assessment & Reassessment for CM in 2023

DHCS seeks to maintain and build on existing policy to connect Members to care management services.

Members Who Must Be Assessed

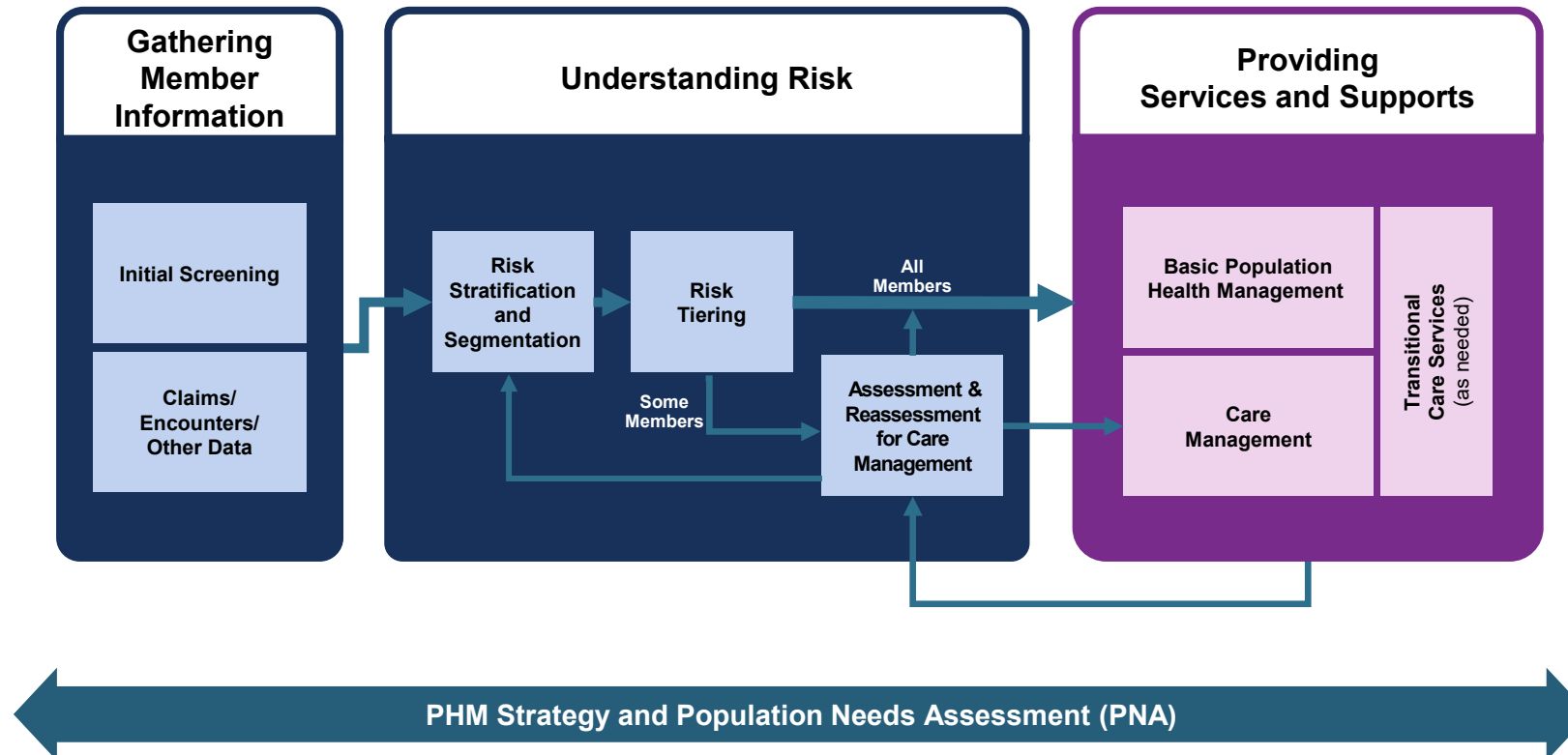
- Those who may qualify for Complex Case Management (based on MCPs own RSS methodologies)
- Those identified as ECM Populations of Focus (POF).
- Those with Long Term Services and Supports (LTSS) needs (as required by state law).
- Any Seniors and Persons with Disabilities (SPDs) not otherwise captured by the above categories but who meet current “high-risk” criteria.
- Members receiving transitional care services.
- Pregnant Women

Timing Requirements

- Within 30 days of identifying the Member and completed within 60 days.
- For Members in ECM or CCM, the assessment for care management must be repeated at least annually.

Once the PHM Service Risk Tiers are deployed, DHCS will work with MCPs to determine how these guardrails should evolve.

#4: Providing Services and Supports



Overview of Required PHM Programs

As part of PHM, MCPs are required to have a broad range of programs and supports to meet the needs of all Members; required PHM programs and supports are grouped in the following three areas:

PHM Programs and Services

- **Basic Population Health Management (BPHM) Program.** These are programs and supports for all MCP Members. Basic Population Health Management includes care coordination and comprehensive wellness and prevention programs.
- **Care Management Services.** These are services for MCP Members that qualify as a result of their risk status and/or as a result of an assessment for care management services.
- **Transitional Care Services.** These services are available for all MCP Members transferring from one setting, or level of care, to another.

Overview of BPHM

PNA &
PHMMS

Gathering
Information

Understanding
Risk

Providing
Services and
Supports

BPHM means an approach to care that ensures needed programs and supports are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting to address their health and health-related needs.

BPHM Defined

The Key components of BPHM include:

- Access, utilization and engagement with primary care
- Care coordination
- Wellness and prevention programs
- Programs addressing chronic disease
- Program to address maternal health outcomes

Health education and cultural & linguistic (C&L) programs and resources, along with linkages to public health, schools, and social service programs, are foundational for the effective delivery of BPHM.

Linkage to EPSDT

Going forward, BPHM will be the framework through which Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) care coordination, wellness, and prevention are delivered, through a primary care-centric approach to children in California and through which DHCS will measure and monitor adherence to requirements. At the individual level, BPHM helps ensure that all Members under 21 receive the EPSDT benefit.

The components of BPHM are not new, and many are included in NCQA PHM standards; however, DHCS has not previously articulated them as a comprehensive a package of programs and supports.

Overview of Care Management

PNA &
PHMMS

Gathering
Information

Understanding
Risk

Providing
Services and
Supports

With CalAIM, DHCS is comprehensively describing and standardizing the continuum of care management programs that MCPs are expected to offer.

Care Management Defined

- Care management means a team-based, person-centered approach to supporting an individual across all health and social needs.
- **Individuals in care management have:**
 - A **single point person** responsible **for managing their care** and an interdisciplinary care team
 - A **care management plan (CMP)**, which assesses strengths, risks, needs, goals and preferences and makes recommendations for service needs.
 - The CMP 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

Overview of the Two Care Management Approaches

DHCS is establishing common terminology and set of expectations that apply across populations who need care management, establishing a continuum between two care management approaches.

Complex Care Management

- Equates to “Complex Case Management” as defined by NCQA.
- For both higher and medium/rising-risk Members.
- Includes chronic care management and interventions for episodic, temporary needs.
- Must include comprehensive assessment and adhere to all NCQA PHM CCM requirements.
- MCPs may use their own staff as care managers.

Enhanced Care Management

- Statewide benefit providing comprehensive, community-based care management.
- For the highest-need, highest-cost Members who meet the ECM Populations of Focus criteria.
- A lead care manager coordinates all their assigned Member’s clinical and non-clinical needs across delivery systems.
- MCPs are required to contract with community-based organizations (CBOs) to serve as the ECM Provider.

Overview of Transitional Care Services

Starting in 2023, MCPs will be expected to provide transitional care services to all Members undergoing a care transition.

Transitional Care Services Defined

- 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, acute care facilities, and skilled nursing facilities to home or community-based settings, community supports, post-acute care facilities, or long-term care settings..

Core responsibilities:

- MCPs are required to assign a single point of contact that will serve as the “Transitional Care Manager”; for Members enrolled in ECM or CCM, their existing Care Manager serves in this role.
- The Transitional Care Manager is responsible for coordinating and verifying that Members receive all appropriate transitional care services regardless of setting.
- Transitional Care Managers must ensure Members are assessed for eligibility for additional care management services, such as CCM or ECM.

PHM: Accountability

DHCS is strengthening oversight of Managed Care and holding MCPs accountable to robust accountability, compliance and oversight programs, including for delegated entities, to ensure Members receive quality care and have access to services.

Overview of Accountability

- MCPs will continue to be responsible for meeting minimum performance levels (MPLs) on select quality measures, including those related to prevention and screening
- DHCS wants to ensure recent Member engagement with their PCP and across range of services, including wellness and prevention.
 - DHCS will also introduce quarterly implementation monitoring reporting for PHM starting in 2023.
 - **DHCS will release the structure for the PHM Quarterly Implementation Monitoring Report in fall 2022.**

Next Steps and Q&A

Upcoming PHM Program Milestones

April

*Late Q2 /
Early Q3*

Q3 / Q4

Jan 1, 2023

2022 Milestones



Strategy and Roadmap Paper

released (elaborates on requirements in the Procurement, and describes 2023 requirements, including NCQA PHM)

2023 PHM Program Requirements

and Guidance for MCP 2023 PHM Readiness Submission released

MCP 2023 PHM Readiness

Submission due to DHCS

PHM Program & Service Go-Live

Q&A

Please visit the DHCS PHM website for more information:

<https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx>

Please send questions to CalAIM@dhcs.ca.gov