CalAIM: October Population Health Management (PHM) Advisory Group Meeting

October 24, 2022 (10:30 am –12:00 pm PT)

Agenda

Welcome and DHCS Notice	2 min
Member Story	5 min
PHM Service Recap + Q&A	35 min
Risk Stratification, Segmentation, and Tiering (RSST) Recap + Discussion	35 min
Beneficiary Contact and Demographic Information (BCDI) Initiative Update	10 min
Look Ahead	3 min

Public Health Emergency (PHE) Unwinding

- **The COVID-19 PHE will end soon and millions of Medi-Cal beneficiaries may lose their coverage.**
- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available

DHCS PHE Unwind Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Launch immediately**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
  - » Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch 60 days prior to COVID-19 PHE termination.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.

Member Story

Risk Stratification at HPSM

- HPSM is a Medi-Cal COHS plan, serving San Mateo County. It is also a CMC/D-SNP and County IHSS plan, serving uninsured community members through County.
  - Total membership: 167,000 lives

- HPSM risk stratifies members into three levels:
  - High risk, emerging/moderate risk, low risk/prevention and early intervention

- The following data elements inform HPSM's risk stratification:
  - HPSM (MCP)
  - HEDIS
  - CBO
  - Behavioral Health and Recovery Services (MHP/DMC-ODS)
  - Aging and Adult (IHSS)
  - ACG risk score

- Risk scores and levels are determined based on acuity plus utilization

- Input from clinical leadership and annual review to inform changes to the risk stratification process

Member Vignette: RSS and PHM - HPSM Integrated Care Management (ICM) and Community Supports (CS)

1. An 80-year-old HPSM member was losing her housing as her son's family was moving and could not bring her along. Member's daughter contacted the County's Aging and Adult Services for help, and they referred member to Health Plan of San Mateo (HPSM).
2. HPSM Integrated Care Management (ICM) team utilized a risk stratification database to screen member. She was found to be high risk and high acuity based on claims, ED and inpatient utilization data. HPSM's assigned care manager noted that she was not connected to any targeted services and faced numerous barriers: She did not speak English, had low health literacy, and was isolated from her community due to the COVID-19 pandemic.
3. ICM case manager referred member to Community Supports Housing Navigation & Transition Services with Brilliant Corners via HPSM's prior authorization process. During this waiting time, member's anxiety increased, and she feared becoming homeless.
4. Brilliant Corners accepted the referral, enrolled member and identified available housing at a senior supportive housing community. Member moved into her new home in September with the assistance of community resources.
5. After housing was secured, HPSM case manager followed up with member's daughter on other identified care gaps (e.g. IHSS, food resources) and will continue periodic outreach. Brilliant Corners team will also check in regularly.
6. On recent follow-up, the member's daughter reports member's mood has improved, she is less anxious and loves her new home. She takes daily walks outside and is able to socialize with others.

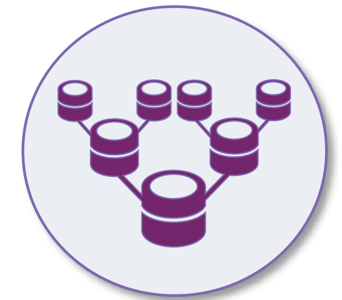
Member Vignette: RSS and PHM - HPSM Integrated Care Management (ICM) and Community Supports (CS)

- This story highlights the impact that risk stratification with meaningful data can have on connecting members to the services that most support them. HPSM identified the member's most pressing needs prior to a crisis point through risk stratification.
- In this example, the consideration of social drivers of health was critical to improving health outcomes and preventing social harm to the member and her family.
- Effective collaboration between local County agencies and HPSM allowed early risk identification and referral to Community Supports Housing Transition and Navigation Services.
- This member story also highlights the potential for close collaboration of health plans with community-based organizations under the Population Health Management Program, allowing for the provision of whole-person-centered services.
- By keeping the member at the center of her care, HPSM and Brilliant Corners were able to help the member to transition to a new home and greatly improve her quality of life. This story shows the potential for similarly impactful interventions through effective population health management.

PHM Service Recap and Q&A

PHM Service Overview

The PHM Service will integrate data, support key population health functions, and provide users access to PHM data.



1. Integrate Data from DHCS and Other Sources

Integrate data (physical, behavioral health, dental and Rx data, social service, developmental, home and community-based services, IHSS, 1915c waiver, and other program, administration and clinical) 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
- gap reporting.

3. Provide Access to PHM Data

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

PHM Service Vendor Update

On September 6th, DHCS released a notice of intent to award, selecting Gainwell Technologies to implement the PHM Service.

PHM Service Overview

- The PHM Service will support whole-person care, integrating a wide range of administrative, medical, behavioral, dental, social service and program information for use by multiple stakeholders' population health needs.
- The PHM Service will support risk-stratification, segmentation and tiering; assessment and screening processes; and analytics and reporting.

Proposed PHM Service Vendor

Rollout Details

- DHCS will partner with Gainwell Technologies to implement the PHM Service. The initial contract will be for three years, with the option to extend for an additional three years.*
- An initial set of PHM Service capabilities will be launched during a pilot phase beginning January 2023.
- By July 2023, DHCS will begin rolling out the PHM Service statewide.

Upcoming PHM Program and Service Milestones

2022/2023 Milestones

Sep 2022

2023 PHM Program Requirements and Guidance for MCP 2023 PHM Readiness Submission released

PHM Service vendor Notice of Intent to Award released

Oct 21, 2022

MCP 2023 PHM Readiness Submission due to DHCS

Jan 2023

PHM Program Go–Live

PHM Service Test Launch with multiple partners*

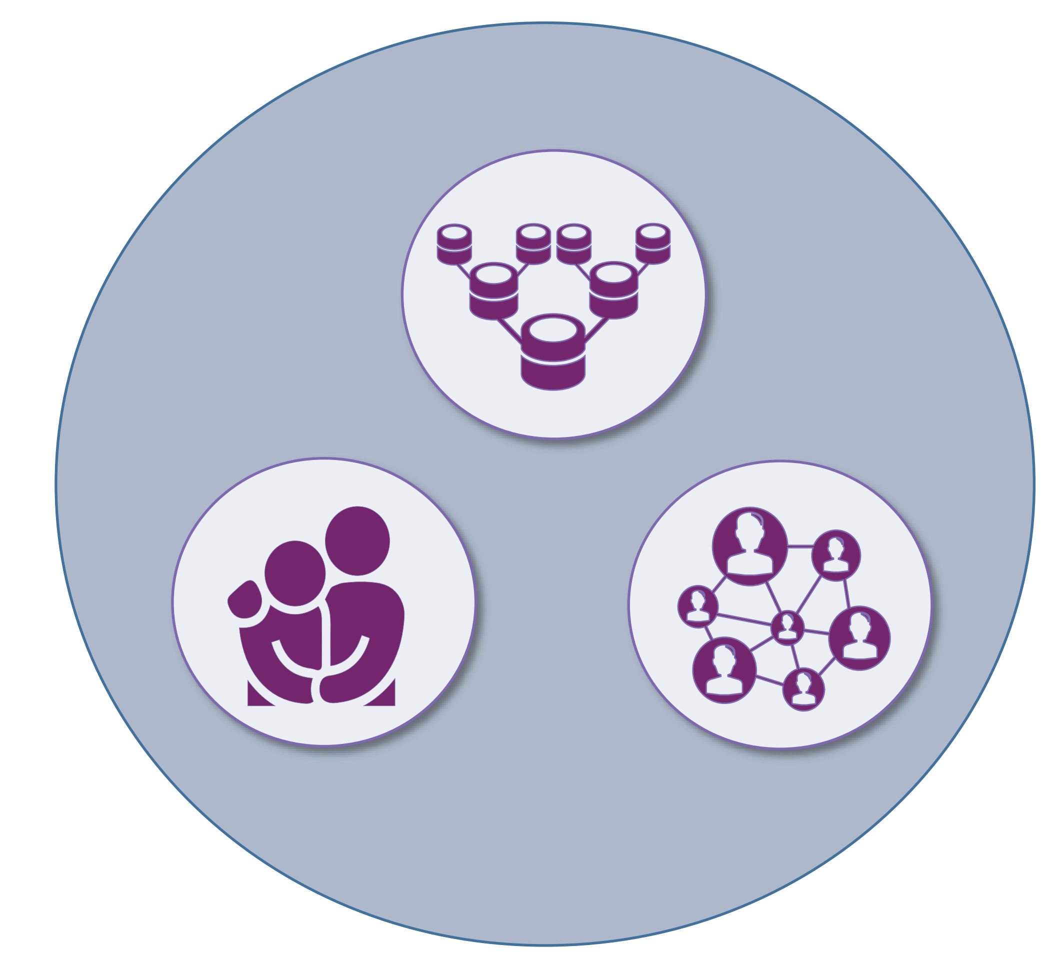
July 2023

PHM Service Statewide Launch and scaling

* PHM AG members may nominate interested entities as potential partners in the test launch phase of PHM Service implementation. PHM AG members may email the DHCS PHM Section mailbox at PHMSection@dhcs.ca.gov with subject “PHM Service Pilot Partner” with the organization name, contact name and information, and the specific functionalities they would be interested in serving as a pilot partner.

PHM Service Q&A

- General Questions on PHM Service
- Specific Functionality and Data Types
- PHM Service Vendor
- PHM Service Pilot
- Others?



Risk Stratification, Segmentation, and Tiering (RSST) Recap + Discussion

Framework for RSST Implementation (*PHM Service*)

The PHM Service will support key population health functions, including RSST.
Implementation of the PHM Service's RSST approach will be achieved in overlapping phases.

Design

Making critical decisions about goals and answering clinical and programmatic questions to inform the statistical models used to create the risk scores

Develop

Using historical data to develop robust statistical models that predict risk

Test

Running models on historical data to test the developed model for accuracy and bias with iterative refinements, as needed

Deploy (*in PHM Service*)

Run the model w/ live data in a production environment, testing the results, & transmitting the information to authorized users

Assess

Assess the accuracy and effectiveness of the RSST results and make improvements as needed

Refine

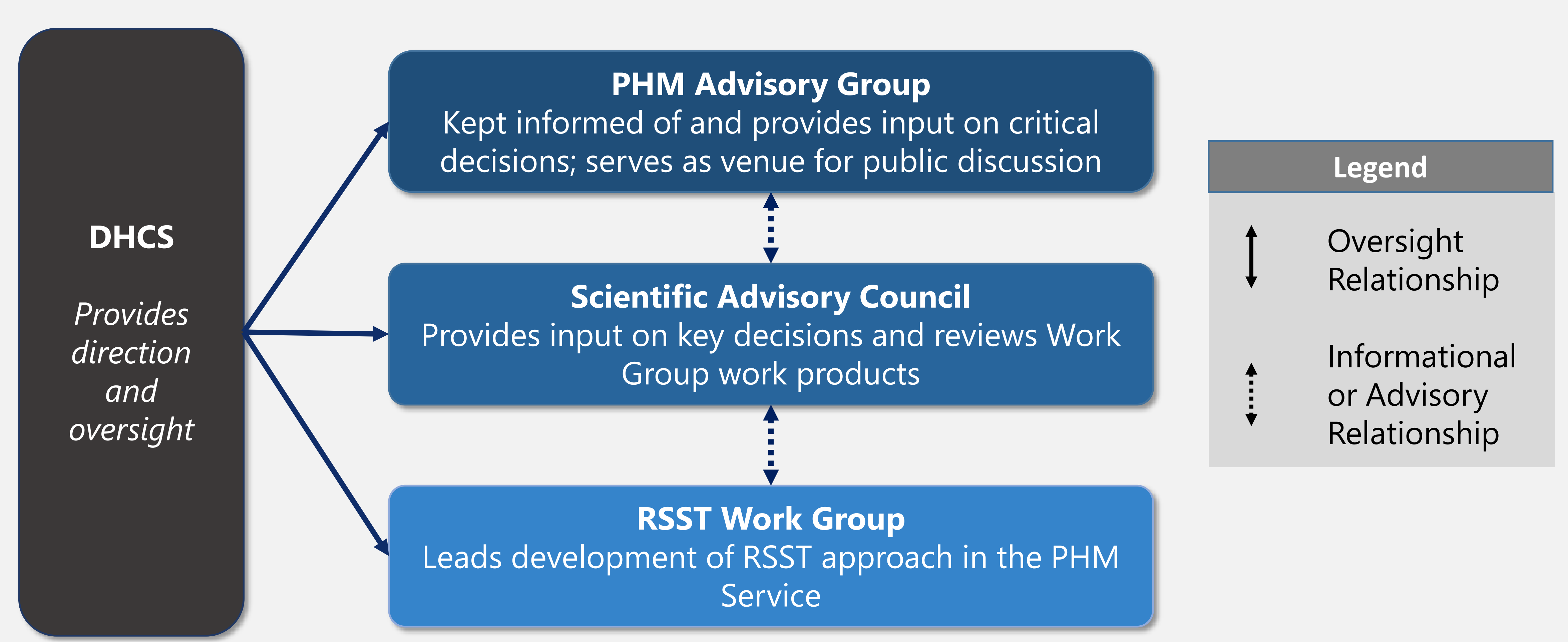
RSST Work Group and Scientific Advisory Council

To inform the design, development, and testing phases, DHCS is establishing (1) a small RSST Work Group of experts; and (2) a Scientific Advisory Council

	RSST Work Group	Scientific Advisory Council (SciAC)
Summary	Leads RSST design and decision-making, with data support from DHCS and the PHM Service Vendor.	Acts in advisory role to DHCS to guide the development & deployment of RSST, provides feedback to RSST workgroup on key decisions.
Responsibilities	• Spearheads early framework design and day to day decision-making on the development of risk scores and tiers including algorithm development • Presents recommendations to Scientific Advisory Council.	• Provides input on critical issues and reviews key decisions • Reviews all de-identified outputs and bias studies. • Keeps PHM AG informed and solicits input on key decisions
Launch	Q4 2022	Q4 2022

Relationships Between Advisory Bodies

The SciAC will advise on the activities of the RSST Work Group and provide input on its work products. DHCS will direct and have oversight responsibility for all advisory bodies as shown below.



Call for Nominations for the Scientific Advisory Council

DHCS seeks nominations for individuals to serve as members of the Scientific Advisory Council.

Prospective members:

- Should possess experience with:
  - Designing and developing RSST approaches and tools;
  - Using RSST outputs to inform care management, care coordination, and care delivery; **and/or**
  - Lived experiences as Medi-Cal members and advocates, of receiving services in the Medi-Cal delivery system
- Be able to commit approximately 4-6 hours per month (inclusive of meeting time)

Nominations should be sent to PHMSection@dhcs.ca.gov with the subject line: '***PHM Scientific Advisory Council – Nomination.*** Both PHM Advisory Group members and non-members may be nominated for inclusion in the Scientific Advisory Council.

RSST Discussion Questions

Program Goals

1. The RSST model must create risk tiers (high, medium/rising-risk, and low). How do we make sure this is meaningful and actionable?
   a) How should we define risk? (Risk of death, risk of admission, risk of having a need)
   b) Is this different for different populations? (kids, older adults, pregnant women)
   c) Is something needed to be reported other than the risk tier to make this information actionable?

2. Risk is constantly changing and the ability to predict risk changes based on new data.
   a. How often do the risk tiers and other outputs need to be updated?
   b. Are there certain events or new data that would trigger/require a new tier assessment/assignment?
   c. How can this be used in a meaningful way by plans and providers?

3. Addressing disparities and ensuring that our algorithms address bias is critically important in this work.
   a. What are important ways that we want to measure/assess if we are doing a good job with this?

Beneficiary Contact and Demographic Information (BCDI) Initiative Update

Beneficiary Contact and Demographic Information (BCDI) Initiative

On October 20th, DHCS convened a BCDI Stakeholder Work Group to inform DHCS's efforts to improve the collection, sharing, and use of beneficiary contact and demographic information.

Background

- In February 2020, DHCS convened a BCDI Stakeholder Work Group to gather input and feedback on options to improve how beneficiary contact and demographic information is updated and exchanged among entities, but its work was paused due to the COVID-19 Public Health Emergency (PHE).
- Given the importance of BCDI to key DHCS initiatives, DHCS is now reconvening a cross-sector stakeholder group to provide input on improving the means through which BCDI is collected, updated, and shared

BCDI Work Group - Role

The BCDI Work Group will provide a mechanism for communication, coordination and strategy development among DHCS and key stakeholders that are vested in improving the collection, updating, and sharing of BCDI.

Purpose

» Help identify options for improving how BCDI is collected, updated, and shared while maintaining compliance with applicable state and federal rules

Tasks

Work Group members will be asked to:

» Provide updates on their respective BCDI-related efforts
» Discuss challenges and barriers, and identify potential solutions
» Offer input on options and recommendations for next steps

Logistics

» ***When***: Monthly meetings, beginning in October 2022 through at least December 2022
» ***Where:*** Virtually

BCDI Initiative: Goals and Priorities

The BCDI Work Group will address topics relevant to two high-priority drivers.

① **Data to Support Medi-Cal Enrollment & Re-Determination**

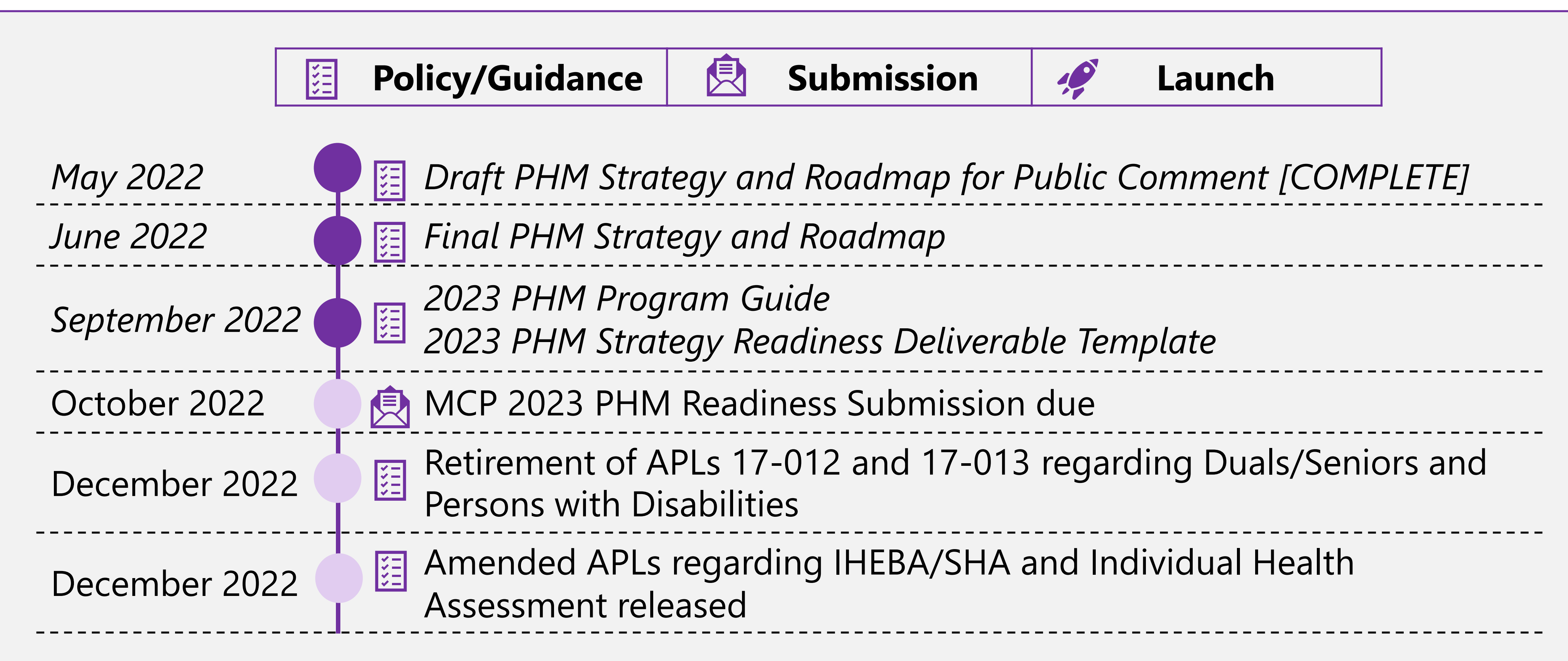
Support the ability of Medi-Cal beneficiaries to update contact information for Medi-Cal enrollment and re-enrollment (including, but not limited to the PHE unwinding).

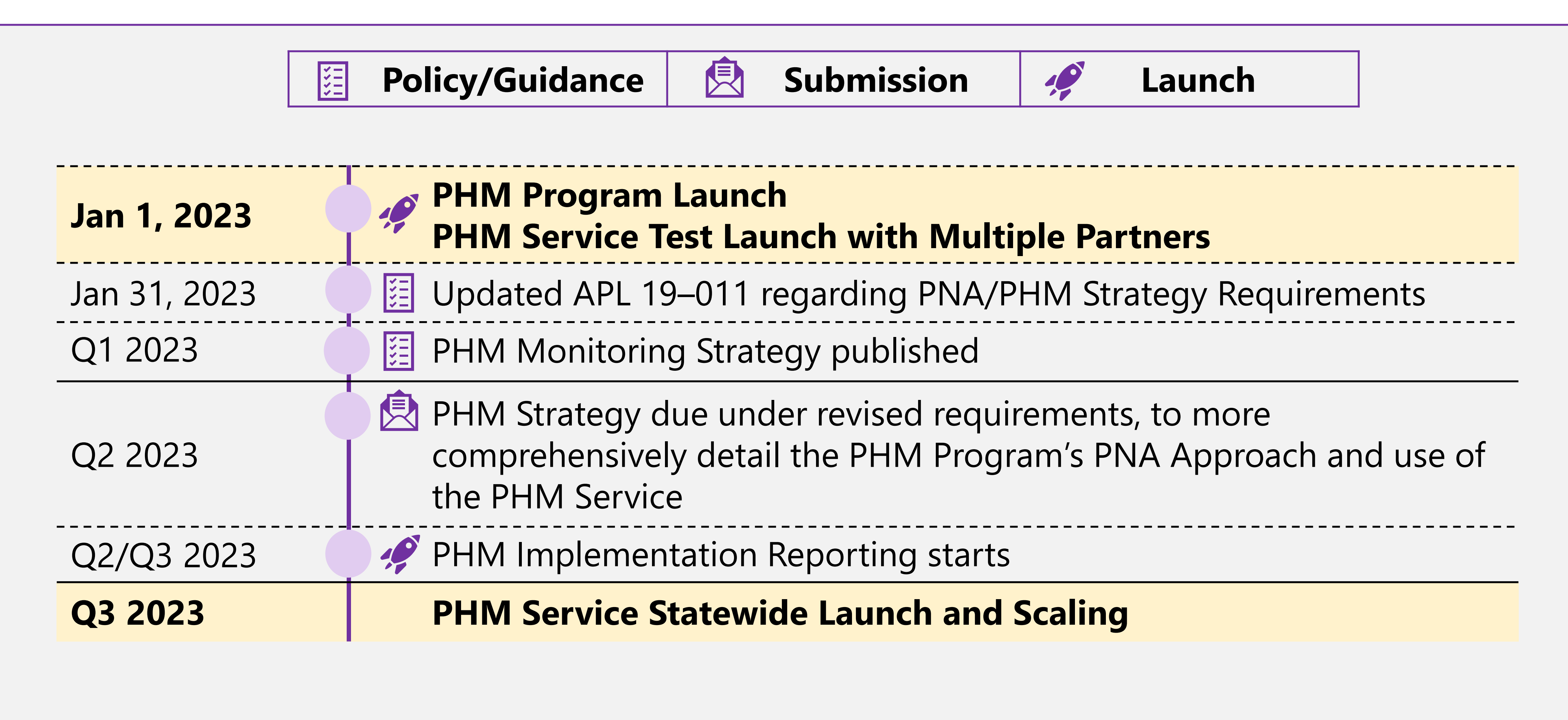
② **Data to Support Population Health, Care Management, & Other Program Outreach**

Support the ability of Medi-Cal, MCPs, Counties, and providers to access accurate, complete, and timely contact and demographic information to conduct population health, care management, and other programmatic outreach efforts.

The PHM Advisory Group will be kept informed of BCDI Work Group activities via updates at future PHM AG meetings.

Look Ahead


Policy/Guidance
Submission
Launch
May 2022
Draft PHM Strategy and Roadmap for Public Comment [COMPLETE]
June 2022
Final PHM Strategy and Roadmap
September 2022
2023 PHM Program Guide
2023 PHM Strategy Readiness Deliverable Template
October 2022
MCP 2023 PHM Readiness Submission due
December 2022
Retirement of APLs 17-012 and 17-013 regarding Duals/Seniors and Persons with Disabilities
December 2022
Amended APLs regarding IHEBA/SHA and Individual Health Assessment released


Policy/Guidance
Submission
Launch
Jan 1, 2023
PHM Program Launch
PHM Service Test Launch with Multiple Partners
Jan 31, 2023
Updated APL 19–011 regarding PNA/PHM Strategy Requirements
Q1 2023
PHM Monitoring Strategy published
Q2 2023
PHM Strategy due under revised requirements, to more comprehensively detail the PHM Program's PNA Approach and use of the PHM Service
Q2/Q3 2023
PHM Implementation Reporting starts
Q3 2023
PHM Service Statewide Launch and Scaling

Upcoming Stakeholder Meeting:

- **Monday, December 5th at 10:00 AM – 11:30 AM PT**
  - December PHM Advisory Group Meeting

THANK YOU

Please visit the DHCS PHM Website for more information and access to the PHM documents and supporting resources: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx

Appendix

PHM Framework