# CALAIM: POPULATION HEALTH MANAGEMENT (PHM) FREQUENTLY ASKED QUESTIONS

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DHCS
CALIFORNIA DEPARTMENT OF
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# I. INTRODUCTION

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

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

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

# I. PHM PROGRAM GENERAL

**1. What National Committee for Quality Assurance (NCQA) requirements were Medi-Cal MCPs required to meet by January 1, 2023 under the PHM Program?**

For information on the NCQA requirements Medi-Cal MCPs are required to meet under the PHM Program, please refer to the PHM Policy Guide Section II. B. 2) Relationship between Population Needs Assessment (PNA), PHM Strategy, and the NCQA Requirements.

# II. PNA AND DHCS PHM STRATEGY DELIVERABLES

**2. How are Medi-Cal MCP PNA and DHCS PHM Strategy Deliverable requirements and DHCS Bold Goals related?**

MCPs are required to meaningfully participate on Local Health Jurisdictions' (LHJs') Community Health Assessments (CHAs)/Community Health Improvement Plans (CHIPs). There is no requirement that these CHAs/CHIPs must align with DHCS Bold Goals; however, we imagine that many CHA/CHIPs will address the Bold Goals' broad focus areas of maternal and child health disparities, mental health, and substance use disorders. DHCS may require MCPs to provide progress updates toward achieving DHCS Bold Goals in annual DHCS PHM Strategy Deliverable submissions.

# III. PHM PROGRAM – GATHERING MEMBER INFORMATION

**3. What are the requirements for the Initial Health Appointment(s) under the PHM Program?**

Please refer to the PHM Policy Guide Section II. C. 2) Streamlining the Initial Screening Process to review the requirements for the Initial Health Appointment(s),[1] as part of the overall streamlining of the initial screening requirements under the PHM Program.

[1] All Plan Letter (APL) 22-030 simplified the previous requirements for the Initial Health Assessment, renaming it the Initial Health Appointment

**4. Can the Initial Health Appointment(s) requirement be completed in multiple visits? Can some of the visits be done via telehealth?**

Yes, the Initial Health Appointment(s) requirement can be completed over the course of multiple visits. Telehealth visits can be used as an option for completing one or more components of the Initial Health Appointment(s). Please refer to the PHM Policy Guide Section II. C. 2) Streamlining the Initial Screening Process.

**5. Does the Initial Health Appointment(s) requirement need to be periodically rescheduled or re-administered to enrolled members?**

No, the Initial Health Appointment(s) requirement does not need to be periodically rescheduled or re-administered to members once completed after enrollment for new members. Please refer to the PHM Policy Guide Section II. C. 2) Streamlining the Initial Screening Process.

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

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

**7. Are the requirements for the HRA and Initial Health Appointment(s) interchangeable? Can one replace the other?**

No. The requirements for the Initial Health Appointment(s) and an HRA are not interchangeable. These are separate and distinct requirements. As mentioned above:

The Initial Health Appointment(s) requirement includes a history of the member's physical and behavioral health, an identification of risks, and screenings of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. And unless a member's Primary Care Provider (PCP) determines that the member's medical record contains complete information that was

[2] PHM Policy Guide, Appendix 3: Standardized LTSS Referral Questions

updated within the previous 12 months, all members must have their Initial Health Appointment(s) requirements met.

The HRA is a more targeted, in-depth assessment focused on Seniors and Persons with Disabilities (SPD), which includes required LTSS referral questions. An HRA is only needed if a member is identified through RSS, referral or other means.

# IV. PHM PROGRAM – UNDERSTANDING RISK

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

Requirements for MCPs related to assessment and RSS processes prior to the PHM Service's RSS and Risk Tiering (RSST) functionalities going live are outlined in the PHM Policy Guide Section II D. 1) RSS and Risk Tiers and 2) Assessment to Understand Member Needs.

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

While MCPs are allowed to use their own RSS methodologies to supplement the PHM Service's statewide risk tiers for their own use or to identify additional high-risk members, MCP must assess ALL members identified as high risk through the PHM Service's risk tiers. The assessment process must include identifying any needs and connecting members to appropriate services. Further details of the required use of the PHM Service risk tiers will be published prior to statewide launch. Please refer to PHM Policy Guide Section II D. 2) b. After the PHM Service RSS and Risk Tiering Functionalities Are Available.

**10. When should members be re-stratified?**

MCPs must re-stratify members based on requirements outlined in the PHM Policy Guide Section II D. 1) RSS and Risk Tiers.

**11. How often should MCP members be re-assessed?**

Similar to the re-stratification requirements, MCPs should re-assess in real-time upon a significant change in the health status or level of care of the member, or upon the receipt of new information that the MCP determines as potentially changing a member's level of risk and need. Refer to PHM Policy Guide Section II D. 2) Assessment to Understand Member Needs.

**12. How does the retirement of APLs 17-012 and 17-013 change requirements related to SPD HRA?**

Retired APLs 17-012 and 17-013 contained care management requirements for SPDs and dual-eligible members. They were developed by DHCS in conjunction with stakeholders as a result of previous initiatives and federal requirements. Given the passage of time, DHCS updated the requirements within APLs 17-012 and 17-013 and eliminated redundancies while keeping specific member protections in place. As such, APLs 17-012 and 17-013 were retired following the November 2022 release of APL 22-024 PHM Policy Guide, and effective January 1, 2023, they were replaced with simplified requirements; however, the majority of the specific member protections contained in these APLs are kept in place through requirements outlined in PHM Policy Guide Section II. D. b. Changes to Assessment Requirements, Box B: Changes to Seniors and Persons with Disabilities HRA Requirements.

# V. PROVIDING PHM PROGRAM SERVICES AND SUPPORTS

## A. General

**13. When will Closed Loop Referrals be required?**

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

## B. Care Management

**14. How does a member graduate from one level of care management to another?**

CCM and ECM are on a care management continuum. Requirements related to these care management programs and how they support a member graduating from one level of care management to another is outlined in PHM Policy Guide, Section II. E. 2) Care Management Programs.

## C. Transitional Care Services (TCS)

### 1) General

**15. What is the implementation timeline for TCS?**

MCPs are accountable for providing strengthened TCS beginning on January 1, 2023 and fully implemented for all members by January 1, 2024 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. Please refer to PHM Policy Guide, Section II. E. 3) Transitional Care Services. A. Phased TCS Implementation Timeline.

**16. Will TCS be required for emergency room (ED) visits, or are TCS for ED visits provided at the discretion of the plan?**

Although TCS are not required for all ED visits at this time, MCPs are strongly encouraged to provide TCS for members who have ED visits but are not admitted inpatient, especially for the highest risk members. Current MCAS quality reporting includes ensuring timely follow-up for members with ED visits for mental health or substance use disorder (SUD) reasons. In addition, MCPs are strongly encouraged to provide ED follow up as part of TCS for pregnant and postpartum individuals (through 12 months postpartum), given the association of ED visits and maternal morbidity and mortality. Based on literature and existing research, primary care follow up post ED visits are highly effective in reducing avoidable hospital admissions and improving outcomes.[3] Please refer to PHM Policy Guide, Section II. E. 3) Transitional Care Services.

## 2) TCS for High- vs. Lower-Risk Members

**17. How are transitioning members identified as high- vs. lower-risk members?**

Please refer to PHM Policy Guide, Section II. E. 3) Transitional Care Services. b. Required TCS Elements and Processes for All MCP Members (Effective 1/1/23) for requirements related to identification of high- vs. lower-risk members.

**18. Are all pregnant and postpartum members high-risk for the purposes of TCS, or is it just a subset of high-risk pregnancies?**

Yes, all pregnant and postpartum members are considered high risk for the purposes of TCS and should receive high-risk TCS, including having an assigned single point of contact/care manager who can ensure all required TCS are complete. High-risk pregnant

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

and postpartum members include individuals hospitalized during pregnancy, admitted during the 12-month period postpartum, and discharges related to delivery. This is because all pregnant individuals on Medi-Cal have one or multiple physical, behavioral or social risks and would benefit from higher levels of coordination and connection to services for the period of pregnancy and postpartum.[4]

## 3) TCS Implementation

**19. How will MCPs know or be notified when their members are Admitted, Discharged, or Transferred (ADT) when they are the secondary payor? Will ADT feeds be available?**

CalHHS Data Exchange Framework (DxF) requirements will support MCPs capabilities to receive ADT notifications from a variety of Participating Facilities. There is no specific policy on ADT notifications for when MCPs are secondary payers. For requirements related to ADT feeds please refer to the requirements outlined in the PHM Policy Guide, Section II. E. 3) b. i. Admission, Discharge, and Transfer (ADT). DHCS currently does not provide real-time data on members' admission, discharges or transfers.

**20. Who can serve as the assigned TCS care manager/single point of contact for high-risk members as defined in the PHM Policy Guide?**

Please refer to the requirements outlined in the PHM Policy Guide, Section II. E. 3) c. i. Identify the Care Manager Responsible for TCS. For members enrolled in ECM or CCM at the time of the care transition, the MCP must ensure that the member's assigned ECM Lead Care Manager or CCM care manager is the assigned TCS care manager and provides all TCS. Many high-risk members at the time of transition will meet criteria for ECM or CCM for the first time on account of the event or condition that necessitated the facility stay. At any time in the TCS process, the discharging facility, or the TCS care manager should screen and refer a member for longer term care management programs (ECM or CCM) and/or Community Supports.

For members who do not already have a care manager through ECM or CCM, the MCP may choose either to use its own staff to provide TCS and longitudinal support spanning the whole transition, or to contract with the hospital, the PCP or another appropriate delegate such as an accountable care organization (ACO). DHCS encourages plans to

[4] According to the California Department of Public Health's Dashboard on Severe Maternal Mortality (SMM), in 2022 California's overall rate of SMM was 101.9 per 10,000 deliveries and SMM for Medi-Cal members was even higher at 114.1 per 10,000 deliveries

work with their networks to create models of care that do not duplicate work, including the engagement of discharging facilities to take on the full scope of longitudinal TCS.

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

**21. If the MCP contracts with hospitals, ACOs, PCPs, or other entities to provide TCS, will these entities be subject to delegation and subcontracting requirements under APL 17-004?**

No. Requirements under APL 17-004, which was superseded by APL 23-006, would not apply if the MCP contracts with network providers, including hospitals, ACOs, PCPs, or other entities to provide TCS requirements. MCPs can fulfill the TCS requirements and assign a single point of contact/care manager either by using its own staff or contracting with other network partners and will be required to submit data to DHCS for PHM program monitoring. Please refer to the updated PHM Policy Guide Section III. Monitoring Approach for Implementation of the PHM Program regarding the guidance on the PHM Monitoring approach for MCPs.

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

Please refer to PHM Policy Guide Section II. E. b. 1) Admission, Discharge, and Transfer for the MCP, acute hospital and emergency department interoperability, notification requirements from CMS.

The MCP must implement processes to ensure that the contact information (name and phone number) for the assigned single point of contact/care manager is shared with the discharging facility and the member. A best practice is to have the discharging facility incorporate the name and contact information in the discharge documents and shared with the member and post-discharge providers.

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

While member choice to receive TCS must be respected, MCPs are accountable for ensuring TCS requirements are met for all members, including those who decline services from a care manager during their transition. Please refer to the requirements

outlined in the PHM Policy Guide, Section II. E. 3) c. i. Identify the Care Manager Responsible for TCS.

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

No, DHCS does not have a specific expectation for the volume of calls MCPs are required to conduct to engage members for TCS support. Please refer to the requirements outlined in the PHM Policy Guide, Section II. E. 3) d. i. Dedicated Team/Phone Number for Member Contact and Support for more information.

**25. What are the medication reconciliation requirements for TCS?**

Poor, or lack of medication reconciliation presents a significant risk[5] for adverse drug events, especially for the highest-risk populations. Accurate and timely medication reconciliation is a critical element of TCS for ensuring patient safety during transitions of care. As such, a crucial component to TCS is ensuring that medication reconciliation is completed upon discharge by the discharging facility, and is completed post-discharge during a follow up visit with a provider. These medication reconciliations are crucial for reducing medication discrepancies, errors, and adverse drug events that are common and can lead to poor outcomes in transitions. Please refer to PHM Policy Guide, Section II. E. 3) Transitional Care Services for medication reconciliation requirements.

**26. Will there be additional funding to reflect the new requirements on MCPs related to TCS?**

DHCS acknowledges the practical challenges and resource needs for TCS implementation on the ground. Based on the expected increased resource needs, DHCS included an explicit adjustment in the MCPs prospective CY 2024 rates to account for the increased work effort in TCS.

## 4) Discharge Collaboration and Discharge Planning Process

**27. What are MCPs responsible for with regard to their oversight of discharging facilities' discharge planning process?**

Under TCS, MCPs are accountable for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as

[5] The Joint Commission, "Quick Safety 26: Transitions of Care: Managing Medications", April 2022

required by federal and state requirements. Specifically, MCPs are required to have oversight of hospital discharge planning processes, and hospitals are responsible for performing those discharge planning activities as outlined in the PHM Policy Guide, Section II. E. 3) b. 4. 4. MCP Oversight of Facility Discharge Planning Process.

TCS requirements on MCPs build on, rather than supplant, existing requirements on facilities, and the goal is to reduce duplication of work between MCPs and facilities.

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

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

**29. Does DHCS require a specific Discharge Risk Assessment?**

DHCS is no longer requiring a specific discharge risk assessment, but instead is requiring MCP oversight of hospitals' discharge planning processes as required by federal and state requirements and as outlined in the PHM Policy Guide.

# VI. PHM PROGRAM – MONITORING

**30. How does DHCS monitor MCPs' PHM program implementation, effectiveness, and outcomes?**

DHCS reviews the holistic performance of each MCP's PHM Program implementation through monitoring performance across multiple PHM categories. These categories are organized by the following monitoring domains: PHM program areas/themes, populations, and cross-cutting priorities. Within each PHM monitoring program area/theme and population, DHCS identified existing quality measures from MCAS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) and high priority Key Performance Indicators (KPIs). The Department reviews the overall picture revealed by MCP performance across all of the measures within a category to understand if core aspects of a MCP's PHM program are working as intended. The intent is also to look over time using early measure performance as a baseline and looking for improvements, as well as identifying outliers. By reviewing each monitoring category, DHCS is able to spot priority issue areas that require direct DHCS follow-up with MCPs and identify areas in the PHM Program requirements that need additional DHCS guidance or clarifications. For more information, please refer to the PHM Policy Guide, III. Monitoring Approach for Implementation of the PHM Program.

Starting in 2023, DHCS began monitoring equity performance based on stratified data that is available on a select subset of PHM KPIs.

**31. What are MCPs required to submit for PHM monitoring? What is the timeline for PHM monitoring submissions?**

MCPs are required to report five PHM monitoring KPIs at the plan level on a quarterly basis. The first submission was on August 15, 2023. Guidance for the next submission is forthcoming. For detailed KPI reporting and stratification requirements, please refer to the PHM Policy Guide, Appendix 5: PHM Monitoring KPI Technical Specifications. Please refer to the PHM Policy Guide, III. Monitoring Approach for Implementation of the PHM Program for detailed lists of Quality Measures and KPIs.

**32. Given DHCS leverages existing MCP reported data, including IPP, for PHM monitoring purposes, what is considered an ADT notification for the two IPP measures below that are also part of the PHM monitoring measure list? For example, is Care Everywhere considered, or other daily reports?**

a. **Percentage of contracted acute care facilities from which MCPs receive ADT notifications**

b. **Percentage of contracted SNFs from which MCPs receive ADT notifications**

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

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

Acute care facilities include inpatient and ED facilities.

**34. Does DHCS share plan-reported PHM monitoring data with MCPs?**

DHCS shares plan-reported PHM Monitoring data with MCPs as newly submitted quarterly data becomes available. PHM Monitoring data captures the five PHM Monitoring KPIs as well as the four IPP measures being used for PHM monitoring. By sharing this data with plans, the Department is aiming to:

- Address any questions or concerns related to PHM Monitoring KPI technical specifications before quarterly submissions;

- Identify measures that may need further refinements or technical assistance;
- Identify PHM Program areas that may need additional implementation support; and
- Encourage dialogue around MCPs' PHM Program performance.

In the future, PHM monitoring data will be made available to the public.

# VII. MEDI-CAL CONNECT

*The PHM Service has been renamed Medi-Cal Connect. For members, it will be referred to as My Medi-Cal Connect. Medi-Cal Connect aims to provide Medi-Cal members with a more seamless user experience, including benefits navigation. It also enables DHCS, its managed care partners, and other critical partners in the Medi-Cal delivery ecosystem to strengthen PHM by integrating data from Medi-Cal delivery systems and select state agencies and enabling multi-party data access and sharing.*

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

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

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

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

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

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

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

**38. Will the PHM Service interface with provider EHRs?**

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

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

HIE networks typically focus on the collection and transmission of clinical data from providers' EHR systems. While the PHM Service will not initially connect to HIE networks to access, link, and/or exchange clinical data from providers' EHR systems, DHCS will assess opportunities for the PHM Service to connect to EHRs and HIE networks as part of the long-term PHM Service strategy.

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

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

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

DHCS has established a RSST Work Group of national experts who will lead the design and development recommendations and considerations for the RSST algorithm(s) in consultation with the Scientific Advisory Council (SciAC), PHM Advisory Group, and DHCS. DHCS has established the SciAC to act in an advisory role to DHCS in guiding the development and deployment of the PHM Service-specific RSST algorithms.

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

No, MCPs will still need to maintain a separate capability to identify individuals eligible for ECM based on POF definitions. Identification of ECM-eligible populations requires

access to a diverse set of timely information, not all of which is expected to be available through the PHM Service at the time of its launch.