Population Health Management (PHM) Advisory Group

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

October 2023

Agenda

Introductions	3 min
Risk Stratification, Segmentation, and Tiering (RSST)	60 min
PHM Transitional Care Services: Policy Changes & Clarifications	25 min
Next Steps	2 min

Risk Stratification, Segmentation, and Tiering (RSST)

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Purpose of Discussion

- Context of RSST algorithm development including:
  - How RSST is connected to the PHM Program and Service
- Provide overview of the algorithm's contextual design and obtain feedback on:
  - How the algorithm is structured
  - How a risk tier is determined
  - Approach to identifying predictor variables and adverse events / outcome measures

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Agenda

1. Risk Stratification, Segmentation, and Tiering Overview
2. Algorithm Contextual Design
3. Approach to Identifying Predictor Variables
4. Approach to Identifying Adverse Events / Outcome Measures

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Risk Stratification, Segmentation, and Tiering Overview

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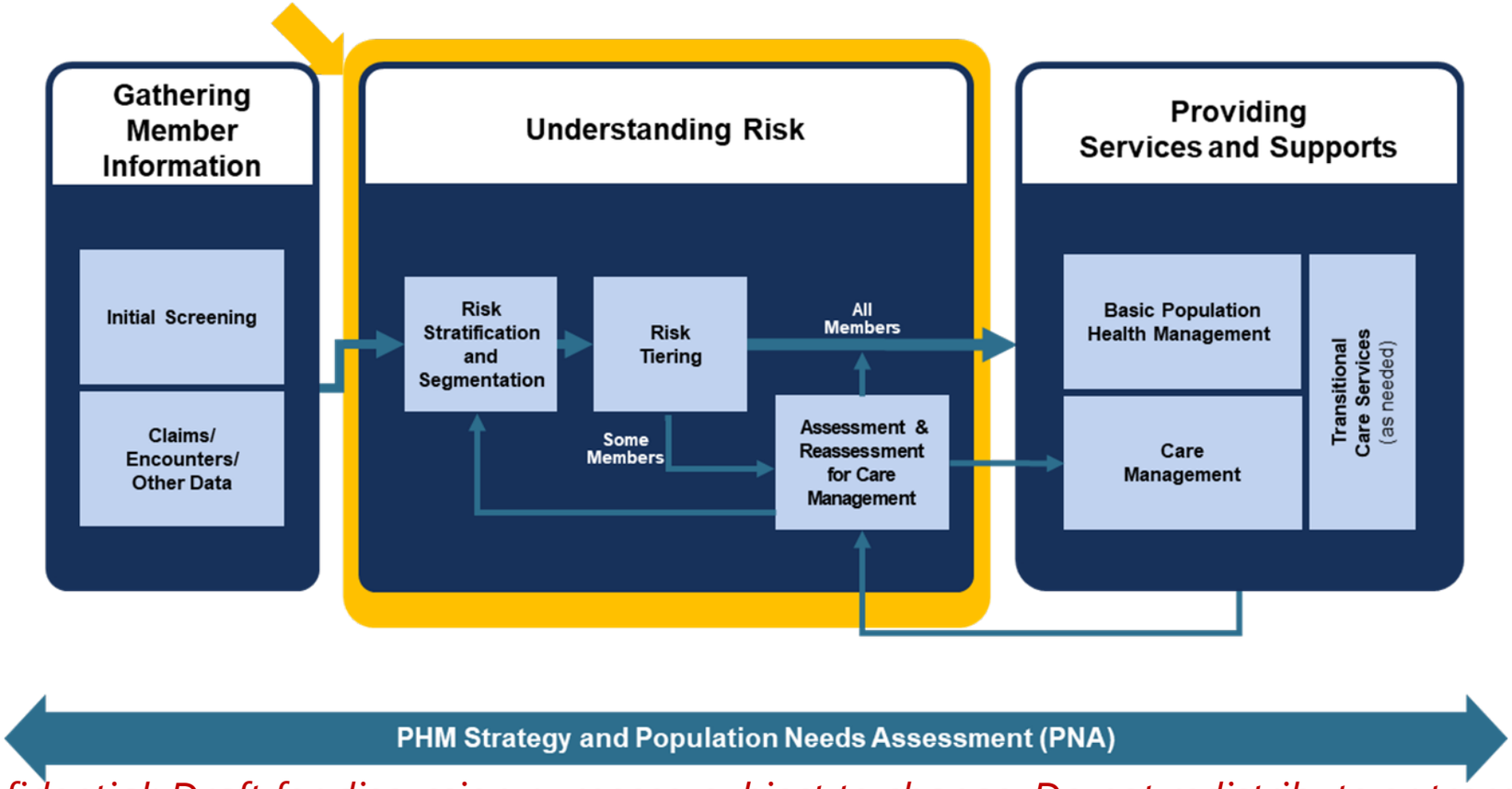
Understanding and addressing risk through the RSST approach is a key objective within the PHM framework



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PHM Policy Guide

DHCS currently requires Medi-Cal managed care plans (MCPs) to implement a risk stratification, segmentation, and tiering methodology that meets NCQA requirements

- **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.

This presentation describes the RSST approach that DHCS will use **after** the PHM Service is available.

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RSST is a key component of the Population Health Management (PHM) Program and Service

PHM Program

A core part of the CalAIM initiative requiring Medi-Cal delivery systems (i.e. MCPs) to develop and maintain systems to provide care for the whole person

PHM Service

A service that supports DHCS's PHM vision by integrating data from disparate sources, performing population health functions, and allowing for multi-party data access and sharing.

SCOPE	**The initial PHM Program design targets Medi-Cal Managed Care Plans (MCPs)**	**The PHM Service includes programs and infrastructure that extend beyond MCPs**
TIMELINE	**Launched 1/1/2023**	**Launch TBD**

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RSST Purpose and Objective

Purpose

The State of California Department of Health Care Services (DHCS), as part of the Population Health Management (PHM) Program, is implementing a Risk Stratification, Segmentation, and Tiering (RSST) methodology and algorithm, to be built and deployed within the PHM Service to identify members at higher risk and standardize how Medi-Cal members are identified for assessment of needs and connection to services.

Objective

Create a state-wide, transparent, standardized risk scoring mechanism and risk tiers to identify members who may benefit from broader services and interventions and to establish a uniform standard throughout the State of California.

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RSST Design Principles

Design Principles

- Risk tiers must be based not only on medical or behavioral health risk, but also social risk and importantly must consider underutilization of services
- Must reduce bias and promote equity with goal of improving disparities; equity goals may be addressed separately from risk estimation
- Must be transparent and informed with stakeholder feedback
- Must be a state-wide, transparent, standardized risk scoring algorithm
- Risk tiers identify members who may benefit from broader services and interventions; MCPs are obligated to conduct a more complete assessment of members in the highest risk tier
- Must be designed with an eye towards monitoring risk tiering goals and the ability to update algorithms and tiering methodology over time; Collect MCP input on new risk tiering policies (e.g., barriers to identifying the right intervention) and member feedback

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The RSST Work Group is charged with developing the RSST contextual design and approach of the algorithm

RSST Work Group Members		
Name	Title	Organization
Maya Petersen (*Lead*)	Professor, Biostatistics and Epidemiology	UC Berkeley
Jonathan Kolstad	Assoc. Professor, Economic Analysis and Policy	UC Berkeley
Michael Barnett	Assoc. Professor, Health Policy and Management	Harvard
Alejandro Schuler	Asst. Professor, Biostatistics	UC Berkeley
Jacob Wallace	Asst. Professor, Public Health (Health Policy)	Yale
Anna Zink	Principal Researcher	Chicago Booth (Center for Applied AI)

The RSST WG is comprised of nationally recognized experts in risk identification, algorithmic design, algorithmic bias, and health services research.

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This work is further supported by a Scientific Advisory Council (SciAC) that includes a broader set of stakeholders (e.g., Managed Care Plans, health care providers).

Scientific Advisory Council Members		
Name	Title	Organization
Belinda Waltman	Director of Analytics Integration	Los Angeles County Department of Health Services
Bhumil Shah	Associate Chief Information Officer	Contra Costa Health Services
Brandon Shelton	Senior Director, Advanced Analytics Lab	Los Angeles Care Health Plan
Danielle Oryn	Chief Medical Officer/Chief Medical Informatics Officer	Petaluma Health Center, Federally Qualified Health Center
Dejene Bikila	Lead Data Scientist	Partnership HealthPlan of California
Frank Song	Senior Director, Healthcare Informatics	Inland Empire Health Plan
Michael Crawford	Vice President, Analytics	Health Net
Neil Wenger	Professor, General Internal Medicine and Health Services Research	University of California, Los Angeles
Parag Agnihotri	Chief Medical Officer of Population Health Services	University of California, San Diego
Anand Shah	Vice President, Social Health	Kaiser Permanente

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Algorithm Contextual Design

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The goal of the RSST algorithm is to identify Medi-Cal members who would benefit from an assessment conducted by their Managed Care Plan

Medi-Cal Population → Algorithm → Risk Tiers

- Low Risk
- Medium-Rising Risk
- **High Risk**

MCPs will be required to conduct an assessment on all members tiered into the "high risk" category per PHM Policy.

Note: The risk tier categories shown are subject to change.

In the context of the RSST algorithm, risk is the likelihood of a negative health event or outcome occurring to an individual.

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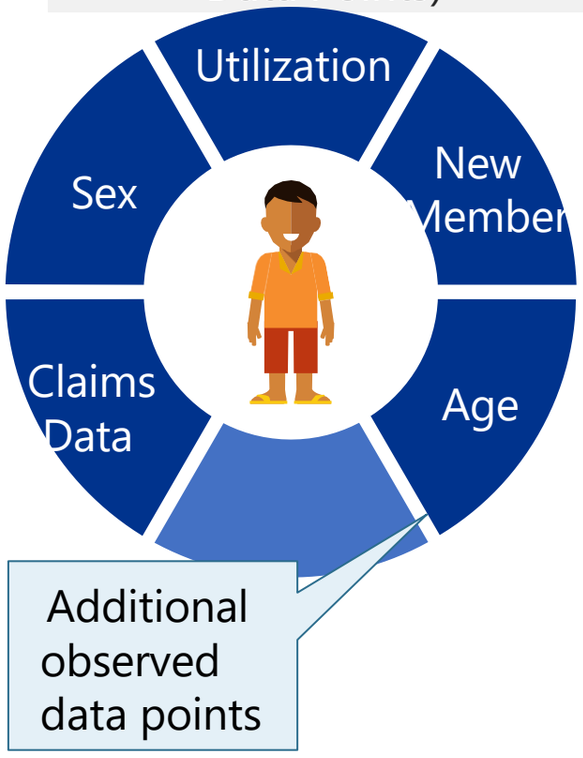
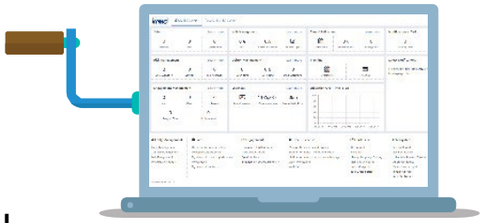
The algorithm will use an individuals observed past data points and provide a risk estimate of a bad outcome within a sub-domain in the next 12 months

Medi-Cal Member Predictor Variable Snapshot (Observed Data Points)



Additional observed data points

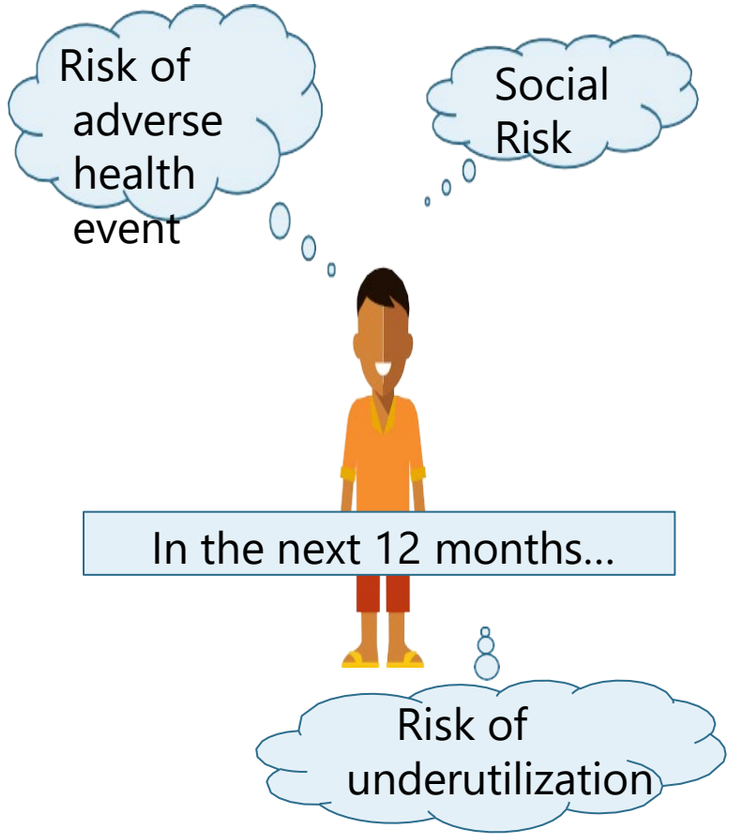
Note: The examples of outcome measures and predictor variables are not comprehensive and only a selection.



Algorithm

Machine learning will use the identified predictor variable data sources to predict the risk of an adverse health outcome

Risk Tier (Adverse Events / Outcomes)



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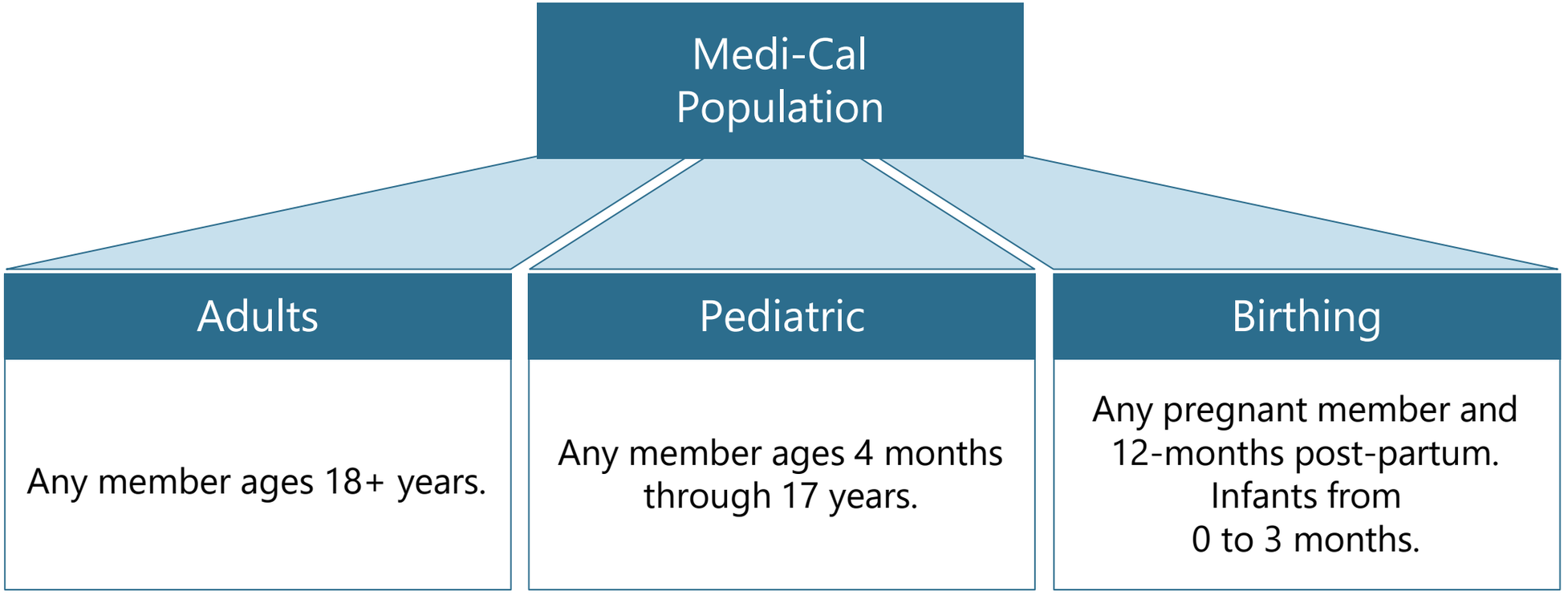
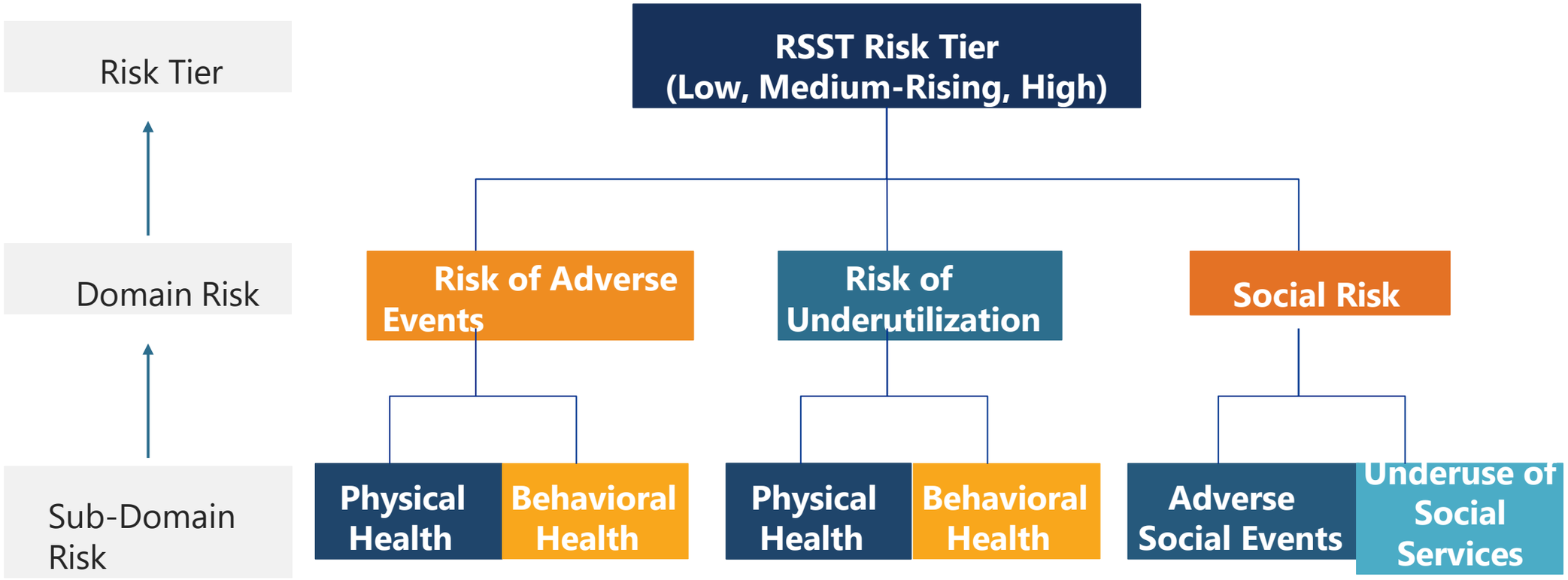
The algorithm will include outcomes and predictor variables for three populations as part of the comprehensive development approach



A comprehensive framework, and whole person approach, was developed to determine a members' risk tier based on their risk score in three domain areas



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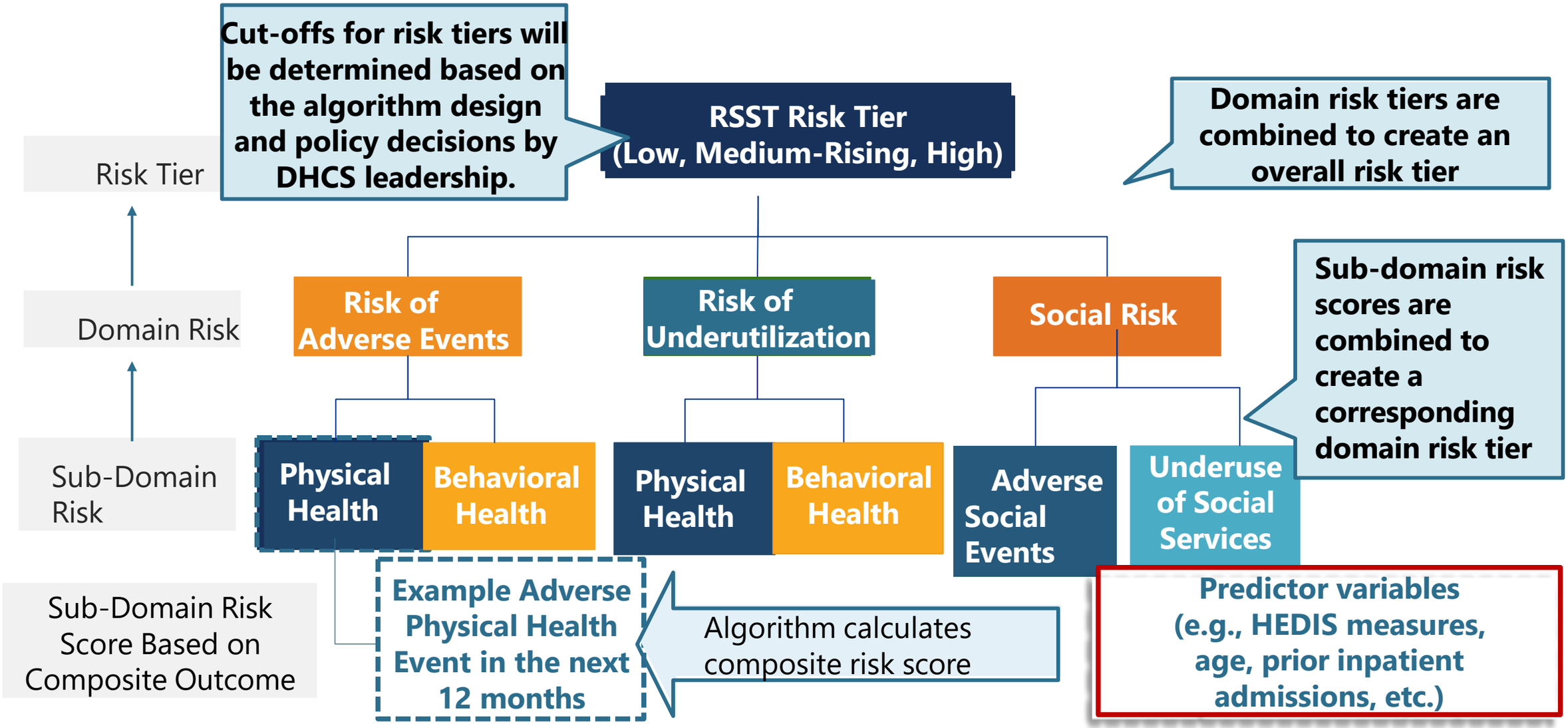
Calculations will occur at each level of the algorithm structure to determine a risk tier for each member



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Approach to Identifying Predictor Variables

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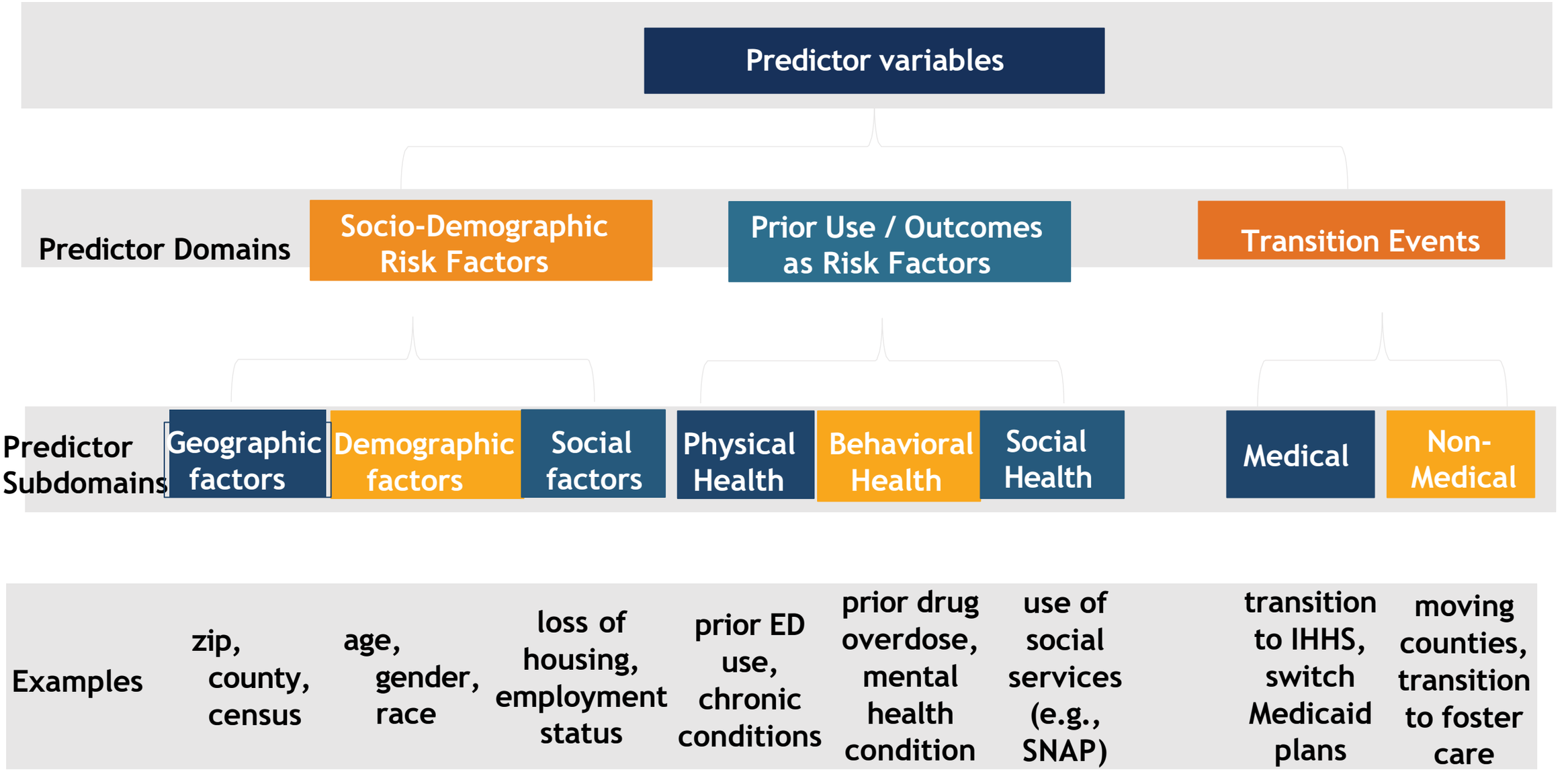
Predictor Domains and Subdomains



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Approach to Identifying Adverse Events / Outcome Measures

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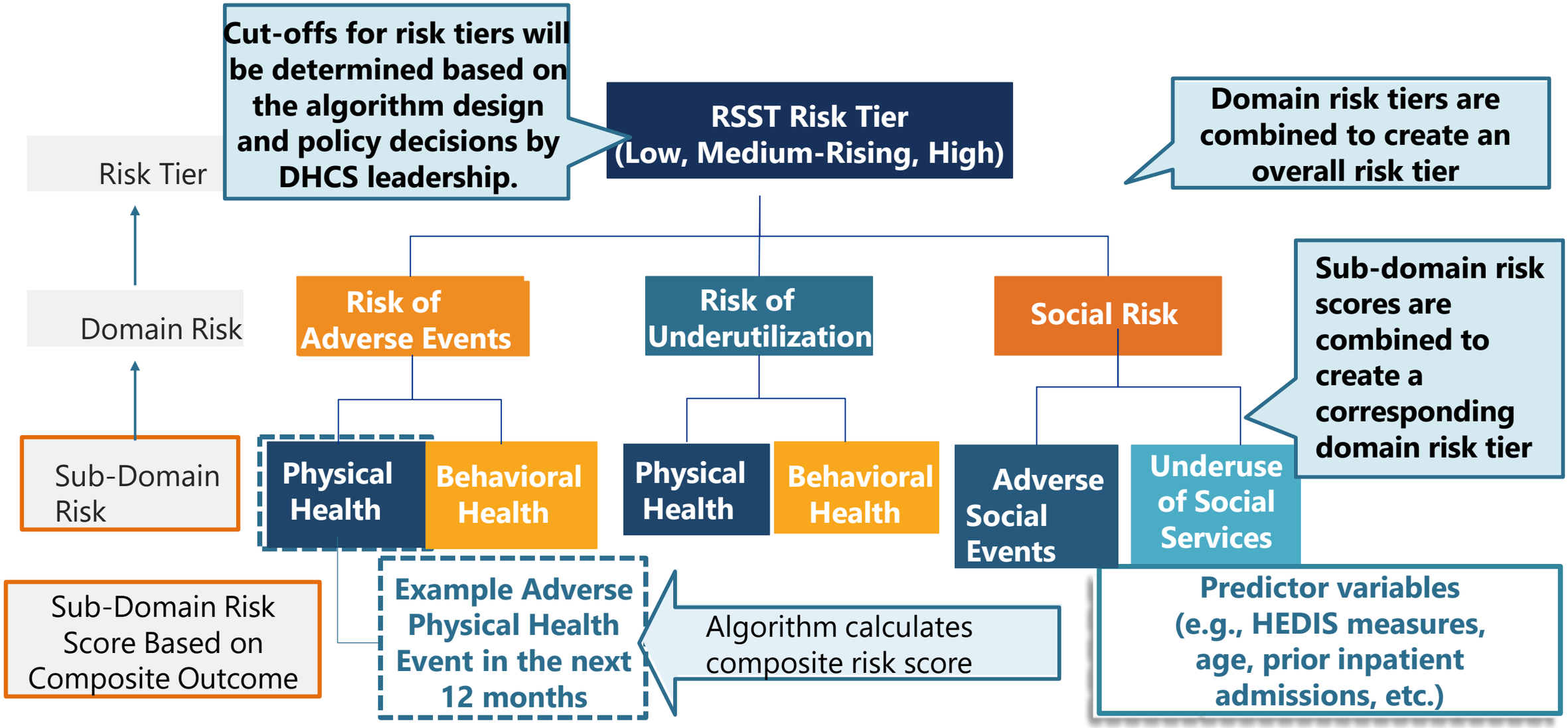
Calculations will occur at each level of the algorithm structure to determine a risk tier for each member



Example of adverse events / outcome measures for each population

Risk of Adverse Events		
Category of Outcomes	Physical Health	Behavioral Health
Utilization	**Adults**: All cause inpatient admissions **Pediatric**: ED visit **Birthing**: Postpartum admission	**Adults**: Psychiatric ED visit **Pediatric**: Substance Use Disorder admission **Birthing**: Psychiatric admission
Adverse Events	**Adults**: Mortality **Pediatric**: Fracture **Birthing**: Emergency c-section	**Adults**: Suicide attempt **Pediatric**: Drug overdose **Birthing**: neonatal abstinence syndrome
Morbidity	**Adults**: Multimorbidity (Charlson Comorbidity Index) **Pediatric**: New diagnosis of common chronic illness (e.g., asthma) **Birthing**: Severe fetal outcomes	

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Example of adverse events / outcome measures for each population

Risk of Underutilization		
Category of Outcomes	Physical Health	Behavioral Health
Outpatient Care	**Adults**: Primary care preventive visit **Pediatric**: Topical Fluoride **Birthing**: Doula services	**Adults**: PCP visit with BH diagnosis **Pediatric**: Mental health specialist visit **Birthing**: Mental health outpatient visit
Screening/ Prevention	**Adults**: Cancer screening receipt **Pediatric**: Lead screening **Birthing**: Prenatal vaccination	**Adults**: Depression screening **Pediatric**: Antipsychotic metabolic monitoring **Birthing**: Pre-natal depression screening
Appropriate Treatments	**Adults**: Diabetes pharmacotherapy **Pediatric**: Asthma Medication Ratio **Birthing**: Continuation of appropriate prenatal chronic medications	**Adults**: Antidepressant medication management **Pediatric**: ADHD follow-up care **Birthing**: Continued OUD treatment

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Example of adverse events / outcome measures for each population

Social Risk		
Category of Outcomes	Adverse Events	Underuse
Individual	**Adults**: Housing instability **Pediatric**: Foster care **Birthing**: Incarceration	**Adults**: CalFresh **Pediatric**: WIC **Birthing**: WIC
Family	**Adults**: *TBD* **Pediatric**: Family member incarcerated **Birthing**: Infant in Foster Care	**Adults**: *TBD* **Pediatric**: *TBD* **Birthing**: *TBD*
Community	**Adults**: *TBD* **Pediatric**: *TBD* **Birthing**: *TBD*	**Adults**: *TBD* **Pediatric**: *TBD* **Birthing**: *TBD*

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Questions?

- PHM Advisory Group members will receive a follow-up email with detailed predictor variables and outcome measures.
- Please share any feedback to PHMSection@dhcs.ca.gov

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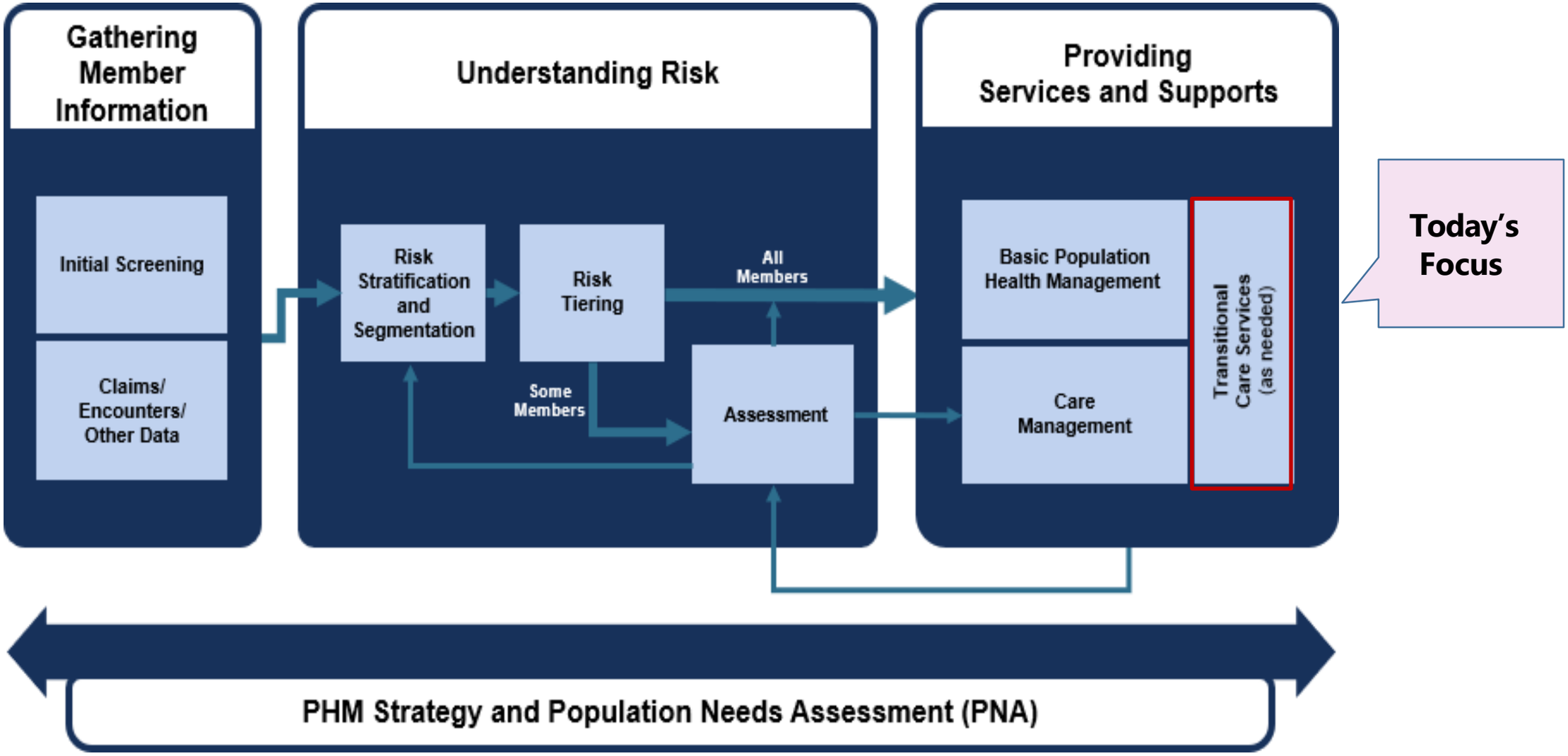
PHM Transitional Care Services:
Policy Updates for Lower-Risk Members and Clarifications for High-Risk Members

Pre-Decisional

PHM Program Framework



Reminder: Overview of Transitional Care Services

Care Transitions Definition:
When a member **transfers 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; to home or community-based settings, Community Supports, post-acute care facilities, or long-term care settings.

Goals for Transitional Care

- ✓ Members can transition to the **least restrictive level of care that meets their needs and is aligned with their preferences** in a timely manner without interruptions in care.
- ✓ Members receive the **needed support and coordination to have a safe and secure transition** with the least burden on the Member as possible.
- ✓ Members continue to have the **needed support and connections to services that make them successful in their new environment**.

Current Guidance on TCS published in December 2022

Pre-Decisional

The PHM Policy Guide currently lays out the following phased approach to TCS:

By 1/1/23	• MCPs must ensure **all transitional care services are complete (including having a care manager/single point of contact[1]) for all high-risk members**.[2] • MCPs must implement **timely prior authorizations,** including assisting with in-network placement (if necessary), and **know when members are admitted, discharged or transferred for all members.**
By 1/1/24 ★	• MCPs are required to ensure **all transitional care services are complete for all members**. As noted in the PHM Policy Guide, MCPs are strongly encouraged to contract with hospitals, Accountable Care Organizations, PCP groups, or other entities to provide transitional care services, particularly for lower- and medium-rising- risk members.

1. *For dual-eligible individuals enrolled in Medicare Medi-Cal Plans (MMPs) or other Dual-Eligible Special Needs Plans (D-SNPs) as per PHM policy guide, the D-SNP is responsible for all TCS and the MCP is not responsible for assigning a care manager or ensuring the care manager tasks are complete.*
2. *High risk members are defined as any population listed under Section D. Understanding Risk, 2) Assessment to Understand Member Needs Section of the PHM Policy Guide*

Updated TCS Approach for CY 2024 and 2025

Pre-Decisional

MCP Feedback:

DHCS received feedback directly and through the TCS survey from MCPs, **requesting policy changes and further guidance for TCS** for the implementation period beginning 1/1/2024. MCPs generally requested:

- For lower risk members, remove the single point of contact requirement and tailor the TCS requirements differently than for higher risk members.
- Clarify the roles of discharging facilities, specifically around expectations on what aspects of the discharge planning and discharge risk assessment should be done by discharging facilities vs. the plan, as well how facilities, plans, and providers are expected to work together.

DHCS Response:

DHCS acknowledges the practical challenges and resource needs of TCS implementation on the ground. Based on MCP feedback, DHCS is:

- **Clarifying the TCS requirements for high-risk populations** related to discharge planning and discharge risk assessment in the 2024 MCP Contract to better align with federal and state requirements.
- Revising the TCS policy for 2024 and 2025 to articulate a **model for transitional care services delivered to lower risk members** that continues to provide member-centered transitional care support, while removing the single point of contact requirement for these lower risk members. The logic of the change is to:
  - Emphasize existing requirements on hospitals regarding discharge planning and discharge risk assessment.
  - Impose a clear but less staff-heavy requirement for an MCP telephonic team that is available to all transitioning members for 30 days to support members' transitional care needs.
  - Emphasize PCP/ambulatory follow up within 30 days.

***Modifications* for Lower-Risk Members 2024 – 25 (Slide 1/3)**

General MCP Requirements			
Knowing when a member is Admitted/Discharged/Transferred (A/D/T)			
Processing Prior Authorizations in a Timely Manner and when possible, prior to discharge. This includes assisting with in-network placement, if necessary.			
Identifying members that belong to the high risk and the lower risk group for transitional services			
Current Requirements ~~(No Change)~~	**Responsible Entity**	**Lower-Risk Members Transitioning (Modification)**	**Responsible Entity**
Assigning/Notifying a Single Point of Contact/Care Manager	MCP	**MCP Dedicated Team/Phone Number for Member Contact:** MCP must ensure transitioning members have a dedicated number to call to connect to a dedicated TCS team who can access discharge documents, if needed. The MCP must directly notify transitioning members of this dedicated team and how to contact them, via text messaging or other modalities.	MCP/Delegate

Modifications for Lower-Risk Members 2024 – 25 (Slide 2/3)

Current Requirements ~~(No Change)~~	**Responsible Entity**	**Lower-Risk Members Transitioning (Modification)**	**Responsible Entity**
Discharge Risk Assessment: Coordination with the discharging facility **Discharge Planning Document** Ensuring sharing with patient, PCP, and other providers, coordinated with discharging facility	Care Manager	**Facility's Discharging Planning Process Fulfills Requirement:** MCPs must oversee and ensure facilities complete a discharge planning process in accordance to federal and state requirements. The facility must also be able to identify members who may benefit from TCS services based on their risks and refer members to the MCP for high- risk TCS or ECM or Community Supports. For high-risk TCS referrals, MCP must consider that member in the TCS high risk pathway. Facilities are responsible for conducting discharge planning activities but MCPs are ultimately accountable to ensure all activities are complete.	Discharging Facility

Modifications for Lower-Risk Members 2024 – 25 (Slide 3/3)

Current Requirements ~~(No Change)~~	Responsible Entity	Lower-Risk Members Transitioning (Modification)	Responsible Entity
Follow Up Ensuring follow-up doctor appointments/ medication reconciliation/referrals are complete	Care Manager	**PCP/Ambulatory Visit Fulfills Follow Up Requirements.** MCP must ensure ambulatory follow up appointment with physician or physician-affiliate (NP, PA) is completed within 30 days, for necessary post-discharge care and services, such as medication reconciliation.	MCP/Delegate
End Services or Continue/Enroll in Longer Term Care Management/Community Supports		**End Services/Enrollment in Care Management Programs:** MCPs must continue to offer TCS support through dedicated telephonic team for at least 30 days post-discharge. In addition to accepting referrals to longer term care management at any point, MCPs must use data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or Community Supports.	MCP/Delegate

Discussion Question

Effective TCS implementation requires close collaboration across various healthcare stakeholders. What type of technical assistance from DHCS will be helpful to support the launch of TCS for all members in 2024?

Next Steps

- **PHM Policy Guide Update:** DHCS will publish the updated PHM Policy Guide with revised TCS policy in October.
  - This latest PHM Policy Guide will include policy revisions for lower-risk members as well as clarifications for the high-risk populations.
- **MCP Contract Amendment A:** The latest TCS Policy will be reflected in the 2024 MCP Contract Amendment A.