Compiled Population Health Management Workgroup Comments (Summarized) and DHCS Responses

Updated: January 16, 2020

Topic: Risk Stratification

Comment	DHCS Response
Allow plans flexibility when determining risk stratification for low, rising, and high-risk categories after requiring health plans to look at specific data sources. Related Comments: • DHCS should specify data element areas but allow plans to choose a validated risk stratification tool. • Recommend that the state allow the plans to use a well-established Medicaid Risk Adjustment model such as CDPS and incorporate other data element categories that are recommended from DHCS.	DHCS plans to standardize the criteria that define the lines between low/medium and medium/high similar to what is done with the SPD high/low risk criteria. MCPs would have to assign the tier using the specified minimum data and report the tier to DHCS. MCPs must also risk stratify their populations and segment them to match services to needs, but MCPs would be able to use their own methods for these activities rather than mapping to DHCS criteria for low/medium/high.
Recommended Data sources: • Age and gender • List of specific diagnosis • Zip code of the individuals • Medications/prescriptions • Past encounter utilization • Social determinants of health. (when available) • ED visits • Disengaged member reports	DHCS will consider for the mandatory minimum data list and template question(s).
Encourage use of SDOH data (e.g., use of ICD-10 codes) but do not mandate given the significant difficulties collecting and analyzing that data. Recommend that DHCS issue guidance as to how to define those indicators (when used), especially if DHCS intends to benchmark and/or ensure transferability.	DHCS has some incentives for providers currently in this area, such as ICD-10 coding for housing stability and may consider more – as well as a learning collaborative focus. The ICD-10 information will be incomplete, but some information will also come from other sources, such as screening questions and demographic data.
It would be difficult to use SDOH data to risk stratify the newly enrolled membership based on the information we currently receive from the state.	The screening tool may assist with SDOH. DHCS is working to improve the format of the data transfer to MCPs.

Comment	DHCS Response
Algorithms: • Collect (and consider publishing) information about the algorithms that plans will use to stratify risk; • Require plans to run test cases to validate their algorithms; • Ensure that all plans are receiving comparable results through their algorithms across the state; • Monitor algorithms to ensure they do not exacerbate biases; • Algorithms should be based on health conditions, risk factors, and disease. progressions rather than just utilization which is not an accurate measure of health risk for communities of color and vulnerable communities who are less likely to utilize care.	DHCS can do this for the DHCS-specified four tiers, but many MCP risk stratification tools will be proprietary so there will not be transparency of the internal algorithm. The minimum data sources will be a DHCS requirement so that will be transparent. But DHCS included several requirements in the proposal and template to address these issues.
Ensure stratification is aligned with interventions: • Differentiate between risk prediction for risk adjustment/rate setting purposes and risk stratification/segmentation for intervention purposes. Statewide stratification will not be useful for risk prediction purposes unless health delivery resources/assets are uniform across the state. • Focus on segmentation and risk stratification within segments to align with selected interventions to achieve desired outcomes for those segments. • Align the population you identify in a segment with specific interventions that are likely to achieve the desired outcomes in the time frame you want to achieve them.	DHCS believes we have addressed these issues in the proposal and PHMS template.
DHCS should work with plans to develop mechanisms that would allow them to obtain and analyze the data they need to	This will be a Learning Collaborative focus.

Comment	DHCS Response
understand member risk and individual needs.	
Risk should not change when people move from plan to plan. Ensure that individual plan risk stratification programs do not yield widely different results.	DHCS will explore a process to check for this.
Risk stratification should align with DHCS' Quality and Disparities data on access and health outcomes, but also larger population trends.	We believe we have addressed this through our connection of the Population Needs Assessment and the NCQA population assessment to the development of the MCP's individual stratification and segmentation strategy – and through the corresponding PHMS template questions.
Institute a process to revise and refine the requirements around risk assessment and stratification as we learn more, both from external research that is being done, and from California's experience.	We will do this through the PHMS periodic resubmission requirements and the learning collaborative.
Comments on Existing Stratification Tools: • Validated tools like ACG or plan internally created algorithms work well for initial risk stratification using typical data elements but are typically black boxes; • CRG (used by North Carolina and Denver Health) may have slightly higher utility because the modeling approach risk stratifies within clinical groups. Denver Health uses CRG to create categories of risk stratification by disease state, then adds in "tiers" based on utilization, cost, etc.	Noted.
Use 'emerging risk' or 'rising' rather than medium risk or use four tiers consistent with NCQA. Medi-Cal beneficiaries are not low risk by virtue of their economic status and should be reassessed annually.	The NCQA groups are four specific focus groups that must be addressed as part of the PHM strategy, but our purpose is identify risk on some scale of low to high. DHCS will incorporate criteria relating to the rising and emerging risk into the "medium" category and ask MCPs how they plan to address the emerging risk group.

Comment	DHCS Response
Engage a health equity expert to review the specifications it provides to plans on their processes for risk assessment and stratification to ensure that it does not replicate or exacerbate disparities.	DHCS built in several measures into the proposal and template to address these issues, but we will also continue to consider involving a health equity expert.
Barriers include inadequate encounter data (claims data is generally good if FFS event) particularly from PCPs, lack of direct EHR clinical data, inadequate use of a valid stratification tool, and lack of access to county BH data.	DHCS is working to improve these issues through the proposal requirements and other means.
If DHCS allows plans to use their own risk stratification methodology, which allows for flexibility and reduced burden, then compiling each plan's three risk categories will be difficult because of variance in the models. Will need to be footnoted that each plan's risk stratification slightly varies. DHCS could create their own technical specifications for high, medium and low risk and take raw data from the plans to create statewide risk categories. Generally, DHCS should define risk stratification categories carefully.	See previous responses on this topic.
Request additional time for plans to complete initial assessments for existing members.	DHCS will allow plans time to complete initial assessments under the new process for existing members; likely spread over a year, according to the anniversary of the member's enrollment date.
Regarding initial assessments, will all aid categories be required or will certain ones (e.g., CCI members) be excluded?	All, except Cal MediConnect (CMC) members.
Is annual reassessment of risk required, and if so, for whom?	Yes, for all. See the proposal for requirements.
It would be helpful to better understand how the State intends to use the results of the statewide analysis [the four risk tiers]. Will health plans (and, in turn, some providers) be held accountable for shifting a specific portion of patients from higher to lower risk tiers? If so, will there	DHCS will use the reported four tier information for internal analysis, and will also provide the reported tier to the new MCP when a member transfers from one MCP to another. DHCS has no intent at this time to engage in the specific activities that are listed in the question.

Comment	DHCS Response
be associated penalties or incentives? Will the statewide analysis be used in any way to change benefits, for example to assess the success of enhanced care management and/or in-lieu-of-services? There could be significant decisions tied to the analysis, so it is important to be clear about how it will be used and how it is limited, and to establish a realistic timeline to demonstrate improvements.	

Topic: Member Assessment/ Contact Survey

Comment	DHCS Response
Implement a standardized member contact survey that is reasonably short in length and includes questions on: • Activities of daily living • Functional limitations • Housing status • SDOH. Questions on SDOH should be based on an existing validated standard, such as the Accountable Communities for Health (ACH) • A self-assessment of health status • Desire or not for CM assistance. • Caregiver assistance • Level of engagement with PCP • Need for assistance with LTSS • Geography (hot-spotting) Recommend required sections be included in the assessment at the plan level and allowing plans flexibility of adding additional questions to reflect regional experience.	DHCS will consider these recommendations and is also looking at MCP and WPC pilot examples. DHCS intends to standardize a single MCP-level risk assessment set of questions (10-15 questions). MCPs would be able to add questions at their discretion.
Standardization should be set on core sets of determinants/risk factors, not what specific tool is utilized, and the core sets	See comments above on this topic.

Comment	DHCS Response
that are required should be consistent across various product lines. The results of the assessments should inform the population analysis and risk stratification, as well as populate various systems across the continuum, so that patients do not receive the questions from different venues over and over again.	
Screening tool should include branching, risk stratification, and actionable items: • Branching logic would allow for brief, high-level questions that lead to more detailed questions if any are positive. This will help prevent assessment fatigue; • Screening question responses should be weighted and ideally contribute to a risk stratification framework; Positive screening questions should include a clear workflow with action steps and a communication plan for accountable team members, ideally in a shared care plan.	This aligns with our intent for the tool and could also be a learning collaborative focus.
Recognize that despite best efforts, some members cannot be reached or will not engage in the risk assessment process. Request that individual care plans not be required for non-engaged members.	This is understood. Individual care plans would not be required for non-engaged members. A thorough process for attempting to engage medium and high risk members will be required.
Comments on Role of Providers: • Risk Assessment should include and be shared with providers, hospitals. • Consider a standardized provider assessment statewide. • Providers should be reimbursed for screenings & trained to conduct them. • Providers are closest to patients and best-positioned to build the trust necessary to ask sensitive questions about health and social needs.	DHCS will continue to consider where these comments fit into the process. DHCS does not plan to not have provider-level requirements for a standardized assessment. The IRA is intended as an initial MCP-level risk assessment tool and will remain an MCP responsibility. There are multiple modalities that MCPs may use to get the information. MCPs may incorporate providers into the process at the MCP's discretion. This will be a focus of the learning collaborative.

Comment	DHCS Response
• Social determinants assessment should happen at the provider level in the primary care setting. • If provider assessments are incorporated, it would be important to have alignment in the consistency in required data elements and how these data are collected between various plans within a county/region.	
Risk assessment should not interfere with plans' other legal obligations and ensure that all beneficiaries are informed about the benefits available to them under the plan.	Agreed.
These models to varying extents seem to assume that "high utilization" or "high disclosure of information" by patients means "high risk." But we know that the opposite is often true. It's important to ensure that MCPs are identifying consumers who are living below the safety-net (i.e. underground).	DHCS build several measures into the proposal and template to address this issue.
Account for the member contact survey's ability to change the member's level of risk.	DHCS is accounting for this in the model.
Information should be transmitted in a usable format.	Noted.
Opposing comments on Scope of Survey • A member-contact assessment is not necessary if administrative data shows that the member is healthy/very low-risk. Administering an assessment to healthy members will create additional burden without providing actionable information. Vs. • All members should receive a member-contact survey.	DHCS is not planning to require a screening for the low risk group. There is a focus on reasonable efforts for the medium and high risk groups.

Comment	DHCS Response
Phone-based surveys/assessments performed by MCPs will exacerbate disparities in patients without a phone or that are non-English speaking. This must be accounted for in systematic models, and the wrong approach could worsen health inequities.	DHCS will address this through the PHMS template and learning collaborative.
Telephonic or remote completion should be a criteria for vetting and approving standardized survey questions.	Agreed.

Topic: Alignment with NCQA

Comment	DHCS Response
NCQA Alignment • Coordinate with NCQA to avoid differences of interpretation on specific standards and reporting requirements. Tie requirements to the NCQA timeline.	DHCS will continue more detailed analysis with NCQA to ensure alignment. See the proposal for our proposed timelines.

Topic: Alignment with PNA

Comment	DHCS Response
The PNA and the proposed PHM strategy should be complementary and not duplicative. The PNA should be an overall assessment of the entire population in the plan and community needs and challenges, versus the more specific and detailed risk assessment and member contact survey information required by the PHM strategy.	Agreed. See the description of the interaction in the proposal.
Require MCPs to produce more granular population data collection and analysis on race, ethnicity, language, functional disabilities, sex, sexual orientation and gender identity and develop plans to address identified disparities similar to DHCS' efforts in PRIME.	See the measures we built into the proposal and template on this issue.
Building off of the PNA strategy, strongly encourage pilot of a regional approach to population health management in areas with high Medicaid eligibility, by requiring	We will continue to review the CACHI projects, particularly for learning collaborative opportunities.

Comment	DHCS Response
or encouraging MCPs to form partnerships with local public health departments, providers and CBOs/CHWs to address and improve regional variation in health outcomes including through the provision of non-medical services. This pilot project could build off-of the successful, multi-payer California Accountable Communities for Health Initiative (CACHI) pilot projects, developed in collaboration with CDPH/OHE and local health departments.	
Consideration should be made for deeming of plans for both the PNA and PHM requirements if the plan is NCQA Accredited and has passed that section upon NCQA review.	We will consider this as we continue a more detailed review of NCQA alignment with the DHCS requirements.

Topic: Data Sharing

Comment	DHCS Response
Data sharing between MCPs and provider entities should leverage existing systems and ongoing efforts, such as the utilization of HIEs. Eliminate the need for duplicate entry of information into multiple systems.	DHCS may include this as a focus for the learning collaborative and on the PHMS template.
Incentive programs should be constructed to support such data sharing/integration efforts for health plan, counties, community providers, reentry partners, hospitals, etc. Counties hold a lot of key data elements that MCPs do not have.	DHCS will support this effort by: • Improving the usability of the fee-for-service behavioral health data that DHCS provides to MCPs; • Exploring guidance and state law to allow data transfer; and • Operating a learning collaborative that includes these topics.
MCPs are well situated to manage the creation and/or maintenance of a searchable database for community resources.	DHCS will include a template question and learning collaborative focus.
MCPs and BH plans have yet to develop adequate beneficiary data sharing arrangements to achieve even basic	DHCS has efforts underway to make progress on data sharing between MCP and MHPs and other providers for care

Comment	DHCS Response
goals, such as identifying shared beneficiaries. With the development of population health management programs, CalAIM provides the state with an opportunity to facilitate the kind of basic enrollee data sharing, in addition to clinical data sharing, which is necessary to achieve its population health management goals across both systems.	coordination purposes – some without consent, and some with consent. This is being done in conjunction with CalAIM, but it is not in the proposal.

Topic: Data Submission

Comment	DHCS Response
Consider standard formatting, minimum reporting criteria, and incentives for outcomes-based integration.	The PHM proposal will address standard formatting and minimum reporting criteria. DHCS is open to ideas for incentives for outcomes-based integration beyond those currently in place.
Request appropriate transition time and financial consideration to help providers adopt technology systems, administrative changes, and reporting criteria.	DHCS is seeking feedback on the transition times and staging proposed.

Topic: Population-Specific Comments

Comment	DHCS Response
Consider allowing plans flexibility to identify their priority member populations and select focused interventions for these specific patient populations.	Flexibility with necessary standardization is our goal. Certain requirements will be standardized, such as ECM target groups, the IRA survey tool, and the criteria for the four risk tiers reported to DHCS. MCPs will have flexibility to use their own methods - driven by the PHM data and process - to risk stratify their populations and segment them to match services to needs.
Given that approximately 50% of California births are covered by Medi-Cal, pregnant women and newborn children should be identified as a key targeted population for the population health management strategy.	Agreed.

Comment	DHCS Response
Recommend the plan determine which sub-populations are of most concern and should have a special focus, though there could be suggestions regarding special populations (e.g. transgender, HIV, severe functional disability, homeless, pregnant). Challenges exist with the ability to define some sub-populations due to lack of data and ability to identify.	See comments above on this topic.
Some type of focal point for communicable disease, specifically HIV, HCV and STDs, as well as expansion of low threshold harm reduction services supporting effective prevention, treatment and care for people who use substances.	Some type of focal point for communicable disease, specifically HIV, HCV and STDs, as well as expansion of low threshold harm reduction services supporting effective prevention, treatment and care for people who use substances.
How will the proposed changes impact the problem of millions of children in Medi-Cal are not receiving preventive health services, as outlined in an audit of Medi-Cal access for children released in March of this year.	DHCS is responding to this issue through measures that are outside of the PHM proposal, but some measures to address this target group have been built into the proposal and template.

Topic: Outcome Measures/Evaluation/Incentives

Comment	DHCS Response
Adopt outcomes measures that can help assess the quality of the behavioral health services offered within systems, as well as “whole-person” health outcomes for behavioral health clients who also access physical health benefits managed by MCPs.	Continuing areas of DHCS policy development will include a review PHM program outcomes goals and measures, and their relation to the broader DHCS managed care quality metric strategy, which may be used to assess each Medi-Cal managed care plan’s PHM program effectiveness, to create incentives, and to drive program improvements.
Establish consistent metrics to measure the success of plans’ PHMS including health outcome measures, quality measures, and measures of consumer satisfaction. Look for strong, validated public health measures in addition to HEDIS and CAPHS measures.	See previous response.
Build in a regular reporting (set year over year targets like in PRIME) and evaluation of the population health management program.	See previous response.

Comment	DHCS Response
Include monitoring of the underutilization of children's preventive care and establish incentives for plans to bolster this utilization.	See previous response.
Publicly report on plan performance.	See previous response.
Consider standard formatting and incentives for outcomes-based integration, reporting on demographic data, and EHR certification.	See previous response.
Set targets for the adoption of Patient Centered Medical Homes and the use of Community Health Workers to help gather this information.	See previous response.

Topic: Learning Collaborative

Comment	DHCS Response
Recommend the operation of state-level PHM learning collaborative for MCPs to address specific populations including children, women, older adults, rural members, etc.	Agreed.
Invite researchers including NCQA and experts in survey and demographic data collection/reporting to advise on PHM tools, identifying barriers and best practices to risk assessment, stratification, and appropriate interventions. These meetings should be open to other interested stakeholders as appropriate including representatives from Covered CA and CalPERS, CHHS, CDPH/OHE, consumer groups and CHWs.	We will include methods for stakeholders and various experts and entities to engage with the MCP PHM learning collaborative, and we agree with the suggested topics.
Consider how cost-effective, innovative dual-generation services such as evidence-based home visiting Centering Pregnancy, and the Comprehensive Perinatal Services Program (CPSP) could be incentivized and scaled through CalAIM.	We will add this to the learning collaborative issue list.

Topic: Implementation Timeline

Comment	DHCS Response
Suggest a more intentional timeline and staging of MCP implementation for the various elements of the proposed PHM MCP requirements, with consideration of other requirements within the larger CalAIM proposal.	DHCS intends to stage the implementation of the new risk screening tool and tier reporting to occur late in 2021. DHCS understands that Non-NCQA MCPs may need more time to implement the NCQA PHM requirements. DHCS is taking any other detailed suggestions on staging.
Consider that providers need to develop PHM infrastructure and it will take time before plans and providers can meet DHCS expectations for performance.	Understood.

Topic: Contract/MOU Requirements

Comment	DHCS Response
It is not clear that a contractual requirement will resolve concerns regarding disparities.	We are open to other suggestions.
Should require MCPs to consult with their county BH plan in the development of the population health management program as it relates to beneficiaries with co-occurring SMI and SUD needs.	This is included in the PHMS template.

Topic: Other

Comment	DHCS Response
DHCS should explicitly include dental care coordination within the Enhanced Care Management component of the CalAIM proposal, and how it is connected with the risk stratification proposal.	Dental care is included in the PHM proposal and template. The ECM comments should be addressed to the ECM workgroup.
DHCS should consider requiring medical managed care plans to use CRA results to ensure that children ages 0 to 6 determined to be at ‘moderate’ or ‘high’ risk of caries development receive robust dental care coordination services as described above.	This could be a learning collaborative topic.
Make PHMS of each plan publicly available on the DHCS website.	DHCS will consider this. Currently certain parts of the strategy relating to the risk

Comment	DHCS Response
	stratification process are intended to be posted for public viewing.
The state plan should expect MCPs to delegate PHM functions to provider entities, when in fact the provider entity can demonstrate capacity and infrastructure to execute a PHM plan for their population of patients.	Noted. There are many types of PHM functions and many are intended to be performed by providers, such as ECM and other direct interventions.