Population Health Management Workgroup
Discussion Questions
12/3/19

Risk Stratification

For this discussion, please review the risk stratification requirements on pages 27 of the CalAIM Proposal, in Section 2.1 Population Health Management Program. The proposal requires that MCPs risk stratify and segment their populations. This stratification will drive targeted health improvement activities for the various segments of the population.

1. What are your recommendations for how the MCP risk stratification requirements should be designed regarding standardization versus flexibility, maximizing effectiveness, and minimizing the administrative burden?

2. Where do we invest the most effort and how do we define populations within the tiers in order to ensure that we're making an impact from a total population health perspective?

3. The proposal also requires MCPs to stratify members into low, medium, and high risk and report this data to DHCS to enable statewide stratification. What are recommendations for maximizing the usefulness and avoiding challenges?

4. What have been the health plan, and others, experiences with specific tools (e.g. ACG) or standardized methodologies for risk stratification?

5. What have plans found to be the essential data elements/sources effective risk-stratification?

6. How can risk stratification be designed to support the identification and segmentation of people who need specific interventions, such as Enhanced Care Management, Long Term Supports and Services, wellness and prevention, and others?

7. Given the challenges associated with collecting and analyzing social determinants data, to what extent should DHCS specify the SDOH data to be collected and incorporated into the MCP-level initial and ongoing risk assessment and stratification? What SDOH data are plans using for risk stratification now,

including sources and types of data? What SDOH data should be a standard statewide requirement for this process, rather than being left as an option? How specific should DHCS be in terms of what is collected and how? Should DHCS require the collection of SDOH via ICD-10 data? (For reference, see pages 10 and 11 in the Institute for Medicaid Innovation report "Innovation and Opportunities to Address Social Determinants of Health in Medicaid Managed Care.")

8. What contractual requirements may be needed to help avoid exacerbation of disparities and to promote health equity in the risk stratification process?

Initial and Ongoing MCP-level Member Risk Assessment

For this discussion, please review the assessment requirements on pages 25 and 26 of the CalAIM Proposal, in Section 2.1 Population Health Management Program. For this initial and ongoing member assessment, the proposal requires the MCP to use two sources: 1) data collected via administrative sources; and 2) information from a member-contact assessment.

1. Which administrative data sources are essential to assess member population health overall and support effective risk assessment? What are notable barriers to these sources? Are there other sources that may not be universally feasible but should be encouraged?

2. If the administrative data assessment shows no risk indicators (very low risk), is a member-contact assessment necessary for these members for the initial assessment or the annual reassessment? It is assumed that if the MCP has no administrative data for the member, then a member-contact assessment would be needed.

3. In what contexts are the member-contact assessment's information most useful for risk stratification and identification of member needs? Are plans using member-contact data for risk stratification or is it most useful after and administrative data risk stratification and in care management contexts?

4. What data should be collected via the member-contact assessment? What elements are essential for health plan to collect (as opposed to providers)?

5. Should there be a standardized member-contact assessment survey, reflecting common health priorities, culturally competency and social determinants factors? If so, what elements are essential? If not, are there guiding principles for the member-contact assessment that DHCS should include in its contracts? Are there parts of the member-contact assessment that should be flexible?

6. How should the current DHCS MCP All Plan Letter requirements for the Population Needs Assessment (PNA) interact with the CalAIM PHM proposal's initial and ongoing MCP-level member risk assessment requirements, including the community components and consumer voice that are built into the PNA?

7. Regarding the proposal's initial and ongoing MCP-level member risk assessment requirements, are there specific priority populations, conditions, or health issues that should be specified for analysis in the MCP contracts?