Population Health Management

02.11.2020 Meeting Summary

The Department of Health Care Services (DHCS) held the fourth and final California Advancing and Innovating Medi-Cal (CalAIM) Population Health Management workgroup meeting on Tuesday, February 11th.

The meeting was attended by DHCS staff, workgroup members, and members of the public. Jennifer Ryan from Harbage Consulting facilitated the meeting and Brian Hansen was the lead presenter for DHCS.

This meeting focused on the changes DHCS has made to the Population Health Management Strategy proposal based on Workgroup discussions and feedback, the Population Health Management Template Discussion Guide, and the next steps regarding the CalAIM proposal. A full agenda can be found here.

Discussion Summary

At the start of the meeting, DHCS updated the Workgroup about the discontinuation of the annual health plan open enrollment proposal within CalAIM initiative. DHCS also announced that the effective date for implementation of the Population Health Management Strategy has been pushed back to January 1, 2022, in order to enable Medi-Cal health plans to focus their resources on preparing for the transition to the new enhanced care management benefit.

DHCS then presented on the feedback the Department received from the Workgroup on the proposal and how that feedback had been incorporated, or not, into the final proposal. Workgroup members appreciated DHCS' inclusion of workgroup feedback into the proposal. Below is a summary of the discussion (see slides here):

Data, Risk Stratification, and Segmentation: DHCS recognizes the importance of developing the right tools and algorithms and it is allowing plans more time to make necessary changes by postponing implementation of the Population Health Management requirements until January 2022.

- When discussing population health data, Workgroup members asked for clarification on the development of appropriate algorithms and expectations around the international classification of diseases (ICD) 10 coding. DHCS explained that coding will not be an immediate requirement but will be phased in.

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- Workgroup members discussed the desire for a universal electronic health record (EHR) system to help with cross-plan and county data sharing was had among workgroup members.
- DHCS noted that plans would be able to use the tools and algorithms they have already developed to avoid duplicative work. This raised questions about how the individual algorithms would be used to help inform DHCS of individual risk, to which DHCS responded that it will analyze stratification to make sure people are getting the services they need.

  Workgroup members then asked about the operational role of the algorithms and how they will benefit the members, identify disparities, and whether or not they would improve the health of the members. Workgroup members shared concerns about the ability of an algorithm to meet the needs of members in the low, medium and high-risk tiers and if the definition of each tier would be consistent across plans.

<u>Enhanced Care Management (ECM), In Lieu of Services (ILOS), and Individual Risk Assessment (IRA):</u>

- DHCS provided a brief overview of ECM/ILOS and how it relates to population health management. Workgroup members noted one of the benefits of ECM is the face-to-face interaction members will have, as opposed to phone-based interactions.
- DHCS shared that the current proposal is for the IRA to include 10-15 standard questions to capture general health risks. Workgroup members suggested increasing the number of questions to ensure the right information is captured. Members also shared concerns about the ability to capture risk for the populations that do not complete IRAs. One member suggested incorporating medical, behavioral and social screenings into IRAs to get a better idea of member's total health risk.
- Several workgroup members shared concerns about inaccurate contact information for members, which leads to unsuccessful outreach efforts. DHCS noted that it is currently working to improve patient contact information.

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Continuing Areas of Policy Development and Comments not Incorporated: DHCS touched on the feedback received that was not incorporated into the final proposal.

- During this piece of the discussion, DHCS explained that criteria would need to be standardized around risk levels to enable the categorization of members into low, medium, rising, or high risk high. The categorization will help to determine the level of equity and health risks costs.
- Workgroup members asked which forms will be required or removed from the member enrollment packets plans send to new members.

Other Key Recommendations Adopted by DHCS and Learning Collaborative Activities - presented by Tricia McGinnis, Center for Healthcare Strategies:

- Workgroup members noted the importance of external stakeholders and working collaboratively with public health departments. DHCS explained there will be an expectation for managed care plans to work with public health departments on community health assessments. Several workgroup members asked for clarification on what the department will require in terms of partnerships, and what the involvement of beneficiaries will be.
- Workgroup members also noted the importance of working with valid, reliable assessment tools to accurately assess population health. A number of workgroup members noted that county health departments are already doing needs assessment and would be willing to share the information they have gained through partnerships with the state and MCPs.
- While discussing the development of a population health management learning collaborative, workgroup members asked who the primary audience will be and how topics will be determined. DHCS explained that the learning collaborative would likely be similar to the Whole Person Care (WPC) learning collaborative which includes WPC pilots and their partners and focused on sharing promising practices and addressing implementation challenges. Workgroup members asked for flexibility to tell

the state what they need rather than be provided information that may not be relevant to their needs.

Population Health Management Strategy Template Discussion: Following the discussion of how feedback was incorporated into the final PHM proposal, the workgroup discussed the format for the population health management strategy template. DHCS shared its initial thinking on the types of information that the state would need to collect in a discussion document, found here. After reviewing the document workgroup members raised concerns about the clarification and specificity of the language used in the document. A number of workgroup members were concerned about the MCPs' ability to accurately address the questions and avoid bias if the data they have is poor quality or out of date. Several workgroup members encouraged DHCS to have a five-year goal in mind when developing the template, in order to ensure the core goals of the CalAIM proposals are not lost.

Next steps

As this was the last meeting of the Population Health Management Workgroup, members asked for direction on what comes next. DHCS noted the following next steps:

- Opportunities for continued stakeholder engagement:
  - Final comments from workgroup on PHMS due on February 21, 2020
  - Final comments on the full proposal due on February 29, 2020
  - Quarterly Stakeholder Advisory Committee (SAC) meetings
- Finalization of CalAIM Proposal
  - Workgroup members noted that they would like to see a redlined version of the proposal and a crosswalk to better understand what changes were made to it through the workgroup process.
  - Jennifer Ryan, Harbage Consulting briefly explained the 1115 and 1915(b) waiver submission process with the Centers for Medicare & Medicaid Services (CMS), noting that the proposal in full will not be presented to CMS but will move forward in the form of waiver language, contract language, information notices, and other policy mechanisms.