California Advancing & Innovating Medi-Cal

Population Health Management Overview

November 5, 2019

California Advancing & Innovating Medi-Cal (CalAIM)

Guiding Principles

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities or inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

CalAIM Key Goals

To achieve such principles, CalAIM has three primary goals:

1. Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;

2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

DHCS

Draft Workgroup Deliverables

Population Health Management – <u>provide recommendations for</u>:

1. Suggested additions and deletions for the elements and details of the PHM proposal.
2. A timeline, and staging, of MCP implementation of the various elements of the proposed PHM MCP requirements, with consideration of other requirements within the larger CalAIM proposal.
3. MCP coordination requirements for: A) member transitions between care settings, and B) coordination with external entities for carved out services.
4. The initial member MCP risk assessment, including specific data elements and sources and SDoH information.

Draft Workgroup Deliverables Cont.

PHM Continued:

5. Where the appropriate balance point is between standardizing specific elements of the PHM at the state level as opposed to providing MCPs with local flexibility: assessment elements and method; risk stratification method; population segmentation and targeting interventions, including case management.

6. The operation of a state-level PHM learning collaborative for MCPs.

Annual Enrollment:

1. Specific to the consumer-friendly exemption process including defining the exceptions and determining how they will be operationalized.

2. Specific to member health plan open enrollment materials including timing and content.

What is Population Health Management (PHM)

- Differing Perspectives
  - A discipline within the healthcare industry that studies and facilitates care delivery across the general population or a group of individuals
  - The aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes
  - An approach to uncovering and filling gaps in care for the benefit of your patients and your medical organization

NCQA Definition of PHM

- "A model of care that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions."

NCQA's definition is based on Population Health Alliance's PHM definition
http://www.populationhealthalliance.org/research/understanding-population-health.html

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Integration with other CalAIM Proposals

1. NCQA Accreditation.
2. Enhanced Care Management (ECM): An intensive case management tool - to integrate within the PHMS.
3. In Lieu of Services (ILOS): Flexible wrap-around services to fill medical and SDoH gaps - to integrate within PHMS.
4. Shared Savings: MCP and provider incentives to maximize the effectiveness of the PHMS and new service options.
5. Behavioral Health payment reform and delivery system transformation.
6. Full Integration Plans: Where one entity would be responsible for the physical, behavioral, and oral health needs of their members.

Each part needs the others to maximize effectiveness.

DHCS' PHM Proposal

- Medi-Cal managed care health plans (MCPs) shall develop and maintain a patient-centered population health strategy.
  - Cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes
- Each MCP shall include, at a minimum, a description of how it will meet the core objectives:
  - Keep all members healthy by focusing on preventive and wellness services;
  - Identify and assess member risks and needs on an ongoing basis;
  - Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
  - Identify and mitigate social determinants of health and reduce health disparities or inequities.
- Timeline: January 1, 2021

DHCS' Intent

- ## PHM Goal:
  - Improve health outcomes and efficiency through standardized core PHM requirements

- ## PHM Proposal
  - Require compliance with NCQA PHM standards and elements
  - Include additional DHCS requirements not addressed by NCQA

- ## Build PHM Infrastructure:
  - Expanding interoperability of health information technology and health information exchanges

Standardization

- Some MCPs have a PHM program in context of NCQA Accreditation, but others do not, leading to potential gaps in care and lack of coordination

- Current contractual requirements do not meet the same comprehensive standards of the PHM Proposal as listed below:
    - Population Assessments and Strategic Interventions
    - Member Assessments and Risk Stratification
    - Addressing Risk and Need through Action

Current DHCS Requirements for Population Assessments and Strategic Interventions

- Population Needs Assessment (PNA)
  - Goal: To improve health outcomes
  - Conducted to:
    - Identify member needs, gaps in care, and health disparities
    - Implement targeted strategies and programs
  - Uses multiple data sources, techniques and tools including member input and provider engagement
- PNA Report
  - Conveys results and specified action plan to address significant findings

DHCS PHM Proposal - Requirements for Population Assessments and Strategic Interventions

- MCPs shall utilize available data sources to identify targeted populations for each core objective, considering health disparities in their membership, and include interventions in the program design that meet the requirements of NCQA and DHCS.
  - Aligns with PNA requirement and builds further upon it
- MCPs will need to use predictive analytics about which patients, communities or populations are emerging as high risk, as well as, identify and address the needs of outliers with more specific services and supports.

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DHCS PHM Core Objectives

- Keep all members healthy by focusing on preventive and wellness services;

- Identify and assess member risks and needs on an ongoing basis;

- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and

- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Current DHCS Requirements for Member Assessments and Risk Stratification

- Multiple types of assessments required, for different members, in different settings, with some redundancies
  - Staying Healthy Assessment/Individual Health Education Behavioral Assessment
  - Health information form/member evaluation tool
  - Health risk stratification and assessment survey for seniors and people with disabilities
  - Additional assessments (ex: Whole Child Model Assessment)

DHCS PHM Proposal - Requirements for Member Assessments and Risk Stratification

- Initial assessment of each new member's risk and need, including emerging risk, by assessing behavioral, developmental, physical, and oral health status, and social determinants of health within 90 days of the effective date of plan enrollment.
  1. Use of available data sources and data analytics
  2. A member-contact, evidence-based screening appropriate to the age of the member.
- The 2 part assessment will be used to risk stratify the population to determine the level of intervention that members require and address all care needs
- Future standardized PHM initial assessment and risk stratification

Data Sources and Analytics

- Previous screening or assessment data;

- Disengaged member reports;

- Claims or encounter data, including all fee-for-service data provided by DHCS;

- Pharmacy data;

- Laboratory data;

- Electronic health records; and

- Results of Medi-Cal managed care plan predictive modeling or specific algorithms

Member Contact Screening

- Behavioral, developmental, physical, and oral health needs;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Ability to function independently and organize his/her own health needs;
- Access to basic needs such as education, food, clothing, household goods, etc.;
- Use or need for Long Term Services and Supports;
- Availability of support/caregiver;
- Access to private and/or public transportation;
- Social or geographic isolation;
- Housing and housing instability assessment; and
- Use of community-based services and supports.

Current DHCS Requirements to Address Risk and Need

- Wellness and Prevention
  - American Academy of Pediatrics Bright Futures
  - United States Preventive Services Task Force
- Medically Necessary Services
  - Early and Periodic Screening, Diagnosis and Treatment
- Care Coordination
  - Basic Care Coordination
  - Complex Care Coordination
- Memorandums of Understanding

DHCS PHM Proposal - Requirements to Address Risk and Need

- General services and medically necessary services
- Wellness and prevention services, including health education
- Manage members with emerging risks
- Case Management
- In Lieu of Services
- Coordination between MCP and External Entities, including Partnerships with Community Entities
- Transitional Services
- Skilled Nursing Facility Coordination

Case Management

- Services actively assist at-risk members in navigating health delivery systems, acquiring self-care skills to improve functioning and health outcomes, and slowing the progression of disease or disability
  - General Case Management
  - Complex Case Management
  - Enhanced Care Management

General Case Management

- Members medium-high risk, or emerging risk
  - Planning and coordination that is not at the highest level of complexity, intensity or duration
- Can be provided by the MCP, clinic, or community staff, including non-licensed staff
- May include
  - A documented individual care plan
  - A case manager
  - A medical home
  - Participation in disease management programs
  - Participation in other MCP PHM programs

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Complex Case Management

- Generally coordination of services for high-risk members with complex conditions

- In accordance with NCQA requirements
  - "a program of coordinated care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources"
  - NCQA allows organizations to define "complex"

Enhanced Care Management

- Members at the highest risk level who need long-term coordination for multiple chronic conditions, including behavioral health conditions, and multiple social needs, as well as utilization of multiple service types and delivery systems
  - See separate CalAIM proposal

In Lieu of Services

- In lieu of services are flexible, wrap-around services that are integrated into the PHM program and used to substitute or avoid utilization of other services

- May fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health

  – See separate CalAIM proposal

Transitional Services

- Services are provided to all members who are transferring from one setting, or level of care, to another to ensure smooth transitions
- Operational agreements with contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to include:
  - Standardized discharge risk assessment
  - Development of written discharge plan
  - Information sharing permissions
  - Discharge planning policies and procedures, including ensuring timely authorizations and educating discharge planning staff to prevent delays in discharge
- Transitions such as aging out of CCS

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Coordination between MCP and External Entities, including Partnerships with Community Entities

- Coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, home and community-based services

- Foster partnerships with community entities

- Referrals must be culturally and linguistically appropriate for the member

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PHM Oversight

- PHM Program Description
  - Submitted annually to DHCS
  - Address all NCQA and DHCS requirements
  - Describes how the MCP will meet all the PHM core objectives
- PHM Program Quality Assurance Reviews
  - Submitted annually to DHCS
  - MCP internal monitoring process to ensure compliance with PHM requirements to include quality assurance reviews of PHM activities
- PHM Delegate Oversight Plan
  - In accordance with NCQA requirements

Where DHCS Adds to NCQA

- As you have seen from these NCQA and DHCS PHM presentations, there are areas where DHCS goes beyond the NCQA requirements:

1. Additional core objectives focused on disparities, SDOH, etc.;
2. Required assessment elements and member-contact assessment, with a Whole-Person focus;
3. More specific risk stratification and segmentation requirements, with a focus on the right balance of state-wide standardization;
4. Incorporating current contract wellness and other services;
5. Enhanced Care Management as a targeted intervention;
6. More specific transition coordination requirements;
7. More comprehensive information sharing goals.

Future Policy Development & Technical Assistance

- Promising Practice examples

- Potential for a DHCS operated learning collaborative

- Pathways to identify best methods and advance promising practices in areas of specific tools and requirements for:

  – Initial assessments;

  – Risk stratification;

  – Coordination with external entities;

  – Transition coordination, including a discharge risk assessment tool;

  – Collection of social determinants of health information for risk stratification and segmentation; and

  – Data exchange protocols and the development of health information technology/health information exchange policies.

- Template Development

A Few Questions to Consider for PHM

- Do any DHCS requirements conflict with or duplicate NCQA?

- Should the initial assessment be a standard tool, created by DHCS? (It will have to be standardized enough for proper data sharing amongst plans.)

- Should Case Management Individual Care Plan elements be standardized?

- How will the timing for PHM requirements interact with other MCP activities and CalAIM proposed activities?

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PHM Questions Continued

- What assessment streamlining can we accomplish for 2021, and what would need more work?

- What do MCPs have in place currently for risk stratification tools and how would this interact with the proposal?

- What is appropriate SDoH information to collect and how should it be used?

- How can this proposal improve data collection, sharing, and use?

Questions?