DEPARTMENT OF HEALTH CARE SERVICES

POPULATION HEALTH MANAGEMENT (PHM) STRATEGY AND ROADMAP

JULY 2022

POPULATION HEALTH MANAGEMENT (PHM) STRATEGY AND ROADMAP

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I. Introduction

The Department of Health Care Services (DHCS) is innovating and transforming the Medi-Cal delivery system. California Advancing and Innovating Medi-Cal (known as CalAIM) is moving Medi-Cal toward a population health approach that prioritizes prevention and whole-person care. The vision is to meet people where they are in life, address social drivers of health (SDOH), and break down the walls of health care. CalAIM will offer Medi-Cal members coordinated and equitable access to services that address their physical, behavioral, developmental, dental, and long-term care needs throughout their lives, from birth to a dignified end of life.

In January 2023, DHCS will launch the **Population Health Management (PHM) Program,** which is a cornerstone of CalAIM. The PHM Program seeks to establish a cohesive, statewide approach to all populations that brings together and expands upon many existing population health strategies. Under PHM, Medi-Cal Managed Care (MCMC) plans and their networks and partners will be responsive to individual member needs within the communities they serve while also working within a common framework and set of expectations.

PHM is a comprehensive, accountable plan of action for addressing member needs and preferences and building on their strengths and resiliencies across the continuum of care that

- Builds trust and meaningfully engages with members;
- Gathers, shares, and assesses timely and accurate data on member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes;

PHM Goals:

- Establish a cohesive, statewide approach to population health management that ensures that all members have access to a comprehensive program that leads to longer, healthier, and happier lives, improved outcomes, and health equity.

PHM Guiding Principles:

- **Drive toward the quadruple aim:** Enhance the patient experience, improve population health, reduce costs, and improve the work life of health care providers, including clinicians and staff.
- Use program and outcomes data to inform policy making and **drive continuous quality improvement (CQI)** efforts across Medi-Cal delivery systems in alignment with DHCS' Comprehensive Quality Strategy (CQS).
- Identify, measure, and **develop solutions that address outcome differences by race, ethnicity, language,** and other factors to advance health equity.
- **Develop a unified approach for PHM** across DHCS and delivery systems to promote accountability and transparency, integrating national standards and evidence-based practices.

- Addresses upstream factors that link to public health and social services;
- Supports all members staying healthy;
- Provides care management for members at higher risk of poor outcomes;
- Provides transitional care services for members transferring from one setting or level of care to another; and
- Identifies and mitigates SDOH to reduce disparities.

While the definitions and requirements described in this paper apply specifically to MCMC plans at this time, PHM is a statewide endeavor. MCMC plans are accountable for the health of almost the entire Medi-Cal population. Even though certain critical services remain carved out of the managed care delivery system (including, but not limited to, specialty mental health services (SMHS), Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services, dental and pharmacy, In Home Supportive Services, and primary/acute care for dually eligible members), MCMC plans are accountable for their members' outcomes, which are strongly impacted by the performance of other delivery systems as well as social factors outside the health care system entirely. Thus, PHM requires meaningful engagement and partnerships among MCMC plans, their members, their network providers and counties, communities, public health agencies, and schools and community-based organizations (CBOs), among others. A central feature of PHM is improvement of data sharing among delivery systems to support integration, as described throughout this paper.

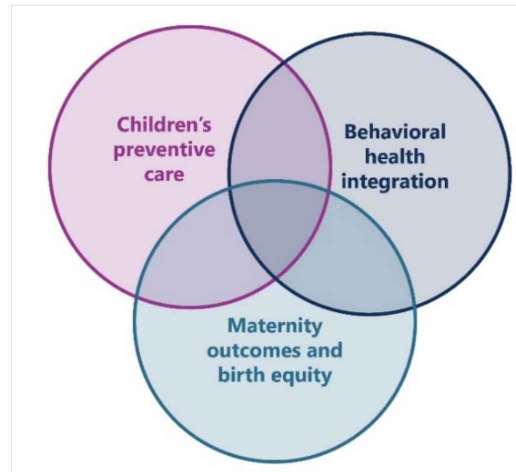
BOLD GOALS: 50x2025

STATE LEVEL

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

PHM is a journey rather than a destination. The Enhanced Care Management (ECM) benefit and Community Supports, which launched in January 2022, are major components of PHM, serving individuals with the most significant health and social needs. Until now, however, PHM principles and requirements have not come under a comprehensive framework that applies to **all** populations served by MCMC plans. In particular, the term "Basic Population Health Management (BPHM)," described below, is being newly introduced to describe the basic set of services and supports, including primary care, to which **all** populations served by MCMC plans have access. Over time, the PHM Program will evolve to support even more integration across delivery systems, moving beyond the current requirements for MCMC plans described in this paper.

Widespread PHM implementation is urgently needed. The COVID-19 pandemic has had a devastating impact on health and well-being. Even before the pandemic, the Medi-Cal program had low preventive care rates for children, high unplanned readmissions, and wide disparities in treatment outcomes for people of color relative to the general population. The launch of PHM should be understood as part of a broader arc of change to improve health outcomes that started with CalAIM and is further articulated in DHCS' Comprehensive Quality Strategy (CQS), which emphasizes the long-lasting impact of coupling quality and health equity efforts with prevention. The CQS highlights the need for urgent improvement in three particular "Clinical Focus Areas" – children's preventive care, behavioral health integration, and maternity outcomes/birth equity. Accordingly, the CQS establishes the Bold Goals: 50x2025 initiative to drive specific and accelerated improvement in these three areas. As described in this paper, certain components of PHM (primarily a modified Population Needs Assessment and new Population Health Management Strategy) will be closely tied to the CQS, Clinical Focus Areas, and Bold Goals to provide alignment across DHCS' multiple quality and equity policy initiatives.



PHM Service

In tandem with the PHM Program rollout, DHCS is building a statewide **PHM Service** designed to collect and integrate disparate information to support DHCS' vision for PHM in myriad ways. Most notably, the PHM Service will:

- Provide MCMC plans, providers, counties, MCMC plan members, and other authorized users with access to comprehensive, historical data on members' health history, needs and risks;
- Include a single, statewide, open-source risk stratification and segmentation (RSS) methodology with standardized risk tier criteria that will place **all** Medi-Cal members into high-risk, medium-rising-risk, and low-risk tiers;
- Improve data accuracy and timeliness by providing members with the ability to update their information;
- Promote trusting relationships for care teams to support individuals with access to health education, their rights and applicable benefits, and information on how their data are being used, among other features; and
- Improve DHCS' ability to understand population health trends and strengthen oversight.

The PHM Service will support whole-person care by integrating and aggregating historical administrative, medical, behavioral, dental, social service and program information from disparate sources to support risk-stratification, segmentation and tiering, assessment and screening processes, and analytics and reporting. The PHM Service is not being designed to provide real-time clinical decision support capabilities.

The PHM Service will be deployed statewide in July 2023, with additional PHM Service capabilities incrementally phased in thereafter. Based on stakeholder feedback, DHCS intends to test-launch the PHM Service with a subset of partners from January 2023 to June 2023 to optimize functionality before the statewide launch. Given the period of time between the launch of the PHM Program (January 2023) and the launch of the PHM Service (July 2023), DHCS is clarifying expectations for PHM within two distinct time periods: before and after the PHM Service is available. Prior to the launch of the PHM Service and prior to any requirements to use the PHM Service, DHCS will not require MCMC plans to develop new infrastructure that would subsequently be replaced by the PHM Service. DHCS will continue to work with stakeholders to identify the priorities and capabilities that the PHM Service will support.

The PHM Service is part of a broader, statewide effort to accelerate and expand access to health and social service information among health care entities, government agencies, and social services organizations under California's Data Exchange Framework (DxF). See Box A.

Box A: California's Data Exchange Framework (DxF)

California's Data Exchange Framework (DxF) will improve how health information is shared across health and human services organizations, improve care delivery, and guide policies aimed at caring for the whole person while maintaining patient privacy, data security, and promoting equity. AB 133, the legislation that enacted the DxF, requires a broad spectrum of health care organizations to exchange health information in conformance with the DxF by January 31, 2024.

The DxF is not a new technology; instead, it's an agreement that health plans, providers, and others must follow in order to share information in alignment with state and federal rules. The DxF will support data-driven efforts to better coordinate health and social services and provide opportunities to deliver services that are more client centered, efficient, effective, and tailored.

The DxF will include a single data sharing agreement (DSA) and set of policies and procedures to govern the exchange of health information among health care entities. Supported by input and advice from a DxF Stakeholder Advisory Group, CalHHS will release the DxF, the DSA, and an initial set of policies and procedures by July 1, 2022. Applicable entities and organizations will be required to execute the DSA prior to January 31, 2023.

PHM Requirements

The requirements established with the 2023 launch of PHM are consistent with the PHM requirements articulated in DHCS' recently released Request for Proposals (RFP) for Commercial MCMC Plans (the 2024 Re-Procurement) and the related new model contract, which sets new contract requirements across all MCMC plan and model types beginning in 2024. In some instances, DHCS will deploy new requirements gradually between January 1, 2023, and the effective date of the new MCMC plan contract on January 1, 2024. Specifically, on January 1, 2023, all MCMC plans will be required to meet PHM standards by either having full National Committee for Quality Assurance[1] (NCQA) Health Plan Accreditation or by demonstrating to DHCS that they meet the PHM standards for NCQA Health Plan Accreditation.[2] By January 1, 2026, all MCMC plans must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation. Appendix 2 delineates a timeline and summary of all changes discussed in this paper.

[1] NCQA is a nonprofit organization committed to evaluating and publicly reporting on the quality of managed care plans.

[2] PHM standards are one component of NCQA Health Plan Accreditation, which also includes standards on Quality Management and Improvement, Network Management, Utilization Management, Credentialing and Recredentialing, Members' Rights and Responsibilities, Member Connections, and Medicaid Benefits and Services.

Purpose of This Strategy and Roadmap Document

The purpose of this document is to:

1. Define and describe the key PHM concepts and terminology that will be used by DHCS to guide work on PHM moving forward.
2. Set out the roadmap for MCMC plans for 2023.

Understanding the Member Perspective

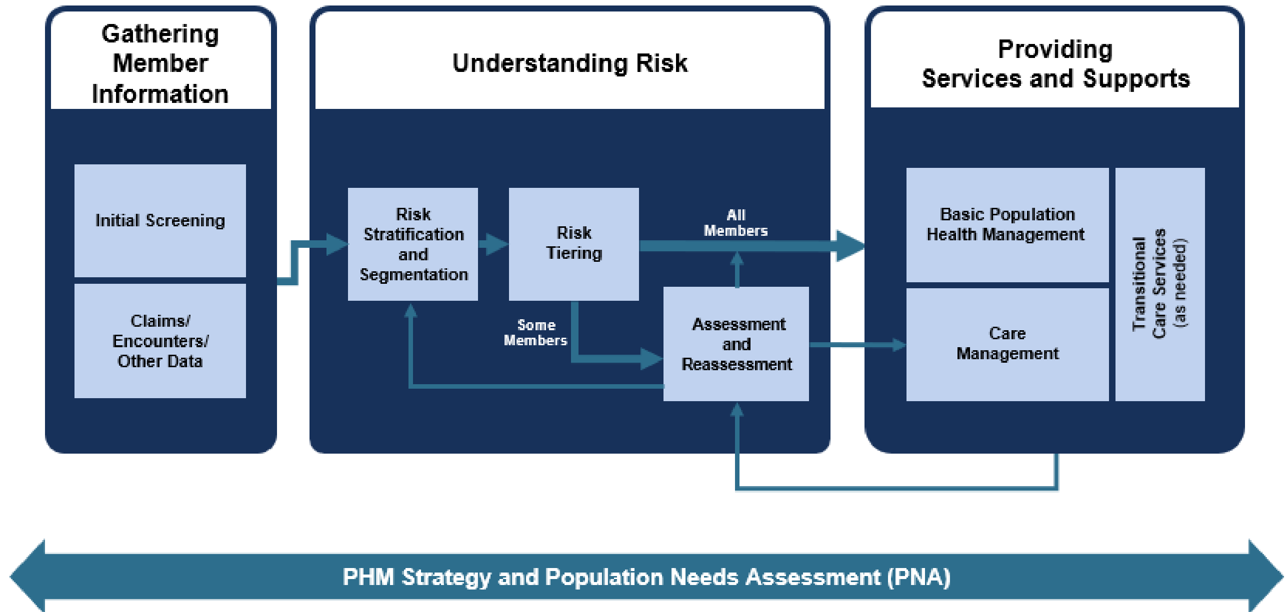
To convey PHM concepts, we highlight the Garcia family, which has Medi-Cal coverage, and the family's interactions with the health care system over the course of a year: Linda, whose preferred language is Spanish, is a 32-year-old pregnant mother who delivers a son, Jacob; Sophia is Linda's 10-year-old daughter; and John is Linda's 55-year-old father-in-law, who has chronic conditions. Provided in the member perspective boxes below are stories about these members' health care interactions and how PHM supports them in their journeys to enjoy longer, healthier, and happier lives.

This is the final version of the PHM Strategy and Roadmap Document, which incorporates stakeholder feedback on the earlier draft of the document released in April 2022. In addition to this document, DHCS will publish a PHM Program Guide in summer 2022 that will also incorporate stakeholder feedback received on this paper. These documents will finalize expectations for 2023 and include the content of a PHM Program Readiness Deliverable that will be due from MCMC plans to DHCS in October 2022. As part of the PHM Program Readiness Deliverable, MCMC plans will be expected to respond to a limited set of questions to describe their PHM programs and to attest to their readiness prior to program launch on January 1, 2023.

Also, toward the end of 2022, DHCS will issue guidance to MCMC plans on PHM reporting, as described below. Details on the Program Guide, MCMC Plan PHM Program Readiness Deliverable, and other milestones are elaborated upon throughout the paper and summarized in Appendix 2.

II. The PHM Program

1. PHM Framework



DHCS intends to use the above PHM framework consistently to promote common terminology and communication about PHM. Within this framework, PHM consists of four domains, which coalesce and expand upon several existing population health strategies that DHCS and many MCMC plans already implement:

Population Health Management Strategy (PHM Strategy) and Population Needs Assessment (PNA). Successful implementation of PHM requires an overarching data-driven strategy that prioritizes collaboration with community partners**.** The PNA is already the mechanism by which each MCMC plan measures health disparities and identifies the priority health and social needs of its members, including cultural and linguistic needs. Under PHM and starting in 2023, the PNA process will evolve to require greater community engagement and support development of a new annual PHM Strategy, which will provide an overview of an MCMC plan's entire PHM program. See Section 2 for more details.

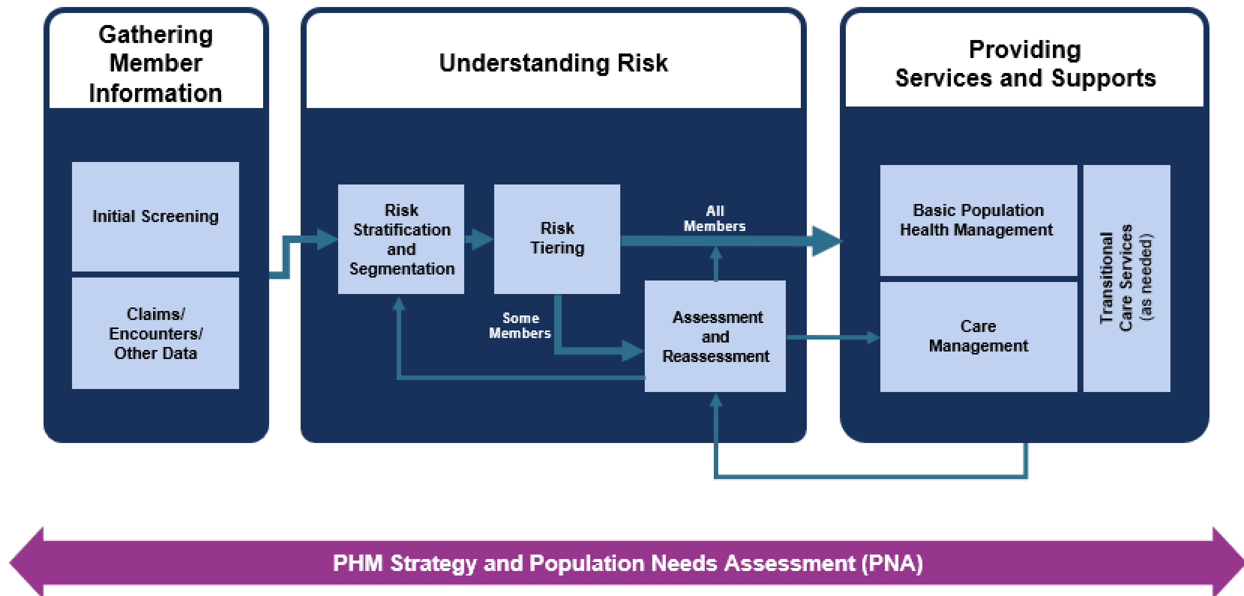
Gathering Member Information. Gathering timely and accurate data on preferences, strengths, and needs for each member is essential to connect every member to services at the individual level, and to allocate resources where they are most needed at the population level. DHCS expects each MCMC plan to gather and use a wide variety of data to conduct PHM, including data generated within the MCMC plan and externally generated information, such as

provider referrals and information from member screening and assessments. See Section 3 for more details.

Understanding Risk. Understanding member risk is critical to identifying opportunities for more efficient and effective interventions, and ideally occurs well before a member requires more intensive treatment and care. DHCS expects each MCMC plan to have a population risk stratification and segmentation (RSS) approach that meets NCQA standards and considers all required information. Once the PHM Service is live, the PHM Service will support gathering information and understanding risks of poor health and well-being outcomes, including development of standardized risk tiers that MCMC plans will be required to use to assess member needs and determine the appropriate level and type of services for individual members. See Section 4 for more details.

Providing Services and Supports. Connecting MCMC plan members to the right services and supports at the right time and place depending on their needs and preferences is one of the main objectives of PHM. DHCS expects each MCMC plan to offer supports and interventions that members need and want along the continuum of care, which will include BPHM for all members; care management, including ECM or Complex Care Management (CCM) for high-risk and select medium-rising-risk members; and transitional care services for members in transition. See Section 5 for more details.

2. PHM Strategy and Population Needs Assessment (PNA)



A successful PHM program requires a robust **PHM Strategy** that details each component of an MCMC plan's PHM approach, prioritizes strong ties in the community, and incorporates cross-sector strategies to improve health in neighborhoods and communities with poor health outcomes.

Critical to a successful PHM Strategy is compilation of comprehensive, meaningful, and accurate data at a population level. The **PNA**, which is already a requirement of MCMC plans,[3] supports an understanding of the unique needs of members in each MCMC plan's population, including health and social needs; health disparities and inequities; and the root causes of barriers related to coverage, access, quality, health outcomes, and SDOH.

Goals for PHM Strategy and PNA

- **Ensure a clear understanding of the health needs, health disparities, and social needs** of members at the level of each MCMC plan.
- **Identify available resources/gaps in resources** that affect members' health and social needs.
- **Promote strong engagement** with local communities.
- **Create a comprehensive strategy for** addressing the specific disparities and gaps in care/resources identified in the PNA.

[3] The current PNA requirements have been in effect since 2019, prior to which MCMC plans were required to submit a Group Needs Assessment. Current PNA requirements are delineated in APL 19-011. DHCS is maintaining current PNA requirements in 2022.

Also, integral to the success of both the PHM Strategy and PNA is a MCMC plan's commitment to the communities of their members. DHCS envisions a stronger connection between MCMC plans and local communities. As such, MCMC plans will be required to demonstrate their commitment to the local communities in which they operate through community reinvestment activities and contributions, which are informed by the PNA.[4]

DHCS' overall vision for changes to the existing PNA, and design of a new PHM Strategy process described below, is to increase the level of meaningful community engagement and local alignment while decreasing administrative burden, duplication and churn relative to today's PNA process.

Member Perspective: How Population Analysis Informs Member Programs

The MCMC plan that enrolls the Garcia family conducts a comprehensive, data-informed, and community-engaged PNA that informs the MCMC plans' PHM Strategy. As a result of the information collected as part of the PNA, the MCMC plan's PHM Strategy has initiatives to meet the needs of the Garcia family, including programs and services for pregnant women, children, and chronically ill individuals. The MCMC plan is piloting a new system for data-sharing with plan providers because the PNA identified the need for seamless referrals into the initiatives available. The PNA also showed access barriers and health disparities for Spanish-speaking pregnant women, and, as a result, the MCMC has strengthened its outreach and engagement efforts by contracting with community-based organizations and leveraging community health workers and doulas to connect Spanish-speaking members to clinically and culturally appropriate services.

The modified PNA process will require less frequent data collection and more meaningful and systematic community engagement than the current requirements. Specifically, the modified PNA process will require greater engagement with a wide range of local stakeholders, including members and families; Medi-Cal providers; local health departments (LHDs); local educational agencies (LEAs); local governmental agencies (LGAs) (including, but not limited to, social services, county child welfare agencies, and safety net providers); home- and community-based services (HCBS) organizations; county mental health plans (MHPs); Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC-ODS) plans; county mental health commissions; Medicare Advantage plans; correctional facilities; Regional Centers, First 5 County Commissions, and CBOs. DHCS is also interested in maximizing alignment with local health

[4] Per 2024 Medi-Cal Managed Care Procurement, Exhibit B, Section 1.17 Community Reinvestment, MCMC plans are required to demonstrate their commitment to the communities in which they operate and contribute the following percentages of their annual net income to community reinvestment activities: 5% of the portion of annual net income that is less than or equal to 7.5% of contract revenues for the year, and 7.5% of the portion of the annual net income that is greater than 7.5%.

strategies, including hospital Community Health Needs Assessments and LHD Community Health Improvement Plans.

DHCS will roll out modified requirements as follows:

- **The PNA will continue to follow the existing All Plan Letter (APL) 19-011 process for 2022.** (i.e., MCMC plans will file the PNA in July 2022). After this 2022 PNA submission, the PNA will move to a three-year process rather than an annual one, so as to allow time for systematic and meaningful community engagement and also reduce administrative burden. Thus, after 2022, the next PNA submission will be due to DHCS in 2025.
- **In October 2022, MCMC plans will be required to submit a PHM Program Readiness Deliverable**, which is precursor to the annual PHM Strategy (described below). As part of this deliverable, MCMC plans will be expected to respond to a set of questions to describe their PHM programs and to attest to their readiness prior to program launch on January 1, 2023.[5] The template for this deliverable will be released in August 2022.
- **In early 2023 (Q1), DHCS will release guidance and a template for the new comprehensive PHM Strategy as well as guidance for a modified PNA structure.** As part of the PHM Strategy, each MCMC plan will work alongside community leaders and partners to develop a single, focused strategy for its PHM program. The PHM Strategy will help MCMC plans reduce bias and error in its decision-making; and track progress toward PHM goals. MCMC plans will be required to detail components of their PHM program, including prevention and wellness strategies and interventions, for children and youth, pregnant and postpartum individuals, and those with behavioral health needs, in their PHM Strategies. Because of the comprehensive scope of the PHM Strategy, MCMC plans will no longer need to submit a PNA Action Plan.
- **In October 2023, current MCMC plans will be required to submit the comprehensive PHM Strategy for the first time.[6]** Thereafter, the PHM Strategy will be submitted annually.
- **In July 2025, MCMC plans will be expected to submit their PNA.** Each MCMC plan will be required to produce a report of its PNA in writing, make it available to the public, and post it on the MCMC plan's website.

DHCS recognizes that NCQA requires submission of an annual PHM Strategy and a Population Assessment for accredited plans, and is committed to minimizing duplication across the new PHM Strategy and modified PNA requirements. The new PHM Strategy will be aligned

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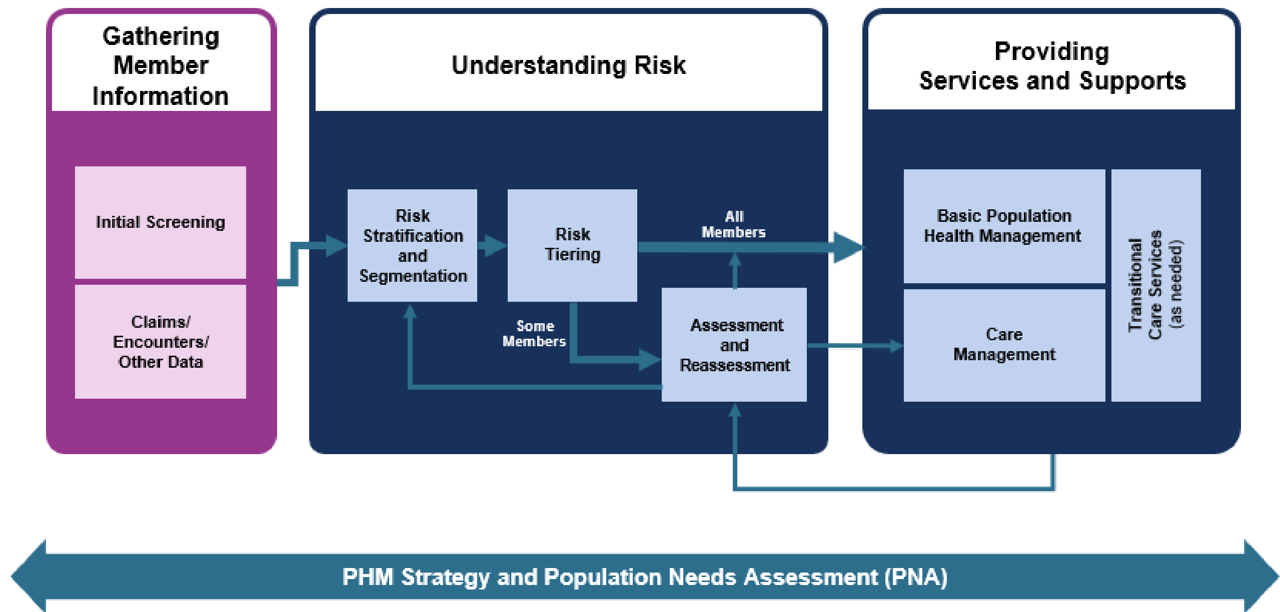
[5] New MCMC plans entering in 2024 will complete the PHM Program Readiness Deliverable within the DHCS schedule of deliverables for 2024 Readiness. Existing MCMC plans will not be required to submit 2024 PHM Readiness deliverables that have already been covered by the PHM Program Readiness Deliverable described here.

[6] New MCMC plans entering in 2024 will complete the PHM Strategy for the first time in Q3 2024.

with the existing NCQA deliverable and will also be due annually but will be more specifically focused on strategies and initiatives that help address the DHCS CQS Clinical Focus Areas and help achieve the Bold Goals, in addition to addressing specific health disparities and conditions identified by each MCMC plan's PNA. The modified PNA aligns with NCQA Population Assessment requirements but will only occur every three years rather than annually to allow more time for deeper community engagement. MCMC Plans can satisfy the annual NCQA Population Assessment with a more limited assessment per NCQA guidelines.

3. Gathering Member Information



An effective PHM approach begins with gathering accurate and robust information to understand each member's health and social needs to ensure that they receive the right services at the right time and right place. Opportunities for information gathering happen upon member enrollment and occur thereafter at provider visits, diagnoses, and transitions of care, among other events.

A strong information-gathering process is one that not only gathers timely, accurate, and holistic data on preferences and needs for all members but also safeguards the privacy of the member; gathers and shares data across physical health, behavioral health, and social service systems in a manner that reduces member screening fatigue; and ultimately builds trust through meaningful engagement.

Goals for Information Gathering

- **Gather timely and accurate data on preferences and needs** for all members in a dynamic way in order to connect members to services at the individual level and family level at the time they are needed.
- **Safeguard the privacy and autonomy of the member,** which means sharing information only within the confines of the law and in accordance with a member's preferences.
- **Build trust by meaningfully engaging** with members, such as by explaining why questions are being asked and what the information will be used for.
- **Gather and share data in a member-centered way** between physical health, behavioral health, and social services systems; this will reduce member screening fatigue by reducing duplication of questions and asking questions in a mode that is accessible to a member (e.g., electronically, during an already existing appointment with a provider).
- **Reduce bias** through data standards that prevent stigma, health inequities and other negative impacts upon individuals and groups who have been who have been economically, socially, culturally, or racially marginalized.

Information gathering relies upon two important tools: screening and assessment.

- **Screening** is a brief process or questionnaire for examining the possible presence of a particular risk factor or problem, to determine whether a more in-depth assessment is needed for a specific area of concern.
- **Assessment** is a more comprehensive process than screening, involving a set of questions for defining the nature of a risk factor or problem, determining the overall needs or health goals and priorities, and developing specific treatment recommendations for addressing the risk factor or problem. Health assessments can vary in length and scope.

Change is needed with respect to information gathering. Existing mechanisms do not always cultivate member trust, are often burdensome to members, do not gather timely and accurate data in a dynamic way, and do not effectively and efficiently share data across the member's care team. Information from beyond the plan and its network (including data from SMHS and DMC-ODS, as well as data on SDOH) is currently not routinely used by all MCMC plans. In addition, studies have shown that an overreliance on claims and utilization data can lead to racial bias in understanding risk in a population because it does not take underutilization into

account.[7] Children, in particular, can be missed entirely in risk stratification processes, despite the importance of ensuring wellness, timely developmental screenings, and preventive care. Thus, it is critical to use as robust and varied a set of data sources as possible to inform data-driven assessments of risk and need.

Not only do current shortcomings in information gathering lead to members not being connected to the services they need and want, but members also experience high levels of fatigue when they must complete duplicative screening and assessment forms – some of which may not be used to drive actions at all – resulting in low response rates, inaccurate data, and overall distrust in the system.

The introduction of the PHM Service, creates a new mechanism and pathway to solve for these issues. As such, DHCS is no longer pursuing the concept of the Individual Risk Assessment, which was introduced in the original CalAIM proposal to improve screening and assessment processes. DHCS is moving forward on improving information gathering efforts, gradually using the PHM service, by (A) leveraging existing health and social data and (B) streamlining the initial screening process.

A. Leveraging Existing Health and Social Data

A wide array of data already exist that can help MCMC plans understand their members' needs. However, today, MCMC plans may have incomplete access to these data and/or do not routinely use them.

Building upon current requirements related to MCMC plans utilizing various data sources for internal management and reporting purposes,[8] DHCS is establishing more comprehensive expectations that MCMC plans will leverage a broad set of data sources (listed in Box B) in their PHM programs. These expectations will increase over time with the introduction of the PHM Service.

From January 2023 until the PHM Service is fully operationalized, DHCS understands that MCMC plans may have limited access to some of the required data sources listed in Box B. As such, during this period, MCMC plans will be expected to make a good-faith effort to use the data sources to the greatest extent possible. MCMC plans will be required to demonstrate the good-faith effort by articulating efforts and barriers to integrating the data sources within the PHM Program Readiness Deliverable they will submit to DHCS in October 2022 (see Appendix 2). DHCS will work with California Health and Human Services (CalHHS) and the Center for Data Insights and Innovations (CDII), who are responsible for establishing the Statewide Data

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[7] Dissecting racial bias in an algorithm used to manage the health of populations.

[8] Under current requirements related to Management Information System Capabilities, MCMC plans must utilize various data elements both for internal management use and to meet the data quality and timeliness requirements of DHCS' Encounter Data submission.

Exchange Framework (see Box A), to issue guidance to MCMC plans in 2023 on ways sexual orientation and gender identity (SOGI) and race/ethnicity data should be collected and shared.

Once the PHM Service is available and supports access to and use of required data sources,[9] MCMC plans will be required to use the PHM Service to access and use the required data sources—in accordance with federal and state privacy rules and regulations—to drive RSS. The PHM Service will support this requirement by aggregating, linking, and sharing member- and population-level data originating beyond the MCMC plan or network providers (e.g., county mental health and SUD delivery systems).

The PHM Service is also intended to support the ability of members to modify, update, and provide information (including demographic and contact information) through a portal or similar means. DHCS is assessing options for enabling members to update clinical and social information as appropriate. DHCS believes that members are best positioned to update various information (e.g., their own contact information). Individuals' ability to update their information will be subject to business rules to support data accuracy and completeness. MCMC plans may continue to supplement the data (e.g., screening and assessment data) provided via the PHM Service with their own data sources.

[9] In addition to promoting enhanced data sharing via the PHM Service, DHCS is exploring how the PHM Service may streamline consent management and released guidance in December 2021 that supports data sharing between MCMC plans, health care providers, community-based social and human service providers, and county and other public agencies that provide services and manage care under CalAIM.

Box B: Data to be used as part of information gathering and to inform RSS:

- Screening or assessment data;
- Claims and encounter data, including fee-for-service data;
- Available social needs data (e.g., CalFresh, WIC, and CalWORKs);
- Electronic health records;
- Referral data;
- Behavioral health data (including Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT), medications for addiction treatment (MAT, also known as medication-assisted treatment) data, and other SUD data; non-specialty mental health services data; and DMC, DMC-OSDS, and SMHS data available through the Short-Doyle/Medi-Cal claims system)
- Pharmacy data;
- Utilization data;
- Disengaged member reports (e.g., assigned members who have not utilized any services);
- Lab results data;
- Admissions, discharge, and transfer (ADT) data;
- Race/ethnicity data;
- Sexual orientation and gender identity (SOGI) data;
- Justice-involved data;
- Housing data; and
- For members under 21, information on developmental and adverse childhood experiences (ACEs) screenings.

B. Streamlining the Initial Screening Process

Currently, to meet federal requirements, DHCS requires MCMC plans to conduct a screening called the Health Information Form (HIF)/Member Evaluation Tool (MET) at the point of enrollment. In addition, MCMC plans are required to hold network providers accountable for routine screening and assessment during the member's initial encounter with an assigned PCP, appropriate medical specialist or non-physician medical provider, through an entirely separate process called the Initial Health Assessment (IHA).[10] A key current component of the IHA and annual prevention visits is the Individual Health Education and Behavior Assessment (IHEBA). Since 2008, MCMC plans have been required to ensure that members complete the IHEBA, which is a process for gathering health and health-related information at the provider level. The Staying Healthy Assessment is the IHEBA developed by DHCS.

[10] From 2023, the Initial Health Assessment will be known as the "Initial Health Appointment." Current requirements for the Initial Health Assessment are contained in APL 13-017; APL 18-004; APL 20-004; PL 08-003; PL 13-001 (Rev); PL 14-004). Specific Timeframes are included in the 2022 Medi-Cal Managed Care Contracts as well as the 2024 re-procurement and the related new model contract.

Having reviewed stakeholder comments on the draft version of this PHM Strategy and Roadmap, **DHCS will proceed with retiring the existing requirements for the IHEBA/SHA**[1] – namely the prescribed questionnaires to be used at these initial visits and intervals thereafter – having heard consistent feedback that state-level prescription of the exact health behavior questions to be asked of patients is unduly burdensome, not evidence-based, and duplicative of other processes providers have in place. For children, the elimination of the current IHEBA/SHA will not affect requirements to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. DHCS will retire the relevant APL provisions that contain the existing IHEBA/SHA requirements.

Box C: Timelines on IHA and HIF/MET

The HIF/MET must be completed within 90 days. If the IHA is also completed within 90 days, then the HIF/MET may be delegated to the provider and combined with the IHA, and DHCS will consider the initial MCMC plan screening requirement fulfilled.

Please note, the IHA does not need to be completed within 90 days.

For members less than 21 years of age:

- For Members less than 18 months of age, Contractor must ensure the provision of an IHA within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.
- For Members ages 18 months and older, Contractor must ensure an IHA is performed within 120 calendar days of Enrollment.

For adults Ages 21 and over:

- Contractor must cover and ensure that an IHA for adult Members is performed within 120 calendar days of Enrollment.

The IHA must continue to include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.[2] DHCS will continue to require that MCMC plans hold network providers accountable for the provision of all preventive screenings for adults per Grade A and B recommendations from the United States Preventive Services Task Force (USPSTF) but will no longer require all of these elements to be completed during the initial appointment, as outlined in current APLs, so long as members receive all required screenings through the course of their care.

In the short term and prior to the introduction of the PHM Service, DHCS will **not** phase out the HIF/MET because federal rules require best efforts to conduct initial screening of all MCMC

[1] Relevant APLs, including but not limited to APL 08-003, APL 13-001, APL 13-017.

[2] These elements are specified in 22 CCR § 53851(b)(1).

plan members within 90 days of enrollment.[13] The HIF/MET will remain in place as is (i.e., MCMC plans may use the DHCS standardized language or develop their own for approval). In the draft version of this PHM Strategy and Roadmap, DHCS considered modifying HIF/MET requirements from 2023 to require across the board sharing of HIF/MET information between MCMC plans and providers. In response to stakeholder concern about administrative burden for both MCMC plans and providers, DHCS is simplifying expectations for 2023 as follows:

- DHCS is clarifying that the HIF/MET may be delegated to the provider level. If the HIF/MET screening is completed by a provider and shared back with the MCMC plan within 90 days of enrollment, DHCS will consider the initial MCMC plan screening requirement fulfilled. If the HIF/MET is delegated to the provider level, the provider is responsible for following up on positive screening results.

- If the HIF/MET is not delegated to the provider level, the MCMC plan must either follow up on positive screening results at the plan level or delegate follow-up to the provider (and share relevant information with the provider to do so).

DHCS will not establish further standards on how the HIF/MET can be shared, allowing MCMC plans to leverage existing communication and data sharing mechanisms as appropriate.

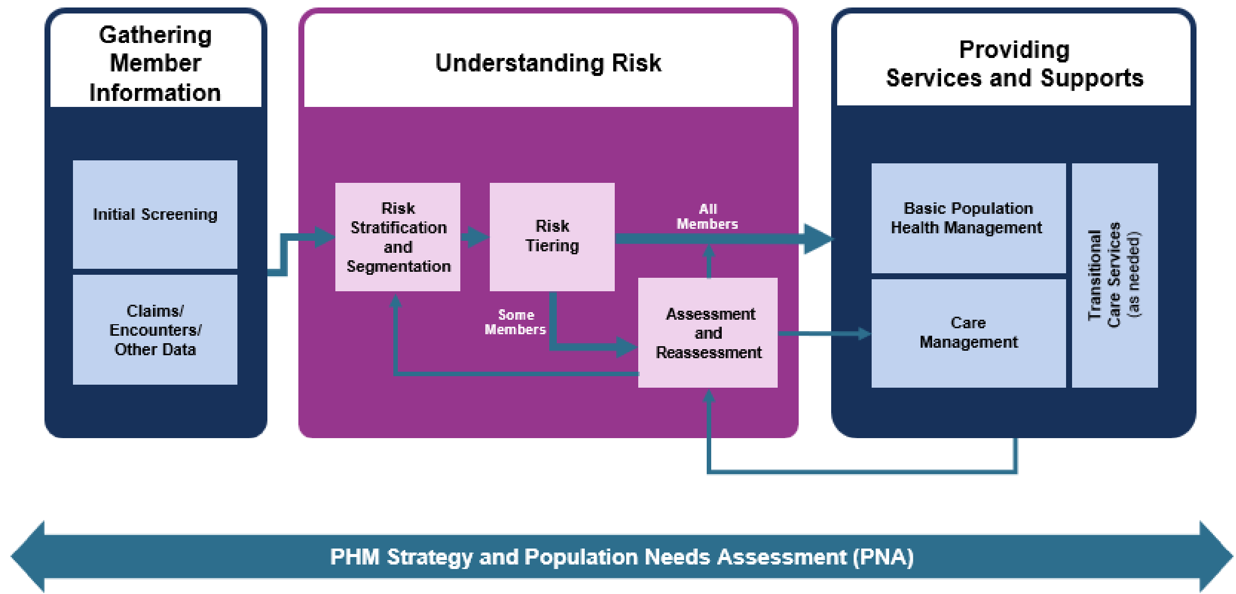
DHCS' ultimate vision for initial screenings is to leverage the PHM Service to reduce member screening fatigue; ask each member high-value, actionable and relevant questions that connect members to services and supports to meet members' needs and preferences; and significantly improve data sharing across settings and between plans and providers via standards that are aligned with California's Data Exchange Framework (DxF). Through design work on the PHM Service, DHCS is exploring how the PHM Service can host screening and assessment functionalities that pre-populate relevant previously collected data to further mitigate duplication and burden on members. Reducing burden on members is only possible if MCMC plans and providers leverage the PHM Service to collect and exchange member information. As the PHM Service is developed, DHCS will be looking for stakeholder input on how best to meet this vision and consider additional innovations.

In an effort to strengthen primary care and promote overall prevention and wellness, DHCS will be measuring primary care visits as a proxy for the IHA, leveraging specific Managed Care Accountability Sets (MCAS) measures (infant and child/adolescent well-child visits and adult preventive visits). For children enrolled in MCMC plans, DHCS will measure primary care visits *and* childhood screenings as a proxy for the IHA, including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and SUD.

[13] 42 CFR § 438.208(b)(3).

MCMC plans will be required to describe their approach to member screening and assessment in light of the changes above as part of October 2022 PHM Program Readiness deliverable[14] (see Appendix 2).

4. Understanding Risk



[14] The PHM Program Readiness Deliverable for current plans is due October 2022 and for new plans is due May 2023. Specifically, the PHM Program Readiness Deliverable will include: Attestation of NCQA PHM accreditation or equivalent; Readiness to use diverse data sources to guide risk stratification and segmentation; Approach to screening and assessment within revised 2023 requirements; Approach to assessing for care management within revised 2023 requirements; and Approach to BPHM, CCM and Transitional Care Services.

Understanding member risk is essential for identifying opportunities both to connect members to services along the continuum of care and to prevent members from requiring more intense treatment and care later. As part of the PHM Program, all MCMC plans will be required to understand each member's risk in a manner that is aligned with NCQA PHM requirements for RSS and have a process for assessing and re-assessing members for care management needs. Taken together, these processes enable each MCMC plan to ensure that all members are connected to primary care, appropriate wellness, prevention, and disease management activities and to identify and connect those members who are at risk for developing complex health issues to more specialized services.

Goals for RSS and Risk Tiering:

- Proactively identify **all members** who may benefit from services or interventions, e.g., wellness and prevention programs or basic PHM services.
- Ensure that **members who may most benefit from additional or specialized care management services or other interventions are identified** and **stratified** and **offered those services**.
- Use data in a standardized way that **reduces bias and promotes equity** in RSS and risk tiering processes.

There are many different terms relating to RSS and risk tiering. For the purposes of the PHM Program, the following definitions apply:

Member Perspective: Understanding Risk

Linda's health plan uses multiple data sources to assess Linda's risk of a poor health outcome: information from Linda's clinician visit, including her food insecurity, her normal physical exam, and abnormal glucose test with a new diagnosis of diabetes; information from her prior claims data; and demographic data, including Linda's race, ethnicity, and preferred language. Her health plan uses a risk stratification and segmentation method that assesses Linda's risk of poor infant and maternal health outcomes and identifies that Linda could benefit from additional services. Someone from Linda's health plan reaches out to Linda and does further assessment for care management needs. They identify that Linda would benefit from food assistance and a Spanish-speaking doula, that she is eligible for participation in a pregnancy wellness program designed for Spanish-speaking individuals, and that she is well connected to her prenatal care provider and is attending normal prenatal care. These services are all available through basic population health management, and Linda feels comfortable accessing these services with the help available to her through the basic care coordination services available in her health plan; she does not require more complex care management services at this time.

Risk stratification and segmentation (RSS) means the process of differentiating all member populations 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 appropriate care management programs or other specific services.

A. RSS and Risk Tiers

Currently, there is wide variation among MCMC plans' processes for understanding risk and connecting members with appropriate care and services based on their risk. This is due to disparate access to and use of data elements, noted above, but is also due to reliance on processes and algorithms that focus specifically on identification of members with high service utilization. PHM, by contrast, is focused on a broader, preemptive use of data and analytics to identify members who have a rising level of risk – not just in terms of medical risk but also social risk – and/or may benefit from broader services and interventions and support, ideally as early as possible to prevent individuals from requiring more intense care and treatment later.

Because the PHM Service will be in testing mode until statewide launch in July 2023, DHCS is setting expectations for RSS and risk tiering across all populations for two distinct time periods: prior to and after the RSS and risk tiering functionalities become available.

As the PHM Service's functionalities become available, DHCS will be moving toward greater standardization of how MCMC plans use RSS algorithms, employ risk tiers, and connect

members to services, with the PHM Service as a critical component to this approach. The PHM Service will include a single, statewide, open-source RSS methodology with standardized risk tier criteria that will place **all** Medi-Cal members into high-, medium-rising-, and low-risk tiers. The RSS methodology and risk tier criteria will be developed with stakeholder input (including input from MCMC plans) and through the implementation of a new Scientific Advisory Committee.

RSS. Prior to the PHM Service's RSS functionalities becoming available, MCMC plans must use an RSS approach that complies with NCQA PHM standards; incorporates a minimum list of data sources, as noted in the "Information Gathering" section; and explains how they will avoid and reduce biases to prevent exacerbation of health disparities.

DHCS recognizes that some plans have developed and significantly invested in their own RSS approaches. Once the PHM Service's RSS functionality is available and vetted, DHCS will require MCMC plans to use the PHM Service RSS outputs and tiers to support statewide standardization and comparisons; MCMC plans may supplement these outputs with local data sources and methodologies. For example, while a MCMC plan must assess the needs of any member who is identified as high risk through the PHM Service, MCMC plans may use additional data sources to identify other members that the PHM Service may not have identified.

Given the differences in children and adult health, specific RSS parameters will be developed to reflect child-specific needs, including distinct needs at different age groupings.

DHCS will conduct a robust stakeholder engagement process before issuing guidance on the required use of the PHM Service once the PHM Service's RSS functionalities are available.

Risk Tiers. Prior to the PHM Service's RSS and risk tiering capabilities becoming available, MCMC plans are **not** required to use standardized risk tiers (i.e., high, medium-rising, or low) across their members, but must use their RSS approach to identify members who should be connected to available interventions and services, including care management, and ensure all members are connected to appropriate BPHM.

Once the PHM Service risk tiers become available, the PHM Service will perform risk tiering using the standardized criteria for all individuals served by Medi-Cal, taking information from all delivery systems into account. The PHM Service will place each individual into a risk tier (i.e., high, medium-rising, or low). Risk tiering will allow for easy communication of a member's risk level to providers and other delivery systems. MCMC plans will be required to use the risk tiers to identify and assess member-level risks and needs and, as needed, connect members to services. MCMC plans will not be able to manually "override" an assessed risk tier given by the PHM Service; however, MCMC plans will be expected to work with network providers to exercise judgment and decision-making about the services a member needs, including through use of real-time information that may be available and through the assessment/reassessment

process described below. MCMC plans will also be expected to work to improve data integrity at the provider and plan level to improve PHM Service RSS accuracy.

Risk tiering will also provide DHCS with a way to monitor across all MCMC plans how members at varying risk levels are being connected to the providers and services they need. DHCS will issue additional guidance after the PHM Service launch on MCMC plans' use of risk tiers and required reporting.

B. Assessment/Reassessment to Understand Member Needs

While the purpose of RSS and tiering is to systematically and continuously identify members who need additional services and supports, understanding risk through data analysis is only one part of a robust PHM approach. Outreach and meaningful engagement with members to understand their needs more deeply and engage them in the services most appropriate for those needs is necessary. DHCS uses the term "assessment" to describe this process. As noted above, assessment is a more comprehensive process than screening, involving a set of questions for defining the nature of a risk factor or problem, determining the overall needs or health goals and priorities, and developing specific treatment recommendations for addressing the risk factor or problem, including (but not only) through care management. Health assessments can vary in length and scope, and some (as described below) are mandated by federal or state law, or by NCQA.

Populations who are required to receive a health assessment include those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver),[15] those entering Complex Care Management (per NCQA),[16] those entering ECM, Children with Special Health Care Needs (CSHCN),[17] and pregnant women.[18]

In addition to federal, state, and NCQA requirements, MCMC plans are currently required to conduct Health Risk Assessments (HRAs) for certain Medi-Cal plan members (notably seniors and persons with disabilities (SPDs)). DHCS has consistently heard feedback that the existing

[15] 42 CFR § 438.208; CA WIC § 14182(c)(12). A Standard Terms and Conditions of Federal 1115 Demonstration Waiver titled "A Bridge to Reform."

[16] **All** populations at rising risk, including (but not limited to) pregnant and postpartum women at risk of poor outcomes.

[17] Aligned with federal regulations, DHCS CQS states, "Each MCMC is required to implement and maintain a program for [CSHCN], who are defined by the state as having, or being at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond that generally required by children. Each MCMC's CSHCN program is required to include standardized procedures for identifying CSHCN at enrollment and on a periodic basis after enrollment. Members identified as CSHCN must receive comprehensive assessment of health and related needs. The MCMC must implement methods for monitoring and improving the quality and appropriateness of care for CSHCN."

[18] Medi-Cal Managed Care Boilerplate Contract, Exhibit A, Attachment 10, Scope of Services, 7. Pregnant Women.

HRA requirements often contribute to duplicative or otherwise burdensome processes for members whereby the same information is taken in via one or more screening tools and by the HRA, as well as through the usual course of care at the provider level. Additionally, since the implementation of ECM in 2022, the HRA requirements can overlap and conflict with the ECM assessment process when an individual is enrolled in ECM. The existence of multiple required tools that overlap with one another – including the existing IHEBA/SHA, which is to be eliminated from 2023 (discussed above) – has contributed to the duplication problem. More fundamentally, lack of data sharing throughout the system is the root cause of duplication, since if one entity cannot view information another entity may have recently solicited and recorded, it must ask for the information again.

Improvement of data sharing is a long-term endeavor involving the entire delivery system that DHCS expects to be accelerated, but never completely solved, by the PHM Service. While that work continues, DHCS is making the following changes effective in 2023 to assessment requirements, balancing continuing federal, state, and NCQA requirements to assess with a focus on eliminating duplication and burden wherever possible:

1. Sharing assessment results between MCMC plans and providers responsible for following up with the member. Similar to the expectation to be put in place for HIF/MET screening (above), MCMC plans must also follow up on any positive assessment result or delegate to the primary care provider for follow up.

2. Establishing an expectation that assessment is integrated with care rather than siloed at the level of the MCMC plan. Again, similar to the HIF/MET screening changes above, DHCS is clarifying that assessment may be delegated to the provider level. In general, assessment should be integrated with care and care management (where applicable) to the greatest extent possible. Whether the assessment is performed in person, telephonically, or by telehealth, it should be conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

3. Simplifying the existing HRA requirements for seniors and persons with disabilities (SPDs) currently contained in APLs 17-013 and 17-012.[19] The care management requirements that have been in place for SPDs and dual-eligible members in APLs 17-013 and 17-012 were instituted by DHCS in conjunction with stakeholders, as a result of previous initiatives and federal requirements. Specifically, in 2010, the state embarked on a multiyear effort to expand mandatory managed care to SPDs who are covered by Medi-Cal. Subsequent to that, in 2014, the Coordinated Care Initiative (CCI) commenced in the seven most populous counties in the state and included Cal MediConnect (a dual-eligible demonstration project), mandatory managed care enrollment for dual-eligible members, and the inclusion of long-term

[19] Risk stratification, care plan, and care management/care coordination requirements also exist for children in the California Children's Services' Whole Child Model in APL 18-023. DHCS will not make changes to these requirements for 2023 but will reassess requirements as the PHM Service is brought online.

services and supports as a managed care benefit. In 2016, the Centers for Medicare & Medicaid Services (CMS) updated the federal rules dictating the care coordination requirements for managed care organizations that cover long-term services and supports.

These initiatives have evolved significantly over time. As of 2019, the majority of non-dual SPDs have been successfully moved into managed care. Additionally, Cal MediConnect is transitioning to an Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plan (D-SNP) model in 2023, with Medicare care coordination and risk assessment standards. Relatedly, beginning in 2023, dual-eligible members will be carved into MCMC in all remaining counties across the state. Given this, and the introduction of CalAIM and the PHM Program, DHCS believes there is an opportunity to update the requirements within APLs 17-013 and 17-012 and eliminate redundancies while keeping specific member protections in place.

Thus, DHCS will retire APLs 17-012 and 17-013 effective January 1, 2023, and replace them with simplified requirements. Following federal and state law, MCMC plans or their delegates must continue to assess members who may need LTSS using the existing standardized LTSS referral questions contained in the APLs.[20] Additionally, for 2023, DHCS will retain the requirement that MCMC plans assess those who meet the definition of "high risk" as established in the existing APL requirements[21], even if they do not have LTSS needs.[22] Starting in 2023, MCMC plans will not be required to retain the use of their existing HRA tools that were previously approved by DHCS under the APLs, although they may choose to do so. MCMC plans may alternatively leverage their ECM and/or CCM assessment tools, or components of those tools, for SPDs considered at "High Risk." If MCMC plans decide to retain existing HRA tools, they are encouraged to adapt them to allow delegation to the provider level. Finally, DHCS will simplify the expected timeline for assessment of those with LTSS needs to align with NCQA's requirements for care management assessments (begin to assess within 30 days of identifying the member through RSS, referral, or other means, and complete assessment within 60 days of that identification).

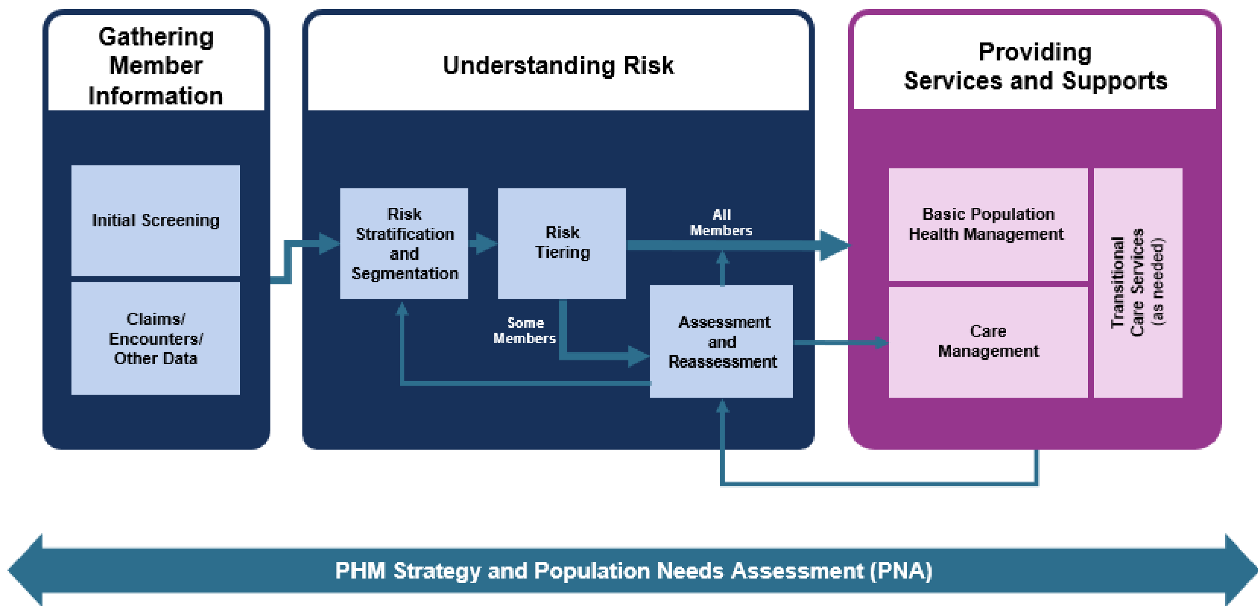
When the PHM Service is live, MCMC plans will be required to use the risk tiers as a starting point for connecting members with services. DHCS will continue to assess the role that the PHM Service can play in streamlining member assessments and intends to issue requirements for sharing of assessment results between plans and providers.

[20] As established in APL 17-013.
[21] See APL 17-012 and APL 17-013 for high risk definitions.
[22] For 2023, D-SNPs will be the primary plan responsible for assessment and care coordination/care management activities for enrolled dual-eligible members. More detailed requirements exist for dual-eligible members served by EAE D-SNPs; please refer to the CalAIM Dual Eligible Special Needs Plans Policy Guidance for additional information.

PHM Program Requirements for Dual Eligible Members

The Medi-Cal PHM Program requirements for dual-eligible members are expected to evolve over time to account for Medicare care coordination and risk assessment standards, especially as specific data and functional capabilities become available through the PHM. For 2023, D-SNPs will be the primary plan responsible for assessment and care coordination/care management activities for dual-eligible members. More detailed risk stratification, assessment, and care management requirements exist for dual-eligible members served by EAE D-SNPs; please refer to the CalAIM Dual Eligible Special Needs Plans Policy Guidance for additional information. For all other dual-eligible members and types of plans, the Medi-Cal plan will be the primary plan responsible for assessment and care coordination/care management activities.

5. Providing Services and Supports



As part of PHM, MCMC plans are required to have a broad range of programs and services to meet the needs of all members. In addition to meeting NCQA standards for PHM in 2023, MCMC plans will be required to describe the range of PHM interventions they offer. From 2023, DHCS will consider MCMC plans' PHM services to be organized into the following three areas:

- **Basic Population Health Management (BPHM).** BPHM is the array of programs and services for **all** MCMC plan members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.
- **Care Management Services.** These are services for MCMC members who qualify as a result of their risk status and/or as a result of an assessment for care management services.
- **Transitional Care Services.** These services are available for all MCMC members transferring from one setting or level of care to another.

Each of these areas is described in greater detail below.

Goals for Providing Services and Supports

- Drive progress toward health equity, CQS targets, and Bold Goals through regular data analysis.

Goals for BPHM and Care Management

Ensure that every member:

- Has a source of care that is appropriate, ongoing, and timely to meet the member's needs.
- Has an assigned primary care provider (PCP) and access to primary care and is engaged with primary care.
- Receives all needed preventive services in partnership with the assigned PCP.
- Has access to an appropriate level of care management through person-centered interventions, care coordination, navigation, and referrals across all health care and social needs based on the intensity of health and social needs and services required.

Goals for Transitional Care

Ensure that every member:

- 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.
- Receives the support and coordination needed to have a safe and secure transition with the least burden on the member as possible.
- Continues to have the needed support and connections to services that make them successful in their new environment.

A. Basic Population Health Management (BPHM)

Through the PHM Program, DHCS is renewing its focus on wellness and prevention – at the member, population, and community levels – as the foundation of all health care.

BPHM is offered to all members, and provided in a manner to address member needs and preferences and address health disparities. BPHM applies an approach to care that ensures that needed programs and services, including primary care, are made available to each member, regardless of the member's risk tier, at the right time and in the right setting. In contrast to care management, which is focused on populations with significant or emerging needs (as described in more detail in the next section), **all** MCMC plan members receive BPHM, regardless of their level of need.

Basic Population Health Management replaces DHCS' previous concept of "Basic Case Management." The revised terminology used in this paper is designed to clarify that Basic Population Health Management is available to all MCMC plan members. Complex care management is designed for members at higher or medium-rising risk but not in the highest risk group, which warrants ECM eligibility.

Member Perspective: BPHM

After Linda's delivery, Jacob is healthy and doing well and receives routine well-child care with his primary care provider. Jacob's health plan monitors him through data to ensure that he is getting all recommended preventive services such as vaccinations (according to the Advisory Committee on Immunization Practices (ACIP) schedule) and regular well-child visits (according to the AAP Bright Futures periodicity schedule). When Jacob's sister, Sophia, gets acute appendicitis and is hospitalized, Jacob misses his six-month well-child checkup and vaccinations. A care coordinator reaches out to Linda, Jacob's mom, to flag the missed appointment and see if she can assist getting Jacob to the well-child visit. She learns that Linda is at home caring for Sophia and can't leave. However, John, Jacob's grandfather, could take Jacob to the visit if he had transportation assistance. The care coordinator reschedules the appointment and sets up transportation. Jacob makes it to his rescheduled checkup and receives his needed vaccines. The care coordinator tracks that Jacob attended the visit.

BPHM is ultimately the responsibility of the MCMC plan. However, components of BPHM can and should be delegated, as appropriate. For example:

- For members who have been seen and are engaged in primary care, MCMC plans should delegate responsibility to primary care providers for care coordination functions, whenever feasible.
- For members who have been assigned a primary care provider but have not yet engaged with the provider (e.g. assigned but not seen or lost to follow up), MCMC plans are fully responsible for the provision of BPHM.

- For members enrolled in ECM, the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of their care management.

In all cases, DCHS recognizes that there will be some functions of BPHM that will still need to be managed or supported by the MCMC plan, such as establishing a community resource directory, and providing the full suite of wellness and prevention programs.

BPHM can truly be seen as the “connective tissue” of all health care for MCMC plan members by bridging the gap between schools, public health, social service programs, primary care, and other health care services, etc. At the individual member level, BPHM means access to the right care at the right place and at the right time. At the population level, BPHM means the organization of resources to meet the population’s needs and achieve improved outcomes, including by targeting health disparities and addressing health education and cultural and linguistic needs.

Integral to DHCS’ vision for BPHM is making improvements in health equity. The Health Equity Roadmap contained within the CQS identifies the need to close equity gaps on select quality measures, including those related to preventive care and wellness and the CQS Bold Goals. The CQS also includes specific initiatives promoting health equity, including the addition of new and anticipated benefits (community health workers (CHWs), doulas) to provide culturally appropriate and community-based care, all of which must be evaluated by MCMC plans under the Quality Improvement and Health Equity Transformation Program (QIHETP) to ensure quality and equity outcomes. BPHM connects these initiatives, and it is through BPHM that MCMC plans will be responsible for deploying these programs.

Although the key components of BPHM are not new, DHCS has not previously articulated them as a comprehensive package of services and supports that **all** MCMC plan members can expect. Clarity for members will allow DHCS to promote stronger and more focused MCMC plan oversight for BPHM, as well as more consistency across MCMC plans and regions. Many components of BPHM are also included in NCQA PHM standards. Each MCMC plan’s strategy for BPHM, particularly its wellness and prevention approaches, will be described in its approved PHM Strategy, starting in 2023. Additionally, as described in Section 6 below (Accountability), DHCS will increase oversight of BPHM beginning in 2023.

The key components of BPHM are as follows:

Access, Utilization, and Engagement with Primary Care. Primary care is the foundation of all health care and is critical to achieving quality and equity. However, Medi-Cal members are currently more likely than commercial populations to report having no usual source of care.[23] Central to the BPHM concept is providing strong access to and utilization of primary care, as well as leveraging culturally and linguistically appropriate primary care to increase trust with members, reduce health care disparities, and provide comprehensive care for physical and behavioral health conditions to all members. As part of BPHM, MCMC plans must ensure that each member – including members for whom there is little or no data with which to conduct RSS – is engaged with their assigned PCP and has continuity of care with their PCP, and that members who have not been seen by the PCP in the past 12 months receive outreach and are supported to re-establish regular contact with the PCP. Additional requirements apply with respect to children, who must receive periodic well-child and developmental screens on a schedule consistent with information provided in Box D.

As part of quarterly reporting requirements for PHM (see below), DHCS is considering requiring MCMC plans to provide data on engagement with PCPs for members who were previously unengaged as well as more robustly measuring access to PCPs. In parallel with these PHM requirements, DHCS is accelerating work to improve the Medi-Cal primary care infrastructure. Starting in 2024, MCMC plans will be reporting on primary care spend as a share of all health care spending, including specific reporting on such spending for children's primary care and demographic stratification of spending. In recognition of the fact that strong primary care is best supported by payment models that provide stability to practices and reward outcomes over volume, DHCS is introducing new MCMC plan reporting requirements from 2024 to track progress toward value-based payment with providers.[24] DHCS is considering setting targets for MCMC plans for both primary care spending and value-based payment models with providers in the future.

DHCS recognizes that strengthening primary care is structural and means reversing decades of underinvestment. To achieve the goals of BPHM, MCMC plans will need to ensure the revitalization and practice transformation of the primary care practices in their network while ensuring best practices such as behavioral health integration and comprehensive behavioral health networks to address mild to moderate behavioral health conditions.

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[23] CHCF, Measuring Up Access to Care in Medi-Cal Compared to Other Types of Health Insurance (2018).

[24] DHCS reserves the right to add required minimum spending targets, as several other state Medicaid programs have begun to do in recent years.

Box D: Basic Population Health Management for Children

All children under the age of 21 enrolled in Medicaid are entitled under federal law to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which requires that children receive all screening, preventive, and medically necessary diagnostic and treatment services, regardless of whether the service is included in the Medicaid State Plan. **Both today and in the future,** the operation of EPSDT means that MCMC plans must:

- Ensure all members under 21 receive an IHA within 120 calendar days of enrollment or within the AAP Bright Futures periodicity timeline for children ages 18 months and younger, whichever is sooner.
- Provide preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the ACIP childhood immunization schedule.
- Provide all medically necessary services, including those that are not necessarily covered for adults, as long as they could be Medicaid-covered services.
- Coordinate health and social services for children between settings of care and across other MCMC plans and delivery systems. Specifically, MCMC plans must assist children and their families in accessing medically necessary physical, behavioral, and dental health services, as well as social and educational services.
- Actively and systematically promote EPSDT screenings and preventive services to children and families.

Going forward, BPHM will be the vehicle through which EPSDT care coordination, wellness, and prevention are delivered to children in California and through which DHCS will measure and monitor adherence to requirements. At the individual level, BPHM is intended to ensure that all members under 21 receive the full scope of the EPSDT benefit. If children are enrolled in ECM or CCM, all the requirements of BPHM and EPSDT continue to apply.

At the population and community levels, BPHM, along with the broader PHM Program, aims to identify gaps in care and social needs and allocate resources where they are most needed to improve services. As part of MCMC plans' PHM Strategy annual deliverable, starting in 2023, MCMC plans will be required to review the utilization of children's preventive health visits and developmental screenings and outline their strategies for improving access to those services. For MCMC plans that fail to meet minimum standards for children's preventive health, there are a number of accountability and oversight measures – including new financial sanctions in 2023 and current use of corrective action plans – that DHCS will leverage. For more details, please see Section 6: Accountability for PHM. Starting in 2024, MCMC plans will also be required to ensure that providers receive EPSDT training at least once every two years and to enter into memorandums of understanding (MOUs) with every Local Education Agency (LEA) in each county within their service area for school-based services to strengthen provision of EPSDT within schools. For more information on DHCS' actions to improve children's health, please see Medi-Cal's Strategy to Support Health and Opportunity for Children and Families.

Care Coordination, Navigation, and Referrals across All Health and Social Services, Including Community Supports. Under federal rules,[25] every state Medicaid program must ensure that each MCMC plan coordinates members' care, not just across the care that the MCMC plan is funding but across services that may be provided by other Medicaid delivery systems and with services that are received from community and social support providers. Thus, in California, even though some Medicaid services – including but not limited to SMHS, oral health, and pharmacy – are typically carved out of the MCMC plan benefit package, it is the responsibility of MCMC plans to ensure that members have access to needed services that address **all** their health and health-related needs, including developmental, physical, mental health, SUD, dementia, long-term services and supports, palliative care, oral health, vision, and pharmacy needs. For example, a MCMC plan must ensure that a pregnant woman at high risk of a poor outcome for both physical and specialty mental health needs is referred to appropriate specialists, has access to genetic screening, has access to appropriate hospitals within the provider network to provide high-risk pregnancy services, and is connected to SMHS.[26]

To ensure that all health and health-related needs are addressed, MCMC plans must not only work in partnership with primary care, as noted above, but with other delivery systems as well as schools and local public health and social benefits programs such as CalWORKS, CalFresh, and Women, Infants and Children (WIC). MCMC plans must also authorize and coordinate access to Community Supports that plans offer. A critical aspect of BPHM is identifying upstream opportunities to leverage public benefits (e.g., enrollment in WIC much earlier in pregnancy) or relevant Community Supports (e.g., asthma remediation for a household with multiple siblings with asthma, one of whom just had an emergency department (ED) visit). To support strong referral management at both the plan and provider levels, BPHM encompasses requirements for electronic referrals tracking, availability of up-to-date network information, and a toll-free number for providers to support referrals.

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[25] 42 CFR § 438.208.

[26] Medi-Cal Managed Care Boilerplate Contract, Exhibit A, Attachment 10, Scope of Services, 7. Pregnant Women.

Box E: Role of Community Supports in Basic Population Health Management

Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address SDOH (factors in people's lives that influence their health). All MCMC plans are encouraged to offer as many of the following 14 Community Supports as possible:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Day Habilitation Programs
- Caregiver Respite Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

With the launch of the PHM program in 2023, DHCS will begin to integrate both wellness programs and Community Supports selections into the broader endeavor of population health; and Community Supports selections and strategies will be built into MCMCs' annual PHM Strategy.

Wellness and Prevention Programs. As described above, BPHM emphasizes the primary care relationship at the heart of preventive care for both adults and children, which refers to those services that "prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency."[27] DHCS is committed to improvement in metrics of preventive care through BPHM. For children, special preventive services requirements are prescribed by EPSDT (see above). In addition, the focus on wellness and prevention should expand beyond prevention of physical diseases such as hypertension or diabetes to leverage early interventions and supports for common mild to moderate/non-specialty behavioral health conditions.

However, DHCS recognizes that wellness is a set of conditions in which people can thrive and pursue optimal health; it is much more than adherence to traditional preventive visits, or even the absence of disease or infirmity. Wellness not only requires proper diet, exercise, and health habits, but also requires addressing issues that will take time to address and efforts

[27] 42 CFR § 440.130(c); see definition of preventive services.

beyond PHM, such as social isolation and community health (e.g., access to fresh foods, local parks, or venues to exercise in). Thus, the rollout of PHM highlights that there is much more work to do to address the larger systemic barriers to health equity and will bring renewed emphasis on strategies and partnerships that move "upstream" to address SDOH.

MCMC plans will be expected to provide comprehensive wellness and prevention programs that, at minimum, meet NCQA requirements. DHCS also will require MCMC plans to report annually through their PHM Strategy on how they are using community-specific information gained in the PNA to design and implement evidence-based wellness and prevention strategies to meet the unique needs of their populations, as well as to drive toward the Clinical Focus Areas and Bold Goals in the CQS. In order to support children enrolled in Medi-Cal in accessing and receiving wellness and prevention programs, MCMC plans should partner with children's health organizations in their local communities, including First 5 County Commissions, Early Start, and other community-based organizations. Future guidance will detail what MCMC plans must report as part of the PHM Strategy. Later this year, DHCS will add new State Plan benefits for doulas and CHWs/promotores de salud. DHCS is particularly interested in encouraging models that engage this workforce in wellness and prevention activities, especially as aligned with DHCS' Bold Goals 50x2025 initiative, as well as further DHCS Health Equity Roadmap goals of having a workforce that is representative of the diversity and lived experience of the Medi-Cal population, and will prompt MCMC plans to describe their approach in this area as part of the PHM Strategy process starting in 2023.

Programs Addressing Chronic Disease. In 2020, approximately 40% of all adults in California reported having at least one of the five most prevalent chronic conditions.[28] For Medi-Cal members, the burden of chronic disease has also been exacerbated by COVID-19 and the potential for long COVID-19; and both chronic disease and COVID-19 disproportionately impact Black, Indigenous and People of Color (BIPOC).[29] While CCM and ECM will serve many with chronic diseases, DHCS is also focused on ensuring that the most common chronic conditions, which are largely preventable and can be managed by routine member engagement with the health care system, supplemented where relevant with Community Supports, are explicitly addressed as part of BPHM.

Thus, from 2023, all MCMC plans will be required to offer evidence-based disease management programs in line with NCQA requirements. Such programs should specifically target (at minimum) diabetes, cardiovascular disease, asthma, and depression and must incorporate health interventions, target members for engagement, and seek to close care gaps for the cohorts of members participating in the interventions with a focus on equity and health disparities. While most of these conditions have been historically treated in the physical health

[28] High blood pressure (28.4%), asthma (14.3%), diabetes (9.1%), psychological distress (8%), and heart disease (6.2%). California Department of Public Health, The Burden of Chronic Disease, Injury, and Environmental Exposure Report.

[29] Comorbidity and its Impact on Patients with COVID-19.

provider network, given the rising incidence of mild to moderate behavioral health conditions, MCMC plans will be required to ensure effective networks for treatment of these conditions and integration with physical health interventions. Again, these programs should tie into the PNA and the PHM Strategy along with other community programs (e.g., local health jurisdiction chronic disease initiatives, focus areas for plan community reinvestment programs, data collection efforts by local public health and community organizations). Although diabetes, asthma, cardiovascular disease, and depression are a common minimum, programs should be tailored to the specific needs of each plan's Medi-Cal populations.

Programs to Address Maternal Health Outcomes. While California has made progress in improving maternal mortality and decreasing caesarean section rates, maternal mortality for Black birthing persons remains three times as high as for white birthing persons, and Black birthing persons also have the highest C-section rates in the state.[30] DHCS is prioritizing maternal health through the Bold Goals (reduce maternity care disparity for Black and Native American persons by 50% by 2025) and is introducing the doula benefit later this year to improve culturally competent birth care. PHM programs offered by MCMC plans have a key role to play in improving outcomes in this area by supporting quality improvement and health disparity reduction efforts with their network providers and addressing systemic discrimination in maternity care, particularly for Black birthing persons. MCMC plans must continue to follow all requirements for pregnant individuals in accordance with American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) standards, which include prenatal care, comprehensive risk assessment, and referral support.[31,32] DHCS plans to issue future guidance for MCMC plans regarding best practices to address maternal health outcomes.

B. Care Management Programs

Care management is a team-based, person-centered approach to supporting an individual. Individuals in care management have a care manager, an interdisciplinary care team, and a care management plan (CMP), which is a written plan that is developed with input from the member and/or their family member(s), guardian, authorized representative, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences and make recommendations for service needs.

[30] DHCS Comprehensive Quality Strategy, p. 5051.
[31] Section 1902(e)(5) of the Social Security Act6; 42 CFR § 435.170. The Centers for Medicaid and CHIP Services, SHO #21-007
[32] Effective April 1, 2022, DHCS extended the postpartum care coverage period for currently eligible and newly eligible pregnant individuals. The American Rescue Plan Act (ARPA) Postpartum Care Expansion (PCE) extends the coverage period from 60 days to 365 days (one year) for individuals eligible for pregnancy and postpartum care services in Medi-Cal and the Medi-Cal Access Program (MCAP). ARPA PCE coverage includes the full breadth of medically necessary services during pregnancy and the extended postpartum period.

Unlike BPHM – which is universal – care management is intended for MCMC plan members, including children, at heightened risk of poor health outcomes and individuals with high-risk pregnancy (including heightened risk related to SDOH, in addition to medical risk). As described above, in the future, the PHM Service will help identify members who must be assessed for care management; in the short term, certain broader subpopulations must be assessed to determine whether they need care management.

Member Perspective: Care Management

John, Linda's father-in-law, is 55, has diabetes and high blood pressure, and suffered a stroke last year. His MCMC plan identified him as eligible to participate in complex care management (CCM) services with an assigned care manager. John's care manager talked with John about his condition, needs, and care goals. John identified that he wanted to get his diabetes under better control because he was scared of having another stroke and wanted to actively participate in caring for his grandkids. Together, John and the care manager developed a care plan that was evidence-based and comprehensive, with measurable goals. John's care manager helped John connect to programs and resources, including medically tailored meal services, and health care services to help him better understand his medications and diet and manage his diabetes. The care manager continued to follow up with John and see how he was doing on his goals, measuring success based on John's A1C level. Within several months, John was doing well; his diabetes was under good control, with an A1C of 6.9%; and he was proud to say how much he could help out the family by caring for his grandkids.

Members enrolled in care management programs must continue to receive all elements of BPHM. Under CalAIM and the 2024 Re-Procurement, care management always includes the expectation that care managers will assess members and link them to Community Supports when available and appropriate.

Care management was already in place in multiple forms in the Medi-Cal program prior to CalAIM. Beyond Medi-Cal Managed Care, Targeted Case Management (TCM) is available as part of SMHS benefits and as an LGA option. TCM will continue to be in place.[33] With CalAIM, however, DHCS is comprehensively mapping and standardizing the continuum of care management programs that MCMC plans are required to offer, including how MCMC plans' care management responsibilities relate to programs outside Medi-Cal Managed Care. Total uniformity is not the goal; care management will still necessarily look very different for MCMC plan members in different high-need populations. With CalAIM, DHCS is establishing common terminology and expectations that apply across populations who need care management, establishing a continuum between two care management approaches:

[33] DHCS Targeted Case Management (TCM).

ECM. ECM, which went live in January 2022, is a new statewide benefit in MCMC that addresses the clinical and nonclinical needs of Medi-Cal's highest-need members through intensive coordination of health and health-related services.[34] ECM is community based, interdisciplinary, high touch, and person centered. MCMC plans are required to contract with "ECM Providers," existing community providers such as Federally Qualified Health Centers (FQHCs), Whole Person Care Lead Entities, Specialty Mental Health Plans, CBOs, and others, who will assign a Lead Care Manager to each enrollee. The Lead Care Manager meets members wherever they are – on the street, in a shelter, in their doctor's office, or at home. As noted in the Understanding Risk section, ECM eligibility is based on members meeting specific "Populations of Focus" criteria. The Populations of Focus going live in 2022[35] are adult high utilizers, individuals and families experiencing homelessness, adults with serious mental illness (SMI)/SUD, and individuals incarcerated and transitioning to the community (certain counties that served individuals post-incarceration in Whole Person Care). In 2023, MCMC plans will extend ECM to members eligible for long-term care and at risk of institutionalization, nursing facility residents transitioning to the community, individuals incarcerated and transitioning to the community (all remaining counties), and certain high-needs children and youth.

Over the course of 2022, MCMC plans are required to demonstrate sustained growth of the ECM program for new members and prepare for the implementation of the ECM Populations of Focus that go live in 2023. Preparation includes developing policies and procedures that describe how the MCMC plan intends to implement and administer ECM to new Populations of Focus, as well as contracting with community-based entities to serve as ECM Providers.[36] Starting in the second quarter of 2022 and extending for at least three years, DHCS is instituting MCMC plan quarterly reporting requirements to monitor the implementation of ECM (and Community Supports, described above), including the number of members referred into the benefit, the number of members otherwise identified by MCMC plans as eligible for the service, and the number actually receiving ECM services in each Population of Focus that quarter.[37] DHCS will monitor outcomes for the group served by ECM and evaluate whether and how the existing Populations of Focus definitions and policies may be improved over time to ensure that the ECM benefit continues to serve those with the highest needs.

Complex Care Management (CCM). Complex Care Management equates to "Complex Case Management" as defined by NCQA. MCMC plans are already required to provide CCM, in line with the requirement that all MCMC plans must meet NCQA PHM standards. CCM will

[34] ECM requirements are contained in the ECM Policy Guide and website. This document does not alter or add to ECM program design or requirements.
[35] Go-live dates depend on counties' previous participation in Whole Person Care or Health Homes Program. Please see Finalized ECM Key Design Implementation Decisions for full details.
[36] More information about this process can be found within the Model of Care Template.
[37] DHCS is engaging in additional monitoring during the current first few months of the benefit, through frequent communications with plans, providers, and other stakeholders.

continue to be a requirement for all MCMC plans in 2023, with the addition of enhanced DHCS oversight, as described below.

An individual cannot be enrolled in ECM and CCM at the same time; rather, CCM is on a care management continuum with ECM.

CCM is a service for MCMC plan members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM is designed to meet the differing health and social needs of higher- and medium-rising-risk members, through both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner. CCM can be used to support members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all members in CCM previously received ECM and not all members who step down from ECM require CCM. As in ECM, CCM must include a comprehensive assessment of each member's condition, as well as development and implementation of a Care Management Plan (CMP) with goals, monitoring, and follow-up. Also, as in ECM, MCMC plans must assign a Care Manager for every member receiving CCM. For children and youth under age 21, CCM, as in ECM, must include EPSDT care coordination. Following NCQA's requirements, MCMC plans must consider CCM to be an opt-out program. Also following NCQA's requirements, MCMC plans may delegate CCM to providers and other entities who are themselves NCQA certified. DHCS encourages MCMC plans to work with providers to contract for a care management continuum of ECM and CCM programs, wherever possible, including as a way to maximize opportunities for members to step down from ECM to CCM or BPHM under the care of a single provider.

CCM is deliberately more flexible in design than ECM and allows MCMC plans to determine (within NCQA guardrails) their own criteria for entry, based on the risk stratification guardrails above and the local needs identified in the PNA. To ensure that CCM always includes a variety of approaches to manage different types of risk and rising risk, DHCS is requiring that CCM includes approaches for longer-term chronic care coordination; interventions for episodic, temporary needs; and disease-specific management interventions that include, but are not limited to, asthma and diabetes. DHCS plans to monitor the provision and penetration rate of CCM through the quarterly implementation monitoring reporting for PHM described below.

C. Transitional Care Services

MCMC plans have long been required to provide and support transitional care coordination to all members undergoing a transition, including as directed by federal and state authorities.[38] Care transitions are defined as a member transferring 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. These transitions are times

[38] 42 CFR § 438.208.

when members are especially in need of support to manage their care and are vulnerable to experiencing adverse health events due to care team changes, inadequate health education and follow-up, changes in the level of support and care they receive, environment changes, and, frequently, medication and supplies changes.

Under CalAIM and as described below, MCMC plans will be required to meet strengthened transitional care services requirements within the PHM Program beginning in 2023 for all members, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports.

These transitional care policies are consistent with the CQS and will be reinforced by the CQS over time. MCMC plans are expected to focus on care transitions across all settings for CalAIM populations of focus irrespective of which delivery system follow up is needed. This is being measured through quality reporting in ensuring timely follow up for members with ED visits for mental health or SUD. Going forward, additional quality and process measures and reporting will also be added to be synergistic with these transitional care policies.

Member Perspective: Transitional Care Services

Linda's 10-year-old daughter, Sophia, goes to the emergency room for abdominal pain and is found to have complicated appendicitis. She is admitted to the hospital and undergoes an open appendectomy but has post-op complications when her surgical incision becomes infected. Her MCMC plan was alerted to her admission and assigned a care manager to support her during this acute health episode. The care manager works with the hospital-based social worker and nurse care manager to plan for discharge and perform a discharge risk assessment to identify Sophia's needs. They find that Sophia will need transportation to her follow-up appointments and will need home health services for wound care. Sophia's care manager at the MCMC plan determines that Sophia will not need ECM or CCM services once she is stabilized after her transition. Her discharging hospitalist refers her to home health services and sets up her follow-up surgical and PCP appointments. Sophia's health plan authorizes her for home health nursing services. At discharge, Sophia receives a discharge planning document that includes information about her discharge, her follow-up appointments, the name and contact information of her home health agency, and the name and contact information of her care manager. The care manager provides support to Sophia and her parents after her discharge, answering questions, checking that Sophia has all the right medications, and ensuring that she makes it to her follow-up appointments. After Sophia gets to her first follow-up appointment and home health has had their first visit, the care manager assesses that Sophia does not have any other additional needs, and she is transitioned back to basic population health management two weeks after discharge.

Identifying the Care Manager Responsible for Transitional Care Services.
MCMC plans are responsible for knowing in a timely manner when their members are

admitted, discharged, or transferred, and therefore experiencing a transition. To the extent that ADT feeds exist, MCMC plans are expected to use them to know when their members are admitted, discharged or transferred, consistent with the requirement to use ADT feeds for RSS.[39] When ADT feeds are not available (for example many skilled nursing facilities (SNFs) do not create ADT data feeds), MCMC plans may create other mechanisms to identify, in a timely manner, members who are admitted, discharged or transferred, including but not limited to requirements for notification by admitting facilities and institutions directly or leveraging existing prior authorization requests. Once a member has been identified as being **admitted**, MCMC plans are required to identify an individual care manager who will be responsible for ensuring completion of all transitional care management services. Since this care manager will be engaged after notification of admission, they are responsible for collaborating with the facility and knowing when members are transferred or discharged. The responsibilities of the care manager also include ensuring non-duplication of services provide by other team members (including facility or PCP based care managers); and collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, emergency departments, LTSS, physicians, nurses, social workers, discharge planners, and service providers. This care manager must be able to provide care management services in a culturally and linguistically appropriate manner for the member experiencing a transition.

For members enrolled in ECM or CCM, their existing ECM/CCM care manager is the care manager responsible for transitional care management services; there is not an additional care manager assigned.

For members not enrolled in ECM or CCM, MCMC plans must assign a care manager for the duration of the member's transitional care needs. The role of the care manager does not need to be employed by the plan and can be delegated (for example to hospital care managers, or ACOs) as long as the plan ensures that all transitional care services can be complete and **a single care manager is assigned for the duration of the transitional care services, including follow-up after discharge**.

Communication of Care Manager Assignment.

MCMC plans will communicate both with the responsible care manager and with the facility where the patient is admitted (referred to as the discharging facility) in a timely manner so that the care manager can participate in discharge planning. MCMC plans will notify the identified responsible care manager of the assignment and of the member's admission status, including the location of admission. MCMC plans must also ensure that the discharging facility has the name and contact information, including phone number, of the assigned care manager.

Care Manager Responsibilities.

The care manager responsible for transitional care services is responsible for coordinating and

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[39] All inpatient hospitals, psychiatric hospitals, and critical access hospitals that use EHRs and participate in Medicare create ADT feeds under Conditions of Participation.

verifying that members receive all appropriate transitional care services, regardless of setting and including but not limited to inpatient facilities, discharging facilities, and community-based organizations. Hospital and nursing home staff who help with discharge plans should work with, but do not supplant the need for, a care manager. Care managers are expected to establish a longitudinal relationship with the member that enables them to coordinate care during discharge planning, at discharge/transfer, and after the member arrives in their new setting. They are also responsible for ensuring that information sharing, and communication occur with appropriate providers to assist members in successful transitions, including with the member's PCP. While the care manager does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, medication reconciliation, and closed-loop referrals. Similar to other MCMC Services, members must be offered the direct assistance of the care manager, but members have choice in their relationship with the care manager and may choose to not have contact with the care manager. In these cases, at minimum the care manager must act as a liaison coordinating care amongst the discharging facility, the PCP, and the MCMC plan.

Discharge Risk Assessment and Discharge Planning Document.
The discharge risk assessment should be completed prior to discharge and is designed to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition, and/or SUD relapse. As part of this discharge risk assessment done prior to discharge, care managers must ensure that members are assessed or reassessed for eligibility for ongoing care management services such as ECM or CCM.

The discharge planning document facilitates communication and information sharing of the member's specific discharge plan with the member; the member's parents, legal guardians, or authorized representatives, as appropriate; and the member's treating providers. The planning document must include a member's pre-admission status, their pre-discharge medical and social support needs, information on the facility to which the member was admitted, specific information on the discharge facility, and the member's scheduled follow-up appointments.[40] In addition to these requirements, the discharge planning document must also include the care manager's name and contact information and a description of transitional care services, and must be in language that is culturally, linguistically, and literacy-level appropriate. The discharge planning document must also be shared with treating providers, including, but not limited to, the discharging facility, the receiving facility or provider, the PCP, and any providers who have scheduled follow-up visits as outlined in the discharge planning document.

The discharge risk assessment and discharge planning document may be completed by the discharging facility (and at minimum should be informed by discharging providers). However, it is the responsibility of the care manager assigned for transitional care services to ensure it is

[40] A list of these requirements is included in the 2024 Re-Procurement, Exhibit A, Attachment III, Section 4.3.11 Transitional Care Services, B. Discharge Planning and Care Coordination.

complete and accurate, coordinated, and shared with appropriate parties as listed above. It is also the responsibility of the care manager to ensure non-duplication so that members do not receive two different discharge documents (one from discharging facility and a separate one from care manager).

Additional Guidance for Members Enrolled with Multiple Payors.

Unmanaged or poorly managed care transitions across multiple payors have contributed to poor outcomes for MCMC plan members. MCMC plans are responsible for care coordination including for carved out services, therefore, DHCS expects each MCMC plan to be responsible for transitional care coordination for its members, even if the MCMC plan is not the primary source of coverage for the triggering service (e.g. hospitalization for a Medicare FFS dual-eligible member, or an inpatient psychiatric admission covered by a SMHS plan). For all members enrolled with multiple payors undergoing any transition, this expectation includes requirements that the MCMC plan must:

1. Know when their members are admitted, discharged, or transferred potentially through data sharing agreements with other plans or with facilities.

2. Be responsible for approving prior authorizations and coordinating, in a timely manner, services where the MCMC plan is the primary payer, such as home services, long-term services and supports for dual-eligible members, Community Supports, medical care for SMHS members, or prenatal or postpartum services for pregnant individuals.

3. Assess members for any additional care management needs that they qualify for such as ECM/CCM or Community Supports and enroll as appropriate.

4. Notify existing care managers of admissions if individual is already enrolled in ECM or CCM.

For admissions, transfers and discharges involving MCMC members dually eligible for Medi-Cal and Medicare **(with the exception of MCMC members enrolled in D-SNP plans)**, MCMC plans are fully responsible for all transitional care requirements, including assigning a care manager who is responsible for all transitional care management tasks[41]. For admissions, transfers and discharges involving MCMC members enrolled in D-SNP plans, D-SNPs are responsible for assigning a care manager who is responsible for all care management tasks and requirements[42].

For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where Specialty Mental Health is the primary payer,

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[41] Requirements of the care manager include medication reconciliation, discharge planning document, discharge risk assessment, closed loop referrals, and ensuring members get all needed follow-up care and services.

[42] More details on timing and expected coordination will be issued in the Program Guide.

and for members who are admitted for inpatient or residential SUD treatment, including residential withdrawal management, where DMC-ODS is the primary payer, MCMC plans are required to assign a care manager who will be responsible for coordinating with the BH or county care manager assigned by Specialty Mental Health and DMC-ODS and ensuring needed follow-ups are completed[43].

Ending Transitional Care Management Services.

When ending transitional care services, the care manager is expected to share the completed care plan with the member and their parents, legal guardians, or authorized representatives, as appropriate, in addition to the member's PCP. Transitional care services and assignment to the relevant care manager end in the following circumstances:

For members eligible for ECM or CCM: The member is enrolled in ECM or CCM, and if the care manager responsible for transitional care services will not continue as their ECM or CCM lead care manager, the member should be connected to their new care manager through a warm handoff.

For members not requiring ECM or CCM: Once the member has been connected to all the needed services, including all that are identified in the Discharge Risk Assessment or Discharge Planning Document. This includes but is not limited to attending the scheduled follow-up visits, ensuring closed-loop referrals to social service organizations have been completed, and ensuring any needed home services have commenced. As noted above, if the MCMC has delegated transitional care services to the provider, the MCMC must ensure the provider follows and coordinates services for the member until all aforementioned activities are completed. For those who have ongoing unmet needs, enrollment in ECM or CCM should be reconsidered.

Beyond 2023.

The clarifications noted above detail how transitional care services support members. However, DHCS recognizes that to achieve DHCS' member goals for transitional care services additional efforts are needed. As such, in addition to improving reporting and accountability for member transitions, which is noted in the section below, DHCS will embark on a larger improvement effort to prioritize members' needs and preferences in the transitional care planning process by:

- Considering the best ways that existing trusted care partners such as PCPs, mental health providers, LTSS providers, home health workers, CHWs, and social support providers can be leveraged and supported to assist members in having safe and supportive transitions.
- Considering how to support members through:

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[43] Needed follow-ups include ensuring member has timely follow-up with PCP and coordinating any needed physical health follow-up, including medication reconciliation.

- Improved coordination among facilities, providers, MCMC plans, and other payors, including through regional/community collaboratives (including Providing Access and Transforming Health (PATH)-supported CalAIM Collaborative Planning efforts); and,
- Data sharing, leveraging the PHM Service to enable real-time information sharing of a member's health status and use of services, across delivery systems and payors and between plan/provider levels.

6. Accountability for PHM

A well-functioning PHM program improves health outcomes, health equity, preventive care access, connections to primary care, and member experience. MCMCs will be held accountable for having well-functioning PHM programs to achieve these improvements. Under CalAIM and as a key component of the 2024 Re-Procurement and the CQS, DHCS is strengthening oversight of MCMC plans, adding robust accountability, compliance, and oversight programs, including for delegated entities, to ensure that members receive quality care and have access to needed services. DHCS is developing and implementing a Managed Care Monitoring and Oversight Framework as part of the implementation of the 2024 Re-Procurement and CQS. Accountability and oversight for PHM will be measured and implemented within this framework, with additional details outlined in forthcoming guidance.

Specifically, starting in 2023, DHCS plans to incorporate MCMC plan performance on key measures (including high-priority clinical quality measures and member experience) as a consideration within plan capitation rate setting. Building on efforts in 2022, MCPs are expected to further incorporate health equity measures and begin to achieve DHCS established targets to reduce disparities for MY2023. In addition, MCMC plans will be required to exceed a 50th percentile minimum performance level (MPL)[44] target on priority MCAS metrics (raised from 25% and expected to be raised further over time).[45] MCAS measures, some of which have established MPLs, are updated annually (available here), and MCMC plans must exceed the established MPL each year. For the 2022 measurement year, there are 39 MCAS measures, 15 of which require an established MPL to be exceeded. These 15 MCAS measures are mostly pediatric and maternal-specific, including measurements on child and adolescent well-care visits, well-child visits, childhood immunization status, lead screening in children, and prenatal and postpartum care measures. If quality metrics are not met, an MCMC plan will be required to allocate an additional 7.5% of its annual net income to

[44] Per APL 19-017, the MPL for each required MCAS measure that is also an NCQA measure is the national Medicaid 50th percentile, as reported in NCQA's Quality Compass.

[45] DHCS already holds MCMC plans accountable for the 50th percentile, although during the COVID-19 Public Health Emergency, DHCS elected not to hold MCMC plans accountable.

community reinvestment, in addition to the amount that they would otherwise be required to contribute.[46]

In addition, aligned with the overall vision of the PHM Program to strengthen and reinforce primary care as the foundation of health care for all Medi-Cal members and to shift from fee-for-service to value-based payment models of care, MCMC plans' reporting requirements will also expand in 2024; they will include reporting on primary care spending as a percentage of total spending – stratified by age ranges and race/ethnicity – to understand investments in primary care as well as disparities in these investments. DHCS will consider setting targets for minimum primary care spending in the future. DHCS will also require MCMC plans to begin reporting on the percentage of their provider contracts (especially primary care) that are in alternative payment models (APMs) using the Health Care Payment Learning and Action Network (HCP-LAN) APM framework, and will consider setting minimum performance targets to support overall delivery system transformation to more value-based models of care.[47]

DHCS is committed to increased oversight of the PHM processes described in this paper without introducing unnecessary administrative burden. Ultimately, increased oversight of processes is needed only when member outcomes are falling short. Once the PHM Service is in place, the PHM Service risk tiers will provide DHCS with the opportunity to monitor penetration rates of services (i.e., the percentage of members who receive each type of service in a given time period) statewide for the first time and compare penetration rates by plan. Acknowledging that the PHM Service will take time to reach this level of functionality, DHCS plans to introduce **quarterly implementation monitoring reporting** for PHM starting in 2023, which will be subsumed under broader MCMC plan reporting requirements and will be modified to account for the role of the PHM Service when it is fully implemented. In 2023, supplemental reporting will leverage the structure already in place for ECM and Community Supports quarterly implementation reporting and will be combined as much as possible into the existing ECM and Community Supports reporting structure, including the use of common time frames and submission mechanisms. Quarterly reports will collect information that is not available from routine encounter submissions and will be brief, actionable, and quantitative. Among the lean set of high-priority data points that DHCS will request is the number of members who are assessed for care management and, of that group, how many become enrolled in care management approaches.

[46] Per 2024 Medi-Cal Managed Care Procurement, Exhibit B, Section 1.17 Community Reinvestment, MCMC plans are required to contribute the following percentages of their annual net income to community reinvestment activities: 5% of the portion of annual net income that is less than or equal to 7.5% of contract revenues for the year, and 7.5% of the portion of the annual net income that is greater than 7.5%. Also, as noted previously, in Section II.2 on the PHM Strategy and PNA, guidance is forthcoming that will also explain how MCMC plans must link their community re-investment strategies to their PNA process and PHM Strategies.
[47] See 2022 Comprehensive Quality Strategy, p. 86.

MCMC plans should already be using their own data to continuously assess the efficacy of specific programs, including ECM, CCM, and wellness and prevention approaches, to gain an internal understanding of the impact on quality and equity for the groups served by the interventions.

DHCS will release the structure for the PHM Quarterly Implementation Monitoring Report in fall 2022.

III. Next Steps and Stakeholder Input

The ultimate goal of the PHM Program is to establish a cohesive, statewide approach to population health management that ensures that all members have access to a comprehensive program that leads to longer, healthier, and happier lives, improved outcomes, and health equity. This goal cannot be realized without robust stakeholder input. Therefore, DHCS has created several opportunities for meaningful and systematic stakeholder engagement, including via the PHM Advisory Group.[48] The PHM Advisory Group is comprised of cross-sector stakeholders that will provide feedback and make recommendations on the CalAIM PHM Program and the PHM Service. The group contains members who represent a broad range of stakeholders – including providers, MCMC plans, counties, advocates, community organizations, government agencies, and foundations – who will be on the front lines of implementing the PHM Program and using the PHM Service. PHM Advisory Group meetings are announced on the CalAIM PHM website and through other DHCS communication channels and are open to the public.

In addition to the PHM Advisory Group, DHCS will provide PHM Program updates in existing forums, including, but not limited to, Managed Care Advisory Group Quarterly meetings, DHCS Medical Directors' meetings, CalAIM Monthly ECM & Community Supports Managed Care Plan meetings, the CalAIM Children and Youth Advisory Group, and the CalAIM Implementation Advisory Group. DHCS will also launch further stakeholder engagement efforts specific to the PHM Service, including the Scientific Advisory Committee, which will support the development of a statewide risk stratification, segmentation, and tiering algorithm(s) in the PHM Service.

This paper will be supplemented by an additional MCMC plan-facing Program Guide, expected to be published in August, which will be iterative and expanded upon. MCMC plans will also be expected to submit a PHM Program Readiness deliverable in October. The supplemental reporting guidance will be issued in fall 2022 for MCMC plan reporting effective in 2023.

DHCS encourages the public to visit the CalAIM PHM website for regular updates.

[48] The PHM Advisory Group has been established in accordance with WIC Code § 14184.204, which requires PHM Program components to be developed in consultation with the appropriate stakeholders as well as relevant state regulations.

Appendix 1: Key Terminology

1. **Assessment** is a process or set of questions for defining the nature of a risk factor or problem, determining the overall needs or health goals and priorities, and developing specific treatment recommendations for addressing the risk factor or problem. Health assessments can vary in length and scope.
2. **Basic Population Health Management** is an approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. Basic Population Health Management includes federal requirements for care coordination (as defined in 42 CFR § 438.208).
3. **Care Manager** means an individual identified as a single point of contact responsible for the provision of care management services for a member.
4. **Care Management Plan (CMP)** means a written plan that is developed with input from the member and/or their family member(s), guardian, authorized representative, caregiver, and/or other authorized support person(s), as appropriate, to assess strengths, risks, needs, goals, and preferences and make recommendations for service needs.
5. **Complex Care Management (CCM)** is an approach to care management that meets differing needs of high- and rising-risk members, including both longer-term chronic care coordination and interventions for episodic, temporary needs. MCMC plans must provide CCM in accordance with all NCQA CCM requirements.
6. **Enhanced Care Management (ECM)** means a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of high-cost and/or high-need members who meet ECM Populations of Focus eligibility criteria, through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch, and person centered.
7. **Risk stratification and segmentation (RSS)** means the process of separating member populations into different risk groups and/or meaningful subsets using information collected through population assessments and other data sources. Risk stratification and segmentation result in the categorization of members with care needs at all levels and intensities.
8. **Risk tiering** means the assigning of members to standard risk tiers (i.e., high, medium-rising, or low), with the goal of determining appropriate care management programs or specific services.
9. **Population Health Management (PHM)** means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
10. **The Population Health Management (PHM) Service** collects and links Medi-Cal beneficiary information from disparate sources and performs risk stratification and segmentation (RSS) and tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multiparty data access and use in accordance with state and federal law and policy.

11. **Population Health Management Strategy (PHM Strategy)** means a comprehensive plan of action for addressing member needs across the continuum of care, based on Population Needs Assessment (PNA) results, data-driven risk stratification, predictive analysis, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions. Each managed care plan would be required to include, at a minimum, a description of how it will:

    - Keep all members healthy by focusing on wellness and prevention services;
    - Identify and manage care and services for members with high and rising risk;
    - Ensure effective transition planning across delivery systems or settings, through care coordination and other means, to minimize patient risk and ensure appropriate clinical outcomes for the member; and
    - Identify and mitigate member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance health equity.

12. **Screening** is a brief process or questionnaire for examining the possible presence of a particular risk factor or problem, to determine whether a more in-depth assessment is needed in a specific area of concern.
13. **Social drivers of health (SDOH)** mean the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning and quality-of-life outcomes and risk factors.
14. **Transitional care services** mean services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).
15. **Wellness and prevention programs** are programs that aim to prevent disease, disability, and other conditions; prolong life; promote physical and mental health and efficiency; and improve overall quality of life and well-being.

Appendix 2: Summary of MCMC Deliverables and Go-Live Dates for PHM[49]

	DHCS Policy/Guidance	MCMC Plan Deliverables	Program Go-Live Dates
2022			
Q1 & Q2	▪ **April: Draft PHM Strategy and Roadmap** published	▪ **June: 2022 PNA and Action Plan** due (no change to current APL 19-011 requirements)	▪ **January 1: ECM goes live in WPC or HHP counties for the Individuals & Families Experiencing Homelessness, High Utilizer Adults, and Adults with SMI/SUD Populations of Focus**
Q3	▪ **July:** This **Final PHM Strategy and Roadmap** published ▪ **August: Final 2023 Program Guide & 2023 PHM Program Readiness Deliverable Template** published		▪ **July 1: ECM goes live in non-WPC or HHP counties for the Individuals & Families Experiencing Homelessness, High Utilizer Adults, and Adults with SMI/SUD Populations of Focus**
Q4	▪ **November: 2023 Supplemental Reporting Guidance for PHM** published ▪ **By end of 2022**, amend APLs regarding IHEBA/SHA and Individual Health Assessment, which include	▪ **October: PHM Program Readiness Deliverable Due for current plans**, to include: ▪ Attestation of NCQA PHM accreditation or equivalent ▪ Readiness to use diverse data sources to guide risk	

[49] Dates are subject to change.

	DHCS Policy/Guidance	MCMC Plan Deliverables	Program Go-Live Dates
	but are not limited to, APL 08-003, APL 13-001, APL 13-017.	stratification and segmentation ▪ Approach to screening and assessment within revised 2023 requirements ▪ Approach to assessing for care management within revised 2023 requirements ▪ Approach to BPHM, CCM and Transitional Care Services	
2023			
Q1	▪ **January 1:** ▪ Elimination of IHEBA/SHA and Replacement of Individual Health Assessment with Individual Health Appointment ▪ Retirement of APLs 17-012 and 17-013 ▪ **Q1:** Release updated APL 19-011 regarding PNA/PHM Strategy requirements		▪ **January 1: PHM Program Goes Live statewide with the following requirements, to the extent not already met:** ▪ NCQA PHM accreditation or show equivalent ▪ Good faith effort to use DHCS listed data sources to perform RSS ▪ Wellness/prevention as required by NCQA ▪ Initiatives to improve pregnancy outcomes ▪ CCM as defined by NCQA ▪ Transitional Care requirements ▪ **January 1: PHM Service Pilot begins**

	DHCS Policy/Guidance	MCMC Plan Deliverables	Program Go-Live Dates
			▪ **January 1: ECM goes live in all counties for Long-Term Care Populations of Focus**
Q2		▪ **Q2: PHM Program Readiness Deliverable due for new plans.**[50] ▪ **PHM Quarterly Implementation Reporting starts**	

Q3		▪ **October:**
		  ▪ **PHM Strategy due** for current plans under revised requirements, to more comprehensively detail the PHM Program's PNA Approach and use of the PHM Service. Annual submission thereafter.
			▪ **July 1: ECM goes live in all counties for Children and Youth Populations of Focus**
			▪ **July: From statewide PHM Service Deployment:**
			  ▪ Use PHM Service and Tiers for RSS
			  ▪ Leverage PHM Service for data sharing, as functionality becomes available

2024			

[50] PHM Program Readiness Deliverable for new plans (due May 2023) is the same as the PHM Program Readiness Deliverable for current plans (due October 2022). Specifically, the PHM Program Readiness Deliverable to include: Attestation of NCQA PHM accreditation or equivalent; Readiness to use diverse data sources to guide risk stratification and segmentation; Approach to screening and assessment within revised 2023 requirements; Approach to assessing for care management within revised 2023 requirements; and Approach to BPHM, CCM and Transitional Care Services.

	DHCS Policy/Guidance	MCMC Plan Deliverables	Program Go-Live Dates
Q1	▪ **January 1: New MCMC Plan Contract Goes Live**		
Q2			
Q3		▪ **October: PHM Strategy due** for the first time for new plans, and annually thereafter.	
2025			
Q1-Q4	▪ CQS Bold Goals must be met	▪ MCMC plans must submit first PNA under new three-year cycle requirements	
2026			
Q1-Q4		▪ MCMC plans must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation	