CalAIM: July Population Health Management (PHM) Advisory Group Meeting

July 27, 2022 (10:30–12:00pm PT)

DHCS

Agenda

Welcome and DHCS Notice	2 min
Member Story	5 min
Discussion: Transitional Care Services and Behavioral Health Intersections	50 min
Final PHM Roadmap and Strategy Updates	25 min
Overview of the PHM Program Guide and MCP Readiness Deliverable	5 min
Look Ahead	3 min

Public Health Emergency (PHE) Unwinding

- **The COVID-19 PHE will end soon and millions of Medi-Cal beneficiaries may lose their coverage.**
- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available

DHCS PHE Unwind Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Launch immediately**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
    - » Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch 60 days prior to COVID-19 PHE termination.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.

Member Story

Member Vignette: Transitions

1. Mr. D has been struggling with alcohol use. Despite several attempts to stop drinking, he came in and out of the ED many times with intoxication and related injuries. He was referred for treatment at every ED visit. However, he never made it to a follow-up appointment.
2. One visit, Mr. D was admitted to the hospital. This allowed a substance use navigator to meet him prior to discharge, when he directly wheeled the patient to the Bridge Clinic to start treatment with intramuscular naltrexone for alcohol use disorder.
3. The substance use navigator then supported Mr. D to access treatment in a residential treatment facility, connect to a language-concordant primary care doctor, and employment assistance.
4. Mr. D did not have any further ED visits for 18 months.
5. A couple weeks ago, Mr. D was seen in the emergency department. When the substance use navigator checked on him, it was for a work-related injury. Mr. D was doing well, providing for his family, and still sober.

Member Vignette: Transitions (continued)

- This story highlights the impact a trusted individual who provides navigation and support services can have for members who may face barriers to receiving their needed care, such as those with co-occurring behavioral health and physical health needs.
- Navigating needs and services across physical health and mental health or substance use can be challenging as they are frequently not offered in the same practice or paid for by the same entity.
- Under PHM, we expect the MCP to be responsible for coordination of care even for carved out services that their members may need, such as substance use treatment, and ensuring non-duplication.
- Drug Medi-Cal Organized Delivery System (DMS-ODS) and County Mental Health Plans (MHPs) are also responsible for coordination of physical and behavioral health services.
- PHM allows care management and navigation activities to be delegated to providers who may have in-person contact in real-time during acute episodes in care, such as this transition from the hospital to the outpatient setting to receive both substance use treatment and medical care.
- ***Goal for today's discussion:*** *How can CalAIM support promising and successful on the ground initiatives like the substance use navigator program?*

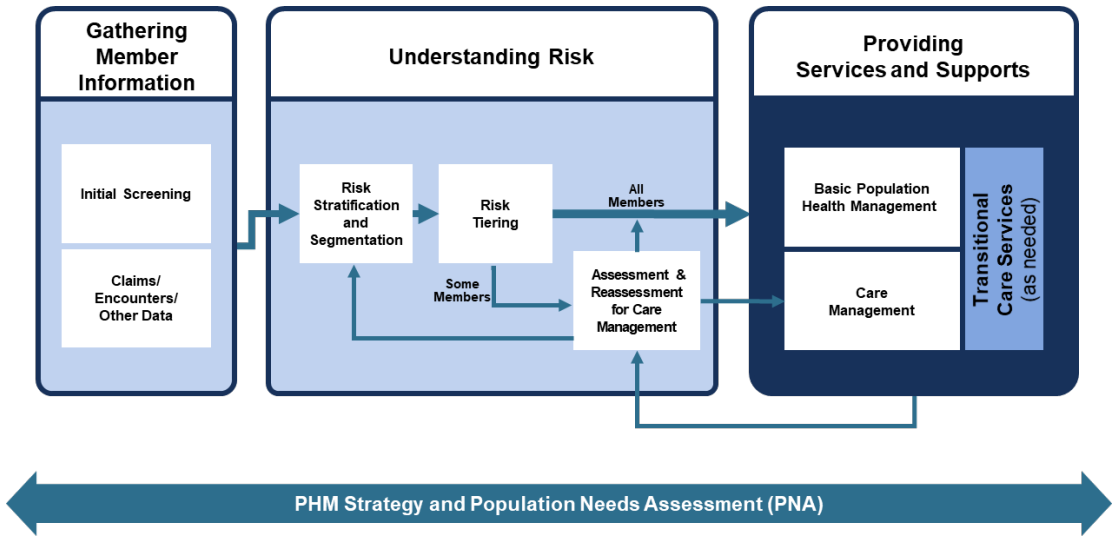
Discussion: Transitional Care Services and Behavioral Health Intersections

DHCS Vision for Transitional Care Services

Goals for Transitional Care

- ✓ Members 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.
- ✓ Members receive the needed support and coordination to have a safe and secure transition with the least burden on the Member as possible.
- ✓ Members continue to have the needed support and connections to services that make them successful in their new environment.

PHM FRAMEWORK: MCP Delivery System

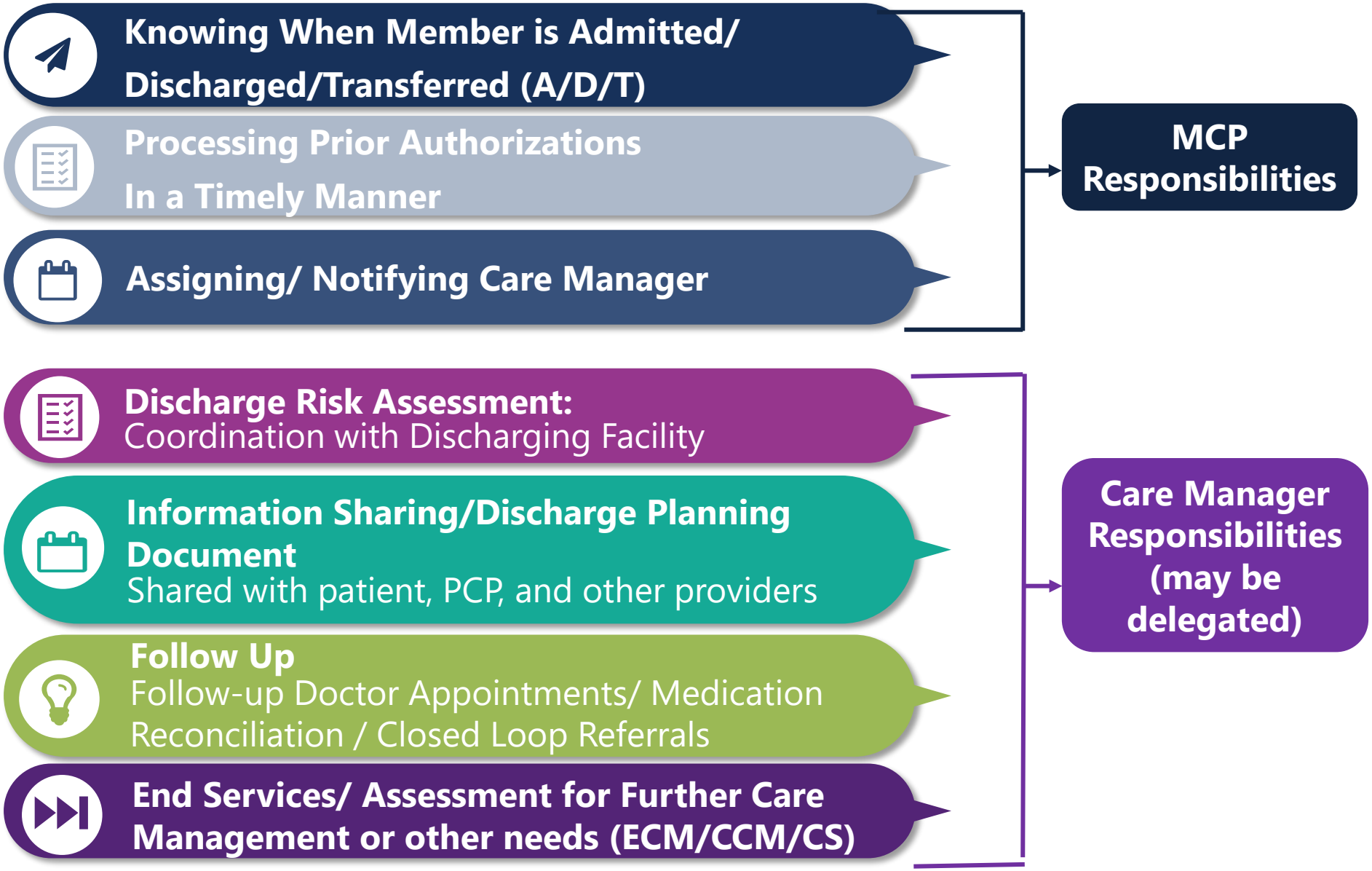


Care Transitions Definition:

When a member transfers 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.

PHM is a journey; DHCS recognizes that a multi-year approach is needed to achieve the vision for a truly seamless experience for members transitioning between levels of care.

Reminder: MCP PHM Requirements on Transitional Care Services



Reminder: Transitional Care Requirements for MHPs and DMC-ODS (1)

Current Requirements

Requirements for Specialty Mental Health (SMH) Services Managed by County Mental Health Plans (MHPs)

- **Coordinate the county MHP services provided between settings of care**, including appropriate discharge planning for short term and long-term hospital and institutional stays.
- **Coordinate the county MHP services as well as services the member receives from other managed care organizations**, FFS Medicaid, community and social support providers, and other human services agencies.
- **Implement a transition of care policy** that is consistent with federal and DHCS requirements.

Requirements for Drug Medi-Cal Organized Delivery System (DMC-ODS)

- **Coordinate the services between settings of care**, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
- **Comprehensively assess each Medicaid member** identified by the Department as having **special health care needs.**
- **Create a treatment or service plan** with member participation, and in consultation with any providers caring for the member.

Source: 2017–2022 SMH Contract, Exhibit A, Attachment 10 ; DMC-ODS Contract, Exhibit A, Attachment I

Reminder: Transitional Care Requirements for MHPs and DMC-ODS (2)

Future Changes

- California will apply for a **new Medicaid Section 1115 demonstration** to **expand access** to and **strengthen the continuum of community-based mental health services** for Medi-Cal beneficiaries living with serious emotional disturbance or mental illness.
  - As a condition of the demonstration, California will be required to improve transitions of care from institutional settings
- **MOU requirements** between MCPs and MHPs and DMC-ODS are being reviewed, and the department will release a draft APL on new MOU requirements for stakeholder feedback as soon as possible.

Source: 2017–2022 SMH Contract, Exhibit A, Attachment 10 ; DMC-ODS Contract, Exhibit A, Attachment I

Context for Discussion

MCP members with medical and behavioral health needs face many barriers to receiving patient-centered, coordinated care when their care crosses different delivery systems.

- *DHCS is committed to working to address the broad, systemic challenges, in partnership with stakeholders, that exist today in order to achieve the goals for transitional care and improve member experiences:*
  - Timely data and information sharing
  - Workforce shortages
  - Confusion over roles/responsibilities
  - Capacity challenges
  - Incentive alignment
  - Coordinating across many different organizations
  - Others? (List in Chat!)

Bright Spots Discussion: Overview

Today, we are hoping to…

- **Learn from you about bright spots in providing transitional care services on the ground now**, specifically for members with SMI or SUD who are enrolled in MCPs and receive services covered through County MHPs or DMC-ODS:
  - *What are the critical points of coordination?*
  - *What kind of data sharing or coordination between MCPs and the behavioral health delivery systems are currently working?*
  - *What are some best practices to date to support these members transitioning between levels of care?*
  - *Who is best positioned to provide care management/coordination (hospitals, behavioral health providers, PCPs, plans, peers)? How can PHM transitional care services be leveraged to enable the most trusted/effective relationships?*
- **Discuss short-term policy solutions and DHCS support needed** to overcome barriers and improve coordination across MCPs and the behavioral health delivery systems.

Discussion: Transitional Care Services & Behavioral Health (1)

1. Inpatient Medical Admission with MCP as Primary Payer: MCP and MHP Coordination

Case Example

Paula, a MCP member, has controlled schizophrenia and receives care through her county MHP. She is admitted to the hospital for acute appendicitis, treated, and discharged back home.

Questions for Discussion:

- What are the critical points of coordination to support Paula during this care transition?
- How do the two delivery systems share information and coordinate now for members like Paula with overlapping physical and mental health needs during a care transition? Where is data/information sharing occurring?
- Knowing this is a multi-year effort and trust relationships are critical for coordinated and connected care, what policy solutions, best practices, or DHCS support are needed to build relationships on the ground between:
  - MCPs and Providers?
  - MCPs and County MHPs and/or DMC-ODS?
  - Providers and with members/patients?

Discussion: Transitional Care Services & Behavioral Health (2)

2. Psychiatric Admissions: MCP and MHP Coordination

Case Example

*Joe has schizophrenia, diabetes, and hypertension, and **is admitted to inpatient psychiatric care** for an acute psychotic episode after stopping his medications due to a death in the family. He is stabilized on his medications and discharged back to his home.*

Questions for Discussion:

- What are the critical points of coordination to support Joe during this care transition?
- How do the two delivery systems share information and coordinate now for members like Joe with overlapping physical and mental health needs during a care transition? Where is data/information sharing occurring?
- How can DHCS support this coordination, so they are more member-centered and integrated across delivery systems (especially for those members who do not qualify for ECM)?
- In addition to MCP and MHP, who are the key stakeholders for this member? What roles does each stakeholder play? How can DHCS facilitate cross-sector sharing of best practices?

Discussion: Transitional Care Services & Behavioral Health (3)

3. Inpatient Medical Admission with Transfer to Residential Rehab: MCP and DMC-ODS Coordination

Case Example

*Katie has opioid use disorder and is **brought to the ED with an opioid overdose** and responds to naloxone. She requires admission to the ICU for a naloxone drip but has no other medical problems. Once she is stabilized off naloxone, she is discharged to a residential drug rehab facility to continue with treatment, including Medication Assisted Treatment (MAT) therapy. She completes her residential treatment and is discharged back to home.*

Questions for Discussion:

- What are the critical points of coordination to support Katie during this care transition?
- How do MCPs and DMC-ODS share information and coordinate care today for patient with substance use disorder and co-occurring medical/behavioral health needs? Where is data/information sharing occurring?
- How can DHCS support and facilitate on-the-ground relationships that enable coordination between physical health and substance use providers and payers?
- After Katie is discharged from residential drug rehab facility to home, what policy solutions are needed so that she is connected to ongoing treatment? Any best practices?

Final PHM Strategy and Roadmap Updates

Recap: *Final PHM Strategy & Roadmap Document*

On July 5th, DHCS released the final PHM Strategy & Roadmap Document, which incorporates updates based on 37 comment letters and feedback from PHM Advisory Group and MCMC Plan meetings. Today we will provide a high-level overview of these updates.

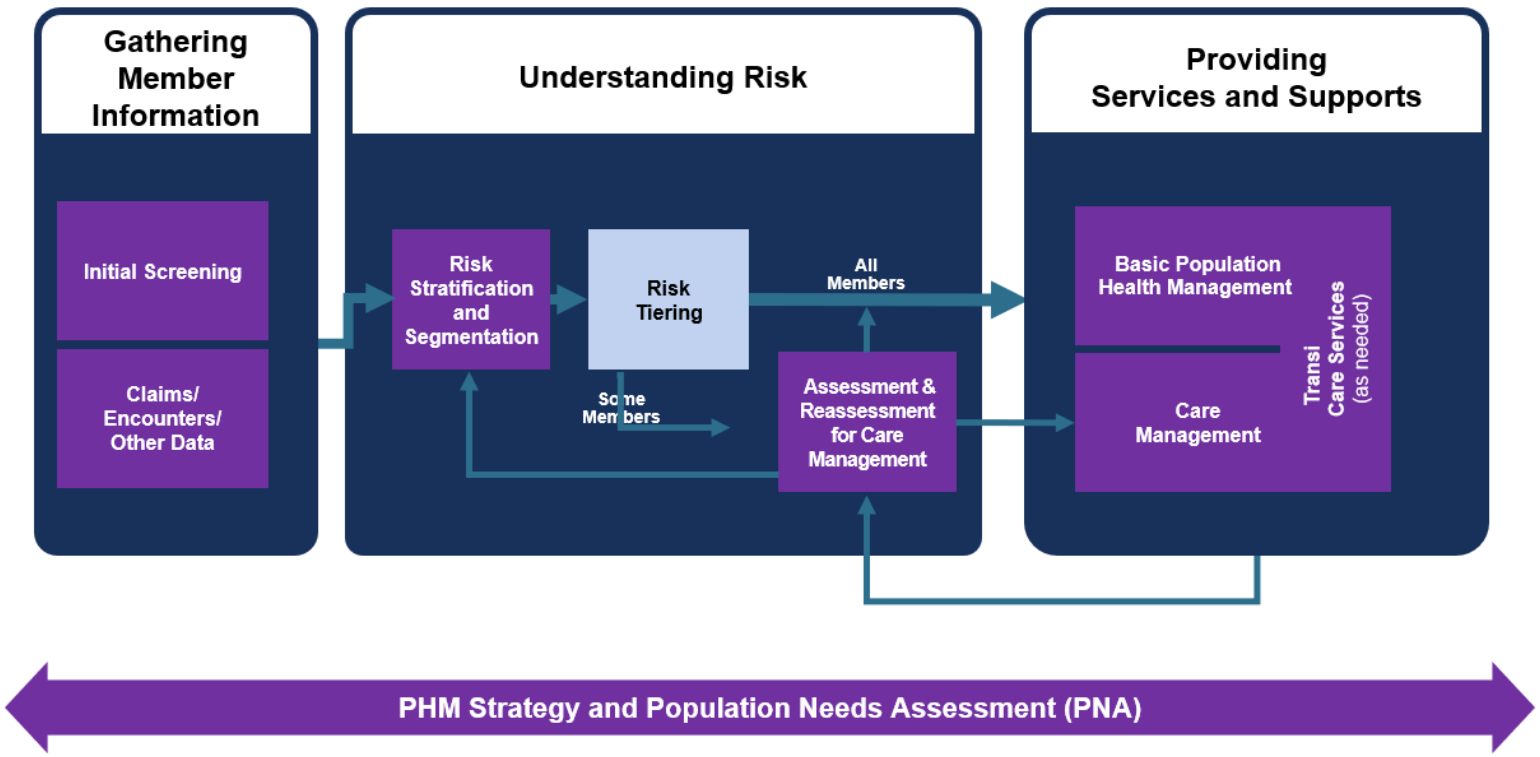
Access the document here

Purpose of the Strategy and Roadmap:

- Defines and describes the key PHM concepts and terminology that will be used by DHCS to support the implementation of the PHM Program moving forward
- Sets out the roadmap for managed care plans (MCPs) for 2023 and beyond
- Includes member goal vignettes to delineate member perspective on the "Why"

Updates to the Final PHM Strategy and Roadmap

- **PHM Strategy and PNA**
- **Gathering Information**
  - Leveraging Existing Health and Social Data
  - Streamlining the Initial Screening Process
- **Understanding Risk**
  - Risk Stratification and Segmentation
  - Assessment and Reassessment for Care Management
- **Providing Services and Supports**
  - Basic PHM
  - Care Management
  - Transitional Care Services



Updates to PHM Strategy and PNA: Timelines and NCQA

- **PHM Strategy Submission Dates:**
  - DHCS revised the PHM Strategy submission dates from July 2023 to October 2023 for current plans and to October 2024 for new plans.

- **NCQA Alignment:**
  - DHCS clarified that the PHM Strategy and PNA will be aligned with existing NCQA requirements but will be distinct in the following ways:
    - The PHM Strategy will also focus on strategies that address the CQS Clinical Focus Areas/Bold Goals, in addition to priorities identified in the PNA.
    - The PNA will place more emphasis on community engagement and occur every three years, not annually.

Dates	Milestones
August 2022	• PHM Program Readiness Deliverable Template published
October 2022*	• PHM Program Readiness Deliverable due
Q1 2023	• Updated APL 19-011 regarding PNA/PHM strategy requirements published • Template for PHM Strategy published
October 2023**	• PHM Strategy due under revised guidance (will also detail use of the PHM service)
2025	• PNA due under revised guidance

* This date only applies to current plans. Current plans must submit PHM Program Readiness Deliverable in October. New plans must submit PHM Program Readiness Deliverable in May 2023.
** This date only applies to current plans. Current plans must submit their PHM Strategy in October 2023. New Plans must submit in October 2024.

Updates to Gathering Member Information:
Leveraging Existing Health and Social Data

Data Sources

- Prior to PHM Service is live, DHCS clarified that plans are expected to make a **good-faith effort** to use required data sources as part of information gathering and to inform RSS.
- **Justice-involved and housing** data were added to the list of required data sources.

PHM Service

- DHCS clarified that PHM Service is under a broader statewide effort to accelerate and expand the exchange of health information **under California's Data Exchange Framework (DxF).** DHCS will work with CalHHS and CDII to issue guidance on the collection and sharing of SOGI and race/ethnicity data.
- DHCS also clarified that the PHM Service will support the ability of individuals to **modify, update, and provide information** through a portal or similar means.

Updates to Gathering Member Information:
Initial Screening

HIF/MET

- DHCS clarified that **HIF/MET will remain in place as is** in the short term and before the PHM Service is live to fulfill the federal initial screening requirement within 90 days of enrollment.
- In response to stakeholder comments regarding broad sharing of HIF/MET information between MCPs and providers, **DHCS is simplifying expectations for 2023**:
  - HIF/MET may be delegated to the provider level. If the HIF/MET screening (or an IHA) is completed by a provider and shared back with the MCPs within 90 days of enrollment, DHCS will consider the requirement fulfilled.
  - MCPs or the provider (if delegated) must follow up on positive screening results.
- In the long term after the PHM Service is live, DHCS expects that screening information will be shared between providers and plans and intends to issue guidance that is aligned with California's DxF.

Elimination of IHEBA/SHA

- IHEBA/SHA is eliminated. However, MCPs are required to continue to meet IHA requirements and hold network providers accountable **for preventive screenings for adults** per Grade A and B recommendations from USPSTF **through the course of their care** (instead of during the initial appointment).

Updates to Understanding Risk

RSS

- DHCS clarified that 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.

Assessment/Reassessment

- Similar to HIF/MET, MCPs must **follow up on any positive assessment results or delegate to the primary care provider for follow up** (and share assessment results with providers responsible for the follow up).
- DHCS clarified that MCMC plans **may leverage their ECM and/or CCM assessment tools**, or components of those tools, to assess SPDs considered at "High Risk" but must use the LTSS questions that are in APL 17-013.

Updates to Providing Services and Supports:
BPHM and Care Management Programs

BPHM

- DHCS clarified that **BPHM is ultimately the responsibility of the MCMC plan**. However, components of BPHM can and should be delegated, as appropriate.
- In all cases, some aspects of BPHM may 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.

Care Management Programs

- DHCS clarified that an individual **cannot be enrolled in ECM and CCM at the same time**; rather, CCM is on a care management continuum with ECM.
  - MCMC plans **may delegate CCM to providers and other entities** who are themselves NCQA certified.
  - DHCS also encourages MCMC plans to work with providers to **contract for a care management continuum of ECM and CCM programs**, wherever possible.

Updates to Providing Services and Supports:
Transitional Care Services

When MHPs or DMC-ODS are the primary payer of triggering services:	When members are enrolled in Medi-Cal and Medicare (Medicare FFS, MA, or D-SNP):
MCP plans are required to cover Basic Transitional Care Services AND… ✓ Assign/notify a care manager who will be responsible for: ✓ Coordinating with the BH or county care manager assigned by county MHP and/or DMC-ODS ✓ Ensuring needed physical health follow-ups are completed[1]	✓ *For MCMC members dually eligible for Medi-Cal and Medicare (with the exception of 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 activities. ✓ *For MCMC members enrolled in D-SNP plans:* ✓ D-SNPs are responsible for assigning a care manager who is responsible for all transitional care activities.

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

Overview of the PHM Program Guide and MCP Readiness Deliverable

PHM Program Guide

The PHM Program Guide sets forth comprehensive requirements for all MCMC plans starting on January 1, 2023. The Program Guide does not articulate new policy, but rather establishes requirements that align with the vision and expectations outlined in the PHM Strategy and Roadmap and the MCMC plan contract template amendment.

Key Details:

- Provides tactical details for MCMCs on how the PHM program will operate in 2023.

- Provides further operational clarification for MCMCs in certain areas beyond what's stated in the PHM Strategy and Roadmap and 2023 MCMC Contract to clarify process, but not set new policy.

- Includes requirements for MCPs via a base APL that links the PHM Program Guide to the 2023 MCP Contract.

Release: August 2022

2023 PHM Program Guide

I. Introduction
II. PHM Program:
    1. Overview of the PHM Framework
    2. PHM Strategy and PNA
    3. Gathering Member Information
    4. Understanding Risk
    5. Providing Services & Supports
        - Basic Population Health Management
        - Care Management Programs
        - Transitional Care Services
    6. Accountability and DHCS Oversight
    7. Implementation Timeline

PHM Program Readiness Deliverable

In October, MCMC plans will be required to submit a PHM Program Readiness Deliverable to DHCS describing specific components of their PHM Programs and attesting to their readiness prior to program launch.

Key Details:

- Contains specific attestations and questions that MCMCs are required to complete for DHCS program readiness review/approval.
- Incorporates readiness on the PHM Program parameters outlined in the PHM Program Guide and PHM Strategy and Roadmap.
- Aligns with the existing NCQA PHM submission deliverable
- Requires plans to identify key performance indicators for key elements of PHM implementation

Release: August 2022 Submission: October 2022

Components of 2023 PHM Readiness Deliverable:

- Gathering Member Information
- Understanding Risk: Approaching RSS & Mitigating Bias in RSS
- Assessments for Special Populations
- Providing Services and Supports:
  - Basic Population Health Management
  - Care Management Programs
  - Transitional Care
- Accountability & Evaluation of PHM Performance

Looking Ahead

Upcoming Stakeholder Meeting:

- **Thursday 9/29, 12:00 – 1:30 PM PT**
  - September PHM Advisory Group Meeting

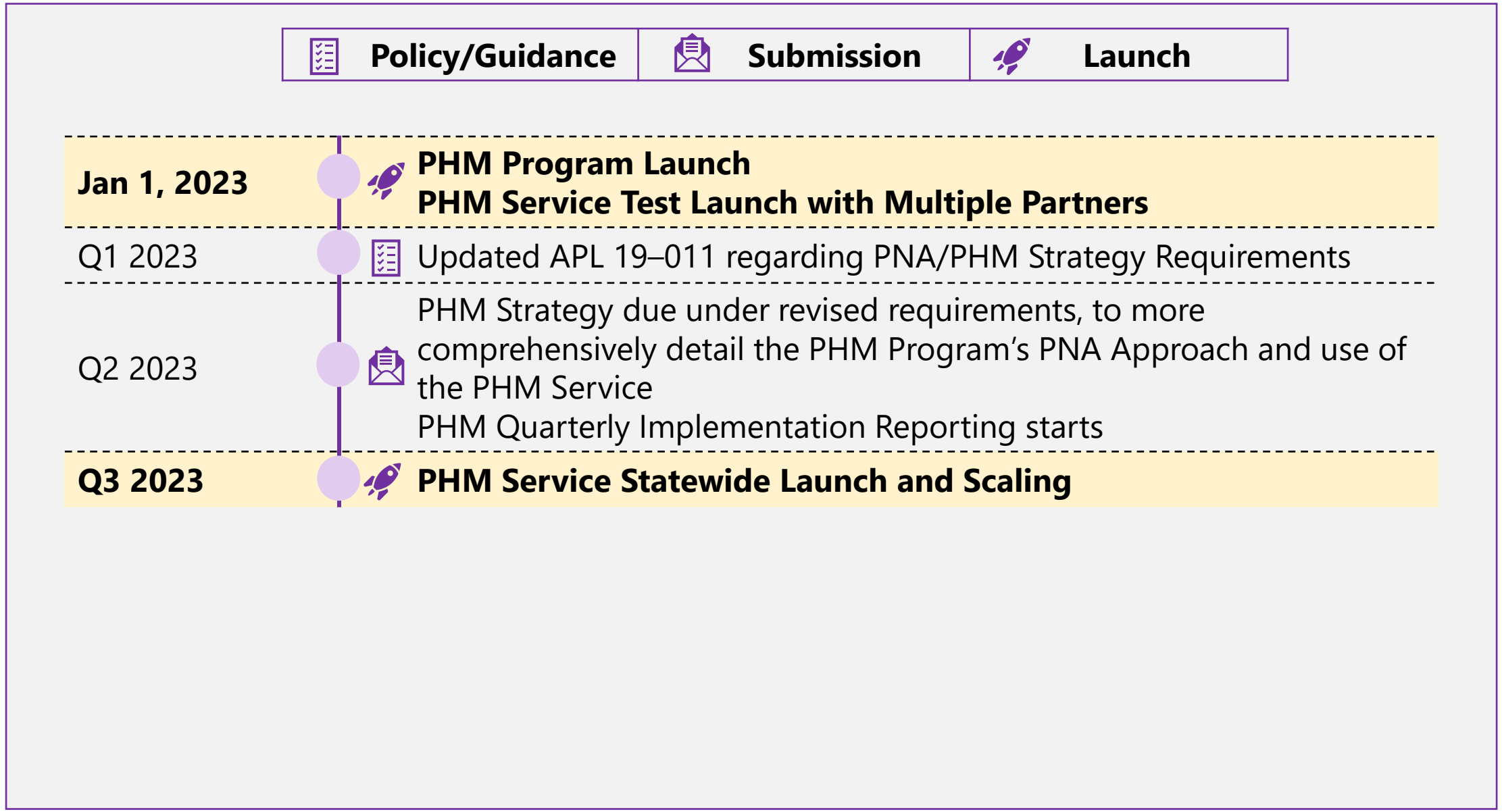
Looking Ahead

Overview: *PHM Initiative High-Level Timeline (1)*

Policy/Guidance | **Submission** | **Launch**

May 2022	*Draft PHM Strategy and Roadmap for Public Comment [COMPLETE]*
June 2022	*Final PHM Strategy and Roadmap*
August 2022	2023 PHM Program Guide 2023 PHM Strategy Readiness Deliverable Template
October 2022	MCP 2023 PHM Readiness Submission due
November 2022	2023 Supplemental Reporting Guidance for PHM published
December 2022	Amended APLs regarding IHEBA/SHA and Individual Health Assessment released

Overview: *PHM Initiative High-Level Timeline (2)*



Q&A

Please visit the DHCS PHM Website for more information and access to the PHM documents and supporting resources: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx

Please send questions to CalAIMECMILOS@dhcs.ca.gov

Appendix

PHM FRAMEWORK