# CalAIM Population Health Management (PHM)

## *DHCS's Proposed Monitoring Approach for Managed Care Plans' (MCPs') Implementation of PHM*

1:30-3:00 pm PT, February 8th, 2023

*Pre-Decisional Draft*

DHCS

# Agenda

| | |
|---|---|
| **Welcome and DHCS Notice** | 2 min |
| **Member Story** | 5 min |
| **Discussion: Draft DHCS Monitoring Approach for MCP Implementation of PHM Program** | 80 min |
| **Look Ahead** | 3 min |

# Continuous Coverage Unwinding

- **The continuous coverage requirement will end on March 31, 2023 and Medi-Cal beneficiaries may lose their coverage.**
- **Medi-Cal redeterminations will begin on April 1, 2023.**
- **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
  - Check out the Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan (Updated January 13, 2023)!

# Continuous Coverage Unwinding Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Already launched**
  - 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 approximately 60 days prior to termination of the Continuous Coverage requirement.**
  - 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

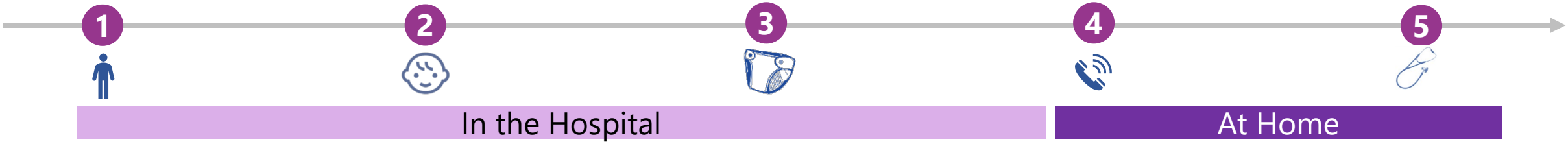
# Health Navigator Programs at Gold Coast Health Plan (GCHP)

Gold Coast Health Plan℠
A Public Entity

- In 2018, GCHP saw a need to **increase postpartum visits** and provide **supportive services to members and infants** based on an analysis of the NCQA Prenatal and Postpartum Care (PPC) measure.
- Therefore, GHCP launched a new **Postpartum Health Navigator Program**. As part of the program:
  - GHCP works with a local County Hospital partner to **identify which Members arrive at the hospital's Labor and Delivery Ward** and their anticipated date of discharge.
  - This information is communicated to a **GCHP Health Navigator**, who **meets with the beneficiary and newborn in person at the hospital**.
  - Health Navigators **offer supports** (e.g., parenting resources), ensure that the Member has **information about how to enroll the newborn in Medi-Cal**, and helps **connect the member back to primary care services**.
  - Members and their newborns are then provided **telephonic follow-up after discharge** to answer questions, address concerns, and ensure linkage back to care.

# **Member Vignette:** BPHM, Transitional Care and PHM

1. A 20-year-old Latina woman, who was a GCHP Member, had not received prenatal care until the third trimester of her first pregnancy. She presented to the hospital in labor, and the hospital labor and delivery department contacted GCHP to coordinate care through GCHP's Health Navigator Program.
2. GCHP's Health Navigator met with the mom and baby at the hospital on the day of discharge. During the conversation, the mom shared that this was her first child and that she did not have a strong family support system. The Health Navigator assured the mom that GCHP is here to offer support and walked through her benefits, including her assigned PCP and available behavioral health services.
3. The Health Navigator reviewed the importance of postpartum care and provided the mom with GCHP's Postpartum Member Packet, including information on GCHP's program resources, such as free diapers, a Newborn Medi-Cal Enrollment Form, as well as information on WIC supportive services, breastfeeding, and other resources on infant well care and screenings.
4. Two weeks after discharge, the Health Navigator called the mom to ensure that a postpartum PCP visit had been scheduled. The mom canceled the visit, and the Navigator made several attempts to reschedule. On the fifth attempt, the mom was reached, and the visit was rescheduled.
5. The mom was able to attend her postpartum PCP visit and completed the Newborn Medi-Cal Enrollment Form.



# **Member Story:** Postpartum Health Navigation

- This Member Story highlights the importance and impact of **member engagement and transitional care activities**, including **follow-up post-discharge**, under the PHM Program to improve outcomes for Medi-Cal members. It also shows the importance of Basic Population Health Management services, including **reaching Members who have not engaged in care** as regularly as recommended.
- GCHP's Postpartum Health Navigation Program is an example of a cross-cutting program that **improves perinatal outcomes for birthing individuals and preventive care for children** and aligns with DHCS's Bold Goals.
- This program also highlights a promising practice for other managed care plans (MCPs) in providing transitional care services to high-risk populations, including people who are pregnant, which went into effect on 1/1/2023:
  - Through improved engagement of birthing individuals and their children, GCHP was able to improve the NCQA PPC measure by 12%, which placed the plan above the 90$^{th}$ percentile of performance
  - In a **"train the trainer" model**, GCHP was able to **train local hospital staff to perform this member engagement work**. Improvements were sustained by using local hospital staff to provide Postpartum Member Packets and request GCHP Health Navigator support when needed

# Draft DHCS Monitoring Approach for MCP Implementation of PHM Program

# DHCS's PHM Program Monitoring Approach for MCPs: Purpose

The purpose of DHCS's PHM Program monitoring approach is to **assess the implementation and effectiveness of each MCP's PHM Program**.

**DHCS's approach for monitoring MCPs' implementation of the PHM Program will include:**

- ❑ A list of new **Key Performance Indicators (KPIs)** required to be reported at **the plan level** on a regular basis by all MCPs.
- ❑ Existing data that DHCS already has from **Medi-Cal Managed Care Accountability Set (MCAS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality measures** reported through the annual Quality and Performance Improvement Process.

*Through these metrics, DHCS will be able to track:*

- PHM Program **implementation, operations and effectiveness** measured at the plan level;
- **Gaps** for additional DHCS guidance or clarifications;
- PHM Program **impact on outcomes** over time; and
- **Priority issue areas** that require DHCS follow-up with MCPs

- *DHCS may request more granular level (e.g., county-level) from MCPs on the KPIs if needed.*
- *The PHM Monitoring approach will evolve over time once the PHM Service is fully implemented, including reporting and analytics functionalities.*

# DHCS's PHM Program Monitoring Approach for MCPs: Overview

DHCS will use a **combination of KPIs and quality measure data** to monitor MCPs' PHM Program implementation.

## KPIs

- KPI Selection: The PHM Program monitoring approach will focus on a set of **high-priority KPIs** for more frequent, active, and real-time monitoring of program operations and effectiveness. KPIs are intended to be indicators that plans should already track internally to manage their own performance.
- Stratification: MCPs will be required to stratify the KPIs by **race, ethnicity, and age.**
- Process: DHCS will require MCPs to report KPIs at the **plan level** on a **quarterly basis**. DHCS will require MCPs to submit their first KPIs in Q3 2023 from Q1 and Q2 2023.
- DHCS proposes to require 12 new KPIs during 2023. Additional KPIs may be added in the future once the PHM Service is live.
- DHCS will align PHM KPIs with IPP measures where possible.

## Quality Measure Data

- Quality Measures: DHCS will use **existing data from a subset of MCAS and CAHPS quality measures** reported through the existing annual Quality and Performance Improvement Process; MCPs will not need to report any additional quality measure data.
- Stratification:
  - Under the existing quality process, MCPs must stratify certain quality measures per NCQA by race and ethnicity.
- Process:
  - MCPs currently submit quality measure data to DHCS at the reporting unit level on an annual basis.
  - For PHM monitoring, DHCS will aggregate the existing data to be able to review **at the plan level**.

# DHCS's PHM Program Monitoring Approach for MCPs: Structure

DHCS's goal for the PHM monitoring process is to gain a **holistic perspective** on PHM Program implementation at each MCP. The monitoring approach will be organized into domains as follows:

| Monitoring Domains | Categories |
|---|---|
| **PHM Program Areas/Themes** | Basic Population Health Management (BPHM)<br>• Prevention Services<br>• Primary Care Engagement/ Appropriate Utilization<br>• Chronic Disease Management<br>• CHW Integration<br>Risk Stratification Segmentation and Tiering (RSST)<br>Complex Care Management (CCM)<br>Enhanced Care Management (ECM)<br>Transitional Care Services (TCS) |
| **Populations** | Children and Youth<br>Birthing Populations<br>Individuals with Behavioral Health Needs |
| **Cross Cutting Priorities** | Equity (include all stratified measures) |

Pre-Decisional Draft

# DHCS's PHM Program Monitoring Approach for MCPs: Monitoring Mechanisms

Unlike the existing analysis of individual MCAS quality measures with set Minimum Performance Levels (MPLs), DHCS will review the **overall picture** revealed by data in each PHM monitoring category, and the data will act as a launching pad for further conversation with each plan on program effectiveness.

## Focus for Each Monitoring Category

- Whether MCPs performed **below benchmarks** (to the extent benchmarks exist);
- How MCPs performed **compared to each other**, with special attention to which plans are outliers;
- Whether MCPs made **year-to-year improvements** or **maintained their performance** if they were already high performers.

## Enforcement Mechanisms

- DHCS will use a **standardized enforcement pathway**, leveraging existing quality improvement and enforcement mechanisms, if any concerns arise in the PHM monitoring data, including the following:
  - Meeting with MCPs to learn more and ask questions about their PHM Program
  - Requesting additional policies and procedures or county level data/data from subcontractors
  - Implementing Plan Do Study Act (PDSA) Cycle Worksheets
  - Conducting Strengths, Weakness, Opportunities, Threats (SWOT) analysis
  - Imposing Corrective Action Plan (inclusive of Quality Improvement Assessment and Strategic Plan), sanctions, or liquidated damages as set out in the MCP contract.

# DHCS's PHM Program Monitoring Approach for MCPs:

## *KPIs By PHM Program Area* (1 of 4)

**Basic PHM**

**Proposed KPIs to be reported starting in July 2023**

- *Primary Care Engagement/Appropriate Utilization:*
  - Primary Care: ED Visit Utilization for Children and Adults
  - Percentage of adults who had a primary care visit with their assigned PCP within the last 12 months
  - Percentage of adult members with no ambulatory visit claims within the past 12 months.
- *CHW Benefit Integration:*
  - Percentage of members who received CHW benefit.

***Proposed BPHM KPIs to be implemented in future years:***

- *Vision Screening for Children*
- *Percentage of eligible members enrolled in WIC*
- *Percentage of eligible members enrolled in CalFresh*
- *Percent of members who had no well-child visits or ambulatory visit claims in the prior year but had CHW services in the current year.*

# DHCS's PHM Program Monitoring Approach for MCPs:
## *KPIs By PHM Program Area* (2 of 4)

**RSST**

***KPIs to be implemented once the PHM Service RSST Functionalities are Available***

- *Percentage of medium-rising and high-risk members identified through the PHM Service RSS who are enrolled in CCM*
- *Percentage of high-risk members identified through the PHM Service RSS who are enrolled in ECM*

# DHCS's PHM Program Monitoring Approach for MCPs:
## *KPIs By PHM Program Area* (3 of 4)

**Care Management**

**Proposed KPIs to be reported starting in July 2023**

- *CCM:*
  - Percentage of eligible members enrolled in CCM
- *ECM:*
  - Percentage of members enrolled in ECM
  - Percentage of members enrolled in each of the ECM Populations of Focus (POFs)

**For the ECM-related KPIs, DHCS will review and assess data from existing ECM Quarterly Implementation Monitoring Reporting; MCPs will not be required to submit additional data.*

***Proposed Care Management KPI to be implemented in future years:***

- *Percentage of members enrolled in ECM Birth Equity POF (go live date for this POF is 1/1/2024)*

# DHCS's PHM Program Monitoring Approach for MCPs:

## *KPIs By PHM Program Area* (4 of 4)

**Transitional Care Services**

**Proposed KPIs to be reported starting in July 2023**

- Percentage of contracted acute care facilities from which MCPs receive ADT notifications
- Percentage of contracted skilled nursing facilities from which MCPs receive ADT notifications
- Percentage of transitions for high-risk members that had at least one visit with their assigned care management post discharge.
- Ambulatory visit within 7 days post hospital discharge
- Percentage of members enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization" Population of Focus (POF) and "Adult Nursing Facility Residents Transitioning to the Community" POF from referrals made by the member's assigned transitional care manager
- Percentage of members enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" POF from referrals made by the member's assigned transitional care manager
- Percentage of members enrolled in CCM from referrals made by the member's assigned transitional care manager

***Proposed Transitional Care Services KPI to be implemented in future years:***

- *Length of Stay (adjusted by Diagnosis-Related Group (DRG))*

# DHCS's PHM Program Monitoring Approach for MCPs: Quality Measures (1 of 2)

For PHM monitoring, DHCS will review a subset of existing quality measure data (MCAS and CAHPS) reported through the annual Quality and Performance Improvement Process. These quality measures include:

## Quality Measures

- Depression Screening and Follow-Up for Adolescents and Adults
- Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits
- Well-Child Visits in the First 30 Months of Life - 15 to 30 Months – Two or More Well-Child Visits
- Child and Adolescent Well-Care Visits
- Developmental Screening for the First Three Years of Life
- Lead Screening for Children
- Childhood Immunization Status: Combination 10
- Immunizations for Adolescents: Combination 2
- Topical Fluoride for Children
- Prenatal Depression Screening and Follow Up
- Postpartum Depression Screening and Follow Up
- Colorectal Cancer Screening
- Chlamydia Screening in Women
- Breast Cancer Screening
- Cervical Cancer Screening
- Ambulatory Care: Emergency Department (ED) Visits
- Adults' Access to Preventive/Ambulatory Health Services
- CAHPS: Getting Needed Care
- CAHPS: Getting Care Quickly

# DHCS's PHM Program Monitoring Approach for MCPs: Quality Measures (2 of 2)

## Quality Measures (Cont'd)

- Depression Remission or Response for Adolescents and Adults
- Asthma Medication Ratio
- Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9%)
- Controlling High Blood Pressure
- Antidepressant Medication Management: Acute Phase Treatment
- Antidepressant Medication Management: Continuation Phase Treatment
- Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
- Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase
- Pharmacotherapy for Opioid Use Disorder
- Follow-Up after ED Visit for Mental Illness - 30 days
- Follow-Up after ED Visit for Substance Use - 30 day*
- Plan All-Cause Readmissions
- Potentially Preventable 30-day Post-Discharge Readmission
- Prenatal and Postpartum Care: Postpartum Care
- Prenatal and Postpartum Care: Timeliness of Prenatal Care
- Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate

# DHCS's PHM Program Monitoring Approach for MCPs: Measures by Populations

DHCS will review specific KPIs and quality measures for the populations listed below to assess the implementation and impact of the PHM Program at a population level.

## Children and Youth

**KPIs**

- Percentage of eligible members under 21 enrolled in CCM
- ED Visit Compared to Primary Care Utilization for Children
- Percentage of members enrolled in all ECM Children and Youth POFs

*These KPIs and quality measures are not additional measures; they are categorized in earlier slides but are included here for a population level analysis.*

**Quality Measures**

- Depression Screening and Follow-Up for Adolescents*
- Depression Remission or Response for Adolescents*
- Well-Child Visits in the First 30 Months of Life-0 to 15 Months-Six or More Well-Child Visits
- Well-Child Visits in the First 30 Months of Life-15 to 30 Months-Two or More Well-Child Visits
- Child and Adolescent Well-Care Visits
- Developmental Screening for the First Three Years of Life
- Lead Screening for Children
- Childhood Immunization Status: Combination 10
- Immunizations for Adolescents: Combination 2
- Topical Fluoride for Children
- Ambulatory Care: Emergency Department (ED) Visits
- Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
- Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase
- CAHPS: Getting Needed Care (Child)
- CAHPS: Getting Care Quickly (Child)

# DHCS's PHM Program Monitoring Approach for MCPs: Measures by Populations (1 of 2)

## Birthing Populations

**KPIs**

- Percentage of members enrolled in ECM Pregnancy and Postpartum POF and Birth Equity POF

*In future years, DHCS may monitor maternal mortality, infant mortality, and low birth weight rate at the plan level.*

**Quality Measures**

- Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits
- Prenatal and Postpartum Care: Timeliness of Prenatal Care
- Prenatal Depression Screening and Follow Up
- Prenatal and Postpartum Care: Postpartum Care
- Postpartum Depression Screening and Follow Up
- Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate

*These KPIs and quality measures are not additional measures; they are categorized in earlier slides but are included here for a population level analysis.*

# DHCS's PHM Program Monitoring Approach for MCPs: Measures by Populations (2 of 2)

## Individuals with Behavioral Health Needs

**KPIs**

- Percentage of members enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs" POF and "Children and Youth with Serious Mental Health and/or SUD Needs" POF

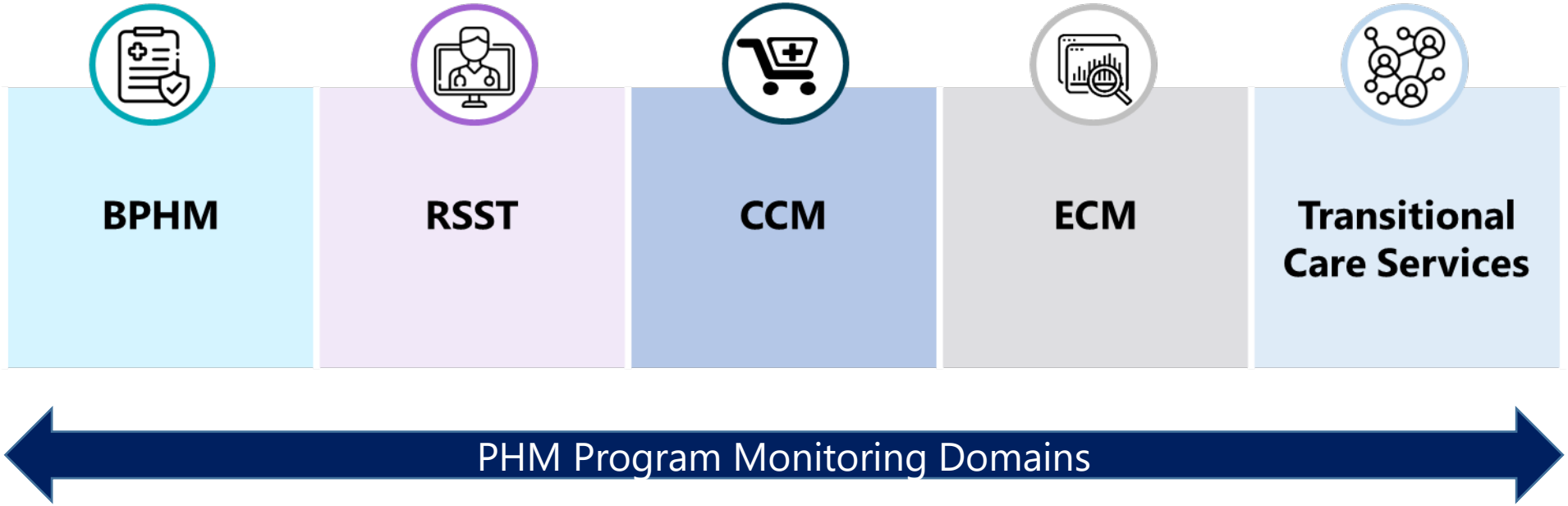
**Quality Measures**

- Depression Screening and Follow-Up for Adolescents and Adults*
- Depression Remission or Response for Adolescents and Adults*
- Follow-Up after ED Visit for Mental Illness - 30 days*
- Follow-Up after ED Visit for Substance Use - 30 days*
- Prenatal Depression Screening and Follow Up
- Postpartum Depression Screening and Follow Up
- Pharmacotherapy for Opioid Use Disorder
- Antidepressant Medication Management: Acute Phase Treatment
- Antidepressant Medication Management: Continuation Phase Treatment
- Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
- Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase

*These KPIs and quality measures are not additional measures; they are categorized in earlier slides but are included here for a population level analysis.*

# DHCS's PHM Program Monitoring Approach for MCPs: Cross Cutting Priorities

To ensure equity across the PHM Program, DHCS will review all KPI data stratified by race, ethnicity and age and a subset of quality measure data required by NCQA to be stratified by race and ethnicity.




**<u>Cross Cutting Priority:</u> Equity (include all stratified measures)**

# DHCS's PHM Program Monitoring Approach for MCPs:
*Discussion Questions*

1) Do the proposed KPIs appropriately assess MCPs' implementation and effectiveness of the overall PHM program? Any KPIs missing that should be included? Any way to streamline measures more?
2) How can DHCS's PHM Program monitoring approach assess MCPs' efforts to support member education that leads to improved member self-management and sufficiency?
3) How can DHCS's PHM Program monitoring approach address members with rising risk and ensuring interventions are implemented more upstream?

# Next Steps

DHCS will accept comments on the PHM Monitoring Approach for MCPs through end of day, **February 24th**. Please email your comments to PHMSection@dhcs.ca.gov with **subject line** "Comments on the Draft DHCS PHM Monitoring Approach for MCPs".