Population Health Management (PHM) Advisory Group Kickoff

March 18, 2022

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 1	00:00:19 - Julian	Hello and welcome. My name is Julian, and I'll be in the background answering any zoom technical questions. If you experience difficulties during this session, please type your question into the Q and A. We encourage you to submit written questions for our speakers at any time using the Q and A. The chat panel will also be available for comments and feedback. During today's event, live close captioning will be available in English and Spanish. You can find them in the link in the chat field. With that, I'd like to introduce Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality and Population Health Management at DHCS. Dr. Palav, you now on the floor.
Slide 1	00:01:14 - Dr. Palav Babaria	Thank you so much, Julian. Welcome everyone. We really appreciate so much all of you joining us today and especially welcome our population health management advisory group members who you'll see on the videos who have also joined us for today's meeting. We can go to the next slide. We're going to be kicking off our meeting today with a member story that we think really signifies what the potential of population health management is. So, I will let you hear directly from our member.

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Slide 2	00:01:45 - Colleen R	I've been homeless for seven years and my health was just deteriorating so bad. I was staying in somebody's yard in a makeshift tent. I had been staying there for a couple of years already. It was very cold and when it rained, it was very wet. I couldn't stand up straight and walk, just standing was painful most of the time. I got to a point where I couldn't even reach above my head. It was about like this. I had not been receiving any other treatment at that time. Your program helped to get me set up with the primary care physician and other medical needs that were necessary at that time. At that time, I was stuck and I just couldn't do it for myself. And the program would set up my appointments for me and tell me where they would pick me up and what time and where. And I just had to show up, which was about all I was capable of at that time. I'm 61 right now. And I felt like I was about 75 before.
Slide 2	00:03:04 - Colleen R	It's working with your program; I've had drastic changes. I don't think I've been in the wheelchair for probably almost a month now. I can't believe it. I feel so much younger. I ride my bike on a regular basis, go to a gym, no longer homeless. I'm in the community room of the place where I live right now. I have a one-bedroom apartment. The rent is extremely affordable for me through my physical health getting better. My emotional and mental health became better as well. I'm most proud that I never gave up. I've hung in here no matter what. And I have accepted and allowed people to help me. Jackie hung in there with me and if it's just making one or two or three phone calls, she just diligently hung in there and made sure that I received all the information that I needed. I needed to be taken care of, like in a childlike manner. I've been in numerous programs and have not received much help at all until I became affiliated with your program. And it was just so different from anything that I had experienced before. It was genuine true care.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 2	00:04:37 - Colleen R	Without the program, I just don't know where I would be. I can't tell you how much this program has done for me. There just aren't words. I'm so grateful.
Slide 2	00:05:20 - Dr. Palav Babaria	I know Colleen is trying to join us this morning, so we will turn to her whenever she is able to join. But we'll go into some of our opening remarks and take a break whenever she is able to log in. So, firstly, to Colleen, I know that some of our other partners from Ventura County are here. Thank you for joining us, for sharing your story so fearlessly and for showing us the type of life transformation that is possible with the right type of support. So, my name is Palav Babaria. I'm a primary care physician and the Chief Quality Officer and Deputy Director for Population Health Management here at DHCS. Colleen's story is a reminder that declines in health do not have to be a one-way street. Traumatic transformations going from using a wheelchair to walking from living in a tent with poor physical and emotional health, to feeling 10 years younger while riding your bike and having a trusting relation with the regular doctor are possible.
Slide 2	00:06:19 - Dr. Palav Babaria	And yet, all of us who work in healthcare know that success stories like Colleen's are rare, but the underlying conditions are not. Right now, 160,000 Californians are experiencing homelessness with the disproportionate impact on low income and communities of color, i.e., those that we serve in the Medi-Cal program, Medi-Cal members like Colleen are more likely to report not having a regular source of care, a primary care provider who could have helped sooner. We believe that the promise of population health management is to make Colleen's success story the norm, not the exception by ensuring that every Medi-Cal member who is struggling, who needs a little extra support to find a provider to get to and from appointments to get off the street and back on her bike receives it when they're ready to. And yet, caring for and supporting members like Colleen is not enough.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 2	00:07:13 - Dr. Palav Babaria	The true vision and success of population health management will be if we can ask ourselves, what are all the missed opportunities where the healthcare system could have reached Colleen before she found herself in a wet, cold tent, unable to stand up and intervene sooner more effectively to prevent such outcomes in the first place? What would it look like if Colleen had received outreach and support to help ensure that she had a primary care provider years earlier if that primary care provider was conducting regular checkups and behavioral health screens who could have provided counseling and support in the early stages when Colleen needed help? What would it look like if Colleen's health plan had known that she was at risk of homelessness and was able to connect her to housing resources and case management support before she became homeless? If we think even harder, what system interventions would've helped 60 years ago when Colleen was an infant to change the trajectory of her future health, how would those interventions need to be tailored to achieve our promise of eliminating disparities in care?
Slide 2	00:08:17 - Dr. Palav Babaria	The Population Health Management Program will help all members stay healthy via preventive and wellness services, identify and assess member risks, to guide care management and care coordination needs and identify and mitigate social drivers of health to reduce healthcare disparities. But also holds the potential to transform the long-term health and wellness for Californians in the Medi-Cal program for decades to come. We thank you all for joining us today. We know there is so much wisdom, experience, innovation and commitment on this call today, far more than we could accommodate in our formal advisory group membership. We've purposefully kept our chat open so that each and every one of you can participate, contribute, and shape this vision for the future of Medi-Cal. Thank you all so much. I'm going to turn it over to Sharon to kick us off.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 3-4	00:09:09 - Sharon Woda	Great. Thank you. All right, on the call today, just so that everyone is aware, you have a big group of DHCS folks. You'll mainly hear from Palav as you already have and Aita, but there are others on the line to listen and to review the chat and to be available as well. There are also some facilitators me from Manatt, as well as Jonah and Natassia, who you also know voices up when we get to the Q and A. So, let's go to the next slide and talk through the agenda. We have a lot to cover today. So, we want to provide some backdrop with context and level setting. Then quickly give overviews of both the PHM service, which I know folks have a lot of questions about as well as the PHM program, and then do a deeper dive on the overview of the PHM program requirements and what's under consideration to date. We'll spend most of our time there.
Slide 3-4	00:10:02 - Sharon Woda	You'll see us moving the dialogue along because we do want to get to next steps and the Q and A, and make sure that we definitely have time for those 15 minutes. So, I think without further ado, I'll hand it over to Aita for context and level setting.
Slide 5 - 6	00:10:17 - Aita Romain	Thank you, Sharon. Just double checking that everyone can hear me. Thank you. Great. So, let's get started with some context. So, DHCS has a 10-year vision for the Medi-Cal program. So, the goal is for members to lead healthier and happier lives measured by improved outcomes and a reduction in disparities. To accomplish this, DHCS is moving towards a proactive, whole system person-centered approach in which healthcare services are only one element of supporting better care for members. Population health management is a cornerstone of this approach.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 6	00:10:54 - Aita Romain	So, PHM is a plan of action for addressing member needs and preferences across the continuum of care. So, PHM is data driven, risk stratification, predictive analytics, identified gaps in care and standardized assessment processes. PHM keeps the focus on the members' wellness by prioritizing prevention and linking to public health and social services. So, PHM also provides care management, care coordination and care transitions, bridging gaps between delivery systems and settings. So, when finally PHM identifies and mitigates social drivers of health to reduce disparities across member populations. Next slide please.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 6	00:11:48 - Aita Romain	So, widespread PHM implementation is urgently needed. So, we know that with the COVID-19 pandemic has had a devastating impact on health and wellbeing, but well before the pandemic, the Medi-Cal program had low preventative care rates for children, high unplanned readmissions, and wide disparities in treatment outcomes for people of color. So, the launch of PHM should be understood as a part of a broader arc of change to improve health outcomes and if you haven't yet, I suggest you reading or skimming, it's a large document. The current draft of the DHCS is comprehensive quality strategy often referred to as the CQS. So, DHCS's comprehensive quality strategy is linked to DHCS's population health management on its website, and it's closely tied to the health equity and quality emphasis. That includes the bold goals of the CQS so other. So, core part of CalAIM initiative is the PHM program. This may feel familiar because it has elements that are rooted in the work that has been done for many years by managed care plans in their quality improvement departments, health education, and culture and linguistics programs. And as a core part of CalAIM initiative, the PHM program requires Medi-Cal delivery systems to develop and maintain a whole system person-centered program. So, currently the PHM program design only applies to the managed care Medi-Cal plans and does not apply to other Medi-Cal delivery systems. And we expect the launch for January 1st, 2023, although benefits like enhanced care management, which will be talked about in more detail later, have already launched this year.

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Slide 7	00:13:47 - Aita Romain	We also have the PHM service, which is a technological service that will support DHCS's PHM vision by integrating data from many sources. The PHM service will perform some of the population health management functions as described in later slides. We also anticipate that the PHM service will allow many users, data access and sharing capabilities. We expect that these components go into effect in January 2023 as well. Although we are looking at flexibility around that date. Next slide, please.
Slide 8	00:14:34 - Aita Romain	So, the PHM program and the PHM service need to be designed to meet the needs of members across the continuum of care. So, the PHM program and service will evolve over time and will be dynamic. And we're looking to get a lot of stakeholder involvement in creating the goals for this service to make sure that we're meeting our needs. And then also we have goals that will cause close collaboration and consultation with stakeholders, which begin with this meeting. And we're hoping that we hear a lot of your input. So, the purpose is that we also have the PHM advisory group, is comprised of cross section of stakeholders that will provide feedback and make recommendations on the CalAIM PHM program, as well as the PHM service. Next slide please.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 9	00:15:39 - Aita Romain	So, our meeting format for today will consist of a presentation from Palav as well as myself. And so, although we will not be asking for public comment or feedback today, at future meetings, we'll continue to be open to the public as well as the chat, which I see individuals are using and thank you very much for using that function. At the next meeting, the PHM advisory group members will be asked to provide feedback on material and concepts that are presented as well as discuss other priority topics based off of some of the conversations that you've been a part of and some of the resources that we will direct you to throughout this meeting today. And there will also be 15 minutes at the end for presentation for Q and A, and both PHM advisory group members and all other attendees are welcome to submit questions through the Q and A feature. Next slide please.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 10 - 12	00:16:36 - Aita Romain	So, part of our PHM advisory group membership, our providers, manage care plans, counties, next slide, please, counties, advocates, community organizations, government agencies, and foundations, and we welcome all of you today. So, thank you so much for taking time out of your Friday to join us. Next slide, please. Thank you. So, let's talk a little bit about the PHM service overview I touched on previously. So, next slide, thank you. The PHM service will support DHCS's vision for the program in a number of ways. Notably the PHM service will provide managed care plans, providers, counties, Medi-Cal members, and other authorized users access to more timely, accurate, and comprehensive data on members' health history and needs, which will help improve care and avoid duplicative processes. It will also support risk stratification and segmentation and have a risk tiering functionality. We're hoping that through this, it will promote trusting relationships between enrollees, members and their care team by making it easier for members to update their information and providing members with access to health education, as well as informing materials such as their rights and applicable benefits.
Slide 13	00:18:15 - Aita Romain	The information on how the data will be used, will hopefully be part of your role in informing us. And we also hope that we'll improve DHCS's ability to understand population health trends and support oversight. Next slide please. So, the PHM service, overview of the capabilities that we're hoping it will offer. So, we're hoping it will bring in data sources from DHCS as well as other sources. So, we're hoping that these data sources will offer physical and behavioral health data, social services data, dental data, developmental data, home and community based support service data, as well as some other key data elements that maybe right now are not speaking to each other. We want to also enable key population health management functions and services.

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Slide 14 - 15	00:19:19 - Aita Romain	As I mentioned before, we want to see some risk stratification out of the system as the service, as well as we want to have the capabilities to do individual screening and assessments, as well as some reporting in population gaps. And finally, we also would like to provide access to the PHM data to end users in a way that makes sense to the end user as well as uses it to prioritize interventions on the program side. Next slide please. So, the population health management service, we're hoping we'll meet multiple stakeholders needs. We're hoping that providers will find it useful. We're hoping that the managed care and other delivery systems will find it useful, state departments and agencies, members as I mentioned before that DHCS will have a system of monitoring that is easy and up-to-date and that local county partners and local social service partners will find it easy to use as well. Next slide please.
Slide 16	00:20:33 - Aita Romain	So, with ease of use, we also need to understand what it could be used for, and these are our priorities for use as they stand at this moment. So, data aggregation and sharing. So, we want to identify source and aggregate and normalize a broad set of data elements to be shared with authorized users. So, we also want to have risk stratification segmentation and tiering. So, we want to create a standard risk stratification algorithm. These are algorithms that some MCPs, but not all are using at this moment, but we'd like to have a standardized risk algorithm that we can rely on for all of our members as a universal tiering system. And this will help with across populations and within subpopulations as well.

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Slide 16	00:21:23 - Aita Romain	We also want to have a screening and assessment component where we can establish a capability with roles and rules based on access for members to securely access in complete health related screening and assessments, so that they're not being asked at multiple different locations for the same information. We know there's screening fatigue for members as well as providers, and we want to help with that and we want the service to be able to meet that need. So, we also want to reduce redundant data entry and the PHM service would pre-populate data fields with information already collected from the beneficiary at a previous time. Next slide, please.
Slide 17	00:22:05 - Aita Romain	We also would like to link in the program enrollment and engagement. So, providing capabilities for members to better understand their eligibility for social service programs and community-based supports. At this time, MCPs can offer community supports and we want to make sure that those systems are meeting the needs of members. We also have member access and updates, so provide capabilities to allow members to access information regarding their rights and benefits, which is sometimes referred to as member informing materials and details regarding the use of their information, so that they understand their privacy and rights around that and to securely update their demographic information and share with that designated entities. This will become essential when we're talking about languages that members speak and how they would like to receive their materials and making sure to meet those needs. And finally-
Slide 17	00:23:00 - Aita Romain	Materials and making sure to meet those needs. And finally, we want to make sure that member informing materials and health education can quickly get to members and there is a platform that can meet that. So this would provide DHCS with the ability to contact and communicate with members as well as MCPs and other end users that are linked to members.

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Slide 18 - 19	00:23:24 - Aita Romain	Next slide please. So to talk about the PHM program overview a little bit, so I just covered the PHM service and the names are very closely linked so it can be a little confusing, but the overview of the program is that DHCS wants to establish a standardized statewide approach to population health management through which MCPs are responsive to community needs and work within a common framework to improve outcomes and reduced disparities. So Palav will talk a little bit more later about the framework that we're using for this but let me give you a little bit of background about the program overview.
Slide 19	00:24:10 - Aita Romain	So a cornerstone of the plan is that it's going to start in 2023, however, we already have some benefits as I mentioned before, under ECM that have already started. Under this system, each MCP will have them maintain a whole system person centered population health management program. So several of the key elements of PHM are already in place and we're just trying to bring these all together. And this is a cohesive set of concepts and requirements that apply to all populations served by managed care plans. So often we have had regulations in the past that may have set seniors and persons with disabilities apart from the universal population, and what we're saying now is that everyone needs to get population health management program services to maintain life of wellness and the system of care needs to meet those needs overall.
Slide 19	00:25:10 - Aita Romain	Next slide please.

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Slide 20	00:25:14 - Aita Romain	So what we expect in terms of timing is that starting in 2023, all MCPs will be required to meet National Committee for Quality Assurance (NCQA) population health management standards. Many of the MCPs are already NCQA accredited, and so they are meeting those standards, but those who do not have accreditation will need to meet those standards regardless of whether or not they have accreditation. MCPs will be expected to adhere to new population health management requirements, which are with the 2020 for re-procurement contract, which went out in February, and aligned with the existing and managed care plan standards to form a path to better wellness for all their members.
Slide 20	00:26:05 - Aita Romain	So broadly, the new requirements will streamline and simplify and standardize existing approaches to population health management. As I mentioned before, many of the managed care plans have been doing this in their quality improvement, health education and culture and linguistics program, and we want to bring that together as a forefront and priority for all their members. And then we also want to incorporate the role of the PHM service, which should be up and running, as I mentioned at the beginning of 2023, into their PHM program so that it can be a reliable set of aggregate data that they can use through risk tiering and other capabilities to meet the needs of their population. And that there will be a set of expectations for member engagement and population health management programs and across services.
Slide 20	00:26:58 - Aita Romain	So to account for PHM service function, DHCS will roll out new PHM requirements over time throughout 2023 and 2024, so it will not all come online at the same time. And Paula, I believe that this slide is for you.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 21-22	00:27:19 - Dr. Palav Babaria	Absolutely. Thank you so much, Aita, for that overview and for everyone on the call, I think we're going to now dig into what our high-level thinking is on the framework. I will say this is a high-level framework, and there's a lot of detail that still needs to be figured out as well as refinement, vetting, and sort of making this framework better, which is why all of you are here today.
Slide 22	00:27:41 - Dr. Palav Babaria	So just to give you quick preview of the PHM strategy and roadmap paper, in mid-April, we will be releasing what we're right now calling the PHM Strategy and Roadmap Document, which will be sort of a policy paper that goes into much more detail about our current thinking of everything that we're about to talk about in the PHM framework. There will be ... Obviously, it'll be in draft form and we hope that everyone on this call will read it, review it, and provide us feedback so that we can really refine our thinking on everything that we are about to go over.
Slide 22	00:28:17 - Dr. Palav Babaria	You can go to the next slide.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 23	00:28:20 - Dr. Palav Babaria	So we're going to walk through sort of what our framework is and then each component of that framework, and at least the high-level thinking that we have so far on how this will all work. As Aita mentioned earlier, the way we are thinking about the population health management program is really in four domains, starting with the population, needs assessment and population health management strategy. How do we gather information about what the needs are in the community and address those needs followed by gathering information, and I see all of the data specific questions in the chat so we'll cover some of that. The third bucket is really understanding risk. How do we use those community-based assessments and individual member level information to really understand the risk of each beneficiary? And then the fourth bucket is really once we know what an individual member's risk is, how do we provide services that are tailored and appropriate for their level of risk?
Slide 23	00:29:14 - Dr. Palav Babaria	We can go the next slide.
Slide 24	00:29:18 - Dr. Palav Babaria	So this is the PHM framework. I recognize it's a busy visual, if you haven't been staring at it for hours on end like we have. So it goes over those four buckets that we just talked about. On the left, you'll see ... Actually, I'm going to start on the bottom. The bottom is really the PHM strategy and population needs assessment. This is where our plans will be really using a data driven strategy that really collaborates with community members. We know local health jurisdictions do community assessments, our hospitals do community assessments, and this is all local information. The local status and needs of the community need to drive what the population health management framework looks like at the local level.

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Slide 24	00:29:59 - Dr. Palav Babaria	Then there's the left bucket of gathering member information. There are initial screenings that are done where we capture information about all Medi-Cal members. There's obviously claims and other types of data that we'll go into in a second. All of that information should then feed into a risk stratification and segmentation process, usually an algorithm of sorts that helps us predict what the level of risk is for an individual member. Members will then be assigned to risk tiers based off of that algorithm. We imagine that all members are going to receive what we are calling basic population health management, which we'll also go into in a few slides, and then certain members who are higher risk are going to need further assessments and reassessments for various care management programs.
Slide 24	00:30:46 - Dr. Palav Babaria	And then you'll see on the right there's also some members who are going to need transitional care services. This is really when they are moving between different levels of care, being discharged from the hospital, being discharged from long term care to home, but are different than those individuals necessarily who need long term or intermediate care management.
Slide 24	00:31:05 - Dr. Palav Babaria	We can go to the next slide.
Slide 25	00:31:08 - Dr. Palav Babaria	So let's dig into each of these sections, so we're going to start with the population needs assessment and the population health management strategy, which you see down in the bottom in purple.
Slide 25	00:31:18 - Dr. Palav Babaria	We can go to the next slide.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 26	00:31:23 - Dr. Palav Babaria	So as we alluded to, the population health management strategy is going to be required of all health plans and it really is going to detail how the population health management framework and structure at the local level really addresses and responds to the unique needs of that local community. It considers different cultural and ethnic groups, different linguistic needs, different health conditions that reside in the community, different rates of social drivers of health, which we know vary by geography across the state. We are a very large and diverse state and this is where the program will be tailored to what those local needs are. There will also be a population needs assessment, which in partnership with community groups, with members, with other entities who also do community assessments will help drive what that strategy looks like.
Slide 26	00:32:16 - Dr. Palav Babaria	We envision that this is going to evolve as a tool so that over time there is more and more broad-based community engagement. We know that we really need to look at those populations who historically have been left behind and are not served as effectively by the Medi-Cal programs, so how do we bring in those diverse data points to really help use this strategy to close health disparities that we are seeing? So we envision right now already the plans do a population needs assessment that will evolve over time, as I just mentioned. In mid-2023, the managed care plans will be required to submit an annual population health management strategy.

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Slide 26	00:32:56 - Dr. Palav Babaria	So this is not something that's envisioned that you submit on 1123 when the PHM program goes live but will be really built and constructed from now through mid-2023. And the PHMS will include all the components of the MCP strategy, really thinking about how it's going to achieve measurable improvements in the department's clinical focus areas, which is outlined in our comprehensive quality strategy that we linked to earlier, and that includes children's preventative care maternity outcomes in birth equity, especially during the postpartum period, and integrated behavioral health. And then we'll also be tackling specific big health disparities and conditions that are informed by that local population needs assessment.
Slide 27	00:33:47 - Dr. Palav Babaria	Great. So the next bucket is really how do we gather member information effectively? We know that we really need to make sure we're gathering not just claims data as I know folks said, but really understanding what is the full spectrum of health for our members, and that includes social data, that includes upstream social drivers of health, that includes behavioral health data. We also know that in an ideal state we will have not just sort of data that is old, claims data often has a lag of three to six months, but real time data. So I know there was a question at some point about is this going to connect to HIEs or local information exchanges? And the answer is yes, ideally it will so that there is as close to real time data about what is happening to members as possible through the service.

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Slide 27	00:34:35 - Dr. Palav Babaria	We also know that the current processes by which we collect data are really cumbersome for both healthcare providers and plans, but most importantly, for our members. When our Medicaid director did the listening tour that led to the creation of Cal Aim, it was really heard over and over again that we ask members the same questions over and over, they're duplicative, they're asked across numerous settings, and so a huge push with both the population health management program and the service is to reduce that duplication in asking these questions, and really reduce the screening fatigue that we hear about all the time.
Slide 27	00:35:15 - Dr. Palav Babaria	We can go to the next slide.
Slide 28	00:35:18 - Dr. Palav Babaria	So I think in terms of the gathering information, we definitely want to leverage existing member data, so the PHM service will aggregate data that the department already has both through claims data, as well as other state departments that we already exchange data with. The MCPs have their own data that they're collecting right now and we are going to be clarifying expectations about which data the MCPs should be using for member risk in 2023. Ultimately, the service will provide most, if not all, of this information.

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Slide 28	00:35:54 - Dr. Palav Babaria	In terms of streamlining screening and assessment, we're going to be adding new requirements and changing existing requirements so that we can really streamline and eliminate all of that duplication. So the proposal for the launch of the population health management program is to eliminate the individual health education behavior assessment, also known as the staying healthy assessment, which we've heard feedback loud and clear across the state is not effective, is not conducted in a way that is easily imported into electronic health records and exchange, while still really focusing on the downstream outcome measures, most of which live in primary care, that these assessments are designed to drive. We also are going to preserve protections. We already follow the USPSTF guidelines and the bright future schedule to make sure that whatever age a member is, they're still getting all of the necessary preventative services as recommended by national bodies.
Slide 28	00:36:55 - Dr. Palav Babaria	We can go to the next slide.
Slide 29	00:36:58 - Dr. Palav Babaria	So I think there's a lot of questions in the chat about this. So this is at a high level the information that we envision being necessary to have a comprehensive picture of what a Medi-Cal member's risk is, and that we would put into the risk algorithm, which we'll get to in a second. So any screening or assessment data that exists would ... Self-reported information from the members would be utilized, claims and encounter data, including fee for service data, which we have at DHCS, any available social needs data, so we hope eventually to be able to have status on who's enrolled in CalFresh, who's enrolled in WIC, housing status from across a number of agencies, et cetera.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 29	00:37:42 - Dr. Palav Babaria	Eventually electronic health record data from available health information exchanges would be desired. Referral data, especially for case management programs, things like community supports and ECM. We obviously cannot assess the whole person without including behavioral health data, and I know there was questions about data exchange and federal regulations, so this will need to be done in compliance with 42 CFR. We also await if there are any changes at the federal level in terms of that regulation and are exploring consent processes to make this data exchange much easier across the state.
Slide 29	00:38:19 - Dr. Palav Babaria	Disengaged member reports. So we know, especially for some populations, underutilization is a huge problem in Medicaid agencies across the country, but especially in Medi-Cal and the underutilization, especially for children, especially for certain racial and ethnic groups, drives a lot of the disparities that we see across the state. So we know that relying only on people who are showing up in utilization actually can perpetuate bias and worsening disparities, and so really looking at who's not showing up as much as who is showing up and what they're using will be critical. We also hope to have lab data, ADT feeds, more robust race and ethnicity data, as well as sexual orientation and gender identity data, so that we can further understand where the disparities are across our populations and address them.
Slide 29	00:39:08 - Dr. Palav Babaria	We can go to the next slide.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 30	00:39:13 - Dr. Palav Babaria	So to further delve into the screening and assessment, MCPs will also be required to share the results of the health information, form and member evaluation tool, which is currently required with primary care providers. And this is really a desire to make sure, again, to lessen the screening fatigue that our members report and that if someone is asking questions of our members and getting valuable information, that that information is being shared with everyone who needs it to take care of that member more effectively.
Slide 30	00:39:49 - Dr. Palav Babaria	I will also flag that this is really a bridge strategy. Right now this HIF/MET is used to meet federal requirements around screening that we have to adhere to. Originally, in the population health management working group that kicked off prior to the COVID 19 pandemic, it was envisioned that there would be an IRA or an individual risk assessment that would replace all of these screening tools and have a single standard screener across the state. That entire process was envisioned before we had budget for the population health management service.
Slide 30	00:40:25 - Dr. Palav Babaria	Currently, we are now thinking that with the population health management service, there are better ways to aggregate various screening data that we want from different places, whether some of those questions are asked on the Medi-Cal application, in the provider office, at the plan level, and bring them all together via this PHM service. So there's still a lot of policy to be worked out. We will be doing a deep dive in this group at future meetings as to what that looks like, but the HIF/MET will stay until that future state process that exists through the PHM service can replace it in a way that is still compliant with federal regulations.
Slide 30	00:41:03 - Dr. Palav Babaria	We can go to the next slide.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 31	00:41:09 - Dr. Palav Babaria	The other screening that we have gotten a lot of feedback about is the initial health assessment, which in current state needs to be completed within 120 days of enrollment into a plan and includes a lot of detailed requirements for the provider office. We are looking to simplify this entire process by retiring all of the requirements, that entire laundry checklist of what should be done in initial health assessment and really viewing this as a way to engage in primary care. That we absolutely think checkups and engagement with primary care are critical. We heard that in Colleen's story. That is the foundation of wellness and prevention, and so making sure that all members have a trusted primary care provider that they're engaged with and seeing regularly for their preventive needs is how we envision fulfilling this requirement. For children, obviously, the elimination of these requirements does not affect any of the required EPSDT screenings that are mandated.
Slide 31	00:42:11 - Dr. Palav Babaria	We can go to the next slide.
Slide 32	00:42:16 - Dr. Palav Babaria	So the next bucket is understanding risks, so we have ideally all of that information that we just walked through from numerous sources gathered in one place. What do we do with it?
Slide 32	00:42:26 - Dr. Palav Babaria	We can go to the next slide.
Slide 33	00:42:28 - Dr. Palav Babaria	So we really see risk stratification as a way to predict how sick or complicated ... How sick or what is the sort of risk of future illness or poor outcomes for an individual member, and then what are the right services that we can get them to address their current needs and then prevent future illness and poor outcomes? So for risk stratification, we would take this data, put it through an algorithm that then helps separate our member populations into different risk groups. This would be done at the population level, but also at the member level. The segmentation then helps us put members into different categories.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 33	00:43:14 - Dr. Palav Babaria	For the risk hearing, we envision and keeping it pretty simple and having high risk, medium or rising risk, and low risk. This would be done through the population health management service so that we at DHCS have a sense of what is the risk tiers, in each individual geographic area in each individual plan, and to be able to compare and contrast those tiers across the entire state. This also will help us inform our policy because we know the state is different, geography is different, populations are different, and we want to make sure that policy is addressing those differences and that the right resources are also being allocated to meet the needs of local populations.
Slide 33	00:43:56 - Dr. Palav Babaria	We can go to the next slide.
Slide 34	00:43:58 - Dr. Palav Babaria	So there's a lot of great questions about how a lot of our plans already do this today. How does that get impacted by the PHM service? So prior to the population health management service launching, we would ask plans to use their current approaches that comply with NCQA standards. We would also ask them to incorporate the minimum data sources that we covered in that information gathering section to the best of their ability, as well as make sure that whatever approaches they are currently using avoid certainly worsening disparities, but also actively reduced biases. Once the PHM service becomes available, and we will be procuring a vendor to come on board and provide this service for the state, that vendor has not been procured yet. We anticipate P going through that process later this spring. Once that vendor and the service become available, DHCS would require managed care plans to use the PHM service methodologies to place members into different tiers so that we can have a single standard across the state, which is one of the key goals of Cal Aim is to reduce all of the variation in services across the state.
Slide 34	00:45:15 - Dr. Palav Babaria	We can go to the next slide.

Population Health Management (PHM) Advisory Group Kickoff

March 18, 2022

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 35	00:45:20 - Dr. Palav Babaria	So in terms of tiering, the service, once it is available will be tiering members into this low, medium, or rising risk, or high-risk categories. These we really view as the baseline categories. Obviously, at a local level there may be additional information that a member provides where even if the algorithm thinks they're high risk, really, they're low risk, and that was a onetime flip. Or if the algorithm thinks they're low risk, but they have a very complicated social situation and other factors that were not contained within our data systems, and really that member is seen as high risk, adjustments will be made so that at the end of the day the member gets the services.
Slide 35	00:46:00 - Dr. Palav Babaria	Adjustments will be made so that, at the end of the day, the member gets the services that they need based off of information that we have about them.
Slide 35	00:46:08 - Dr. Palav Babaria	Prior to the PHM service existing, MCPs will not be required to use any standardized risk tiers. That part of the policy will really come to bear once the PHM service is up and running. You can go to the next slide.
Slide 36	00:46:28 - Dr. Palav Babaria	So this next bucket is really once we suspect, or the algorithm suggests that someone is a higher risk, or rising risk and needs something, what happens next? You can go to the next slide.
Slide 37	00:46:50 - Dr. Palav Babaria	So for the assessment and reassessment for case management in 2023, we really want to build upon existing infrastructure, which is already codified in numerous APLs and regulations. So in current state members who may qualify for complex case management based on off of existing methodologies that the MCPs have, we would hope that all of those are assessed for further care management services.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 37	00:47:18 - Dr. Palav Babaria	For ECM populations of focus, there is already an entire workflow and process for how those members are assessed, and referred, and enrolled into ECM. But, as required by state law, anyone who is identified long-term services and supports needs, needs a follow-up assessment and enrollment in appropriate services. Also, for any seniors and persons with disabilities who are high risk already in current practice, those individuals are assessed on a more expedited fashion and connected to services. Members receiving transitional care services are also required to be assessed and connected to the services they need. And then, under CPSP requirements, there are already very specific requirements for all pregnant women for assessment. So, we imagine until the PHM service goes live that these would be members for all of the plans we're already assessing today and would continue assessing in compliance with both state and federal regulations.
Slide 38	00:48:21 - Dr. Palav Babaria	And I should have just said on that last slide, once the PHM service becomes available, the ones based off of risk tiering, those that are higher risk would be assessed in addition to those existing populations.
Slide 38	00:48:38 - Dr. Palav Babaria	Great so, the last bucket that we're going to go through and then, hopefully, we'll have enough time for robust at Q&A is once people are assessed, what are the services that we actually expect people to get through the Population Health Management Program? You can go to the next slide.
Slide 39	00:48:58 - Dr. Palav Babaria	So, these are the three buckets of the programs that we'll be walking through. As I mentioned earlier, we envision that every single Medi-Cal member independent of their needs, or risks will receive basic population health management. And then, there are some members who based off of their conditions, and risk, and needs will also receive care management services, and transitional care services. Go to the next slide.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 40	00:49:25 - Dr. Palav Babaria	So, the foundation of our Population Health Management Program is this concept, which we are terming basic population health management. As I mentioned earlier, if all we do is provide the wraparound services for our patients, who are complex and high utilizers, we will have missed the point of population health management. The bottom of the population health pyramid really is an incredibly robust foundation of prevention and upstream intervention to prevent illness and prevent disease.
Slide 41	00:49:56 - Dr. Palav Babaria	So the key parts of basic population health management really include strengthening primary care as the center of the healthcare delivery system. This includes working on primary care access, improving primary care utilization for those populations who are underutilizing primary care and preventative services. As well as focusing on continuity and engagement with primary care. Throughout the COVID-19 pandemic, we saw that trusted relationships with primary care providers were often one of the biggest drivers of vaccine acceptance in our communities. Care coordination is critical. As mentioned earlier, there are numerous aspects to health, including behavioral healthcare services, oral healthcare services, coordination across delivery systems, providers, different follow-up needs. So, for all members effective care coordination to navigate the healthcare system and receive the services they need will be critical. Broad wellness and prevention programs that really look at community health, individual prevention and wellness. As well as looking at the rising risk to avert long-term chronic disease will be critical.
Slide 41	00:51:08 - Dr. Palav Babaria	The next bucket, addressing chronic disease. We know we have a long way to go to really control cardiovascular disease, diabetes, pulmonary diseases, and really having a robust foundation that is patient centered, and empowering will be critical.

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Slide 41	00:51:23 - Dr. Palav Babaria	And then, we also know we have a maternal health crisis in this country. And our disparities in the state are significant. So, really thinking about what we need to do to address maternal health outcomes, which then has significant impact on the health of the child, and the family subsequently. We also expect that these will be culturally and linguistically appropriate to really tackle the disparities that we see and document by race, ethnicity, and language. And then, also want to just call out that for children, especially, we see basic population health management to be built on EPSDT, which is a guaranteed benefit and significantly underutilized throughout our state. You can go to the next slide.
Slide 42	00:52:11 - Dr. Palav Babaria	So, in terms of care management, unlike basic population health management, care management really is thought to be a service where a specific, whether it's a team or an individual care manager supports a member who has higher needs that need to be addressed. And so, we expect that everyone who's enrolled in care management will have a single point person, that there's going to be a care management plan, which assesses their individual members' strengths, risks, needs, goals, and preferences. And that this plan is made with input from the member, as well as any family members, guardians, or others that they need, or want involved in their care. You can go to the next slide.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 42	00:52:58 - Dr. Palav Babaria	Great. So, in terms of complex care management versus enhanced care management, complex care management, we envision will follow the same definition as is defined by the NCQA. And since all of our health plans are required to follow the NCQA population health management requirements, we are trying to align with them wherever possible to avoid duplication and/or additional administrative burden. Complex case management can be for higher and medium rising risk members. It includes chronic care management, as well as interventions for sort of episodic temporary needs, where people may be temporarily higher risk. It also still includes the comprehensive assessments as required NCQA. And manage care plans can use their own staff as care managers.
Slide 42	00:53:46 - Dr. Palav Babaria	Enhanced care management is the statewide benefit that rolled out earlier this year. That is a comprehensive community-based care management. That is for the highest need, highest cost members who specifically meet the ECM populations of focus criteria. Within the ECM benefit, there's a lead care manager who coordinates all of the members' clinical, but also nonclinical needs across multiple sectors, and delivery systems for ECM and CPs are required to contract with community based providers, as opposed to using their own staff as care managers. You can go to the next slide. And then, transitional care services, I think has been around for a lot longer than some of those other definitions. But this is really defined as what happens when a member is transferring from one setting, or level of care to another. So being discharged from the hospital, being discharged from a skilled nursing facility to home, having surgery and needing to be discharged, even if it's same day surgery. And we recognize that some of those transitions can be the riskiest times for our members where they may have new medications, other follow-up needs, DME needs, home health needs.

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Slide 43	00:55:06 - Dr. Palav Babaria	So, managed care plans are going to be required to assign a single point of contact who will be the transitional care manager for members enrolled in ECM or CCM, whoever their existing care managers can fill that role so that it is much more coordinated, and aligned for that member. The transitional care manager is going to be responsible for coordinating a follow-up care and verifying that the members get everything that they need as they are transitioning across the settings. And then, transitional care managers will also assess numbers to see if they need a more longer-term care management, or additional care management program, such as CCM or ECM. Go to the next slide.
Slide 44	00:55:57 - Dr. Palav Babaria	And the last slide. So, just want to give a nod to accountability. So as many of you know, we are re-procuring our managed care contracts in 2024. And we are strengthening our oversight of managed care, so that managed care plans really are held accountable to all of the requirements as stated in our programs, and in the contract. And so, even with these changes that we have outlined, especially the streamlining of many of those screening tools, all managed care plans will still be responsible for meeting minimum performance levels on select quality measures, including those that are really related to prevention and screening. And that will become one of our main accountability tools to measure outcomes related to prevention and wellness.
Slide 44	00:56:46 - Dr. Palav Babaria	We also want to ensure that there is member engagement with their primary care provider across a range of services. So, starting in 2023, we are going to be introducing quarterly monitoring for population health management, where plans will report a quarterly report to us on certain key measures that are key performance indicators for these elements that we just talked about. The exact structure and content of that quarterly report will be released later this year in the fall.

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VISUAL	TIME AND SPEAKER	AUDIO
Slide 45	00:57:21 - Dr. Palav Babaria	So, that was just a lot of talking. Sharon, I'm going to turn it over to you. And if there's any key things that [Aita 00:57:27] or I missed, please feel free to chime in before we dig into Q&A.
N/A – Q&A	00:57:32 - Sharon Woda	All right, why don't we stick on the Q&A slide? So, I will start going through some of the questions and I'll start with some questions. And then, Jonah will also come in with some questions he has. So the first one is on the PNA. The question is, "The PNA stated in this presentation, is this the same as the current day PNA definition or are there new requirements to be added to what we know today as the PNA?
N/A – Q&A	00:57:57 - Dr. Palav Babaria	Hey, Aita do you want to take that one?
N/A – Q&A	00:58:04 - Aita Romain	Yes. So, the population needs assessment is a combination of an assessment as well as a report. So, when we're talking about it in this... When we're referring to the report, we'll say the report. And when we're talking about the actual assessment of data, we'll talk about it as the assessment. But when we're saying that potentially the PNA will transition in terms of how often it's submitted, or the system of the submission that is regarding the report.
N/A – Q&A	00:58:41 - Aita Romain	Anything specific around the population needs assessment?
N/A – Q&A	00:58:49 - Sharon Woda	No, I think that did it.
N/A – Q&A	00:58:53 - Sharon Woda	There was also a question on the equity guardrails on data standards. So, I think a lot of the questions with all the data questions that came in, and I'm paraphrasing here about what are some of the equity guardrails that facilitate the data standards that do not create stigma, or health inequities that impact different population groups. So I think the question, if I have to paraphrase a few is both how do you make sure that there are equity guardrails in bringing in the data? And then also questions about how the risk stratification algorithm will work to prevent inequities and work to prevent disparities?

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N/A – Q&A	00:59:34 - Dr. Palav Babaria	I'll take that question. So I think, in current state, there are algorithms that are used, there are best practices for how you can interrogate your algorithm to make sure that it's free from bias. So, we will be looking to issue some of those best practices in the interim.
N/A – Q&A	00:59:49 - Dr. Palav Babaria	For the state PHM service, one of our commitments is we'll be putting together a scientific advisory committee who will be enmeshed in really figuring out the algorithm that is ultimately used at the state level, that it really does follow best practice. That it is free of bias. So, obviously, that's going to be an iterative process, and will need to be updated, and reprogrammed, and change over time as we learn more, both about our data and our members. But we are fully committed to making that a transparent, open source process. So that is not a black box that data goes into, and spits out of, but that we can see exactly what's happening. And as errors are found, or opportunities to make that algorithm better are found that we can incorporate those via our scientific advisory committee, and our pop health management service vendor.
N/A – Q&A	01:00:39 - Sharon Woda	Okay.
N/A – Q&A	01:00:45 - Julian	Palav there's a related question here. I think it came from Priya. And also, I think one from James. It's really around the data collection for certain data types, especially SOGI data, and other data around race, ethnicity, language demographics that may not be standardized and EHR, for example. And I think the question generally is how will this data be collected if there aren't uniform standards? And how will the department address them and the more issues around more protected data, like part two data. So I think, for example, will the department try to USCDI version 2 standards that are coming out that are going to be required for healthcare services, or is there other approaches to standardize these data?

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N/A – Q&A	01:01:42 - Dr. Palav Babaria	Great question. So I think at a high level, two related efforts to flag for everyone, if you're not aware of them, one is the Cal HHS Data Exchange Framework, which is looking at how do we have robust data exchange and standards across the state, which is being led by our Health and Human Services Agency. The second one is the interoperability role, and sort of federal requirements for all healthcare entities on data sharing, and data interoperability standards. So we at DHCS are trying to align with both of those efforts in as much as possible, including following federal standards. So, as we are updating, or in the process of updating our Medi-Cal application to include collection of sexual orientation and gender identity, our teams have been working with the interoperability teams to make sure that they follow those federal standards because, at the end of the day, if we all want to measure things and make them better we do need to be speaking in the same language. So, more to come on that. We don't have final definitions yet, but we are looking at both of those efforts to help us align at the state level, and at the federal level.
N/A – Q&A	01:02:49 - Julian	Great.
N/A – Q&A	01:02:51 - Julian	Related question. Again, there are a couple of questions people wrote in one about guardrails around newer data comes in, how do you make sure that there are guardrails about overriding older data, when it should be overwritten? So like what kind of data governance? Is that being considered as part of this process?
N/A – Q&A	01:03:14 - Dr. Palav Babaria	Short answer is yes, we will absolutely need a data governance process that looks not just at the date and time of the data, but the source of the data, how it was collected, who collected it, is it a more or less reliable source. And so, we're not quite there yet. But as we go through the process of implementation with this vendor, a sort of real governance process will also occur where we make all of those decisions about data overwriting. And that will also be presented to this committee at some point in time.

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N/A – Q&A	01:03:48 - Sharon Woda	And I think, a related turn that you had used Palav is the scientific advisory committee. I think there's a couple questions about what is that committee, and are they currently active, or what are they planning to do?
N/A – Q&A	01:04:02 - Dr. Palav Babaria	It's a name that I came up with and exists in name only. And so, it is a commitment, and a principle that we want to use best practices that are evidence-based, and sort of the best talent and knowledge that we have both in the state and outside of the state. So, that this algorithm really is one that all of us are going to want to use, because it is the best one out there. So, we have not stood up that committee yet. It will be happening it the coming months, and more to come at future meetings about that process.
N/A – Q&A	01:04:34 - Sharon Woda	There's another question here about the intersection with the service, and if the plan is for everything to be discontinued after the service is implemented, or what really is the plan without the service, and will that kind of continue on after the service is available?
N/A – Q&A	01:04:55 - Dr. Palav Babaria	Great question. So I do think the plan is for it to be discontinued. And I think that is both because we've heard from a lot of people, response rates are low. It is not very widely sort of used for driving clinical improvement and response rates. And many people do not find it very helpful. We also have a regulatory requirement to meet around screening. And so, that is why we're continuing it temporarily, so that we can still stay in compliance. But once we have an alternative screening process through the PHM service, we do intend to discontinue it.
N/A – Q&A	01:05:28 - Sharon Woda	And a similar thing, there was also a question about when the IHA is expected to be phased out?

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N/A – Q&A	01:05:36 - Dr. Palav Babaria	That one, we hope to tackle a little bit sooner so that all of those detailed requirements that are outlined in the APL can be dropped sooner. And then, as mentioned, we will really be viewing the IHA as a way to measure primary care engagement.
N/A – Q&A	01:05:57 - Sharon Woda	Okay, back to you, Jonah.
N/A – Q&A	01:05:59 - Julian	Palav, so there were some questions about the platform, the PHM service platform, and whether there's any yet decisions about what that platform, or the vendor is going to be?
N/A – Q&A	01:06:13 - Dr. Palav Babaria	We have not selected a vendor. So we will be releasing our procurement later this spring. And after that process, based off of who bids and applies, we will select a vendor thereafter. So, we do anticipate pulling together our advisory group relatively shortly in the coming months so that we can do a deeper dive into the PHM service as well.
N/A – Q&A	01:06:42 - Julian	Great. And there's also some questions I think from James about just sort of the quantity of data coming from these various sources. And it may help to sort of describe is this service intended to be a new database? It's aggregating all this, is it really intending to leverage other sources, and present them to members and plans, and counties, and providers, beneficiaries and others. Can you describe the extent you can sort of the vision here?
N/A – Q&A	01:07:16 - Dr. Palav Babaria	Great question. So we, at DHCS, we already have a data warehouse, so that is the database in another word where all the data lives. This service is really going to help us analyze that data and present it to the people who need it in a useful, meaningful way.

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N/A – Q&A	01:07:33 - Dr. Palav Babaria	So, as you saw on the slide that Aita walked through, there's different types of users. Plans may have their own data infrastructure where they just want a data feed of all of their assigned members. That includes all this aggregated data for behavioral health plus oral health plus previous claims maybe that member was assigned to a different plan, but they still need that history. If you're a Medi-Cal member, you are not going to want some data digest of your history. So what this interface looks like for a Medi-Cal member who needs to log in needs to be very different, needs to be very user friendly, digestible, understandable, in different languages for a Medi-Cal member.
N/A – Q&A	01:08:13 - Dr. Palav Babaria	There may be individual case managers who need something in between. There may be provider groups who want to just connect this to their EHR versus others that have a data repository. So, we really want to make sure that a big part of what the service is going to do is going to be digesting that data and presenting it in a way that is appropriate for all the different users. But the actual data lives at DHCS in our data warehouse.
N/A – Q&A	01:08:41 - Julian	Great. And then one other, and I'll go back to Sharon here, but there is a question, I think, from Natalie. "Will the data be made available to county programs or CBOs?" Like essentially who is the target to be able to access and use information through the service?
N/A – Q&A	01:09:00 - Dr. Palav Babaria	So, ideally, we've been doing sort of focus groups of all the...
N/A – Q&A	01:09:00 - Dr. Palav Babaria	So we ideally, we've been doing sort of focus groups with all the people who may be interested, anyone who is serving Medi-Cal members we want them to be able to use this data for clinical purposes for serving those members. Obviously, it still needs to be HIPAA compliant and we need to follow all federal and state regulations around data exchange, but that is the goal.

Population Health Management (PHM) Advisory Group Kickoff

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VISUAL	TIME AND SPEAKER	AUDIO
N/A – Q&A	01:09:22 - Sharon Woda	All right. A question here on the requirements for managed care plans to use the risk stratification functionality of the service, so just a statement here that the RFP PHM language says that the managed care plans will be able to use their own risk stratification methodology, so maybe you can just speak a little bit into the thinking there around the intersection of what the plans are required to do for risk strat.
N/A – Q&A	01:09:53 - Dr. Palav Babaria	Great. So, obviously once the PHM service exists, it doesn't exist today, our goal and desire is that everyone uses it we do recognize that local plans absolutely have sometimes additional data and additional ways of sort of analyzing their populations. So I don't think we envision that would be prohibited, but the way DHCS will be monitoring and doing the compliance will be based off of the DHCS algorithm.
N/A – Q&A	01:10:23 - Sharon Woda	Right. Can you speak a little bit more about how risk tiers are used to connect the care management types and specifically the fear around, I think a little bit of a fear around is the risk tiering going to be used to limit care management to members or how should folks think about that?
N/A – Q&A	01:10:44 - Dr. Palav Babaria	Great question. So two things. One, no, a risk tier should not limit any services. The risk tier is really, it's like your first cut, right, to just say, here are the buckets, this high-risk group, I need to go understand their needs a little bit more because something is flagging them as high risk. So I think for all members independent of what tier they're assigned to, as whoever is engaging with that member discovers more of their story and they meet eligibility criteria for whatever programs, that they can and should and will be enrolled into the services for which they're eligible for.

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N/A – Q&A	01:11:20 - Dr. Palav Babaria	But from a practical standpoint, we have 14.5 million people in Medi-Cal. We would not be able to outreach to each and every single one of them and do a deep dive assessment for various care management programs. The flip side of that is we also don't envision that every single high-risk member is going to need to be in care management, right?
N/A – Q&A	01:11:38 - Dr. Palav Babaria	So if someone is high risk, we definitely want them to be assessed. It means that someone needs to outreach. Someone needs to ask them a series of questions and understand what their needs are. And maybe that interview and assessment is going to show that they just need to get hooked up to transportation for appointments, and they go into basic population health management, and someone helps provide a little bit of care coordination. Maybe it's going to show that they meet the ECM criteria and need to be rolled into ECM, but it really is just a flag that this member needs something and someone has to connect with them and outreach and figure out what that need is and how best to meet it.
N/A – Q&A	01:12:14 - Sharon Woda	Got it. Yep. And the follow-up for that was how to think about risk tiers be the populations of focus in ECM. And I think you covered that, they would still, the populations of focus would still qualify for ECM.
N/A – Q&A	01:12:28 - Dr. Palav Babaria	Yeah. So ideally, in dream state, right, a hundred percent of the people who are high risk would be assessed. A hundred percent of them will not be enrolled in something likely. Maybe whatever percentage may be enrolled in ECM, certain percentage will be enrolled in CCM, a certain percentage, are going to decline or not need any of that.

Transcript

VISUAL	TIME AND SPEAKER	AUDIO
N/A – Q&A	01:12:50 - Sharon Woda	All right. I'll have one more question for you then pass it back to Jonah. Real question here about, "How is basic pop health management different from current Medi-Cal services? Very variation on these questions, including how it differs from, I think it's called basic case management now. So we'd love to just have your take on how basic pop health management is different and what's new.
N/A – Q&A	01:13:13 - Dr. Palav Babaria	Great question. So I think, some of the elements are not new. So some of the elements around care coordination have been in our managed care contracts for many, many years. EPSDT is federal statute. It is not new. It has been a requirement for a very, very long time. CPSP requirements are not new. I think what is new is one, they are all in one place and packaged in a way that I think is more clinically understandable.
N/A – Q&A	01:13:38 - Dr. Palav Babaria	And two, there is a real centering of underutilization in primary care, which I think is new because that is at the end of the day, a root cause of many of the disparities that we see the avoidable hospitalizations, avoidable EV visits, and avoidable preventable illness and morbidity and mortality for our population. So there are specific requirements, both in the population health management program, as well as in our managed care procurement that really get at that.
N/A – Q&A	01:14:08 - Julian	Great. They're also call offing some questions about the algorithm itself and some concerns as you're well aware that algorithms can reinforce disparities and questions. Will the algorithm be pubic? Will it be open source? Will it be exposed? So what do you think the department's current stance is?
N/A – Q&A	01:14:32 - Dr. Palav Babaria	Yeah, I mean, I think this is going to be one of the prime questions for our scientific advisory committee, but as long as it is sort of feasible and make sense, we do intend to make it public and available.

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VISUAL	TIME AND SPEAKER	AUDIO
N/A – Q&A	01:14:47 - Julian	And related, lots of questions on data. There's the dreaded data lag challenge, not all data that are going to be received are going to be timely. Encounter data itself is usually three plus months old. So there's already some lag there. So there's just a general question about what might be done and how are these data going to be collected to address with things like data lag, if anything?
N/A – Q&A	01:15:18 - Dr. Palav Babaria	Yes. I think there's two uses for this data. One is the understanding our population and the gaps and the needs and the analytics and three months of claim lags may not affect those processes so much. The other is the real time needs of members and making sure that they're receiving those services. So we do not think that the PHM service in of itself is going to, it's not a replacement for those real time interventions.
N/A – Q&A	01:15:45 - Dr. Palav Babaria	And a lot of what we'll be focusing on, for example, in the transitional care management elements is what does that communication link look like between inpatient or long-term care facilities and care managers for members who are being discharge? That is not a function that's going to be served by the PHM service necessarily. That's going to be served by humans who are coordinating care and moving through in different settings, as it were. Obviously as our agency data exchange framework gets off the ground and there are more real time data exchanges via HIEs, I think there's definitely an opportunity to make the service more robust with real-time data exchange.
N/A – Q&A	01:16:27 - Julian	Great. And I think just somewhat related to that as well, is this question about encounter data really flows from the provider or the originating provider to potential an IPA, to a delegated plan, to a plan to the DHCS, right? There's this pretty long upward cascade of how the data ultimately get to the department and that increases the lag.

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VISUAL	TIME AND SPEAKER	AUDIO
N/A – Q&A	01:16:48 - Julian	And one question came up, "Is there any plan to get the data directly from the providers?" And sort of almost a counter question is, "Primary care providers are really burned out, especially after two years of COVID. If there is an expected increase reporting on the primary care providers, how is that going to be addressed?" So that's a bit of a sticky question, but any guidance you might provide folks here?
N/A – Q&A	01:17:16 - Dr. Palav Babaria	So I think principles are, we want a single source of truth, right? We do not want data where it's like, if you look over here, here's what the data says. If you look somewhere else, the data tells a different story. If you look at the state, the data tells a different story. So there is a lot of work to be done as everyone on this call knows to make sure that as data is going through the different layers, which we're not eliminating any of those layers tomorrow that the data exchange is accurate, that it is timely. And I think there's a lot that we can do to partner collectively to improve that flow.
N/A – Q&A	01:17:49 - Dr. Palav Babaria	I will also say as a primary care provider, I was just in clinic this morning and I led my previous organization's EHR rollout. There is so much on the ground transformation that can be done in EHR as to reduce documentation burden, reporting burden on providers.
N/A – Q&A	01:18:04 - Dr. Palav Babaria	And so we're really excited that hopefully if the current budget proposal for the equity and practice transformation grants goes through where we would be giving, the department would be administering via managed care plans grants to providers, to support local transformation efforts towards population health and closing care gaps. There's a lot of improvements in programming that can be done that automates that whole process for providers and lets them focus on the clinical care that they love and enjoy and not the documentation and administrative burden.

Transcript

VISUAL	TIME AND SPEAKER	AUDIO
N/A – Q&A	01:18:38 - Julian	Great. I have one more, and this is a very specific question about oral health and about the department and whether they'll collect oral health assessment or those they share with primary care provider, I think really is part of the service and make that available.
N/A – Q&A	01:19:00 - Dr. Palav Babaria	So definitely our PHM service will include all dental data that we have, which is largely in the form of claims right now. I think oral health is a major area of interest. It's critical to the long-term physical health of all of our members. And so we are also looking at additional opportunities, whether its measures or other assessments where we can incorporate both vision and oral health more robustly.
N/A – Q&A	01:19:27 - Sharon Woda	All right.
N/A – Q&A	01:19:27 - Julian	Thank you.
N/A – Q&A	01:19:29 - Sharon Woda	All right. Couple of questions are in about care managers. So we're using the term care manager a lot where you're saying the ECM, or saying the complex care manager, we have the transitional care manager. And I think there's a question about, "Are these three different people?" So can you explain a little bit about the role of the care manager and is it a new person, or can it be a role where it's one individual that does multiple things?
N/A – Q&A	01:19:53 - Dr. Palav Babaria	Great question. And I don't know that we have all the answers to be clear. So for ECM, the role of the care manager and who it can, or cannot be, is pretty well defined in ECM. Our entire website has all the documents for those of you who haven't seen it, but those are really envisioned to be community-based providers or community-based organizations, not employed at the plan.

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VISUAL	TIME AND SPEAKER	AUDIO
N/A – Q&A	01:20:18 - Dr. Palav Babaria	I think for the transitional care manager and the complex care managers many of our health plans have these care managers in place today. In some cases, they are employed directly by the health plan. In some cases, those functions are delegated to the provider group. Who's already caring for these patients. In some cases, it's a mix of both, and we would envision retaining that flexibility so that what makes sense for the local community can be implemented.
N/A – Q&A	01:20:45 - Sharon Woda	That makes sense. All right. And then question here. I surprised it came so far down is around NCQA and how does the population health effort really consider the NCQA requirements and notably of course, the broader requirement for accreditation, as well as the NCQA requirement for the pop health management strategy?
N/A – Q&A	01:21:14 - Dr. Palav Babaria	There is NCQA health plan accreditation, which all of our health plans will be required to achieve by 2026. We are also requiring all health plans to achieve the health equity accreditation, which was recently renamed to that by 2026.
N/A – Q&A	01:21:28 - Dr. Palav Babaria	As a part of the population health management program, there is a subset of those requirements that are specifically around population health management of the overall accreditation and we would envision that all plans would meet that subset of just the population health management requirements sooner, i.e. in January of 2023.
N/A – Q&A	01:21:48 - Dr. Palav Babaria	Everything that we talked about today is aligned with NCQA population health management requirements. In many areas we have gone above and beyond that in alignment with DHCS's larger vision and our quality strategy, but to point out a few, the population health management strategy is an NCQA requirement. That is why you see that same exact terminology here. Complex care management is an NCQA requirement. That's why you also see that same requirement here.

Transcript

VISUAL	TIME AND SPEAKER	AUDIO
N/A – Q&A	01:22:17 - Sharon Woda	Okay. Got it. A question. Going back up to screening and assessment. "So will the changes proposed to the current screening and assessment tools, how do we ensure that kids will still get screened and sort of what's the role in the kids for children given these changes to these tools?"
N/A – Q&A	01:22:36 - Dr. Palav Babaria	Great question. And so for children, specifically, EPSDT as well as all the USPSTF guidelines and the bright feature schedule, all of those are still required and are in all of our APLs and requirements and are not going away. So when we do facility site reviews and audits, we will be looking for all of those elements being met as well as we added a number of children's preventive measures to our managed care accountability set this year for 2022, so we will be monitoring all of those clinical outcome measures, which we think if that's the ultimate truth of whether or not something is happening is if the service was provided and the clinical benefit was felt. So we'll be monitoring those two ways, at least.
N/A – Q&A	01:23:21 - Sharon Woda	All right. I think that's about it for some of the questions. There's one other sort of more general theme question that's sort of picking from a few different other ones, which is just speaking a little bit more of the role of primary care and basic pop health management, and then the program overall, and what the vision is there.
N/A – Q&A	01:23:41 - Dr. Palav Babaria	So, I think two things. In almost every single patient story you hear, there's very few where there weren't things that could have been done with much more regular engagement with primary care and preventative services. And we know there was a National Academy of Science, Engineering, and Medicine article that as you all know, came out last year, really talking about the crisis of not having a primary care centered healthcare system. For those of you haven't read it, I refer you back to it.

Transcript

VISUAL	TIME AND SPEAKER	AUDIO
N/A – Q&A	01:24:11 - Dr. Palav Babaria	It's really excellent and talking about primary care is good. We know that primary care results in better outcomes, lower cost, and better life expectancy as proven in numerous studies. And so if we truly want to achieve population health management, we really need to make sure that Medi-Cal members who again, report on average, more so than commercially covered members or others to not have a regular source of care to not have that trusted relationship we need. We know it's a gap and we know it's a driver of worse outcomes.
N/A – Q&A	01:24:45 - Dr. Palav Babaria	So a lot of effort is going to be spent on sort of that connecting people to primary care, supporting care transformation. To the earlier questions about there is a real burnout and crisis and administrative burden. So how do we support the clinics and the practices to transform? How do we get all of the members there who maybe aren't showing up there today? But I think the department is also looking more broadly than that, so that's on the healthcare delivery system side.
N/A – Q&A	01:25:11 - Dr. Palav Babaria	We know there are ample opportunities to address the social drivers of health, even outside of the healthcare delivery system. And so when we think about this foundation in population health management of wellness and prevention, it's not just with primary care practices. It is partnerships with local health jurisdictions, with schools, with social service agencies with first five associations who are really well positioned to intervene in the community, to intervene upstream as well as drive health outcomes on all of these key indicators that we are tracking.
N/A – Q&A	01:25:46 - Julian	All right. Palav, I've got two more for you and they're doozies, so get ready. This is a great question. "Is the platform envisioned as a way to harmonize and possibly also deploy incentive payments for ECM and community services or other nonprofit services?" That's the first question.

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VISUAL	TIME AND SPEAKER	AUDIO
N/A – Q&A	01:26:04 - Dr. Palav Babaria	That is a great question. And it is a doozy and I can honestly say we have not gotten that far in our thinking yet, but we're going to take that back and discuss it.
N/A – Q&A	01:26:16 - Julian	I agree. I love it. And then the last one from Serita, this is regarding actual duals. She asked, "How might there be combined Medicare data," I would assume that means fee for service, "and MA, which is even harder to get and assessments with the data to support pop health management?"
N/A – Q&A	01:26:39 - Dr. Palav Babaria	The short answer is yes. So we are absolutely thinking about the service being inclusive of all of our work for duals. As you know, the data aggregation functions are a little bit more challenging there just because of where we have to get the data from, but those conversations are absolutely ongoing and thinking about how we leverage this specifically for duals. It may not be the first phase, just because of all the work that is needed to get the data and the time lag, especially for Medicare data that exists, but we are working on it and that is the intention.
N/A – Q&A	01:27:14 - Julian	Perfect. Well, you've just made it through the shooting gallery. Thank you, Palav. I think we got through as many questions as we could. There are a few more that we've noted here. We won't have time to answer, but we'll collect them and try to get answers to them and I think we're ready to wrap up and it's over to you Palav, to do so.
N/A – Q&A	01:27:34 - Dr. Palav Babaria	So I feel like I just ran a marathon. Thank you all so much for joining and I promise I'm not going to be talking this much at future meetings and you'll get to hear from the brain trust that is our population health management advisory group. So a few dates just to flag for all of you. In April, mid-April, we'll be releasing the detailed strategy and roadmap paper. We will need all of your best thinking to help us make it better.

Population Health Management (PHM) Advisory Group Kickoff

March 18, 2022

Transcript

VISUAL	TIME AND SPEAKER	AUDIO
Slide 46	01:27:59 - Dr. Palav Babaria	In late quarter two and early quarter three, we're going to be releasing the detailed PHM program requirements. Many of you have asked great detailed questions today. They will be answered when those final program requirements, at least for 2023 are released. And so all of the feedback that we get between now on the April paper and these advisory group meetings will obviously inform what goes into those 2023 PHM program requirements.
Slide 46	01:28:28 - Dr. Palav Babaria	Starting in quarter three and quarter four we will be also collecting from all of the plans, the PHM readiness submissions, so that we can make sure that all of our planned partners are meeting all of the requirements and ready to meet them. And then on January 1st, 2023, the program will formally go live. And I will flag the PHM service since we have not procured that vendor yet. We are aiming for it to launch in 2023, but the exact date is still TBD. So we will be posting all of the materials on the website so that all of you can follow up. If you want to see the slides, if you want to re-watch this wonderful recording or at least our member story, which is the best part I think, and you all so, so much for joining. We're really grateful for everyone's presence.
Slide 46	01:29:20 - Speaker 1	Thank you for joining. You may now disconnect.