

2.1 Population Health Management Program

2.1.1 Background

DHCS currently does not have a specific requirement that Medi-Cal managed care plans maintain a population health management program, which is a model of care and a plan of action designed to identify and address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized core population health management requirements for Medi-Cal managed care plans, including NCQA requirements and additional DHCS requirements. The population health management program will be comprehensive and address the full spectrum of care coordination, including: data collection and monitoring; assessing population level and individual member health risks and health related social needs; creating wellness, prevention, case management, care transitions programs to address identified risks and needs, and using stratification to identify and connect adult and pediatric members to the appropriate programs. Additionally, Medi-Cal managed care plans will develop predictive analytics about which patients, communities or populations are emerging as high risk, as well as identify and address the needs of members with more specific services and supports.

2.1.2 Proposal

All Medi-Cal managed care plans shall develop and maintain a member-centered population health management program, as part of which the Medi-Cal managed care plan will partner with health care providers and community based partners to identify and address members' health and health related social needs. In addition to the NCQA accreditation processes, the population health management (PHM) plan description must be filed with the state annually via the PHM Template.

Each Medi-Cal managed care plan shall include, at a minimum, a description of how it will meet the core objectives to:

- Identify and assess member health risks and needs on an ongoing basis;
- Keep all members healthy by focusing on preventive and wellness services;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination;

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

The population health management program description shall:

- Include the goal to improve the health outcomes of identified communities and groups;
- Utilize data to analyze community and population level health and health-related social needs and set measureable goals for improvement;
- Utilize initial and ongoing assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted health improvement activities;
- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- Coordinate care across the continuum of medical, behavioral health, developmental, oral health, and long-term services and supports, including tracking provider referrals and outcomes of referrals;
- Deploy strategies to address individual needs to mitigate social determinants of health issues
- Deploy strategies to drive improvements in health specifically for populations proactively identified as experiencing health disparities;
- Partner with appropriate community based providers to support individual members, families and caregivers in managing care;
- Utilize evidence-based practices in screening and intervention;
- Utilize a Person-Centered and Family-Centered approach for care planning; and
- Continually evaluate and improve on the strategic plan on an ongoing basis through meaningful quality measurement.

Assessment of Risk and Need

1. Initial Data Collection and Population Assessment

As reflected in the NCQA Population Health Management (PHM) requirements and [DHCS' Population Needs Assessment \(PNA\) All Plan Letter \(APL\)](#), the Medi-Cal managed care plan shall collect electronically available data sources in order to analyze data that capture the information on member health status and utilization (including physical, behavioral, and oral health), health-related social needs, and linguistic, racial and cultural characteristics. As part of the PHM requirements, DHCS will continue to apply the existing PNA APL requirements to hold the Medi-Cal managed care plans accountable for a population assessment, which include requirements for analyzing health disparities and engaging external stakeholders as part of the process. DHCS will consult with NCQA to ensure the PNA APL data requirements meet NCQA data requirements for the population health assessment.

The PNA and NCQA require that Medi-Cal managed care plans collect and analyze this data across the contractor's entire Medi-Cal member population in order to identify opportunities at a population level to improve health. One example of how this might be done is through a type of analysis commonly known as "hotspotting." As noted in the PNA and NCQA requirements, key issues Medi-Cal managed care plans must analyze in this assessment include: acute, chronic and prevention/wellness health needs; areas of clinically inappropriate, over and under-utilization of health care resources; opportunities for better care management and quality improvement; health disparities by race, ethnicity, language, functional disabilities; and health-related social needs at the community or local level. The results of the population assessment will inform the development of programs and strategies that the contractor will use to address the needs of specific populations. Which individuals receive these specific programs and strategies will be driven by the subsequent member-level risk stratification, population segmentation, and case management activities. Consistent with the PNA APL, Medi-Cal managed care plans must use the assessment to develop and implement an action plan to address community and population needs. DHCS will not have more specific requirements regarding community and population level program development at this time, but in the PHM template Medi-Cal managed care plans will indicate what they will be doing in this area, and it may be a focus of future learning collaborative best practice work.

2. Initial Risk Stratification or Segmentation and Tiering

Risk stratification or segmentation will enable the Medi-Cal managed care plan to identify specific members who may benefit from wellness, prevention, and disease management activities; members who can benefit from case management; and members who are at risk for developing complex health issues. Consistent with NCQA PHM requirements, the Medi-Cal managed care plan is required to risk stratify or segment members into groups that it will use to develop and implement case management, wellness, and health improvement programs and strategies. Medi-Cal managed care plans will also be required to use DHCS defined criteria to tier its members into four risk tier categories and report that information to DHCS.

Consistent with the NCQA PHM requirements, Medi-Cal managed care plans shall conduct the risk stratification or segmentation and DHCS risk tiering using an integrated data and analytics assessment that considers at least the following sources:

- Claims or encounter data, including all fee-for-service data provided by DHCS;
- Pharmacy data;
- Laboratory data;
- Previous screening or assessment data;
- Disengaged member reports;
- And to the extent available:
 - Available social needs data, including housing status ICD-10 data; and
 - Electronic health records

Risk Stratification or Segmentation. Consistent with NCQA PHM requirements for risk stratification or population segmentation, Medi-Cal managed care plans will analyze each individual's data based on the minimum, mandatory list of data sources described above and will either risk stratify or segment members into meaningful sub-populations. The Medi-Cal managed care plan will use risk stratification or segmentation to identify specific members who may benefit from targeted intervention(s) and programs designed to meet identified member needs. Risk stratification or segmentation must occur within 44 days of the effective date of plan enrollment.

The Medi-Cal managed care plan may use its own algorithm to risk stratify or segment its population or it may use the DHCS-defined risk tiers described below as a starting point for further stratification and segmentation. The design of the algorithm, including how the data is stratified or segmented as part of the algorithm, should be informed by the health needs identified through the population assessment and designed so that the Medi-Cal managed care plan can group individual members into meaningful categories and subsequently outreach to individual members within those categories for tailored interventions and programs designed to achieve specific health outcomes. Medi-Cal managed care plans will incorporate ECM into their segmentation in accordance with DHCS ECM target population guidance and Medi-Cal managed care plan flexibility afforded for the ECM benefit. If risk stratifying its member population, Medi-Cal managed care plans must use a validated risk grouper.

Risk stratification or segmentation algorithms shall include past medical service utilization, but must also incorporate other data such as health conditions, risk factors, and disease progressions, in order to avoid exacerbating underlying biases in utilization data that may drive health disparities. The Medi-Cal managed care plan must analyze the results of its stratification/segmentation algorithm to identify and correct any biases the algorithm may introduce based on race, ethnicity, language, functional status or other sources of health disparities. In the Population Health Management Strategy template, the Medi-Cal managed care plan will submit to DHCS its list of stratification/segmentation data sources, the risk stratification/segmentation algorithm (or the name of the tool if it is a proprietary), and also the method of bias analysis. To promote transparency and best practices, these three pieces of information will be made available for public viewing on DHCS' website, and will also be a focus of continuing Medi-Cal managed care plan learning collaborative activities.

Based on the risk stratification/segmentation and the finding from Individual Risk Assessment (IRA) described below, the Medi-Cal managed care plan will link the member with the appropriate services, including, but not limited to wellness and prevention, general case management, complex case management, Enhanced Care Management, external entity coordination, and transition coordination. Specific minimum requirements for each of these categories are listed in their own sections below.

DHCS Risk Tiering Requirements. This risk tiering process, including the IRA described below, will satisfy the federal Medicaid Managed Care Final Rule requirements for initial risk assessment.

Medi-Cal managed care plans will use DHCS-defined criteria to assign each member into one of four risk tiers: (1) low risk; (2) medium and rising risk; (3) high risk; and (4) unknown risk. The criteria for these tiers will be developed by DHCS. The types of criteria used will be similar (but not the same) as the DHCS criteria for risk stratifying SPDs into low and high risk groups. The criteria will align with the questions that DHCS will develop for the IRA survey tool, which is addressed in the next section. "High risk" members are those who are at increased risk of having an adverse health outcome or worsening of their health status. "Medium and Rising risk" members are those that are stable at a medium risk level and those whose health status suggest they have the potential to move into the high risk category. Members at the medium/rising and high risk levels likely require additional provider-level assessment, care coordination, and/or possibly case management, Enhanced Care Management, or other specific services, which will be determined by the Medi-Cal managed care plan's population segmentation strategy and coordination with

providers. “Low risk” members are those who, in general, only require support for wellness and prevention. “Unknown risk” members are those who do not have sufficient data to stratify into a risk tier and for whom the Medi-Cal managed care plan is unable to complete a member-contact screening risk assessment. The IRA survey tool will be designed to have enough information to allow for risk tier assignment on its own in the event that there is insufficient available historical data for the member.

DHCS will develop a process to validate the Medi-Cal managed care plan’s implementation of the DHCS risk tier criteria to ensure consistent application and output statewide.

3. Individual Risk Assessment Survey Tool

DHCS will develop a standardized, 10-15 question Individual Risk Assessment (IRA) Survey Tool. There will be two versions, one for children and one for adults. Medi-Cal managed care plans will use the IRA to: (1) confirm or revise the initial DHCS risk tier to which the member was assigned; (2) gather consistent information for members without sufficient data; and (3) add information that will be used as part of its own stratification/segmentation algorithms and PHM strategy. DHCS’ goal in the development of the questions will be that they are validated and can be used with a scoring mechanism so that the IRA information can be integrated into the Medi-Cal managed care plan’s risk stratification/segmentation process. DHCS will translate the questions into the threshold languages. Medi-Cal managed care plans will have the flexibility to add questions of their choosing to the IRA and would then also translate those additional questions into all threshold languages. It is expected that Medi-Cal managed care plans will conduct subsequent and separate screenings (or add supplemental questions) to identify specific issues and priorities to address.

The IRA will replace the following assessments:

- Staying Healthy Assessment/Individual Health Education Behavioral Assessment (SHA/IHEBA)
- Health Information Form/Member Evaluation Tool (HIF/MET)
- Health Risk Stratification and Assessment Survey (HRA) for Seniors and People with Disabilities
- Whole Child Model Assessment

- The Initial Health Assessment (IHA) provider visit (within 120 days of enrollment) will remain a requirement, but DHCS contracts and policies will not specify provider requirements for that visit. Medi-Cal managed care plans will continue to be required to ensure the provision of preventive and other services in accordance with contractual requirements and accepted standards of clinical care.

Members assigned to the DHCS medium/rising, high, and unknown risk tiers must be contacted within 105 (medium/rising) and 45 (high and unknown) calendar days to assess their needs using either the child or adult IRA. The IRA may be done via multiple modalities, including phone, in-person, electronic, or mail, as long as the screening responses can be transposed into an electronic format that allows for data mining and data exchange of key elements with DHCS. Data exchange of IRA elements with DHCS is not required at this time. The Medi-Cal managed care plan should use this modality flexibility to maximize successful contact. The Medi-Cal managed care plan shall make at least three (3) attempts to contact a member using available modalities.

If the Medi-Cal managed care plan is unable to obtain a completed IRA from a member, it has the option to create a process for working with the member's assigned primary care provider to: 1) have the member complete the assessment and 2) transfer the information to the Medi-Cal managed care plan.

The Medi-Cal managed care plan will use the IRA information to assign or revise the member's DHCS risk tier, if necessary. Once that is complete, Medi-Cal managed care plans will be responsible for reporting the beneficiary's assigned risk tier to DHCS in an electronic format to enable better tracking and assessment of the impacts of the Population Health Management Strategy. The Medi-Cal managed care plan will also share information regarding the assigned member's risk tier to the member's assigned PCP in an electronic format. If the member transfers to another Medi-Cal managed care plan, DHCS will provide the risk tier to the new Medi-Cal managed care plan.

The IRA questions will align with the DHCS-specified criteria for high, medium/rising, and low risk tiers. It is DHCS's intent that the structure of the IRA will meet NCQA requirements for a Health Appraisal. The IRA will include 10-15 questions which seek to identify preliminary risk information for the following elements:

- Behavioral, developmental, physical, and oral health needs;
- Emergency department visits within the last six months;

- Self-assessment of health status;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Ability to function independently and organize his/her own health needs;
- Use of, or need for, long-term services and supports;
- Desire for case management;
- Availability of support/caregiver;
- Access to private and/or public transportation;
- Access to basic needs such as food, clothing, household goods, education, etc.;
- Social or geographic isolation; and
- Housing and housing instability assessment.

The criteria for the DHCS-specified risk tiers and the IRA will be developed later in 2020. The discontinuance of the current DHCS-required assessments, which were listed above, will align with the implementation of the IRA.

4. Reassessment

At a minimum, the Medi-Cal managed care plan shall assess the risk and need, including emerging risk, of all members annually through both the DCHS risk tiering and its own risk stratification/segmentation process.

Individual members' risk and need may need to be re-evaluated throughout the year based on a change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction.

Medi-Cal managed care plans must describe what events or data will trigger the re-evaluation process for individual members. In the population health management program description, the Medi-Cal managed care plan must inform the department what minimum risk groups would require regular assessment in between the annual risk stratification process. However, this does not limit the Medi-Cal managed care plan from conducting additional assessments beyond what is defined as the minimum in the program description.

5. Provider Referrals

The Medi-Cal managed care plan must establish a process by which providers may make referrals for members to receive case management or services for other emerging needs. Referrals for case management should lead to a reassessment of risk stratification and the DHCS risk tier assignment. Medi-Cal managed care plans must consider and integrate information received through those referrals when determining the member risk stratification.

Actions to Support Wellness and Address Risk and Need

1. General Requirements and Services

The Medi-Cal managed care plan shall integrate required activities with the population health management program as appropriate, including, but not limited to: member services, utilization management, referrals, transportation, health/plan/benefit education, appointment assistance, warm-handoffs to community-based organizations or other delivery systems, system navigation, primary care provider member assignment, community outreach, preventive services, and screenings for all members.

The Medi-Cal managed care plan shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. Available information shall include assistance in arranging for referrals, including mental health and substance use disorder treatment referrals, developmental services referrals, dental referrals and referrals to long-term services and supports. Communication about the availability of this consultation service shall be found on the front-page of the Medi-Cal managed care plan's website and in materials supplied to providers.

The Medi-Cal managed care plan shall provide a 24 hours a day, seven (7) days a week, toll-free nurse advice line for members who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.

The Medi-Cal managed care plan shall demonstrate how they support practice change activities, the deployment of evidence-based tools for providers, and models of service delivery that optimize health care and coordinated health care and social services. Finally, the Medi-Cal managed care plan shall develop or provide access to a current and updated community resource directory for case managers and contracted providers.

2. Wellness and Prevention Services

The Medi-Cal managed care plan shall provide wellness and prevention services in accordance with NCQA and contractual requirements. The population health management program shall integrate wellness and prevention services for all members, regardless of risk tier according to the benefits outlined in the managed care contract, including but not limited to the following:

- Provide preventive health visits and services for:
 - All children (under 21 years of age) in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule.
 - All adults in accordance with US Preventive Services Task Force Grade “A” and “B” recommendations.
- Monitor and support the provision of wellness and preventive services by primary care providers as part of the Medi-Cal managed care plan Facility Site Review process.
- Provide health educational materials about topics such as disease management, preventive services, Early and Periodic Screening, Diagnostic, and Treatment services, how to access benefits, and other managed care plan health promotion materials.

3. Managing Members with Emerging Risks

The population health management program shall:

- Ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs, including preventive care, care for chronic conditions, and referrals to long-term services and supports, as appropriate;
- Refer members identified, through assessment or reassessment, as needing care coordination or case management to the member’s case manager for follow-up care and needed services within thirty (30) calendar days; and
- Assess individual social care needs and deploy appropriate community resources and strategies to mitigate impacts of social determinants of health, in partnership with providers and community organizations.

Additionally, Medi-Cal managed care plans will be required to use predictive analytics to inform them about which patients, communities or populations are high risk, as well as identify and address the needs of outliers with more specific services and supports. To address this focus, Medi-Cal managed care plans shall incorporate the DHCS Population Needs Assessment and NCQA PHM requirements on this topic into their PHM strategy. Identifying and addressing the needs of specific high-risk communities and populations – sometimes referred to as “hotspotting” - will be a focus of the PHM learning collaborative and DHCS will continue to assess best practices in this area.

4. Case Management

Case management services actively assist at-risk members in navigating health delivery systems, acquiring self-care skills to improve functioning and health outcomes, and slowing the progression of disease or disability. Case management services are intended for members who are medium- or high-risk or may have emerging risks that would benefit from case management services. Members determined to be low-risk should continue to receive wellness and prevention services, as well as other medically necessary services.

Case management services include the following, as needed and appropriate:

- Screening beyond the IRA to identify and prioritize goals and needs for case management, including both health issues and health-related social needs.
- Documentation in an electronic format of the individual care plan and assigned case manager for each member (required for all case management).
- Utilization of evidence-based practices in screening and intervention.
- Ongoing review of the member's goals and care plan as well as identifying and addressing gaps in care.
- Support from an inter-professional team with one primary point of contact for the member.
- Access to person-centered care planning, including education and training for providers and families.
- Continuous information sharing and communication with the member and their providers.
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s).
- Coordination and access to medically necessary health services and coordination with entities that provide mental health, substance use disorder services, developmental, and oral health services.
- Ensuring coordination and access to community-based services, such as home care, personal care services, and long-term services and supports.
- Developing relationships with local community organizations to implement social care needs interventions (e.g. housing support services, nutritional classes, etc.).
- Coordinating authorization of services including timely approval of and arranging for durable medical equipment, pharmacy, private duty nursing, and medical supplies.
- Promoting recovery using community health workers, peer counselors, and other community supports.

- Requesting modifications to treatment plans to address unmet service needs that limit progress.
- Assisting members in relapse/crisis prevention planning that includes development and incorporation of recovery action plans and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization.
- Performance measurement and quality improvement using feedback from the member and caregivers.
- Delivery of services in a culturally competent manner that addresses the cultural and linguistic needs by interacting with the member and his or her family in the member's primary language (use of interpreter allowed), with appropriate consideration of literacy and cultural preference.
- If the Medi-Cal managed care plan assigns a case manager outside the plan, written agreements shall define the responsibility of each party in meeting the requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the Medi-Cal managed care plan shall identify a lead care coordinator.

If a member changes enrollment to another Medi-Cal managed care plan, the Medi-Cal managed care plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. The Medi-Cal managed care plan must also ensure member confidentiality and member rights are protected.

Members may be assigned to one of three types of case management based on assessment of risk and need. The three types of case management include:

- **Basic Case Management:** Basic case management would be appropriate for members who require planning and coordination that is not at the highest level of complexity, intensity, or duration. These services are provided by the Medi-Cal managed care plan, clinic-based staff, or community-based staff, and may be provided by non-licensed staff. These services may include assignment to a certified patient-centered medical home; participation in a Medi-Cal managed care plan disease management program; or participation in another Medi-Cal managed care plan population health management program.
- **Complex Case Management:** The Medi-Cal managed care plan shall provide complex case management in accordance with NCQA requirements. NCQA defines complex case management as "a program of coordinated care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources." NCQA allows organizations to define

“complex.” Complex case management generally involves the coordination of services for high-risk members with complex conditions.

- **Enhanced Care Management:** Enhanced Care Management is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, including behavioral health conditions, and multiple social needs, as well as utilization of multiple service types and delivery systems (similar to the current Whole Person Care or Health Home Programs in intensity). See the separate Medi-Cal Healthier California for All Enhanced Care Management proposal for more details, including proposed member target groups and model of care requirements.

The population health management program shall describe how and when the services are utilized in conjunction with the risk stratification process, as members with changing risk and needs may require changing levels of case management. If the Medi-Cal managed care plan delegates or contracts with a provider for case management or transition of care services, it must do so in accordance with the NCQA’s population health management delegation requirements.

5. In Lieu of Services

“In lieu of services” are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management program. These services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. In lieu of services should be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of in lieu of services to serve as a transition of the work done through existing pilots (e.g. Whole Person Care, Health Homes, Coordinated Care Initiative, etc.), as well as inform the development of future statewide benefits that may be instituted.

Examples of the in lieu of services that DHCS proposes to cover include many of the services currently provided in the Whole Person Care Pilot Program that are not covered as State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically-tailored meals, supplemental personal care services, and housing tenancy navigation and sustaining services. Medi-Cal managed care plans will develop a network of providers of allowable in lieu of services with consideration for which community providers have expertise and capacity regarding specific types

of services. See the separate Medi-Cal Healthier California for All In Lieu of Services proposal for more details.

6. Coordination between Medi-Cal Managed Care Plans and External Entities

The Medi-Cal managed care plan shall describe in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, and home and community-based services. Referrals must be culturally and linguistically appropriate for the member. The plan must coordinate with competent external entities to provide all necessary services and resources to the beneficiary. These entities should be listed as part of the population health management plan identifying specific services each named entity will provide plan members.

7. Transitional Services

The Medi-Cal managed care plan shall ensure transitional services are provided to all members who are transferring from one setting, or level of care, to another. The plan shall work with appropriate staff at any hospital that provides services to its members (whether contracted or non-contracted in the case of emergency services), to implement a safe, comprehensive discharge plan. The plan must provide continued access to medically necessary covered services that will support the member's recovery and prevent readmission. The Medi-Cal managed care plan shall have in place operational agreements or shall incorporate transitional language into existing subcontracts with the Medi-Cal managed care plan's contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to ensure smooth transitions.

The operational agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge risk assessment tool. The tool shall encompass a risk assessment for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Each Medi-Cal managed care plan's discharge screening tool must be approved by DHCS;
- Development of a written discharge plan, shared with the beneficiary and all treating providers, in order to mitigate the risk of readmission and other negative health outcomes;
- Obtain the member's permission to share information with clinical and non-clinical providers to facilitate care transitions;
- Develop discharge planning policies and procedures in collaboration with all hospitals;

- Process all hospital prior authorization requests for clinic services required for the member within two (2) business days. Such services shall include authorizations for therapy, home care services, equipment, medical supplies or pharmaceuticals;
- Educate hospital discharge planning staff on the clinical services requiring pre-authorization to facilitate timely discharge from the hospital; and
- Prevent delayed discharges from a hospital due to Medi-Cal managed care plan authorization procedures or transition to a lower level of care.

8. Skilled Nursing Facility Coordination

The Medi-Cal managed care plan shall coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled nursing facility or nursing facility. The Medi-Cal managed care plan shall coordinate with the facility to provide case management and transitional care services and shall ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes but is not limited to prescription medications, durable medical equipment, intravenous medications, and any other medically necessary service or product.

- If the Medi-Cal managed care plan, in coordination with the nursing facility or skilled nursing facility, anticipates the member will be in the facility after a member no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Medi-Cal managed care plan shall assist the member in exploring all available care options. This includes potential discharge to a home or community residential setting, or to remain in the skilled nursing facility for long-term services and supports.
- If the member is discharged to a home or to a community residential setting, the Medi-Cal managed care plan shall coordinate with the facility to ensure the member is in a safe location. The plan shall ensure medically necessary services are available including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services and any other services necessary to facilitate the member's recovery. The Medi-Cal managed care plan shall also ensure follow-up care is provided consistent with the transitional services requirements listed above.

Population Health Management Oversight

The Medi-Cal managed care plan shall have internal monitoring processes in place to ensure compliance with the population health management program requirements. Quality assurance reviews of documented population health management activities shall include:

- Case identification and assessment according to established risk stratification system;
- Electronically documented treatment plans and care plans with evidence of periodic revision as appropriate to emerging member needs;
- Referral management;
- Effective coordination of care, including coordination of services that the member receives through the fee-for-service system; and
- Identification of appropriate actions for the case manager to take in support of the member, and the case manager's follow-through in performing the identified tasks.

The Medi-Cal managed care plan shall document quality assurance reviews on an annual basis, or upon DHCS' request and submit them to DHCS for review. Medi-Cal managed care plans are responsible for ensuring that their delegates comply with all applicable State and federal laws and regulations, contract requirements, and other DHCS guidance, including All plan Letters, Policy Letters, and Dual plan Letters. These requirements must be communicated by each Medi-Cal managed care plan to all delegated entities and sub-Medi-Cal managed care plans. The Medi-Cal managed care plan must submit a population health management oversight plan in accordance with NCQA requirements for any entities to which they delegate population health management functions. Such plans would be reviewed and approved by the State.

Health Information Technology to Support Integrated Care and Care Coordination

The Medi-Cal managed care plan will work to implement health information technology to support population health principles, integrated care and care coordination across the delivery system. Examples of health information technology include, but are not limited to, electronic health records, emergency department information exchange, clinical data repositories, registries, decision support and reporting tools that support clinical decision-making and case management. An overarching goal of population health management is to expand interoperable health information technology and health information exchange infrastructure, so that relevant data (including clinical and non-clinical) can be captured, analyzed, and shared to support provider integration of behavioral health and medical services, case management oversight and transitional planning, value based payment models and care delivery redesign.

The Medi-Cal managed care plan shall develop data exchange protocols, including member information sharing protocols, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including, but not limited to, sharing of claims and pharmacy data, treatment plans or care plans and Advance Directives necessary to coordinate service delivery, and care

management for each member in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.

Improved data collection, specifically of encounter data at the provider level, is a critical component of achieving the goals of this proposal, and DHCS will be working with plans and providers to achieve this goal.

Accountability and Oversight of Medi-Cal Managed Care Plans

In order to hold Medi-Cal Managed Care plans accountable for the activities proposed here, DHCS will increase its oversight and assessment of the plans, including changes to our audit procedures and our imposition of corrective action plans and financial sanctions, when appropriate. DHCS recognizes that through this and the other proposals contained within Medi-Cal Healthier California for All that the responsibility of the Medi-Cal Managed Care plans is increasing, and therefore DHCS oversight to hold the plans accountable must also grow and change in conjunction with these proposals. To assist with such large change, DHCS is committed to providing Medi-Cal managed care plans technical assistance through such changes.

Future Policy Development and Technical Assistance

As technical assistance for Medi-Cal managed care plan development of their population health management program, DHCS will provide submission templates and “best practice” examples of current Medi-Cal managed care plan population health management programs from California and other States. DHCS will also create a DHCS-operated learning collaborative for Medi-Cal managed care plans to share information and promising practices. The learning collaborative would address promising practices in all of the DHCS-required population health management activities, but would also address the following topics that have been identified by stakeholders:

- Coordination with external entities that provide carved-out services, such as specialty mental health, Drug Medi-Cal, and community-based social services ;
- Engaging with consumers who have health needs but are unidentified, unengaged, and are underutilizing services, including methods to engage with these members, build trust, and obtain information from the member about their needs;
- Care transition coordination including sharing discharge risk assessment tools;
- Incorporating social drivers of health and health-related social care needs into case management and community-level population improvement activities;
- Collection of social determinants of health information for risk stratification and segmentation, and for state-level data collection for strategic planning purposes;

- Best practices in how to use population health management programs to support specific populations of interest such as children and maternity patients, in ways that align with other DHCS initiatives;
- Use of population data for “hotspotting” and other population analysis promising practices;
- Use of general beneficiary medical record release consent to allow Medi-Cal managed care plans and providers to share data broadly for the purposes of care coordination;
- Learning best practices from California Accountable Communities for Health Initiative activities, including opportunities for partnership and elements that may be appropriate to integrate into the PHM strategies;
- Data exchange protocols and the development of health information technology/health information exchange policies; and
- Submission of housing status data to DHCS via ICD-10 coding, in alignment with the current DHCS Value Based Payment incentive program for these codes.

The best method to advance promising practices in these areas may be to allow them to emerge through a learning collaborative and assessment of Medi-Cal managed care plan outcomes. DHCS may also standardize certain requirements after research and consultation with stakeholders.

Continuing areas of DHCS policy development will include the following:

- DHCS Risk Tiering criteria;
- DCHS IRA to gather individual member information for risk tiering and stratification;
- Detailed review of alignment with NCQA PHM requirements, in coordination with NCQA and Medi-Cal managed care plans;
- Review of PHM program outcomes goals and measures, and their relation to the broader DHCS managed care quality metric strategy, which may be used to assess each Medi-Cal managed care plan’s PHM program effectiveness, to create incentives, and to drive program improvements;

2.1.3 Rationale

The population health management program requirement will ensure that there is a cohesive plan to address beneficiary needs across the continuum of care, from prevention and wellness to complex case management. This proposal will work in conjunction with other Medi-Cal Healthier California for All proposals to meet the overarching Medi-Cal Healthier California for All goals of improving coordination and quality, while also reducing

unnecessary administrative burden and redundancy. The following Medi-Cal Healthier California for All elements of the population health management program will magnify the positive impact on member outcomes:

- **NCQA Accreditation** provides a foundation of quality best practices and an oversight structure for the population health management program and other Medi-Cal managed care plan activities;
- The new **Enhanced Care Management** benefit will provide a critical new set of services as well as an effective case management tool to integrate within the population health management program;
- The adoption of a menu of **In Lieu of Services** – flexible wrap-around services designed to fill medical and social determinants of health gaps – will similarly integrate within population health management program; and
- Making **shared risk/savings and incentive payments** available to Medi-Cal managed care plans and providers in order to maximize the effectiveness of the population health management program and new service options.

2.1.4 Proposed Timeline

The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an effective date of January 1, 2022. The date for the first population health management plan submission and other required submissions from Medi-Cal managed care plans to DHCS is to be determined.