Northwest and Southwest PATH Collaborative Planning & Implementation November 2023

Q&A Follow-Up from the Population Health Management Strategy Presentation by
Randi Arias-Fontenot, Nurse Consultant III (Specialist) and
Addie Sherman Chief of Population Health Management Policy at
Quality Population Health Management
Department of Health Care Services (DHCS)
Distributed January 10, 2024

Populations of Focus Questions:

Q: Where can providers find more specific information on the Birth Equity Population of Focus?
A: Starting January 1, 2024, the Birth Equity Population of Focus (PoF) will go live to address known disparities in health and birth outcomes in racial and ethnic groups with high maternal morbidity and mortality rates. Specific information regarding PoF definitions and other operational guidance can be found within the Enhanced Care Management (ECM) Policy Guide. This workstream will also be tied to the ongoing DHCS efforts to create a Birthing Care Pathway to cover conception through 12 months postpartum. The Birthing Care Pathway project will culminate with a public report outlining the policy recommendations for how DHCS can most effectively reduce maternal morbidity and mortality and address racial and ethnic disparities. The report is expected to be published in Summer 2024. Further information can be found on the DHCS website. If you have additional questions, please feel free to reach out to the ECM mailbox at CalAIMECMandILOS@dhcs.ca.gov (soon to be EnhancedCareManagement@dhcs.ca.gov; formal communication will be issued once this update goes live).

Q: Based on the California Department of Public Health's most recent State public health data (including the Prenatal Care Dashboard and Pregnancy-Related Mortality Dashboard), the racial and ethnic groups experiencing disparities in care for maternal morbidity and mortality are Black, American Indian and Alaska Native, and Pacific Islander pregnant and postpartum individuals. The data also shows that the maternal morbidity and mortality for the mixed-race group is concerning. *Can DHCS provide insight to how "mixed race" impacts eligibility for this benefit? How does access to care impact eligibility?*
A: This is an important consideration that DHCS is hoping to address in 2024. For now, please reach out to the ECM mailbox (CalAIMECMandILOS@dhcs.ca.gov). Further formal guidance will be shared when finalized.

Q: Will there be additional criteria offered for inclusion in the Birth Equity POF besides race and ethnicity?
A: While the Department agrees that there are other significant factors that account for birth inequalities that extend beyond race and ethnicity, we are unlikely to provide major policy changes to the Birth Equity POF at this time. These risk factors are actively being accounted for in the development of the Birthing Care Pathway and through Risk Stratification Segmentation and Tiering (RSST). A report that will include policy and payment model recommendations from the Birthing Care Pathway is scheduled to be published in Summer 2024.

Q: Can a patient get both Comprehensive Perinatal Services Program (CPSP) and Birth Equity Population of Focus ECM benefits? Where can providers find resources to understand how to bill and check eligibility for these programs?
A: According to the ECM Policy Guide, "For Members enrolled in CPSP, the ECM Provider is expected to leverage the comprehensive assessments conducted by CPSP, including the CPSP individualized care plan and postpartum assessment, in developing the Member's ECM care management plan. The CPSP individualized care plan is reassessed at each trimester with a strengths-based assessment."

Q: How will ECM JI providers know if their county probation/sheriff/CF facility is choosing an embedded model where they will need to refer out for ECM services or an in-reach model where the pre-release provider becomes the ECM provider whenever possible?
A: DHCS will develop and maintain a publicly accessible report on the DHCS JI website to display the pre-release service go-live date for correctional facilities in each county, updated on a quarterly basis. The report will also include information on whether each facility plans to pursue an in-reach or embedded care management model. DHCS encourages county-level communication between implementing partners, to facilitate the collaborative drafting of readiness assessments and sharing of approved readiness assessment to ensure all implementing partners are aligned with roles and responsibilities.

CITED Questions:

Q: Now in the third round of PATH CITED, is there an updated timeline from application to funds distribution? Consider providing feedback given the following circumstances experienced by lower capacity CBOS: *We are hearing with a January open; we would not receive any of the funds before Oct/Nov. For a CBO that has been hiring for CalAIM, that is a long window from Round 2. We just missed the May deadline, so we will have to find funding for 18 months.*
A: The applications will begin in January 2024. As for the release of funds for Round 3, the dates are still in progress.

Q: What are the areas of focus for PATH CITED 3 funding?
A: Find the CITED priorities for Round 3 in the CITED Round 3 Guidance Document.

Managed Care Plan Transition:

Q: What type of oversight will the Department of Health Care Services have in Kaiser Permanente engagement with locally based organizations?
A: The Department is developing audit and investigative procedures for Population Health Management policies that they will be following up with. DHCS is also hopeful to work together to avoid conflict. The Managed Care Networks and Access Branch within the Managed Care Quality and Monitoring (MCQMD) Division will be leading this effort. Please reach out to Sean Barber at Sean.Barber@dhcs.ca.gov and Camella Taylor at Camella.Taylor@dhcs.ca.gov for further information.

Data Exchange:

Q: Is there a technology platform for care management that is being recommended?
A: Currently, it is up to the MCP and their contracted partners. However, DHCS aims to begin initiating the Population Health Management (PHM) Service on a rolling basis starting later in 2024. The PHM Service will provide a wide-range of Medi-Cal stakeholders with data access and availability for Medi-Cal members' health history, needs, and risks, including historical administrative, medical, behavioral, dental, social service data, and other program information from current disparate sources. The PHM Service will utilize this data to support risk stratification, segmentation, and tiering; assessment and screening processes; potential medical, behavioral, and social supports; and analytics and reporting functions. The PHM Service will also improve data accuracy and improve DHCS' ability to understand population health trends and the efficacy of various PHM interventions and strengthen oversight. Further information can be found on the DHCS website and PHM Policy Guide.

Q: What is the objective concerning closed-loop referrals, and how does DHCS intend to collaborate with the existing networks throughout California to minimize redundancy?
A: DHCS intends to minimize redundancy and increase utilization of existing networks and data frameworks in several ways. These efforts include the roll out of the PHM Service, a restructuring of the Population Needs Assessment (PNA) process, and Closed Loop Referral policy implementation in 2025. The PHM Service will reduce redundancy by connecting relevant parties with a broad set of data sources to support PHM Program information gathering, inform Risk Stratification and Segmentation (RSS), provide a broader understanding of the health needs and preferences of the member, and support more meaningful member engagement. Furthermore, the restructuring of the PNA to better foster collaboration between Medi-Cal managed care plans (MCPs) and local health entities will additionally reduce redundant workstreams. Finally, formal Closed Loop Referral policy will roll out January 1, 2025. In the meantime, MCPs are expected to begin building relationships with providers to support this policy implementation.

Miscellaneous Population Health Management Questions:

Q: Is the Population Needs Assessment a directive under CalAIM? Further, is there the opportunity to encourage MCP and local health departments to include CBOs in the steering committee that oversees community health assessments (CHAs) and Community Health Improvement Plans (CHIP) processes?

A: The PNA is a component of Population Health Management, falling under the CalAIM Initiative. It also represents a new directive in partnership with the California Department of Public Health (CDPH) to facilitate coordination among local health entities and MCPs when completing the CHA and CHIP process. The cycles for local health jurisdictions' (LHJs') CHA/CHIP development will become standardized starting in 2028. Between 2024 and 2027, LHJs' CHAs/CHIPs will largely remain on different cycles. MCPs will be required to work with each LHJ on its CHA/CHIP according to the guidance below. Some LHJs will be expected to complete a CHA, others a CHIP, and others a full CHA/CHIP cycle within this three-year window. Starting in 2028, all LHJs will be expected to be on the same three-year cycle with the LHJ CHA to be completed in December 2028 and the CHIP to be completed by June 30, 2029. Alignment of timelines across the state will help both LHJs and MCPs manage CHAs/CHIPs more effectively, including MCPs that operate in multiple counties, and will allow the state agencies to provide more effective TA. We support further exploration into how CBOs can contribute to this process as well.

Facilitator Questions:

Q: What is the DHCS vision for how MCPs can best support successful implementation of Care Coordination, Navigation, and Referrals across all health and social services providers, including Community Supports providers?

A: Basic Population Health Management (BPHM) includes access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the new CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children under early and periodic screening, diagnostic, and treatment (EPSDT). BPHM is ultimately the responsibility of the MCP. Some functions of BPHM will need to be retained by the MCP, such as authorizing specialty services in a timely manner and providing a full suite of wellness and prevention and chronic disease management programs. However, MCPs are encouraged to contract with providers to provide certain components of BPHM, as described below, while ensuring appropriate oversight in meeting required responsibilities and functions. For further information, and to understand how this policy overlaps with ECM and Community Supports, please reference the following policy guides: PHM Policy Guide, ECM Policy Guide.

Q: How is DHCS aiming to support systems interoperability for CBO's, tribal entities, and organizations that serve historically underserved populations with traditional healthcare providers without them having to compromise culturally appropriate services or unreasonable cost burden?

A: As part of the comprehensive rollout of PHM policies and procedures, DHCS is enhancing collaboration with MCPs to establish policies addressing interoperability, thereby alleviating the burdens faced by community and tribal partners. Additionally, the re-imagined PNA aims to comprehend cultural and linguistic considerations, adopt a holistic perspective on social drivers of health, and explore upstream interventions. Enhancing interoperability will also be a main function of the PHM Service, which will begin a phased roll-out toward the end of 2024. The goal is to support and use existing processes that effectively assess the needs of communities. For further information, please refer to the PHM Policy Guide.

Q: How is DHCS encouraging contracts with community and social service organizations for some of the other Basic Population Health Management services (e.g. wellness and prevention, Addressing Chronic Disease, Maternal Health outcomes, etc.)?

A: DHCS encourages contracts with community and social service organizations to promote BPHM. Beginning 2025, MCPs will be required to further ensure services like access to care coordination, navigation, and reliance upon CHWs by establishing relationships and processes to meet Closed Loop Referral requirements. For members enrolled in ECM, and since ECM, by design, happens in the community by an ECM provider, the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of their care management. In these cases, further encouragement to contract comes in the form of the Incentive Payment Program (IPP) for MCPs and the Providing Access and Transforming Health (PATH) program for providers.

Q: How are local provider organizations in each region participating in the Population Needs Assessment and what are the plans to ensure that there is no duplicative burden on organizations, or the people served with other required needs assessments?

A: The PNA is the mechanism that MCPs use to identify the priority needs of their local communities and members and to identify health disparities. Under the PHM Program, MCPs fulfill their PNA requirement by meaningfully participating in the Community Health Assessments (CHAs)/and Community Health Improvement Plans (CHIPs) conducted by Local Health Jurisdictions (LHJs). DHCS' vision is for the PNA process to evolve to help either initiate or strengthen engagement among MCPs, LHJs and community stakeholders over time, fostering a deeper understanding of the health and social needs of members and the communities in which they live through cross-sector partnerships. This collaboration will ultimately enhance MCPs' ability to identify needs and strengths within members' communities so that MCPs and their community partners can reduce siloed approaches to population health management and more effectively improve the lives of members.

Since 2013, public health entities across the country (including state, local, territorial, and Tribal public health entities) have been required to complete a CHA/CHIP when seeking to obtain and maintain voluntary Public Health Accreditation Board (PHAB) accreditation. PHAB accreditation requires that CHAs/CHIPs are completed at least every five years. Separately, non-profit hospitals develop CHAs to meet federal and state requirements to obtain and maintain their tax-exempt status. Some, public health entities choose to complete a CHA/CHIP every three years to align with non-profit hospital community health needs assessments especially when there is geographic overlap between non-profit hospitals and public health entities. PHAB provides broad guidance on how a CHA/CHIP should be conducted, allowing for significant variation by an entity. As such, an array of tools and processes may be used to conduct a CHA that complies with accreditation standards; the essential feature is that the assessment is developed through a participatory, collaborative process with various sectors of the community.

Between 2024 and 2027, LHJs' CHAs/CHIPs will largely remain on different cycles. MCPs will be required to work with each LHJ on its CHA/CHIP according to the guidance below. Some LHJs will be expected to complete a CHA, others a CHIP, and others a full CHA/CHIP cycle within this three-year window. Starting in 2028, all LHJs will be expected to be on the same three-year cycle with the LHJ CHA to be completed in December 2028 and the CHIP to be completed by June 30, 2029. Alignment of timelines across the state will help both LHJs and MCPs manage CHAs/CHIPs more effectively, including MCPs that operate in multiple counties, and will allow the state agencies to provide more effective TA. Given the significant investments in time and resources to CHA/CHIP development cycles and CHIP implementation, the LHJs would be permitted to consider the subsequent three-year cycle to be a "refresh" to quantitative data for both the CHA and CHIP in consultation with stakeholders.

For more information and resources, please visit the CPI page on the PHIL website under "Past Events." For additional questions or support, please contact the PHIL team at path@pophealthinnovationlab.org.