CALAIM INCENTIVE PAYMENT PROGRAM

Appendix B: Technical Specifications and Submission Guidance

Contents

HEDIS® Measure Modification Disclaimer

Measures 4.4-4.9 were based on Healthcare Effectiveness Data and Information Set (HEDIS®) measures and modified by the Department of Health Care Services (DHCS) for purposes of the IPP program.

Measure modifications were made in accordance with National Committee for Quality Assurance's (NCQA) guidance on allowable adjustments. NCQA has not approved the altered measure specifications.

Priority Area 1: Delivery System Infrastructure Measures

1.1 Number and percentage point increase in contracted ECM providers that engage in bi-directional Health Information Exchange (HIE)

Description
Number and percentage point increase in contracted ECM providers that engage in bi-directional Health Information Exchange (HIE)
Eligible Population
All community-based ECM providers with contracts in place for the MCP's provider network to provide ECM services during the measurement period.
Calculation
Numerator: Number of identified ECM providers with contracts in place for the MCP's provider network to provide ECM services during the measurement period that engage in bi-directional Health Information Exchange (HIE) as evidenced by the ECM provider having: • A signed statewide CalHHS Data Sharing Agreement (DSA); AND any of the following: • Attest to having a signed participation agreement with a health information exchange organization (HIO); • A signed attestation certifying that the provider has an active Fast Healthcare Interoperability Resources (FHIR) Application Programming Interface (API) in place; • A signed attestation certifying that the ECM providers use their EHR system to engage in bi-directional HIE, with submission of a data sharing transaction log or deidentified HL7 messages (or other equivalent documentation) to and from other providers in the MCP's contracted network. *NOTE: ECM providers only include community-based providers that enter into contracts with MCPs to provide ECM services. This numerator excludes ECM providers employed by the MCP. See Technical Specifications for list of allowable ECM provider types.* **Denominator:** Total number of identified ECM providers with contracts in place for the MCP's provider network to provide ECM services during the measurement period *NOTE: ECM providers only include community-based providers that enter into contracts with MCPs to provide ECM services. This denominator excludes ECM providers employed by the MCP. See Technical Specifications for list of allowable ECM provider types.*

Technical Specifications
Allowable ECM provider types include: • County • County behavioral health provider • Primary care or specialist physician or physician group • Federally Qualified Health Center • Community Health Center • Hospital or hospital-based physician group or clinic • Public hospital, district/municipal public hospital or healthcare system • Rural Health Center/Indian Health Center • Local health department • Behavioral health entity • Community mental health center • Substance use disorder treatment provider • Organization serving individuals experiencing homelessness • Organization serving justice-involved individuals • Other qualified provider or entity not listed above This is a point in time measurement captured as of the last day of the measurement period.
Exclusions
MCPs that have DHCS approved exceptions for in-house providers of ECM cannot count the ECM providers employed by the MCP.

1.2 Number and percentage point increase in contracted Community Supports providers for those Community Supports offered by the MCP during the measurement period with access to closed-loop referral systems

Description
Number and percentage point increase in contracted Community Supports providers for those Community Supports offered by the MCP during the measurement period with access to closed-loop referral systems
Eligible Population
All contracted Community Supports providers for those Community Supports offered by the MCP during the measurement period
Calculation
Numerator: Number of identified Community Supports providers with contracts in place for MCP's provider network to offer Community Supports during the measurement period and who have access to closed-loop referral systems.

Denominator: Total number of identified Community Supports providers with contracts in place for the MCP's provider network to provide Community Supports services during the measurement period.

Technical Specifications

Closed-loop referrals are defined as coordinating and referring a Member to available community resources and following up to ensure services were rendered.

A closed-loop referral system refers to a system or process which ensures the referring provider receives information that the Member was appropriately referred to, and received, services.

This is a point in time measurement captured as of the last day of the measurement period.

Priority Area 2: ECM Provider Capacity Building Measures

2.1 Number of contracted ECM care team FTEs

Description
Number of contracted ECM care team full time equivalents (FTEs)
Eligible Population (A and B)
All community-based ECM providers with contracts in place for the MCP's provider network to provide ECM services during the measurement period
Calculation (A)
Numerator: Number of ECM care team FTEs contracted to serve adult Members ages 21 and older. *NOTE: Excludes ECM providers employed by the MCP.* **Denominator:** Total number of ECM care team FTEs needed to serve adult Members ages 21 and older who meet eligibility criteria for ECM services as of the last day of the measurement period
Calculation (B)
Numerator: Number of ECM care team FTEs contracted to serve children and youth Members under 21 years of age **Denominator:** Total number of ECM care team FTEs needed to serve children and youth Members under 21 years of age who meet eligibility criteria for ECM services as of the last day of the measurement period
Technical Specifications (A and B)
Total FTEs are defined as the sum of ECM care team members' working hours divided by their employer's full-time working hours (i.e. 40 hours per week); multiple part-time ECM care team members can equate to one (1) FTE. ECM care team members include staff who directly and indirectly provide ECM services and coordination of care but are not limited to the following: • Providers (MD, DO, NP, PA) • Nursing (RN, LVN, MA, CNA) • Ancillary staff (Community Health Workers, care coordinators, health navigators, promotores, social workers, care managers, case managers) In addition to total FTEs as described in the numerator, include in the required Network Adequacy Measures Methodology Attachment the total number of staff that encompasses the total FTEs (i.e., 3 FTEs with 5 staff). List all ECM care team members and describe their titles, roles and responsibilities. We strongly encourage a minimum of 0.5 FTE staff whenever possible to maintain continuity of care.

MCPs are required to submit a separate attachment, the Network Adequacy Measures Methodology attachment, outlining the Plan's methodology for estimating the denominators for this measure. See Quantitative Reporting Template instructions for further information.

The estimated denominators of providers needed to serve all Members eligible for ECM should be based on the MCP's specified methodology. MCPs must report on all ECM Populations of Focus live during the measurement period.

This is a point in time measurement captured as of the last day of the measurement period.

Exclusions (A and B)

MCPs that have DHCS approved exceptions for in-house providers of ECM cannot count ECM FTEs employed by the MCP in the numerator.

2.2 Number of Members enrolled in ECM

Description
Number of Members enrolled in ECM
Eligible Population (A and B)
All MCP Members that meet the eligibility criteria for any ECM Population of Focus that is live during the measurement period
Calculation (A)
Numerator: Total number of adult Members ages 21 and older enrolled in ECM during the measurement period **Denominator:** Total number of adult Members ages 21 and older that meet the eligibility criteria for any ECM Populations of Focus that are live during the measurement period
Calculation (B)
Numerator: Total number of child and youth Members under 21 years of age enrolled in ECM during the measurement period **Denominator:** Total number of child and youth Members under 21 years of age that meet the eligibility criteria for any ECM Populations of Focus that are live during the measurement period
Technical Specifications (A and B)
To be eligible for ECM, Members must be enrolled in a Medi-Cal managed care plan and meet at least one of the ECM Populations of Focus definitions. Refer to the latest ECM Policy Guide (December 2022) for specific eligibility criteria. The page numbers in the ECM Policy Guide for eligibility criteria for each POF are listed below for reference. • Individuals Experiencing Homelessness (p. 11-13)

- Individuals At Risk for Avoidable Hospital or Emergency Department Utilization (p. 16)
- Individuals with Series Mental Health and/or SUD Needs (p. 19-20)
- Individuals Transitioning from Incarceration (p. 25-26)
- Adults Living in the Community and At Risk for LTC Institutionalization (p. 30)
- Adults Nursing Facility Residents Transitioning to the Community (p. 33)
- Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition (p. 36)
- Children and Youth Involved in Child Welfare (p. 39)
- Birth Equity Population of Focus (p. 44)

This is a cumulative count over the entire measurement period.

2.3 Number of Members who are Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness that are enrolled in ECM during the measurement period

Description
Number of Members who are Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness that are enrolled in ECM during the measurement period
Eligible Population (A, B and C)
All MCP Members who are Black/African American or other racial and ethnic groups who are disproportionately experiencing homelessness in the county. Members must be ECM eligible to be counted
Calculation (A)
Numerator: Number of Black/African American Members who 1) were enrolled in ECM and 2) were experiencing homelessness or were at risk of experiencing homelessness during the measurement period. **Denominator:** Number of Black/African American Members who were experiencing homelessness or were at risk of experiencing homelessness during the measurement period. The Member needs to be ECM eligible to be counted.
Calculation (B and C)
Numerator: Number of _____ [racial or ethnic group disproportionately experiencing homelessness in the county] Members who 1) were enrolled in ECM and 2) were experiencing homelessness or were at risk of experiencing homelessness during the measurement period.

MCP should select the top racial or ethnic groups who are disproportionately experiencing homelessness in the county and indicate the group reported on. Reported top racial or ethnic group should align with those reported in measures 1.2.9, 2A.2.9, and 2B.2.3 in prior measurement periods.

Denominator: Number of _____ [racial or ethnic group disproportionately experiencing homelessness in the county] Members who were experiencing homelessness or were at risk of experiencing homelessness during the measurement period. The Member needs to be ECM eligible to be counted.

MCP should select the top racial or ethnic groups who are disproportionately experiencing homelessness in the county and indicate the group reported on. Reported top racial or ethnic group should align with the group identified in the numerator.

Technical Specifications (A, B and C)

The racial and ethnic groups reported on should be consistent across all measurement periods. Racial/ethnic group selections must be identified in the applicable reporting template.

Identification of groups disproportionately experiencing homelessness:
The proportion of Members experiencing homelessness is greater than the proportion of the general population (e.g. 50% of those experiencing homelessness are Black/African American compared to 25% of the general population identifying as Black/African American).

Inability to identify three racial/ethnic groups disproportionately experiencing homelessness:
If there are fewer than 3 groups reasonably experiencing homelessness at a disproportionate rate, or the Membership of the population is too low to valuably report (i.e. those who identify as American Indian or Alaska Native (AI/AN) may be disproportionately experiencing homelessness but the MCP only has one Member that is AI/AN and experiencing homelessness in the county), the MCP should pick an alternative group to report on. MCPs should identify any alternative racial/ethnic groups in the applicable reporting template.

Example: Asian (Alternative group)

This is a cumulative count over the entire measurement period.

2.4 Network Development for Justice-Involved Population of Focus

Description (A)

Submission 3 Only

Describe the MCP's activities completed during the measurement period to establish a network of ECM providers who will serve the Justice-Involved Population of Focus (PoF). The response should include:

- List of correctional facilities in the county with description of outreach the MCP conducted to each during the measurement period, including: facility name(s), date(s) of outreach, outreach method(s), contact person(s) outreached to, and outcome of outreach (i.e. phone call, in-person meeting, no response);
- List of organizations serving justice-involved individuals (adults, juveniles, or both) in the county with description of outreach the MCP conducted to each during the measurement period, including: organization name(s), service(s) provided by organization, date(s) of outreach, outreach method(s), contact person(s) outreached to, and outcome of outreach (i.e. phone call, in-person meeting, no response);
- Description of actions taken by the MCP to assess the capability and willingness of currently contracted, community-based ECM providers to serve the Justice-Involved PoF, including: number of community-based ECM providers currently contracted, number of community-based ECM providers currently contracted who were queried about capability and willingness to serve the Justice-Involved PoF, and number of community-based ECM providers queried who responded affirmatively; and
- Description of the MCP's strategy to meet the ECM needs of adults and juveniles in the Justice-Involved PoF by supporting currently contracted and prospective community-based ECM providers, including through infrastructure spending, individualized or group technical assistance, sponsorship of training, provision of information technology resources, or other activities.

Description (B)

Submission 4 Only

Percentage of correctional facilities engaged by MCP outreach

Eligible Population

(A) Not applicable
(B) All correctional facilities serving the county

Calculation (B)

Numerator: Number of correctional facilities serving the county whom the MCP has met with 2 or more times as of the last day of the measurement period

Denominator: Number of correctional facilities serving the county

Technical Specifications (A)

MCPs reporting for multiple counties should produce distinct, original responses for each county. Each narrative response should be submitted on a separate page, but responses are not limited to one page in length.

Correctional facilities include state prisons, county jails, and county youth correctional facilities.

Organizations serving justice-involved individuals include but are not limited to community-based organizations, medical and behavioral health providers, reentry services providers and other social services providers.

MCP's narratives will be scored based on inclusion of the following criteria:

1. Did the MCP provide a list identifying outreach attempts to all county correctional facilities?
    a. Are all correctional facilities in the county identified?
    b. Did the MCP identify a point of contact for each correctional facility listed?
    c. Did the MCP specify method(s) and date(s) of outreach to each correctional facility?
    d. Did the MCP specify the outcome of each outreach attempt to each correctional facility?
2. Did the MCP provide a list of all organizations in the county serving justice-involved individuals, including the following for each listed organization:
    a. Name of organization;
    b. Services provided by the organization;
    c. Population served by the organization (adults, juveniles, or both);
    d. Point of contact for the organization;
    e. Method(s) and date(s) of outreach to the organization; and
    f. Outcome of outreach.
3. Did the MCP provide an outline of actions taken to assess the capability and willingness of currently contracted community-based ECM providers to serve the JI PoF?
    a. Did the MCP specify the number of community-based ECM providers currently contracted?
    b. Did the MCP specify the number of currently contracted community-based ECM providers who were queried about capability and willingness to serve the Justice-Involved PoF and the number who responded affirmatively?
    c. Did the MCP include a description of how they outreached to currently contracted ECM providers?
    d. Did the MCP include any takeaways and/or concerns from currently contracted providers about ability and willingness to serve the Justice-

Involved POF?

4. Did the MCP provide a description of their strategy to meet the ECM needs of Members in the Justice-Involved PoF?
    a. Did the MCP's strategy include activities to support currently contracted community-based ECM providers, including through infrastructure spending, individualized or group technical assistance, sponsorship of training, provision of information technology resources, or other activities.
        i. Did the MCP provide specific examples of completed or planned activities to support currently contracted community-based ECM providers?
    b. Did the MCP's strategy include activities to support prospective community-based ECM providers, including through infrastructure spending, individualized or group technical assistance, sponsorship of training, provision of information technology resources, or other activities.
        i. Did the MCP provide specific examples of completed or planned activities to support prospective community-based ECM providers?
    c. For non-COHS counties, did the MCP describe efforts to collaborate to achieve 100% overlap in contracted ECM provider networks serving the Justice-Involved PoF in the county?
5. Is the MCP's response county-specific and addresses any circumstances specific to the county or region?

Technical Specifications (B)

This is a point in time measurement captured as of the last day of the measurement period.

2.5 Network Development for Justice-Involved Population of Focus

Description (A)

Submissions 4 and 5 Only

Percentage of currently contracted ECM providers which employ staff with lived experience of justice system involvement

Description (B)

Submission 5 Only

Percentage of Justice-Involved ECM providers contracted with all MCPs in the county

Eligible Population (A and B)

All community-based ECM providers with contracts in place for the MCP's provider network to provide ECM services to the Justice-Involved PoF during the measurement period

Calculation (A)

Numerator: Number of currently contracted ECM providers which employ staff with lived experience of justice system involvement

Denominator: Total number of currently contracted ECM providers serving the Justice-Involved PoF
Calculation (B)
Numerator: Number of currently contracted ECM providers serving the Justice-Involved PoF which are contracted with all Medi-Cal MCPs in the county **Denominator:** Total number of currently contracted ECM providers serving the Justice-Involved PoF
Technical Specifications (A and B)
This is a point in time measurement captured as of the last day of the measurement period.

Priority Area 3: Community Supports Provider Capacity Building and Community Supports Take-Up

3.1 Number of and percentage of eligible members receiving Community Supports, and number of unique Community Supports received by members

Description (A and B)
Number of and percentage of eligible members receiving Community Supports, and number of unique Community Supports received by members
Eligible Population (A and B)
All MCP Members who were referred to at least one Community Support offered in the county during the measurement period.
Calculation (A)
Numerator: Total number of members that received at least one Community Support during the measurement period. (Members may only be counted once.) **Denominator:** Total number of members that were referred to at least one Community Support offered in the county during the measurement period. (Members may only be counted once.)
Calculation (B)
Numerator: Total number of unique Community Supports received by members during the measurement period. (Members may be counted more than once if receiving more than one Community Supports.) **Denominator:** Total number of referrals for Community Support offered in the county during the measurement period. (If a member had referrals for more than one Community Support, each referral should be counted separately).
Technical Specifications (A)
Numerator Specifications: Any Member enrolled in the managed care plan who received at least one Community Support service during the measurement period should be counted. Members who received more than one Community Support should only be counted once. MCPs must include all Members, including those enrolled in a subcontracted MCP. The count should include all Community Supports live during the measurement period, including any Community Supports offered by subcontracted MCPs. **Denominator Specifications:** Any Member enrolled in the managed care plan who was referred to at least one Community Support service during the measurement period should be counted. Members who were referred to more than one Community Support should only be counted once. MCPs must include all Members, including those enrolled in a subcontracted MCP. The count should include all Community Supports live during the measurement period, including any Community Supports offered by subcontracted MCPs.

Eligible referrals include:

- Referrals from ECM and/or Community Supports providers
- Referrals from any health or social services provider
- Self-referrals from a Member or the Member's family

This is a cumulative count over the entire measurement period.

Technical Specifications (B)

Numerator Specifications: Count of all Community Supports services received by Members during the measurement period, including any Community Supports received by Members enrolled in a subcontracted MCP. If a Member received more than one of the approved Community Supports, each Community Support received should be counted. Multiple encounters for one Member for one Community Support should only be counted once. The count should include all Community Supports live during the measurement period, including any Community Supports offered by subcontracted MCPs.

Denominator Specifications: Count of all referrals for Members enrolled in the MCP for Community Supports services during the measurement period, including any referrals for Members enrolled in a subcontracted MCP. If a Member is referred to multiple Community Supports, each referral should be counted. If a Member has multiple referrals to the same Community Support, referrals from separate entities should be counted separately. The count should include all Community Supports live during the measurement period, including any Community Supports offered by subcontracted MCPs.

Eligible referrals include:

- Referrals from ECM and/or Community Supports providers
- Referrals from any health or social services provider
- Self-referrals from a Member or the Member's family

This is a cumulative count over the entire measurement period.

3.2 Number of contracted Community Supports providers

Description
Number of contracted Community Supports providers
Eligible Population
All Community Supports providers with contracts in place for the MCP's provider network to provide Community Supports services during the measurement period
Calculation
Numerator: Number of Community Supports providers with contracts in place for the MCP's provider network to provide *[specified Community Support]* during the measurement period

Denominator: Number of providers needed to serve members who are eligible for *[specified Community Support]*

NOTE: MCPs should report only on Community Supports that were live and which the MCP offered during the measurement period. For Community Supports not offered, MCPs should input "0" in the numerator. In the denominator, MCPs should provide an estimate for the number of providers for all Community Supports live during the measurement period and all Community Supports planned for implementation during the following measurement period; if the MCP does not intend to offer a Community Support in future measurement periods, MCPs should input "0" in the denominator. DHCS will validate MCP submissions against MCP Final Elections reported in the current approved Community Supports Model of Care. MCPs must describe the methodology for these estimates in the required Network Adequacy Measures Methodology attachment.

Technical Specifications

Numerator Specifications: Count each contracted provider for each specified Community Support. Providers should be identified based on contracts in place with the MCP and not based on FTEs. Only providers with contracts in place to provide Community Supports during the measurement period should be counted. If a provider is contracted to provide more than one Community Support, the provider should be counted for each Community Support they provide. MCPs must report on all Community Supports live during the measurement period, including Community Supports offered by subcontracted MCPs.

Denominator Specifications: The identified number of providers needed to serve all eligible Members for each Community Support should be based on the MCP's specified methodology. Providers should be identified based on contracts in place with the MCP and not based on FTEs. MCPs are required to submit a description of the methodology for determining the number of providers needed to serve all eligible Members, including a description of methodology to estimate number of eligible Members. MCPs must report on all Community Supports live during the measurement period, including Community Supports offered by subcontracted MCPs.

MCPs are required to submit a separate attachment, the Network Adequacy Measures Methodology attachment, outlining the Plan's methodology for estimating the denominators for this measure. See Quantitative Reporting Template instructions for further information.

This is a point in time measurement captured as of the last day of the measurement period.

Priority Area 4: Quality and Emerging CalAIM Priorities

4.1 Percentage of Members who received Community Health Worker (CHW) benefit, and CHW benefit utilization rate

Description
(A) Percentage of Members who received community health worker (CHW) benefit and (B) number of CHW encounters per 1,000 member months.

Eligible Population
• **Plan continuous enrollment criteria:** None • **Ages:** All ages • Member must not be enrolled in ECM to be counted • See Addendum: Claims Data Run-Out

Calculation (A)
Numerator: The number of unique Members who had at least one CHW benefit encounter during the measurement period *NOTE: Report the total number of Members that received at least one CHW benefit during the measurement period. Members may only be counted once. The MCP cannot count more than one CHW encounter claim for the same unique member within the numerator within the current or subsequent IPP measurement periods. Do not include Members who were enrolled in ECM at the time of the CHW encounter claim.* **Denominator:** The total number of enrolled Members in the MCP during the measurement period *NOTE: MCPs must include all Members, including those enrolled in a subcontracted MCP. Do not include Members who were enrolled in ECM at any point during the measurement period.*

Calculation (B)
Numerator: The number of CHW benefit encounters during the measurement period *NOTE: Report the total number of CHW encounters provided during the measurement period. MCP should include repeated CHW benefit claims for unique members if they occurred within the measurement period. Count each CHW visit once, regardless of the intensity or duration of the visit. Count multiple CHW visits on the same date of service as one visit.* **Denominator:** The total number of enrolled member months during the measurement period

NOTE: Report total member months for the eligible population during any month in the 6-month measurement period.

Technical Specifications

CHW definition per APL 22-016: "CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals…"

A CHW benefit encounter must be provided by a CHW who:

1. Possesses the required CHW minimum qualifications specified within APL 22-016 (e.g. CHW- or Violence Prevention Professional-certified; Work Experience Pathway), and;
2. Is supervised by a Supervising Provider employing or otherwise overseeing the CHW with which the MCP contracts.

CHW benefit encounter claims must meet the following minimum criteria:

1. Claim must have occurred during the IPP measurement period
2. Claim must be submitted by the CHW's Supervising Provider, meeting the definition outlined in APL 22-016
3. Claim is eligible for reporting if the Supervising Provider utilized at least one CHW benefit claim CPT code described within the Billing Codes section of the DHCS CHW Preventative Services user manual issued July 2022

This is a point in time measurement captured as of the last day of the measurement period.

Exclusions

If the member is enrolled in ECM, MCPs are not precluded from continuing to leverage CHWs in-house at the MCP or otherwise outside the scope of this benefit. In the case of CHWs performing a role in ECM, however, providers may not bill for both ECM and the CHW benefit for the same member, per APL 22-016, as this would be considered a duplication of services. As such, no CHW encounters occurring after member enrollment into ECM should be included in the numerator, if applicable.

Exclude members in hospice or using hospice services anytime during the measurement period.

4.2 Percentage of contracted acute care facilities from which MCPs receive Admission, Discharge and Transfer (ADT) notifications, and percentage of contracted skilled nursing facilities (SNFs) from which MCPs receive ADT notifications

Description
(A) Percentage of contracted general acute care facilities from which MCPs receive ADT notifications and (B) Percentage of contracted skilled nursing facilities (SNFs) from which MCPs receive ADT notifications
Calculation (A)
Numerator: The number of contracted general acute care facilities from which MCPs receive ADT feeds **Denominator:** The total number of contracted general acute care facilities
Calculation (B)
Numerator: The number of contracted skilled nursing facilities (SNFs) from which MCPs receive ADT feeds **Denominator:** The total number of contracted skilled nursing facilities (SNFs)
Technical Specification (A)
Acute care facilities are defined as general acute care facilities. ADT notification is defined as any receipt of ADT feeds within the measurement period (can have just been initiated in this time period, or can be longstanding). Acute care facilities exclude intermediate care facilities/developmentally disabled (ICF/DD). This is a point in time measurement captured as of the last day of the measurement period.
Technical Specifications (B)
Skilled nursing facilities exclude intermediate care facilities/developmentally disabled (ICF/DD). ADT notification is defined as any receipt of ADT feeds within the time period of the measure (can have just been initiated in the time period or can be long-standing). This is a point in time measurement captured as of the last day of the measurement period.

4.3 Percentage of acute hospital stay discharges which had follow-up ambulatory visits within 7 days post hospital discharge

Description
Percentage of members who had ambulatory visits within 7 days post hospital discharge
Eligible Population
• **Plan continuous enrollment criteria:** None

- All enrolled MCP Members
- See Addendum: Claims Data Run-Out

Calculation

Numerator: The number of acute care hospital live discharges among enrolled MCP members during the measurement period with an ambulatory visit within 7 days post hospital discharge

Denominator: The number of live discharges from acute care hospitals among enrolled MCP members during the measurement period

Technical Specifications

An ambulatory visit is defined as a visit with a primary care provider (MD, DO, NP, PA) or with a specialist (e.g. cardiology, nephrology) within 7 days of discharge. The day of discharge is considered Day 0. Members who die in the hospital are excluded from this measure. Discharges for Members who have given birth during the hospital stay are also excluded. Members who are discharged to a long-term care facility are excluded from this measure.

Numerator: Use the following value sets to identify ambulatory or preventive care visits 7 days post hospital discharge during the 6-month measurement period:

- Ambulatory Visits Value Set
- Other Ambulatory Visits Value Set
- Telephone Visits Value Set

Denominator:
Step 1: Identify all acute inpatient and observation stay discharges in the past 6 months through 8 days prior to the last day of the 6-month period. To identify acute inpatient and observation stay discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.

The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2: For discharges with one or more direct transfers, use the last discharge.

Step 3: Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4: Exclude hospital stays for the following reasons:

- The member died during the stay.
- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

4.4 Emergency Department (ED) Visits

Description

Rate of emergency department (ED) visits per 1,000 member months for members ages 21 and older who are eligible for ECM

Eligible Population

- **Plan continuous enrollment criteria:** None
- All MCP Members ages 21 years and older as of the date of discharge who meet the eligibility criteria for any ECM Population of Focus that is live during the measurement period.

IPP Modifications

- **Eligible Population:** Eligible for ECM during any month in the 6-month measurement period.
- See Addendum: Claims Data Run-Out

Source of Measure Specification

HEDIS® Ambulatory Care (AMB) (MY2021)

Calculation

Member months: Report all member months for members eligible for ECM during any month in the 6-month measurement period.

Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits during the 6-month measurement period for the denominator-eligible population using either of the following:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Exclusions
Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less. Exclude visits for mental health or chemical dependency that meet any of the following criteria: • A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set). • Psychiatry (Psychiatry Value Set). • Electroconvulsive therapy (Electroconvulsive Therapy Value Set). Exclude members in hospice or using hospice services anytime during the measurement period.
Notes
Supplemental data may not be used for this measure. In addition, supplemental data may not be used for the mental health and chemical dependency required exclusion.

4.5 Follow-Up After Emergency Department Visit for Mental Illness

Description
Percentage of emergency department (ED) visits with a discharge diagnosis of mental illness or intentional self-harm for members ages 21 and older and who are eligible for ECM who had a follow-up visit with any practitioner within 30 days of the ED visit (31 total days)
Eligible Population
• **Plan continuous enrollment criteria:** The date of the ED visit through 30 days after the ED visit (31 total days) • **Age:** 21 years and older as of the date of the ED visit
IPP Modifications
• **Eligible Population:** eligible for ECM during any month in the 6-month measurement period. • See Addendum: Claims Data Run-Out
Source of Measure Specification
HEDIS® Follow-Up After Emergency Department Visit for Mental Illness (FUM) (MY2021)
Calculation
Numerator Specifications:

30-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

Any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental

health disorder (Mental Health Diagnosis Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

Denominator Specifications: An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) during the 6-month period (through first day of last month), where the member was 21 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits and do not include more than one visit per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

Note

Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate

claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit).

Exclusions

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Exclude members in hospice or using hospice services anytime during the measurement period.

4.6 Follow-Up After Emergency Department Visit for Substance Use

Description

Percentage of emergency department (ED) visits with a discharge diagnosis of alcohol or other drug (AOD) use or dependence for members ages 21 and older and who are eligible for ECM who had a follow-up visit with any practitioner within 30 days of the ED visit (31 total days)

Eligible Population

- **Plan continuous enrollment criteria:** The date of the ED visit through 30 days after the ED visit (31 total days)
- **Age:** 21 years and older as of the date of the ED visit

IPP Modifications

- **Eligible Population:** Eligible for ECM during any month in the 6-month measurement period.
- See Addendum: Claims Data Run-Out

Source of Measure Specification

HEDIS® Follow-Up After Emergency Department Visit for Substance Use (FUA) (MY 2021)

Eligible Population

- **Plan continuous enrollment criteria:** The date of the ED visit through 30 days after the ED visit (31 total days)

- **Age:** 21 years and older as of the date of the ED visit

Calculation

Numerator Specifications:

30-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- OUD Weekly Non Drug Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- OUD Monthly Office Based Treatment Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- OUD Weekly Drug Treatment Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)

Denominator Specifications: An ED visit (ED Value Set) with a principal diagnosis of AOD or dependence (AOD Abuse and Dependence Value Set) during the 6-month measurement period (through first day of last month), where the member was 21 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits and do not include more than one visit per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

Note

Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit).

Exclusions

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission.

To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Exclude members in hospice or using hospice services anytime during the measurement period.

4.7 Access to Preventive/Ambulatory Services

Description

Percentage of members ages 21 and older and who are eligible for ECM who had an ambulatory or preventive care visit.

Eligible Population

- **Plan continuous enrollment criteria:** None
- **Age:** 21 years and older as of last day of the measurement period

IPP Modifications

- **Eligible Population:** eligible for ECM during any month in the 6-month measurement period.
- See Addendum: Claims Data Run-Out

Source of Measure Specification

HEDIS® Adults' Access to Preventive/Ambulatory Health Services (AAP) (MY2021)

Eligible Population

- **Plan continuous enrollment criteria:** None

- **Ages:** 21 years and older as of last day of the measurement period

Calculation

Numerator Specification: One or more ambulatory or preventive care visits during the measurement period.

Use the following value sets to identify ambulatory or preventive care visits during the 6-month measurement period:

- Ambulatory Visits Value Set
- Other Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set

Denominator Specification: The eligible population

Exclusions

Exclude members in hospice or using hospice services anytime during the measurement period.

4.8 Child and Adolescent Well-Care Visits

Description

The percentage of members 3-20 years of age and who are eligible for ECM who had at least one comprehensive well-care visit with a primary care provider (PCP) or an Obstetrics/Gynecology (OB/GYN) practitioner

Eligible Population

- **Plan continuous enrollment criteria:** None
- **Age:** 3 to 20 years as of last day of the measurement period

IPP Modifications

- **Eligible Population:** Eligible for ECM during any month in the 6-month measurement period.
- See Addendum: Claims Data Run-Out

Source of Measure Specification

HEDIS® Child and Adolescent Well-Care Visits (WCV) (MY2021)

Calculation

Numerator Specification: One or more well-care visits (Well-Care Value Set) during the 6-month period. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Denominator Specification: The eligible population

Exclusions

Exclude members in hospice or using hospice services anytime during the measurement period.

4.9 Follow-Up After Hospitalization for Mental Illness

Description

Percentage of hospital discharges for members ages 21 and older and who are eligible for ECM who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge (31 total days)

Eligible Population

- **Plan continuous enrollment criteria:** The date of discharge through 30 days after discharge
- **Age:** 21 years and older as of the date of discharge

IPP Modifications

- **Eligible Population:** Eligible for ECM during any month in the 6-month measurement period.
- See Addendum: Claims Data Run-Out

Source of Measure Specification

HEDIS® Follow-Up After Hospitalization for Mental Illness (FUH) (MY2021)

Calculation

Numerator Specification: A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.
Any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) ***with*** (Community Mental Health Center POS Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), ***with*** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider.

Denominator Specification: An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim during a 6-month period. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges during the 6-month measurement period.

Acute readmission or direct transfer: Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).
4. Identify the discharge date for the stay.

Nonacute readmission or direct transfer: To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

Note

Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Organizations whose billing

methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after discharge).

Exclusions

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after first day of the last month in the 6-month measurement period.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

Exclude members in hospice or using hospice services anytime during the measurement period.

4.10 Collaborations to Support Effective Care Transitions

Description (A)

Submission 3 Only

Establish collaborations with hospital, skilled nursing facility and long term acute care hospital partners to improve care transitions for Members entering, transferring, and being discharged from acute and post-acute care facilities.

The response must include how the MCP will develop processes, policies and protocols for contracted general acute care hospitals, long-term acute care hospitals and skilled nursing facilities to improve care transitions from and between their facilities and to the home and other community-based settings, specifically how the MCP is:

(1) Establishing discharge planning and care transition protocols for each of the facility types above. The MCP will submit planning meeting notes and/or emails that show progress towards this goal.

(2) Developing requirements for facilities to notify and communicate with ECM and other primary care providers to support seamless care transitions, including discharge summaries and medication lists upon discharge. The MCP will submit evidence of work to develop these requirements.

(3) Requiring contracted facilities to establish policies and procedures to support effective care transitions. The MCP will submit evidence of communications with contracted facilities.

(4) Demonstrating progress toward establishing periodic joint operating meetings (JOM) to review status of care transition practices and outcomes

(5) Developing contracting requirements that incorporate the above requirements into managed care contracts

Description (B)

Submission 4 Only

MCP will submit:
(1) Written protocols for discharge planning and care transitions for each of these facility types:

- General acute care hospital
- Long term acute care hospital
- Skilled nursing facility

These protocols should include requirements for facilities to notify and communicate with primary care, and coordinate continuity of care with prior PCP and ECM providers, including sharing of discharge summaries, care plans, and medication lists.

(2) Meeting notes or emails showing progress toward requiring facilities to establish policies and procedures to support effective care transitions

(3) Narrative describing plan to establish periodic JOM with facilities serving the largest proportion of members. *See Technical Specifications for a suggested methodology to identify facilities.*

Description (C)

Submission 5 Only

MCP will submit:
(1) Meeting minutes from joint operating meetings (JOM) with the top nine facilities as identified in Submission 4. If there are not nine facilities under the plan contract, submit JOM notes from 50% of the facilities contracted with the MCP in the county.

(2) Contract language requiring facilities to support care transitions, including protocols,

policies and procedures to support effective care transitions.

(3) MCP's plan to monitor effectiveness of care transitions.

Technical Specifications (A)

MCPs reporting for multiple counties should produce distinct, original responses for each county. Each narrative response should be submitted on a separate page, but responses are not limited to one page in length.

MCP's narratives will be scored based on inclusion of the following criteria:

1. Did the MCP provide an explanation of how it will collaboratively establish discharge planning and care transition protocols?
    a. Does the response describe collaboration with providers representing each of the specified facility types (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities)?
    b. If the MCP has no contracts with one or more of the specified facility types, does the response explain this fact?
    c. Does the response include attached meeting notes and/or email correspondence between the MCP and contracted providers showing sustained efforts during the measurement period to establish discharge planning and care transition protocols?
2. Did the MCP develop requirements for facilities to notify and communicate with primary care providers and ECM lead care managers to support seamless care transitions?
    a. Does the response specifically address requirements for sharing discharge summaries and medication lists?
    b. Does the response include attached work products (e.g., final or draft specifications documents, meeting notes, or emails, etc.) demonstrating progress towards defining, communicating, and enforcing these requirements?
3. Did the MCP require contracted facilities to establish policies and procedures supporting effective care transitions?
    a. Does the response demonstrate the facilities' receipt and understanding of these requirements?
    b. Does the response include attached communications (e.g., email correspondence, webinar materials, etc.) conveying these requirements to contracted facilities?
4. Did the MCP demonstrate progress toward establishing periodic joint operating meetings (JOM) to review status of care transition practices and outcomes?
    a. Does the response describe efforts to establish JOM through outreach to contracted facilities?
    b. Does the response describe the outcome of efforts to establish JOM, including

the number of JOM scheduled and held as of the last day of the measurement period?

5. Did the MCP develop contracting requirements that incorporate the above requirements into managed care contracts?
    a. Does the response describe efforts to develop contracting requirements which support effective care transitions for Members entering, transferring, and being discharged from acute and post-acute care facilities?
    b. Does the response describe the outcomes of these efforts, including successes and challenges as of the last day of the measurement period?
6. Did the MCP include a clearly labelled list of attachments as part of the narrative response?

Technical Specifications (B)

Suggested methodology for identifying facilities serving the largest proportion of Members for JOM purposes:

- Rank contracted facilities by population served, for each of the specified facility types (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities)
- Select the top three facilities in each facility type
- Create a plan to develop JOM with each of these nine facilities

If an MCP does not have contracts with nine facilities as described above, they should focus JOM efforts on 50% of their contracted facilities in each county served.

4.11 MCP Strategy for Provider Education, Training, and Technical Assistance (TA)

Description (A)

Submission 3 Only

Describe the MCP's strategy to provide comprehensive provider education and training on ECM and Community Supports to its entire contracted provider network.

The response must include how the MCP is supporting the following:

- Outreach and education on ECM and Community Supports for the MCP's entire contracted provider network in the county;
- Ongoing training and TA for the entire contracted provider network in the county on timely identification and referral of members eligible for ECM and Community Supports;
- Ongoing training and TA for the ECM and Community Supports workforce in the

county (including but not limited to billing, contracting, authorization for ECM services, Medi-Cal certification, workforce recruitment and retention, and cultural competency needs by county);
- Outreach to and education for local organizations that serve the eligible populations for ECM and Community Supports.

MCPs must provide details regarding (1) specific activities and steps taken to implement this plan during the measurement period, (2) proposed timelines/dates for TA/training offerings, and (3) clarification on whether TA/trainings are offered directly through the MCP, external sources, or other means (e.g. participation in local health fairs, conferences, roundtables, and workgroups).

MCPs are both allowed and encouraged to collaborate with other MCPs, providers, PATH Collaborative Planning Facilitators and other local partners in their communities when developing this strategy.

Description (B)

Submissions 4 and 5 (for new market entrant MCPs) Only

Demonstrate that the MCP provided a series of educational webinars/technical assistance (TA) sessions to its entire contracted network of providers during the measurement period focused on describing the ECM and Community Supports benefits and the process for submitting referrals and authorizations. The content of the webinar(s)/TA session(s) must include:

1) An overview of what ECM and Community Supports are;
2) Which Populations of Focus are eligible to receive ECM;
3) Information about which Community Supports are provided by the MCP;
4) How Providers can refer Members to ECM and Community Supports; and
5) The process the MCP follows to authorize ECM and Community Supports.

MCP must attest that it completed a series of educational webinars/TA sessions, as outlined above, and also respond to the quantitative measure prompt.

Calculation (B)

Numerator: Number of contracted providers in the county that have attended at least one educational webinar/TA session on ECM and Community Supports (as described in the measure description) during the measurement period

Denominator: Total number of contracted providers in the MCP's provider network in the county during the measurement period

Technical Specifications (A)

MCPs reporting for multiple counties should produce distinct, original responses for each county. Each narrative response should be submitted on a separate page, but responses are not limited to one page in length. Responses should focus on trainings and/or TA sessions

provided in-person or virtually.

MCP's narratives will be scored based on inclusion of the following criteria:

1. Did the MCP describe its plan to deliver outreach and education on ECM and Community Supports to all contracted providers in the county?
    a. Does the response describe specific outreach and education activities conducted during the measurement period?
    b. Does the response describe specific outreach and education activities planned for upcoming measurement periods?
2. Did the MCP describe its plan to deliver ongoing training and TA on the topic of "timely identification and referral of Members eligible for ECM and Community Supports" to all contracted providers in the county?
    a. Does the response include timelines/date for training and TA offerings, including those delivered during the measurement period and planned for upcoming measurement period(s)?
    b. Does the response specify whether training and TA was offered directly through the MCP, external sources, or other means?
3. Did the MCP describe its plan to deliver ongoing training and TA for the ECM and Community Supports workforce in the county?
    a. Does the response describe the topic areas covered, including but not limited to billing, contracting, authorization, Medi-Cal certification, workforce recruitment and retention, and cultural competency needs?
        i. Additional training and TA topics may be included, but should not substitute the minimum topics identified above.
    b. Does the response include timelines/date for training and TA offerings, including those delivered during the measurement period and planned for upcoming measurement period(s)?
    c. Does the response specify whether training and TA was offered directly through the MCP, external sources, or other means?
4. Did the MCP describe its plan to deliver outreach and education on ECM and Community Supports to local organizations that serve the eligible populations for these services?
    a. Does the response describe efforts by the MCP to assess and design effective engagement strategies for various types of local organizations?
    b. Does the response describe specific outreach and education activities conducted during the measurement period?
    c. Does the response describe specific outreach and education activities planned for upcoming measurement periods?

Technical Specifications (B)

MCPs should report on contracted providers in the entire network, not only providers directly

or indirectly involved with ECM and Community Supports. The goal of this measure is to increase awareness of ECM and Community Supports to the Plan's entire network, including information on eligibility criteria, referral pathways, authorization processes, and prospective provider information.

Numerator should include entire contracted provider network (not just ECM and Community Supports providers). MCPs should define "provider" at the provider contract level, counting providers for which at least one representative engaged in training/TA. Trainings and/or TA sessions must be attended by providers in-person or virtually. Do not count pre-recorded trainings or TA sessions.

Denominator should include entire contracted provider network (not just ECM and Community Supports providers). MCPs should define "provider" at the provider contract level and not individual clinicians or staff.

This is a point in time measurement captured as of the last day of the measurement period.

4.12 ECM provider network continuity for MCPs newly entering the Medi-Cal Managed Care market within a county, including MCP transitions from subcontracts to prime contracts

Description (A)

Submission 4 Only

For all MCPs operating in counties where at least one MCP will be exiting or entering the Medi-Cal Managed Care market as of 1/1/2024, inclusive of MCP transitions from subcontracts to prime contracts.

Submission of a managed care transition plan outlining the MCP's plan to:

1. Support the transition of MCPs exiting the Medi-Cal Managed Care market in the given county by December 31, 2023; and
2. Support and collaborate with MCPs entering the market or transitioning from subcontract to prime contract in the given county on January 1, 2024.

The transition plan should describe how MCPs:

1. Supported transition of and coordination and collaboration with ECM and Community Supports provider networks to promote continuity of care for the member population, including:
    a. Sharing the exiting MCPs' network rosters of currently and previously

contracted ECM and Community Supports providers, inclusive of provider contact information;
   b. Sharing the exiting MCPs' detailed documentation on plan-provider data exchange standards and protocols used to share member data with all currently contracted ECM and Community Supports providers;
   c. Facilitating meetings between the exiting and entering MCPs with all ECM and Community Supports providers contracted in the prior plan year (MCPs may leverage PATH Regional Collaborative Planning meetings to meet this requirement);
   d. Collaborating with other Medi-Cal MCPs operating in the county to align ECM and Community Supports authorization and referral processes and related data sharing requirements and specifications; and
   e. Facilitating meetings between the exiting and entering MCPs with all county and regional partners engaged in ECM and Community Supports collaboration, including county behavioral health providers, county offices of California Children's Services, local Continuums of Care, and local California Wraparound Hubs. (MCPs may leverage PATH Regional Collaborative Planning meetings to meet this requirement)
2. Supported coordination and transition of PATH funded activities (e.g., MCP engagement in the Collaborative Planning initiative);
3. Determined the needs and gaps in the county related to:
   a. Delivery system infrastructure;
   b. ECM provider capacity building;
   c. Community Supports provider capacity building and Community Supports take-up; and,
4. Communicated these needs and gaps to all incumbent, entering, or exiting MCPs in the county.

MCPs must also submit a signed attestation from MCPs both exiting and entering the county on January 1, 2024, as well as incumbent MCPs remaining in the county, indicating that the parties were provided opportunities to review, comment and provide input into the transition plan and describing their support for the transition plan.

Description (B)

Submission 5 Only

For all MCPs operating in counties where at least one MCP entered or exited the Medi-Cal Managed Care market at the end of CY 2023, inclusive of MCP transitions from subcontracts to prime contracts.

Did the MCP support transition of and coordination and collaboration with ECM and Community Supports provider networks for MCPs exiting and/or entering the county on January 1, 2024 by supporting transition of and coordination and collaboration with ECM and

Community Supports provider networks to promote continuity of care for the member population, including:

a. Sharing the exiting MCPs' network rosters of currently and previously contracted ECM and Community Supports providers, inclusive of provider contact information;
b. Sharing the exiting MCPs' detailed documentation on plan-provider data exchange standards and protocols used to share member data with all currently contracted ECM and Community Supports providers;
c. Facilitating meetings between the exiting and entering MCPs with all ECM and Community Supports providers contracted in the prior plan year; and
d. Facilitating meetings between the exiting and entering MCPs with all county and regional partners engaged in ECM and Community Supports collaboration, including county behavioral health providers, county offices of California Children's Services, local Continuums of Care, and local California Wraparound Hubs.

Calculation (B)

Numerator: As of January 1, 2024, number of unique ECM and Community Supports providers that (1) contracted with the MCP(s) entering the county's Medi-Cal market; and (2) contracted with the MCP(s) exiting the market after December 31, 2023

Denominator: Total number of unique ECM and Community Supports providers contracted with the MCP(s) exiting the market after December 31, 2023

Technical Specifications (B)

Numerator Specifications: Count of all unique ECM and Community Supports providers contracted with MCP(s) entering the county on January 1, 2024, AND contracted with MCP(s) that exited the county on December 31, 2023. MCPs should report on providers with contracts to offer ECM and/or Community Supports on January 1, 2024. Providers offering both ECM and Community Supports, or multiple Community Supports, should only be counted once.

Denominator Specifications: Count of all unique ECM and Community Supports providers contracted with MCP(s) that exited the county on December 31, 2023. MCPs should report on providers contracted with exiting MCPs with contracts to offer ECM and/or Community Supports on December 31, 2023. Providers offering both ECM and Community Supports, or multiple Community Supports, should only be counted once.

This is a point in time measurement captured as of the last day of the measurement period.

Addendum: Claims Data Run-Out

For baseline and subsequent measurement periods, apply a 60-day data run-out to performance reporting. For example, when reporting for Submission 3, claims received after September 1, 2023, may not be included in the rate calculation. Claims received after the 60-day data run-out may ***not*** be included in IPP reporting, even if the service date on the claim is during the measurement period.

Submission	Measurement Period	60-Day Data Run-out Date*
Submission 3	January 1, 2023 – June 30, 2023	September 1, 2023
Submission 4	July 1, 2023 – December 31, 2023	March 1, 2024
Submission 5	January 1, 2024 – June 30, 2024	September 1, 2024

**Claims received by the MCP after this date may not be included in IPP reporting for the specified submission*

DHCS recognizes that limiting IPP submissions to a 60-day claims run-out date may impact the completeness of data submissions due to claims lag. MCPs should work with providers and other sub-contractors to ensure timely receipt of claims.