APPENDIX A: Definitions of Commonly Used Terms

Term	Definition
Community Health Workers (CHW) Benefit	Starting July 1, 2022, Community Health Worker (CHW) services will be added as a Medi-Cal benefit. CHW services are preventive services, as defined in 42 CFR Section 440.130(c), for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and wellbeing. For more information, please visit the DHCS website.
Community Supports	Services that Medi-Cal managed care plans (MCPs) are strongly encouraged but not required to provide as substitutes for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. These services are sometimes referred to as "in lieu of services" (ILOS). For more information, please visit the DHCS website.
Disproportionate	In several Gap-Filling Progress Report measures, DHCS asks that MCPs identify which groups disproportionately experience certain events. This means identifying which groups have a higher probability of experiencing certain events than other groups, or, said differently, identifying which groups experience certain events at a higher rate than their proportion within a population.
ECM Care Team FTEs	The interdisciplinary team needed to appropriately provide care for the Member based on the Member's level of need. MCPs should determine which providers are necessary as part of the Member's care team.
Electronic Health Records (EHRs)	An Electronic Health Record (EHR) is an electronic version of a patient's medical history that is maintained by the provider over time and may include all of the key administrative clinical data relevant to that person's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports.

Enhanced Care Management (ECM)	A Medi-Cal managed care benefit that addresses clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management. For more information, please visit the DHCS website.
Gap-Filling Plan	Submission information associated with Payment 1 of the IPP that outlines MCP implementation approaches to addressing the gaps identified through the Needs Assessment. *Corresponds with Narrative Responses in the Gap-Filling Progress Report.*
Gap-Filling Progress Report	Submission information associated with Payment 2 and all subsequent Payments of the IPP, which demonstrates MCP progress against the Gap-Filling Plan that was developed for Payment 1. There are two components of the Gap-Filling Progress Report: 1. Narrative Reporting Template (this Word document) 2. Quantitative Reporting Template (Excel document)
Health Information Exchange (HIE) Bi-Directional Exchange	HIE enables health care providers and organizations to share health information electronically. For the purposes of Measures 2.1.1 and 2.1.5, there are two ways providers can demonstrate their capacity to engage in bi-directional data exchange: • Attest to being able to secure, bidirectional exchange to occur for every patient encounter, transition or referral, and records are stored or maintained in the EHR during the performance period in accordance with applicable law and policy; OR **Contract with a health information exchange organization that is able to meet this bi-directional exchange requirement in accordance with applicable law and policy.** See California's Data Exchange Framework for more guidance on applicable policies. *NOTE: MCPs do not need to submit copies of provider attestations or HIE contracts to DHCS, but should keep record of these items in the event they are requested by DHCS.*

Incentive Payment Program (IPP)	The CalAIM Incentive Payment Program (IPP) is intended to support the implementation and expansion of ECM and Community Supports by incentivizing managed care plans (MCPs), in accordance with 42 CFR Section 438.6(b), to: • Drive MCP delivery system investment in provider capacity and delivery system infrastructure • Bridge current silos across physical and behavioral health care service delivery • Reduce health disparities and promote health equity • Achieve improvements in quality performance • Encourage take-up of Community Supports
Local Partners	Refers to other community entities, including but not limited to other MCPs, county social services, county behavioral health, public health care systems, county/local public health jurisdictions, community based organizations (CBOs), correctional partners, housing continuum organizations, Tribes and Tribal providers, ECM providers, and others within the county.
Mandatory Measure	Mandatory measures are those to which MCPs must respond in order for the submission materials to be considered complete. There are both quantitative and narrative mandatory measures. **MCPs are required to respond to *ALL* mandatory measures.**
Narrative Responses	Measures within the Gap-Filling Progress Report that require a written, descriptive response and/or submission of attachments and reference materials.
Needs Assessment	Submission information associated with Payment 1 of the IPP that provides baseline data pertaining to ECM and Community Supports delivery system infrastructure, provider capacity, and Community Supports take-up. *Corresponds with Quantitative Responses in the Gap-Filling Progress Report.*

Optional Measure	Program Priority Areas 2-3 each have a set of optional measures. MCPs must select and respond to a minimum number of these optional measures for each Program Priority Area, as indicated in the instructions, for the submission materials to be complete. There are both quantitative and narrative optional measures—MCPs may not create their own measure or otherwise alter the measure options available. **MCPs are required to respond to *SOME* optional measures.** • **Program Priority Area 2: MCPs must select and respond to <u>five (5)</u> of the optional measures below:** o *2.2.6 (Narrative Response AND Submission):* Addressing health disparities through strategic partnerships o *2.2.10 (Quantitative AND Narrative Response):* Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings o *2.2.12 (Narrative Response Only):* Hiring of a full-time Health Equity Officer o *2.2.13 (Quantitative Response Only):* Plan 30-Day Readmissions (PCR) o *2.2.14 (Quantitative Response Only):* Ambulatory Care—Emergency Department Visits (AMB) o *2.2.15 (Quantitative Response Only):* Depression Screening and Follow-Up for Adolescents and Adults (DSF) o *2.2.16 (Quantitative Response Only):* Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS) o *2.2.17 (Quantitative Response Only):* Follow-Up After Emergency Department Visit for Mental Illness (FUM) o *2.2.18 (Quantitative Response Only):* Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) o *2.2.19 (Quantitative Response Only):* Controlling High Blood Pressure (CBP)

	○ *2.2.20 (Quantitative Response Only):* Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) • **Program Priority Area 3: MCPs must select and respond to <u>one (1)</u> of the optional measures below:** ○ *2.3.8 (Quantitative Response Only):* Asthma Medication Ratio (AMR) ○ *2.3.9 (Quantitative Response Only):* Housed individuals for more than 6 consecutive months ○ *2.3.10 (Quantitative Response Only):* Controlling High Blood Pressure (CBP) ○ *2.3.11 (Quantitative Response Only):* Comprehensive Diabetes Care (CDC)
PATH Collaborative Planning Initiative	Providing Access and Transforming Health (PATH) is a five-year initiative to build up the capacity and infrastructure of on-the-ground partners, such as community-based organizations (CBOs), public hospitals, county agencies, Tribes, and others, to successfully participate in the Medi-Cal delivery system as California widely implements Enhanced Care Management and Community Supports and Justice Involved services under CalAIM. PATH will fund regional collaborative planning and implementation efforts among managed care plans, providers, CBOs, county agencies, public hospitals, Tribes, and others to promote readiness for Enhanced Care Management and Community Supports. For more information, please visit the DHCS website.

Population of Focus (POF)	To be eligible for ECM, Medi-Cal members must be enrolled in managed care and meet certain criteria to fall within one of the below Populations of Focus (POFs): • Individuals and families experiencing homelessness • Adults, youth, and children who are high utilizers of avoidable emergency department, hospital, or short-term skilled nursing facility services • Adults with serious mental illness or substance use disorder • Children and youth with serious emotional disturbance, identified to be at clinical high risk for psychosis or experiencing a first episode of psychosis • Adults and youth who are incarcerated and transitioning to the community • Adults at risk of institutionalization and eligible for long-term care • Adult nursing facility residents transitioning to the community • Children and youth enrolled in California Children's Services (CCS) with additional needs beyond CCS • Children and youth involved in child welfare (including those with a history of involvement in welfare, and foster care up to age 26) For more information on POF eligibility criteria, please refer to the ECM Policy Guide.
Program Priority Area	Components of the IPP submission materials, which broadly categorize measures into the primary goals of IPP, including: 1. Delivery System Infrastructure 2. ECM Provider Capacity Building 3. Community Supports Provider Capacity Building and Community Supports Take-Up For more information, please refer to the IPP APL.
Quantitative Responses	Measures within the Gap-Filling Progress Report that require only a numerical response from MCPs. *Quantitative responses will be submitted via the* ***Quantitative Reporting Template.***

End of Section

APPENDIX B: Quality Measure References

The quantitative IPP measure set is a combination of DHCS-developed and externally developed measures. Where applicable, the table below provides references to measure specifications. Please note, the IPP measures draw on and are intended to align with specifications for other DHCS incentive and value-based care programs.

IPP Payment 2 Measure	Description	Specifications Reference[1]
2.1.1	Number and percentage point increase in contracted ECM providers that engage in bi-directional Health Information Exchange (HIE)	*Please refer to Health Information Exchange (HIE) Bi-Directional Exchange definition in Appendix A*
2.1.5	Number and percentage point increase in behavioral health providers with contracts in place to provide ECM that engage in bi-directional Health Information Exchange (HIE)	*Please refer to Health Information Exchange (HIE) Bi-Directional Exchange definition in Appendix A*
2.2.13	Plan 30-Day Readmissions (PCR)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.2.14	Ambulatory Care—Emergency Department Visits (AMB)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.2.15	Depression Screening and Follow-Up for Adolescents and Adults (DSF)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.2.16	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)	HEDIS® Measurement Volume 2 Technical Specifications for Health

[1] Please note that the measure specifications listed here are for reference only and not inclusive of the IPP-specific stratification, reporting period, or other specifications required for this program.

2.2.17	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.2.18	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.2.19	Controlling High Blood Pressure (CBP)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.2.20	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.3.8	Asthma Medication Ratio (AMR)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.3.10	Controlling High Blood Pressure (CBP)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.3.11	Comprehensive Diabetes Care (CDC)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans

End of Section